Nebraska Urology

5500 Pine Lake Road Lincoln, Nebraska 68516 (402) 489-8888 Fax (402) 421-1945

The physicians and staff of Nebraska Urology would like to welcome you to our facility. Please bring all completed forms with you to your appointment. You are scheduled for an appointment regarding infertility or a condition related. This is to inform you that **your insurance may or may not cover your services**. It is your responsibility to contact your insurance company to find out if you have coverage for this condition. Often lab work is done and prescriptions or medications are given that also may not be covered. We want you to be aware that the charges for the services provided will be your responsibility if it is deemed a non-covered benefit. Regardless of your insurance coverage, **we require a $150 payment due at check-in for this appointment and future related appointments**. Please be prepared to make this payment or your appointment will be rescheduled. If you have further questions, please contact our billing department at 402-489-8888 option 4.

Please arrive 30 minutes prior to your appointment time, this will allow us to make your experience here more pleasant and efficient. It is important for us to meet your medical needs; therefore, we request the following information for your appointment:

1) Medical information pertaining to your visit
2) List of your prescriptions or over-the-counter or herbal medications including doses
3) Lab results (urine cultures, PSA, blood work, etc.)
4) X-rays (actual films preferred)
5) Referrals or Pre-authorizations if required by your Insurance
6) All Insurance Cards (Medicare, Medicaid, etc.)
7) Photo ID (Driver's License, Military ID, etc.)
8) Guardianship if applicable

We are located on the NW corner of 56th & Pine Lake Road in Lincoln, Nebraska. If you have any further questions or concerns regarding the above information, please feel free to contact us at (402) 489-8888 and we will be happy to assist you.

Due to liability, we are unable to assist you to or from your vehicle. Please make arrangements if you need assistance. The nature of our practice is to give our patients the utmost in care and service, please plan plenty of time for your appointment.

Select prescriptions may be dispensed at Nebraska Urology's in-office dispensary. The in-office dispensary's hours of operation are the same as Nebraska Urology's hours.

Please Note: Due to the unpredictability of a surgical practice, our surgeons may be called to emergency surgery during your appointment time. Under these circumstances, you will see your physician's specific Urology-trained Physician Assistant or Nurse Practitioner.

We look forward to caring for you.

Nebraska Urology

Visit us at www.ne-urology.com.

(OVER ➔)

NEBRASKA UROLOGY/UROLOGY SURGICAL CENTER FINANCIAL POLICY

5500 Pine Lake Road, Lincoln, NE 68516 Phone: (402) 489-8888 Fax: (402) 421-1945

We would like to take this opportunity to welcome you to our office and to assure you that Nebraska Urology / Urology Surgical Center is committed to providing you with the best possible care. Please read the following information regarding our Financial Policy.

If you have insurance coverage we will file insurance claims with an assignment of benefits, with the exception of Medi-Share and other medical expense sharing plans. If necessary, a claim form will be provided for any unfiled claims. We participate with most major insurance companies. Please contact your insurance company directly if you have any questions regarding participation.

Please remember the following regarding insurance:

- Your insurance is a contract between you and your insurance company.
- Not all services are a covered benefit in all insurance policies.
- You are responsible for any balance due on your account.
- We reserve the right to pre-collect for any medical condition, regardless of coverage.

High Deductible Health Plan (HDHP):
If you have a HDHP (i.e. you do **not** have a copay when you visit your physician office) and your deductible is **unmet**, you will be asked to pay $50 at the time of check-in. The $50 will be applied toward the total cost of your care for the day and Nebraska Urology will bill you for the remaining balance. If you are uncertain if you have a HDHP, please be prepared to pay $50 at the time of check-in.

No Insurance Coverage/Self Pay:
If you have no insurance coverage or insurance information is not provided at check-in, you will be asked to pay $50 at the time of check-in. The $50 will be applied toward the total cost of your care for the day, and Nebraska Urology will bill you for the remaining balance.

Copays will be collected at the time of check-in.

There will be a $25 fee for any no show clinic appointments and a $50 fee for any surgery center procedure. This must be paid prior to rescheduling.

We accept cash, check, MasterCard, Visa, Discover and American Express. There will be a $25 charge on all returned checks.

Please contact our billing department promptly at **402-489-8888 option 4** if you have questions or are unable to pay your bill in full within 30 days of the first statement you receive. We offer monthly auto debit payment plans based on account balance and low interest bank loans upon request. We do use outside agencies as a means of collections should we deem it necessary.

Please remember to bring your current insurance card and any referrals required by your insurance. At your request, we can provide you an estimate of your financial obligations regarding any proposed treatment/surgery.

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NEBRASKA UROLOGY & UROLOGY SURGICAL CENTER – Patient Registration

Referring Physician: | **Today's Date**

Primary Care Physician: Address:

PATIENT INFORMATION

Patient's LEGAL Name

Last Name: | First: | M.I. | Birth Date: | Birth Sex: ❑ Male ❑ Female

Preferred Name: | Former/Maiden name(s):

Relationship Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated | SSN:

Street Address: | Billing Address (if different):

City | State | Zip Code | **Land Line:** ( ) ☐ Primary | **Cell Phone:** ( ) ☐ Primary

Email address:

Current Work Status: ❑ Full Time ❑ Part Time ❑ Retired ❑ Disabled ❑ Not Employed ❑ College Student

Occupation: | Employer Name | Address: | Work Phone & Ext.:

PRIMARY EMERGENCY CONTACT PERSON (SPOUSE, PARENT, SIGNIFICANT OTHER, ETC.)

Name: | Relationship:

Address: | Employer:

Home Phone: ( ) | Work Phone: ( ) | Cell Phone: ( )

SECONDARY EMERGENCY CONTACT PERSON (PARENT, CHILD, NEXT OF KIN, ETC.)

Name: | Relationship:

Address: | Employer:

Home Phone: ( ) | Work Phone: ( ) | Cell Phone: ( )

GUARDIANSHIP

Does someone have **court appointed guardianship** for patient? (bring paperwork) ❑ Yes ❑ No | Guardian Name: Phone:

Is this patient a Ward of the State? ❑ Yes ❑ No | Case Manager: Phone:

INSURANCE COVERAGE

Is this patient covered by insurance? ❑ Yes ❑ No **If yes, please complete appropriate insurance information below.**

MEDICARE COVERAGE (specify)

Is Medicare Primary? ❑ Yes ❑ No

Medicare #

Railroad Medicare #

Medicare (Hospital Only) #

Medicare Advantage Plan (Blue Advantage, Aetna Premier, etc.)

Plan Name:

Plan # | Group #

MEDICAID (WELFARE) COVERAGE

Is this patient covered by Medicaid? ❑ Yes ❑ No

NE Total Care #

Molina #

UHC Community Plan #

HOME HEALTH CARE

❑ Yes ❑ No

If Yes, list Provider:

PRIMARY or SECONDARY INSURANCE COVERAGE

Insurance Company & Address: | Primary Insurance: ❑ Yes ❑ No

Subscriber's Name | Subscriber's SSN | Subscriber's Date of Birth | Is this a Self/Individual Plan? ❑ Yes ❑ No

Member ID | Group # | Subscriber's Relationship to Patient | Subscriber's Employer

SUPPLEMENTAL or OTHER INSURANCE COVERAGE

Insurance Company & Address: | Primary Insurance: ❑ Yes ❑ No

Subscriber's Name | Subscriber's SSN | Subscriber's Date of Birth | Is this a Self/Individual Plan? ❑ Yes ❑ No

Member ID | Group # | Subscriber's Relationship to Patient | Subscriber's Employer

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What is your preferred pharmacy? _____ Location _____

Race/Ethnicity (circle one): **White** **Hispanic/Latino** **Black/African American** **Asian** **Multi-Racial** **Native American** **Decline to specify**

Preferred Language (circle one): **English** **Other** _____ ❑ Interpreter Required

Do you have an ACTIVE Medical Power of Attorney (This means that someone else makes medical decisions for you.)? **YES** **NO**

If yes, please indicate name, address & phone: _____

If yes, please provide a copy of the documentation _____

Is this urology medical condition due to an accident of any kind? **YES** **NO**

If yes, was it (choose one): **Work Related** **Auto** **Home** **Other**

MEDICARE PATIENTS ONLY 	1. Has the VA authorized and agreed to pay for your visit today? **YES** **NO** 2. Are you receiving benefits from a government research grant? **YES** **NO** 3. Do you have a Federal Black Lung Card? **YES** **NO** 4. Are you covered by a current employer's health insurance plan through you or your spouse's employer? **YES** **NO** 5. Are you entitled to Medicare because of disability or End Stage Renal Disease? **YES** **NO** *If patient marks yes to any of the above 5 questions or accident related question above, complete full MSPQ.

→ AUTHORIZATION TO TREAT

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

→ ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. I understand that I am financially responsible for all allowed charges or co-insurance amounts which are not paid by my insurance company in full within 30 days of the first statement received. I understand that not all services are a covered benefit in all insurance plans and that my insurance coverage is an agreement between me and my insurance company. Should I elect to proceed with a non-covered benefit service, I understand I am financially responsible. We offer monthly auto debit payment plans based on account balance and low interest bank loans upon request. We do use outside agencies as a means of collections should we deem it necessary.

→ ADVANCE DIRECTIVES

You have the right to have an advance directive, such as a living will or health care proxy. However, due to CMS regulations, our clinic and surgical center will suspend Advance Directives at our facilities. In the event of an emergency, we will attempt to stabilize you and transfer you to an acute care facility for evaluation and treatment as appropriate.

→ RELEASE OF INFORMATION TO INSURANCE COMPANY

I authorize Nebraska Urology and/or Urology Surgical Center to release to the Medicare carrier and/or the Insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to Nebraska Urology or Urology Surgical Center.

→ **NEBRASKA STATE LAW REGARDING MINORS -** Nebraska state law defines a minor as anyone 18 years of age and younger. These patients are required by this law to have a legal guardian present or if this is not possible, you must make prior arrangements with our office. If prior arrangements are not made, it could result in the appointment needing to be rescheduled.

→ I understand there will be a $25 fee for a no show appointment or returned check (See also Financial Policy) payable only by cash, money order, credit or debit card.

→ I understand the Patient Rights and Responsibilities are listed on Nebraska Urology's website at www.ne-urology.com and I may request a copy at any time. I hereby consent to receive calls, texts and emails from Nebraska Urology or any business associates Nebraska Urology has contracted with at the phone number(s) and email addresses provided or associated with my account. I understand that methods of contact may include pre-recorded or artificial message and/or use of an automated dialing system.

I understand that I will be responsible for all charges if the listed insurance information is not correct.

Signature_____ Date _____

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Nebraska Urology Health History

Name:	DOB:	Ht:	Wt:

Current Gender:	Gender Identity:	Preferred Pronoun:

REASON FOR VISIT:	Pharmacy Name & Address:

Have you had a flu shot? NO YES When? _____ **Pneumonia Vaccination?** NO YES When?_____

List all **CURRENT MEDICATIONS** and dose including over-the-counter, aspirin meds, fish oil, inhalers and vitamins. ☐ **None**

List all **ALLERGIES** to **medications** and your **reactions**. ☐ **None**

Allergy	Reaction	Allergy	Reaction
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown

Allergy to Latex? NO YES

Have you had a reaction to or do you have an allergy to iodine? NO YES

Have you ever had an antibiotic resistant infection

such as MRSA, VRE or CRE? NO YES if Yes circle, ACTIVE HISTORY OF

Please List all **PREVIOUS SURGERIES** ☐ **None**

Surgery	Surgery

Have you ever had a Colonoscopy? NO YES What year was it performed?_____

Personal Alcohol Use: None How Much:_____ How Often:_____

Personal Caffeine Use: None How Much:_____ How Often:_____

Tobacco Use: (please circle) Never Current Former Age Quit? _____

Type: Cigarettes Cigar Pipe Smokeless How much daily? _____

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Personal Past Medical History: (please circle appropriate answer)

Cancer: NO YES **Type of Cancer:**_____ **Treatment:** Surgery Chemo Radiation

Anemia: NO YES	**Arthritis:** NO YES	**Asthma:** NO YES
COPD/Emphysema/ Chronic Bronchitis: NO YES	**Diabetes:** NO YES If yes, do you take medication for this? NO YES	**Heart Disease (bypass/ stent, surgery):** NO YES
Heart Rhythm Problems: NO YES	**Hepatitis / Liver Disease:** NO YES	**High Blood Pressure:** NO YES
History of Seizure: NO YES	**History of Stroke or TIA:** NO YES	**HIV:** NO YES
Kidney Disease: NO YES	**Multiple Sclerosis:** NO YES	**Muscular Dystrophy:** NO YES
Osteoporosis: NO YES	**Pacemaker/Defibrillator:** NO YES	**Parkinson's:** NO YES
Systemic Lupus: NO YES	**Thyroid Problems:** NO YES	**Urinary or Kidney Stones:** NO YES

Family Cancer History: (Please indicate type and family member) ☐ None

	Cancer	Cancer	Cancer	Cancer
What family member?				
What type?				

☐ I was adopted and have no available health history.

Have you ever had a Total or Partial Joint Replacement NO YES

If yes, What joint? _____ When was surgery?_____

If yes, have you been told to take antibiotics prior to surgery or dental procedures? NO YES

Anyone in your family have issues with anesthesia: NO YES

Do you have sleep apnea? NO YES

If yes, do you use a CPAP machine at night? NO YES

If patient is 19 or younger:

Was patient born prematurely? NO YES If yes, how many weeks early?_____
Any developmental delays as a child? NO YES

Signature/Form Completed by: _____ Date: _____

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5500 Pine Lake Road ·Lincoln, NE 68516

Name: _____
Date of Birth: _____
Date: _____

MARITAL HISTORY

1. Patient's Age _____ Previous Marriage _____ Any Children _____
2. Wife's Age _____ Previous Marriage _____ Any Children _____
3. Year's Married _____ Duration of Infertility _____
4. Contraceptive Measures _____
5. Coital Lubricants _____
6. Premature Ejaculation _____
7. Frequency of Intercourse _____
8. Wife's Evaluation: _____ Physician: _____
   Any Abnormalities: _____
   _____

PERSONAL HISTORY

- ☐ Undescended Testes
- ☐ Venereal Disease
- ☐ Urinary Tract Infection
- ☐ Testicular Swelling/Trauma
- ☐ Irradiation, Chemicals
- ☐ Tight Shorts
- ☐ Allergies _____
- ☐ Mumps
- ☐ Prostatitis
- ☐ Epididymitis
- ☐ Diabetes
- ☐ Sauna or Tub Bath
- ☐ Fever 101° in Past 3 Months
- ☐ Blood Transfusion

SOCIAL HISTORY

Occupation _____
Alcohol _____ Quantity _____
Smoking: Tobacco _____ Marijuana _____
Recreational Drug Use _____ Type _____

FAMILY HISTORY

Family History of Cystic Fibrosis Yes _____ No _____

PRIOR EVALUATION

Semen Analysis Yes _____ No _____, if yes, please have results faxed to 402-421-1945

PRIOR INFERTILITY THERAPY

_____