

WELCOME TO MICHIGAN UROLOGICAL CLINIC

We are pleased to welcome you to our office. We believe that building a long-term relationship between the doctor and patient provides the best care. We hope to build that relationship with you and your family for years to come. This goal will be accomplished by continuing to improve our level of service and commitment to quality care, today and in the future.

ABOUT YOUR VISIT

NEW PATIENTS

Please arrive 15 minutes early for your first appointment with your completed new patient forms if they were not returned prior to your appointment. **Please bring a photo id and all insurance cards, along with the names of current medications and medical history.**

In most cases you will also be asked to supply us with a urine specimen upon arrival for your appointment.

Any recent X-rays or imaging studies pertaining to your appointment should be brought with you to your appointment.

RETURNING PATIENTS

Please provide your current insurance card upon arrival. Please inform our receptionist of any changes to your insurance coverage, or any address or contact information updates.

RESCHEDULING APPOINTMENTS

If you are unable to keep your appointment, please call our office as soon as possible so that we may reschedule your visit.

Please provide at least 24-hour notice.

OFFICE HOURS/TELEPHONE CALLS

Our office hours are 8:00 am to 5:00 pm Monday through Friday. Phones are answered Monday through Friday from 8:30 am to 12 noon and 1:15 to 4:45 pm. For patients who call during office hours with an urgent medical concern, our policy is to schedule them with a provider the same day or during extended hours. Calls after hours should be reserved for emergencies only.

PRESCRIPTION REFILLS

Please If you require a refill between appointments, please call during regular office hours. Please follow these guidelines:

-Provide your name and phone number, medication name and dosage, pharmacy name and phone number.

-Please allow 24 hours to renew your prescription.

-If you have not been seen in our office recently, we may not be able to refill your prescription over the phone and an office visit may be required.

-Medication will not be refilled evenings or weekends except in emergencies.

OUR FINANCIAL POLICY

Insurances - We will bill your insurance carrier as a courtesy to you. Co pays, office visits and deductibles not covered by your insurance company are due AT THE TIME OF YOUR APPOINTMENT. Your insurance coverage is a contract between you and your insurance company and not a substitute for payment. **CO-PAYMENTS WILL BE COLLECTED AT YOUR APPOINTMENT**

Pre-authorization

It is important that you understand your insurance companies requirements for payment. Pre-authorizations are becoming a requirement for many insurance companies. While we are here to assist you in securing a pre-authorization for a procedure or surgery, it is important that you understand your insurance's requirements, as you are ultimately responsible for payment of your services at Michigan Urological Clinic.

Self-pay accounts

Self-pay accounts are patients that have no insurance coverage, have not met their deductible or are covered by insurance plans we do not participate with. **Payment must be made at the time of service.** If this is not possible please discuss the situation with our billing department before your scheduled appointment. Private pay patients must make a deposit on their procedure prior to scheduling.

Payment Methods

For your convenience, we accept the following methods of payment: Cash, Personal and Certified Checks, Visa, Master Card, Discover and debit cards. All returned checks will be subject to a \$15.00 fee and applied to the account balance.

MICHIGAN UROLOGICAL CLINIC, P.C.

PROVIDER NOTICE OF INFORMATION PRACTICES

Uses and disclosures of health information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may use or disclose your health information to provide you with appointment reminders (such as voice mail message, postcards or letters).

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting areas and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you a fee of \$25.00 to copy your record and will require up to fourteen days (14) to make the copies. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. We do have the right to deny your request under certain circumstances.

You may request in writing that we do not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances.

We will consider your request but we are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are described in this notice.

Acknowledgment

You acknowledge receipt of this *PROVIDER NOTICE OF INFORMATION PRACTICES* by signing your name to the signature page provided in this packet. Your signature will be kept on file at our office with your patient records.

If you have any questions or complaints, please contact:

Office Manager

4047 Saladin S.E. Grand Rapids, MI 49546

Phone: (616) 956-9577

SIGNATURE PAGE

Patient name (please print) _____ date of birth _____

Privacy Practices and HIPAA

(Our *Provider Notice of Information Practices* are included in this packet)

I hereby acknowledge that I have been offered a copy of Michigan Urological Clinic, P.C.'s Notice of Privacy Practices.

Signature _____

(Parent/Guardian signature if patient a minor) _____

AUTHORIZATION AND RELEASE

I hereby authorize payment to **Michigan Urological Clinic, P.C.** for medical services rendered to me or others covered by my insurance company. I authorize the release of such information as may be necessary for the billing office to file claim(s) for payment. I understand the financial policy and accept personal responsibility for payment of covered and non-covered services.

PATIENT SIGNATURE _____ DATE _____

(If patient a minor, Parent or Guardian to sign)

Release of Information

YES: ___ I authorize the physicians and staff of **Michigan Urological Clinic** to leave information at the designated phone number, and/or answering machine regarding my care including (but not limited to), scheduled appointments, lab and x-ray reports.

NO: ___ I do NOT authorize the physicians and staff at **Michigan Urological Clinic** to leave information regarding my health career scheduled appointment on an answering machine or given to any person except myself.

I hereby grant permission to **Michigan Urological Clinic, P.C.** release my protected health information to the following family members and/or friends who may be involved in my care:

PLEASE PRINT

__ Spouse (Name) _____

__ Parent(s) Name _____

__ Other (Name/Relation) _____

_____ (patient signature) _____ (date)

MICHIGAN UROLOGICAL CLINIC, P.C. Patient Specialist Partnership Agreement

At **Michigan Urological Clinic**, our goal is to provide you with the highest standard of healthcare. This can happen by establishing us as your Patient-Centered Specialty Care physician in partnership with your Primary Care Physician (PCP) who acts as your Patient Centered Medical Home (PCMH). Below are some guidelines for us to make the best of our care partnership:

PHYSICIANS:

- We will identify your Primary Care Physician (PCP) and coordinate your care directly with your PCP in a timely manner.
- We will have open and honest discussions regarding your health and plans for managing your care either by following up with your PCP and/or with our office.
- We will be available to you by phone and in the office to answer your questions and concerns as they arise.

PATIENTS:

- Follow up with your Primary Care Physician as directed.
- Make and keep all recommended appointments with our office and with your PCP. If you must cancel an appointment, make every attempt to reschedule it as soon as possible.
- Be sure you understand the treatment plan. If you do not understand, ask questions until you feel comfortable with what you need to do after leaving our office.
- Commit to following the treatment plan we discussed during your appointment.
- If you are not able to follow the treatment plan for any reason, tell us immediately so we can assist you in adjusting the plan so you get the best results.

If it is determined by your primary care physician that our practice should continue to be involved in the management of a specific condition, the following guidelines will apply:

PHYSICIANS:

- We will coordinate your care with your PCP by communicating directly to your PCP in a timely manner. Your PCP will be informed of your treatment plan and goals to assist you in coordinating all your health care needs.
- We will provide you with information; help you to learn how to self-manage your condition, and assist you with establishing goals for the chronic condition we are managing along with your PCP.
- We will be available to you by phone and in the office to answer your questions and concerns as they arise.
- We will work with you to set up a plan to best manage your chronic condition. We will also help you to create a plan for any other urgent health care need that may arise related to your chronic condition.

PATIENTS:

- Be sure you understand and commit to the treatment plan we have made to manage your condition. If you do not understand, ask questions until you feel comfortable with the treatment plan.
- If you are not able to follow the treatment plan for any reason, tell us immediately so we can assist you in adjusting the plan so you get the best results.
- Inform your PCP of any concerns in managing your overall health or with coordinating your care.

PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT

Michigan Urological Clinic

A Professional Corporation

4047 Saladin Dr. S.E
Grand Rapids, MI 49546
(616) 956-9577 FAX (616) 956-5988

George G. Carothers, D.O., F.A.C.O.S.
Thomas J. Maatman, D.O. F.A.C.S., F.A.C.O.S.
Kenneth F. Shockley, D.O., F.A.C.O.S.
Christopher M. LaFlure, PA-C.

You have an appointment on _____ at _____ AM / PM at the following location:

_____ Michigan Urological Clinic 4047 Saladin Dr. SE Grand Rapids, MI 49546 616.956.9577

_____ Sparrow Carson Hospital Urology Clinic
406 E. Elm Street
Carson City, MI 48811
Phone: 989.584.3131

_____ Sheridan Hospital Urology Clinic
301 N. Main Street
Sheridan, MI 48884
Phone: 989.291.3261

_____ Spectrum - Kelsey Hospital Urology Clinic
418 Washington Avenue
Lakeview, MI 48850
Phone: 989.352.7211

_____ Metro Health Cedar Springs
Urology Clinic
14211 White Creek Road
Cedar Springs, MI 49319
Phone: 616.252.6300

PATIENT INFORMATION (Please print or type) Single__ Married__ Widowed__ Divorced__ Separated__

Name _____ Date _____

Address _____ City _____ State _____ ZIP _____

Seasonal Address _____ City _____ State _____ ZIP _____

Phone _____ (home) _____ (work/cell) email _____

Sex _____ Date of birth _____ Social Security # _____

Emergency Contact _____ Relationship _____ Phone _____

If patient is a minor:

Parent's name _____ Phone _____ (home/cell)

Address if different from patient _____

Primary Care physician's name _____ Physician's Phone No. _____

Address _____ City _____ State _____ Zip _____

Were you referred by your Primary Care Physician? Yes _____ No _____

If not, who referred you to our practice? _____

Referring Physician's address and phone number _____

Preferred Pharmacy _____ Phone _____

What is the chief problem that brings you to the Clinic? _____

How long have you had the problem? _____

INSURANCE INFORMATION

Primary Insurance

Secondary Insurance

Insurance Company _____	Insurance Company _____
Policy # _____	Policy # _____
Group # _____ Copay \$ _____	Group # _____ Copay \$ _____
Subscriber's name _____	Subscriber's name _____
Relationship to patient _____	Relationship to patient _____
Birthdate ___/___/___ SSN _____	Birthdate ___/___/___ SSN _____

SOCIAL HISTORY

Tobacco? _____ amount per day _____ If not smoking now, previously? _____

Alcohol? (amount per week) _____ Caffeinated beverages per day _____

PAST HOSPITAL & SURGICAL HISTORY

Year	Diagnosis	Surgeries (if any)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER SERIOUS ILLNESSES:

Year	Diagnosis
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY: (list parents and all brothers and sisters)

	Living?	Age	State of Health or Cause of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
_____	_____	_____	_____

Is there a family history of any of the following in a blood relative? (please check)

_____ Alcoholism _____ Migraine _____ Diabetes _____ Epilepsy _____ High Blood Pressure
_____ Tuberculosis _____ Glaucoma _____ Stroke _____ Nervous Breakdown _____ Heart Attack before 60
_____ Kidney stones _____ Kidney failure _____ Breast Cancer _____ Colon Cancer _____ Prostate Cancer
_____ Other Cancers (specify) _____ _____ Others (specify) _____

MEDICINES: List all medications that you have been taking recently

(Please include all vitamins as well as prescribed medicine)

1. _____	7. _____
2. _____	8. _____
3. _____	9. _____
4. _____	10. _____
5. _____	11. _____
6. _____	12. _____

ALLERGIES: List all medications and other substances to which you are allergic.

X RAY STUDIES: Have you had any of the following x-ray studies? List most recent studies.

	Year	Results (if known)	Test location
Kidney	_____	_____	_____
Chest	_____	_____	_____
CT Urogram	_____	_____	_____
Others	_____	_____	_____

PATIENT QUESTIONNAIRE:

Symptom	Yes	No	If Yes, Explanation
Frequent Urination			How many times:
Urinate at night			How many times per night:
Burning with urination			How many times per day:
Inability to urinate			Date:
Bladder infection/UTI			Date:
Blood in urine			Date:
Kidney stones			Date:
Kidney infection			Date:
Leakage of urine			pads per day:
Cancer			Type/date:
Erectile dysfunction			
Sexually transmitted diseases			Type:
Weight loss			How much:
Fever/chills			Date:
Night sweats			Date:
Constipation/diarrhea			BM/week:
Blood in stool			Date:
Cirrosis			
Hepatitis			Type:
Ulcers			
Chest pain			Date:
Irregular heartbeat			
Artificial heart valve			Type:
Heart Disease			
High blood pressure			
Swelling of the legs or feet			
Shortness of breath			
Coughing up blood			Date:
Fainting spells			Date:
Stroke			Date:
Numbness			
Enlarged Glands			Location
Bone pain			Location
Blurred vision			
Depression			
Increased stress			
Diabetes			Type:
Difficult child deliveries			Date: