Oxford Urology Patient Information

Date: _____

Name: _____ **Age:** _____ **Birth Date:** _____

How did you hear about us? _____

Current Symptoms: _____

Allergies: (medication allergies, X-Ray dye allergies) _____

_____

Surgeries: _____

_____

Do you have an implanted device? (ex. Pacemaker, Defibrillator, InterStim, etc) YES NO

Do you have the card for this device? YES NO

Do you take Nitroglycerin for chest pain? YES NO

Do you have a medical condition that requires prophylactic antibiotic treatment prior to any procedure being performed (artificial joint, mitral valve prolapse or heart valve)? If yes, please explain:

_____

Past Medical History: (Circle those that apply)

Autoimmune Disorder
Arthritis
Artificial joint/ joint replacement
Bleeding disorder/ blood transfusion
Personal Cancer history _____
Lung Disease : Oxygen or CPAP
Diabetes
Skin disorders
Heart disease, heart attack, stroke, congestive heart failure
Gastric reflux/ Ulcers
Eye disorders/ glaucoma
Liver disease
High blood pressure/ High cholesterol
Psychiatric illness
Kidney disease/ kidney failure/ dialysis
Thyroid disease
Ear, nose, throat problems
Seizures

Family History:

Diabetes	YES	NO	Bladder Cancer	YES	NO
Heart Disease	YES	NO	Kidney Cancer	YES	NO
Lung disorders	YES	NO	Prostate Cancer	YES	NO
Renal disease/failure	YES	NO	Penile/Testicular Cancer	YES	NO
Kidney Stones	YES	NO	Other Cancer	YES_____	NO

Family Member :_____ History of: _____

Social History:

Current Smoker? YES NO Prior Smoker? YES NO
Packs per day? _____ How many years? _____How many years quit? _____
Do you drink alcohol? YES NO How often? _____ Illegal drugs? YES NO
Occupation/Former Occupation: _____

Patient Signature: _____
Physician Signature: _____ **Date:** _____

06/03/2021wr

Oxford Urology Associates, PLLC

D. Land Renfroe, M.D. Brent M. Hardin, M.D.

Joshua G. Griffin, M.D. Andrew R. Gowdey, M.D. James R. Hardin, M.D.

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Lisa Clark, FNP-BC Darian Wales, FNP-BC

Patient Information

Patient's Name (First)_____(Middle)_____(Last)_____

Mailing Address_____City_____State_____Zip_____

Home Phone _____Cell Phone _____ Social Security #_____

Sex: M or F Marital Status_____ Date of Birth _____ Age _____

Employer _____ Work Phone: _____

In an emergency call_____ Relationship:_____ Phone: _____

Primary Physician_____Phone #_____

Pharmacy_____City_____

Email Address_____

Spouse/Parent/Responsible Party Information

Name _____Date of Birth_____

Address _____City_____State_____Zip_____

Social Security #_____Home Phone_____Cell Phone_____

Employer _____ Work Phone_____

Insurance Information

Primary Insurance _____Insured Person's Name_____

ID # _____Relationship_____ Insured Person's Date of Birth _____

Secondary Insurance _____Insured Person's Name_____

ID #_____Relationship_____ Insured Person's Date of Birth _____

****Please allow receptionist to copy all insurance cards and picture ID after completion of paperwork****

Signature of Patient or Legal Representative_____

Today's Date _____

You must pay your copay and any coinsurance at each visit. You must pay any deductible or coinsurance BEFORE any office procedure, CT, or surgery is performed.

Financial Responsibility

Oxford Urology participates in the Medicare and Mississippi Medicaid programs as well as other commercial insurance products. We do not participate in some HMO plans. If the clinic participates in your insurance plan you will be responsible for all copays, deductibles, and coinsurance amounts at the time of service. You will also be responsible for any services not covered by your insurance plan. **You must bring your insurance card(s) to every visit.**

If the clinic does not participate in your insurance, you will be considered Self Pay. You will be required to pay $250.00 deposit on your first visit which will be applied to your charges. If you have any questions regarding the networks we participate in, please ask prior to being seen.

If you do not have any insurance, you will be required to pay a $250.00 on your first visit which will be applied to against your charge. This must be paid before you are seen. All future charges should be paid at time of service unless you work out other payment arrangements with our billing staff. We do offer patients with no insurance coverage a discount when charges are paid in full at time of service. Please ask any of our billing or check out staff about this discount.

You understand that you are financially responsible for all Clinic charges unless covered and paid by your third-party insurance as explained above. If you should default on your financial responsibility, you understand that your account may be turned over to a collection agency. If this occurs, you may be charged for all reasonable collection fees incurred by the Clinic. You consent to receive communications regarding your account from the Clinic or its collectors by any phone number(s) you provide including cell, employer, and home landline numbers.

The clinic reserves the right to charge patients a no-show fee who continually do not show up for appointments.

The Clinic reserves the right to charge patients a fee for returned checks.

Consent for Treatment

The undersigned authorizes the physician assigned to furnish medical and/or surgical treatment of those means he/she considers necessary and proper in the treatment of the patient identified below while a patient of Oxford Urology Associates, PLLC. This treatment may require diagnostic procedures including but not limited to laboratory testing, blood drawing for those test(s), CT scans, Ultrasound, Urodynamics, etc.

Assignment of Benefits

Medicare and Medicaid: You hereby request that the payment of authorized Medicare/Medicaid benefits for services rendered by the Clinic on your behalf, shall be made to the Clinic, and you specifically assign such benefits to the Clinic. You hereby certify that all information given by you in connection with applying for such benefits is correct and complete in all respects. You understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid Programs to pay any and all copays, coinsurance, and deductibles upon demand by the Clinic, including at the time of service.

Commercial Insurance: You hereby assign to the Clinic all rights, benefits, and interest under any insurance policy, health plan, or workers compensation plan in consideration for services rendered by the Clinic. You hereby authorize payment of such benefits directly to the Clinic for treatment you receive by the Clinic. You understand that you are required to pay any and all copays, coinsurance, and deductibles upon demand by the Clinic, including at the time of service.

Disclaimer: Oxford Urology utilizes an independent lab for lab services/pathology. The billing is independent of Oxford Urology Associates, PLLC. It is your responsibility to determine whether the independent lab is in-network with your insurance. I also acknowledge if any CAT Scans are performed here in the office, I will receive a separate bill from Radiology Associates for their interpretation.

Consent to Release Health Information for Billing and Payment Purposes

You hereby consent to the release of your health information by the Clinic for the purpose of obtaining authorization and payment of services rendered to you by the Clinic. Your consent does NOT waive your privacy rights under federal law (known as the Health Insurance Portability and Accountability Act, or HIPAA).

_____ _____

Patient or Guardian Signature **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see our record or get more information about it by contacting the Clinic Administrator.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or Legally authorized individual signature Date Time

_____ _____

Printed Name if signed on behalf of the patient Relationship to Patient
(Notation, if any, by staff)

Telephone Message Authorization

I **DO** **DO NOT** authorize Oxford Urology Associates to leave a detailed message on my
(Circle one)
home and/or cell telephone. **Initials_____**

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

_____ _____ _____

Print Name of person/organization Relationship to Patient Phone Number

_____ _____ _____

Print name of person/organization Relationship to Patient Phone Number

NO SHOW/CANCELLATION POLICY

In order to provide the best care in a timely manner we ask that you give 48 hour notice if you will not be able to keep your scheduled appointment/procedure. Those not giving adequate notice may be assessed a $250.00 cancellation fee. By signing you acknowledge Oxford Urology Associates cancellation policy.

_____

Patient or Legally authorized individual signature

OXFORD UROLOGY ASSOCIATES MEDICATION RECONCILIATION SHEET

PATIENT NAME:_____DATE OF BIRTH_____

			date/initial	date/initial	date/initial	date/initial	date/initial
Medication name	**dose**	**frequency**					
							9-22-15mb