Welcome Letter

THE UROLOGY GROUP
Advanced Care. Improving Lives.

Dear Patient:

We would like to take this opportunity to welcome you to our practice. We look forward to meeting you and providing the highest quality urologic care. To facilitate your appointment, we ask that you please take a few moments and complete the enclosed forms. By doing this prior to your office visit, we hope to make your visit as efficient as possible.

Our Norwood office will call you to get your medical information 2-3 days prior to your appointment. If you do not receive this call 24 hours before your appointment, please call 513-841-7410.

We need you to bring the following to your appointment:

- Completed forms
- Insurance cards
- Driver's license or picture ID
- Insurance co pay
- List of medications and allergies
- CD disk or x-ray forms, if performed, relating to your current problem

If your insurance requires a referral or pre-authorization when seeing a specialist, please contact your primary care physician and confirm this has been completed.

We appreciate your taking the time to help us streamline your visit and serve you as efficiently as possible. If you have any questions or need any assistance, please call our office. We will be happy to help you in any way we can.

We are looking forward to meeting you.

Sincerely,

The Urology Group
2000 Joseph E. Sanker Blvd.
Cincinnati, OH 45212

Registration Form

THE UROLOGY GROUP
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Patient Name: _____ Age _____ Date of Birth _____
LAST FIRST MI

Please circle: Male / Female Marital Status: Single Married Divorced Surviving Spouse

Address: _____ ☐ Home Phone: _____

City / State / Zip: _____ ☐ Work Phone: _____

Social Security #: _____ ☐ Cell Phone: _____
(Mark Primary Number)

Email: _____

Employer: _____ Occupation / Dept.: _____

Employer Address: _____

Are you in Hospice? _____ Name of Facility: _____

Do you live in a Nursing Home? _____ Address of Facility: _____

Emergency Contact: _____ DOB: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Spouse Name: _____ Date of Birth _____
LAST FIRST MI

Social Security #: _____ Employer: _____ Occupation: _____

Address: _____

Person Responsible for Charges? _____
(If patient has a legal Guardian) Name Home Phone Work Phone

Family Physician: _____ Reason for Appointment: _____

Referring Physician: _____ Address: _____

Drug Allergies: _____ Latex Allergy? _____

Pharmacy: _____ Phone: _____

Primary Insurance: _____ Policy #: _____ Group #: _____

Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Today's Date: _____

(Please turn over)

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at each time of service exactly what those guidelines are. Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work, x-rays, or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. As the policy holder, YOU ARE RESPONSIBLE for knowing the benefits and restrictions of your insurance coverage.

WAIVER: I understand that should my insurance company require a REFERRAL/AUTHORIZATION prior to my receiving Medical Service and I have not obtained this and/or this office has not received this, I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

I understand that should it become necessary to place my account with an outside collection agency there will be an **additional 30% late fee** added to my delinquent balance.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Signature:_____ Date: _____

*A $35.00 charge will be collected for all RETURNED CHECKS.
**A $35.00 charge will be collected for all DECLINED CREDIT CARDS.

Medicare Lifetime Signature on File

_____
Name of Beneficiary

_____
HIC Number

I request that payment of authorized Medicare benefits be made either to me or on my behalf to TRI STATE UROLOGIC SERVICES, P.S.C., INC. for any services furnished me by TRI STATE UROLOGIC SERVICES, P.S.C., INC. or their contracted agents PeriOp Anesthesia, P.S.C. or Professional Radiology Inc. or Southern Ohio Pathology. I authorize any holder of medical information about me to release the Center for Medicare/Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medical assigned cases, the physician agrees to accept the charge determination of the Medical carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. In Medicare non-assigned cases, the patient is responsible for the entire charge.

Patient Signature:_____ Date: _____

_____
Witness if signed with an “X”

Acknowledgement of Receipt of Notice of Privacy Practices

I_____acknowledge that either ***[Please check appropriate box].***

☐ I have received a copy of Tri State Urologic Services P.S.C., Inc dba The Urology Group/The Urology Center's Notice of Privacy Practices.

or

☐ I declined the offered copy of Tri State Urologic Services P.S.C., Inc dba The Urology Group/The Urology Center's Notice of Privacy Practices.

This notice describes how Tri State Urologic Services P.S.C., Inc dba The Urology Group/The Urology Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

BY CHECKING ONE OF THE BOXES BELOW, YOU CAN AUTHORIZE US TO DISCLOSE INFORMATION (OR RESTRICT ANY SUCH DISCLOSURES) YOU MAY:

☐ Leave messages on my answering machine or voicemail: ☐Home, ☐Office, ☐Cell, ☐Voicemail

☐ Leave information with anyone who answers my home phone.

☐ My health Information can be left/discussed with the following Individuals:

First Name	Last Name	Relationship to patient	Phone number

☐ Do not give/leave information with anyone other than myself **(This will exclude your information from spouses, significant others, parents, children or any other family member)**

(Signature of patient or Personal Representative) (Date)

Relationship to Patient

Financial Policy

THE UROLOGY GROUP
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All copays are due at the time of service.

Self-Pay patients are expected to pay for office services at the time of their appointments unless other arrangements have been made **prior** to the appointment.

Patient balances for Hospital Charges are due upon receipt of the initial statement. It may be possible to set up a payment plan but the Business Office must be contacted first. **We do not accept any random payments received as a negotiated agreement.**

Statements are sent on a monthly basis for patient balances.

If there is no response from the second statement, a final letter is sent allowing 10 days for payment in full and states that the account may be placed with an outside collection agency.

A **30% Late Fee** will be added to any account that is turned over to an outside collection agency.

There is a $35 NSF charge for all returned checks.

There is a $35 charge for all DECLINED credit cards.

Revised 09/10/12

THE UROLOGY GROUP
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THE UROLOGY GROUP
RESEARCH INFORMATION FORM

The Urology Group is one of the leading clinical research centers in the country in the area of urology. This is both positive for our patients and society as a whole. By participating, you may receive novel new treatments and closer monitoring of your condition. You are routinely not charged for these services during your study participation and are commonly compensated for your time and travel.

If you would be interested in participating and would qualify for a specific trial we would like to call and discuss additional information with you. Signing below shows your interest. We will contact you or you may also call us at 513 841-7550. You may request a list of our studies by calling this number or by going to our website www. urologygroup. com and clicking on the clinical trials tab.

DOB: _____

Patient Name: _____

Signature: _____

TRI STATE UROLOGIC SERVICES P.S.C., INC. dba THE UROLOGY GROUP
NONDISCRIMINATION NOTICE

Tri State Urologic Services P.S.C., Inc. doing business as The Urology Group ("The Urology Group") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Urology Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Urology Group:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

○ Qualified sign language interpreters

○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

○ Qualified interpreters

○ Information written in other languages

If you need these services, contact Robin Brinck, Civil Rights Coordinator.

If you believe that The Urology Group has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Robin Brinck, Civil Rights Coordinator,
2000 Joseph E. Sanker Boulevard
Cincinnati, Ohio 45212
Phone: 513-841-7471,
Fax: 513-841-7402,
Email: civilrightscoordinator@urologygroup.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Robin Brinck, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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TAGLINES:

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-513-841-7471.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-513-841-7471.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-513-841-7471。

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-513-841-7471.

(Arabic)
7471-841-513رقم ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (1-

Deitsch (Pennsylvania Dutch)
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-513-841- 7471.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-513-841-7471.

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-513-841-7471.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-513-841-7471.

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-513-841-7471 번으로 전화해 주십시오.

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-513-841-7471.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-513-841-7471まで、お電話にてご連絡ください。

Nederlands (Dutch)
AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-513-841-7471.

Українська (Ukrainian)
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-513-841-7471.

Română (Romanian)
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-513-841-7471.

Srpsko-hrvatski (Serbo-Croatian)
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-513-841-7471.

नेपाली (Nepali)
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको दनम्ति भाषा सहायता सेवाहरू दनिःशुल्क रूपमा उपलब्ध छ । फोन गनु्होस् 1-513-841-7471 ।

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-513-841-7471.

Ikirundi (Bantu – Kirundi)
ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-513-841-7471.

မြန်မာ (Burmese)
သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကိုေျပာပါက၊ ဘာသာစကား အခမဲ့ အကူအညီ၊
သင့္အတြက္ စစ္ဥေျဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-513-841-7471 သို႔ ေခၚဆိုပါ။

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-513-841-7471 'ਤੇ ਕਾਲ ਕਰੋ।

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-513-841- 7471 पर कॉल करें।