PATIENT DATA SHEET (Child)

Patient's Name			
Home Address	First	Initial	Birth Date
			Home Phone
City		State	Zip Code
Patient Social Security #		□ Male □ Fema	ale
Does the Patient live with:	Both Parents Mother Only	Father Only Other	
	Race *Please Check One ☐ American Indiana/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ White ☐ Unknown/Refuse to Provide	Ethnicity *Please Check One Hispanic or Latino Non Hispanic or Latino Unknown/Refuse to Provide Preferred Language Spoken	
		FORMATION	
			#
Address			Phone
			irth
Employer		Occupation	on
Mothers Name		Soc. Sec.	#
Address		Daytime I	Phone
		Date of B	irth
Employer		Occupation	on
	INSURANCE I	INFORMATION	
Name of Insurance Compan	ny:		
Name of Policyholder:			
Is There Any Additional Ins	urance Coverage? Please List Below:		
Insurance Company Name:		Policy Holder:	
	ndered are charged to the patient. Necessary an) is responsible for all fees, regardless of		rance claims.
	FINANCIAL RI	ESPONSIBILITY	
I have read the Fin Associates, Inc.:	nancial Policy and acknowled	ge my financial responsibiliti	es to Urology
(Patient signature)		Today's Date	
I have received a c	opy of Urology Associates of	Elkhart, Inc. Notice of Privac	cy Practices:
(Patient signature)		Today's Date	

06/13

Urology Associates of Elkhart, Inc.

Jerald A. Hochstetler, M.D. Anish H. Nayee, M.D. Peter C. Fretz, M.D.

Urologic and Genitourinary Surgeons
Diplomates of the American Board of Urology
Fellows of the American College of Surgeons

Our Financial Policy

Thank you for choosing Urology Associates of Elkhart, Inc. as your healthcare provider. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

- *Payment is due at the time of service unless arrangements have been made in advance of the appointment time. We accept cash, money order, personal checks, Visa and MasterCard. There is a returned item charge for any returned checks.
- *Please keep in mind that your insurance policy is basically a contract between you and your insurance company. As a courtesy to you, we will file your insurance claim if provide us with prompt, accurate insurance information and you assign the benefits to the doctor in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable time period (30-45 days), we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. We will bill your insurance company for urologic care provided in the hospital if adequate insurance information is provided to our office by the patient. You are responsible for any balance due.
- *We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits based on a contracted fee schedule. We will bill these companies as in-network providers. You will be responsible for payment of any co-payment at the time of service and may later be billed for patient deductible and coinsurance amounts. In the event of an elective procedure, our insurance department may telephone the insurer prior to the appointment to determine your patient responsibility for payment at time of service.
- *If you are insured by a plan that we do not have a prior arrangement with (discount contract), we will prepare and send the claim for you as a courtesy, if adequate information is provided. You, as the patient, are fully responsible for all of our charges and may be asked to make payment at the time of service. Typically, seeing a provider who is out of network, means greater out-of-pocket expense for the patient and your claim may be subject to higher deductible and coinsurance amounts. You are responsible for any and all amounts not paid by your insurance company.
- *Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" due to plan limitations or restrictions, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- *Our office has a cash only at time of service policy for all former collection and bankrupt accounts. We will expect payment in full at the time of service or prior to surgery. Insurance will be filed as a courtesy if adequate information is supplied and benefits will be assigned to the patient. This policy is permanent and will not expire or change. (We reserve the right to terminate patients placed for collection action based on conditions outlined in our current office policies.) You will be notified by mail should we choose to terminate your account.