PATIENT DATA SHEET (Medicare)

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) ☐

Patient's Name _____ _____
Last First Initial Birth Date

Home Address _____ _____
Home Phone

_____ _____
City State Zip Code

Patient Social Security # _____

Race *Please Check One	**Ethnicity** *Please Check One
☐ American Indiana/Alaska Native	☐ Hispanic or Latino
☐ Asian	☐ Non Hispanic or Latino
☐ Black	☐ Unknown/Refuse to Provide
☐ Native Hawaiian/Pacific Islander	
☐ Other_____	Preferred Language Spoken
☐ White	_____
☐ Unknown/Refuse to Provide	

Please give us the name and address of a close relative, friend or neighbor whom we could contact in case of emergency, changes, etc. if you are unavailable:

Name: _____ Relationship: _____ Telephone: _____

SPOUSE INFORMATION

Name _____ Birth Date _____ _____
Social Security #

INSURANCE INFORMATION

Do you have Medicare Part B Coverage? ☐ YES ☐ NO*

***If you do not pay for Medicare Part B coverage, you are responsible for all of our charges.**

Is Medicare Primary? ☐ YES ☐ NO

Supplemental Insurance Company Name: _____

****Medicare pays only 80% of their approved fees, the patient is responsible for payment of the remaining 20% at the time of service if there is no supplemental insurance.**

FINANCIAL RESPONSIBILITY

All services are billed to Indiana Medicare Part B. The patient is responsible for Medicare Part B deductible and any coinsurance amounts not covered by a supplemental policy. If the patient belongs to a Medicare HMO or alternative Medicare policy in which we are not a participating provider, they will be considered a self-pay patient and will be directly responsible for our standard non-Medicare charges. Payment for these charges will be expected at the time of service.

I have read the Financial Policy and acknowledge my financial responsibilities to Urology Associates, Inc.:

(Patient signature) _____ Today's Date _____

I have received a copy of Urology Associates of Elkhart, Inc. Notice of Privacy Practices:

(Patient signature) _____ Today's Date _____

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. <u>You are responsible for any and all amounts not paid by your insurance company.</u>

*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.