SALINA UROLOGY
ASSOCIATES

SANTA FE MEDICAL PLAZA
501 S SANTA FE, SUITE 380
SALINA, KS 67401
PH: (785) 827-9635
FAX: (785) 827-6697

WILLIAM D. MAUCH, MD, FACS
BRIAN G. SMITH, MD
RYAN A. PAYNE, MD
MICHAEL J. MATTEUCCI, MD
JULIANNE R. RATHBUN, MD
JULIA M. JENNINGS, APRN-BC

Patient Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Contact Phone Number: _____ E-MAIL ADDRESS _____

Social Security Number: _____

Family Physician: _____ Referring Physician: _____

Preferred Pharmacy: _____ City: _____

SPOUSE OR RESPONSIBLE PERSON:

Name: _____ Contact Phone Number: _____

Relationship to patient if other than Spouse _____?

If the insurance is in the above person's name, please provide:

Date of Birth: _____ Social Security Number: _____

EMERGENCY CONTACT OTHER THAN SPOUSE:

Name: _____ Contact Phone Number: _____

PRIMARY INSURANCE INFORMATION:

Kind of Insurance _____

Insureds Name as it appears on insurance card: _____

Insureds Date of Birth: _____ Insured Social Security Number: _____

SECONDARY INSURANCE INFORMATION:

Kind of Insurance: _____

Insureds Name as it appears on insurance card: _____

Insureds Date of Birth: _____ Insured Social Security Number: _____

SALINA UROLOGY ASSOCIATES, P.A.

Please complete this form prior to your appointment as it helps us get the most out of your visit. Thank you for helping us.

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

State in your own words your reason(s) for seeing the doctor:

_____

Do you have or have you ever had an infection that is resistant to antibiotics or required a health care provider to use isolation techniques?

(MRSA) _____ YES _____ NO_____

Circle or list your medical problems:

Asthma	Back or neck injury	Cancer	COPD/emphysema	Parkinson's
Diabetes	Epilepsy	Glaucoma	Heart Disease	UTI
Hepatitis/Liver Disease	High Blood Pressure	Multiple Sclerosis	HIV/AIDS	Stroke/TIA
Tuberculosis	Kidney Disease	Interstitial Cystitis		

Other: _____

Surgical History: List all surgeries you have had

_____

_____

Social History:

Occupation: (previous, if retired: _____

Marital Status: (Circle) Married Widowed Divorced Single # of Children _____

Tobacco Use: Yes, I currently smoke _____ packs/daily for _____ years.

No, I formerly smoked _____ packs/daily for _____ years and quit _____

No, I have never smoked.

Alcohol use: (Circle) Yes Not anymore (quit _____years ago) Never

Caffeine intake: How many caffeinated drinks do you consume daily _____?

Family History: Has any blood relative had any of the following illnesses? Circle all that apply and list relationship

Bladder Cancer	Breast Cancer	Diabetes	Heart Attack	Kidney Cancer
Kidney Disease	Thyroid Disease	Stroke	Prostate Cancer	Urinary Stones

Other: _____

Urological Problems: Circle all that apply

Burning with urination	Pain with urination	Frequency of urination	Urgency of urination	
Leakage of urine	Blood in the urine	Hesitancy/Straining with urination	Kidney stone	
Difficulty emptying	Decreased stream	Starting/Stopping of stream while voiding		
Intimacy problems		Have you ever had a blood transfusion?	Yes	No

Name _____ Date _____

Date of Birth _____ Updated _____

_____

MEDICATION SHEET

Do you require antibiotics prior to procedures?	Yes	No
Have you ever had problems with anesthesia?	Yes	No
Are you allergic to IODINE or CONTRAST DYE?	Yes	No

Please list Allergies to Medications:

Please list other Allergies:

Medications: Include over the counter medications, vitamins, herbals and aspirin.

Medication Name	Dose	How often	Reason

OMB No. 0938-0214

MEDICARE SECONDARY PAYER QUESTIONAIRE
(TO BE COMPLETED FOR ALL MEDICARE PATIENTS)

NAME: _____

DATE OF SERVICE:_____

(If any answer to question 1a. through 4. is yes, the corresponding section of the "Other Insurance" form must be filled out completely.)

		YES	NO
1.	IS THE PATIENT A VETERAN?	_____	_____
	A. Did the VA refer you here for treatment?	_____	_____
	B. Does the patient have a VA "fee basic ID Card?"	_____	_____
2.	DO YOU HAVE A FEDERAL BLACK LUNG CARD?	_____	_____
3.	IS THIS MEDICAL CONDITION DUE TO AN ACCIDENT OF ANY KIND?	_____	_____
	If yes, was it: Work Related ____ Auto ____ Injured in own home ____ Other____		
4.	IS THE PATIENT COVERED BY AN EMPLOYER'S HEALTH INSURANCE PLAN THROUGH THEIR OWN EMPLOYMENT OR THAT OF A FAMILY MEMBER?	_____	_____

ONE TIME AUTHORIZATION

Patient Name:

_____

Medicare ID number:

_____

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to:

Salina Urology Associates, P.A.
and/or
Salina Urology Care Center, LLC

for any services furnished to me by that facility. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

_____ _____

Patient's Signature Date Signed

Patient name (please print):_____

Birthdate:_____

INSURANCE AUTHORIZATION AND PAYMENT

1. I understand that all co-pays are due at the time of service.
2. I understand I may request a payment plan prior to seeing the provider.
3. I request that payment of benefits be made on my behalf to Salina Urology Associates, P.A.
4. I hereby authorize Salina Urology Associates, P.A. to furnish information to insurance carriers concerning my illness and treatments.
5. I understand and verify all information is correct to the best of my knowledge.
6. TRICARE PATIENTS: If a referral is required it is your responsibility to ensure our office receives this prior to your appointment.
7. ALL OTHER INSURANCES: If our office is "not assigned or contracting with your insurance company", you will be required to pay for all services rendered to you. ***If you are not sure if we are a contracting provider it is your responsibility to check with your insurance company prior to your appointment.***
8. I acknowledge that I am financially responsible for all charges incurred regardless of my insurance's process.

Patient's Signature:_____ Date:_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE (HIPAA)

1. I acknowledge that I have had an opportunity to review and/or received Salina Urology Associates, P.A. "Notice of Privacy Practices." *You may request a copy of our Notice in person or by writing to Salina Urology Associates, P.A.*
2. I consent to Salina Urology Associates, P.A. use and disclosure of my personal health information to carry out treatment, payment and heathcare services.
3. I understand this means Salina Urology Associates, P.A. may call and leave a message on an answering machine, voice mail or in person in reference to any items that assist in meeting my healthcare needs, such as appointment reminders, insurance items, laboratory results, clinical care information among others. I also understand Salina Urology Associates, P.A. may also mail items to my home or other designated location such as appointment reminders, statements, brochures, and other items.
4. I understand I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. I understand if I do not sign this consent, Salina Urology Associates, P.A. may decline to provide treatment to me.

Patient's Signature:_____ Date:_____

Salina Urology Care Center, L.L.C.

Salina Urology Associates, P.A.

Patient name (please print):_____

Birthdate: _____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and all account information. This information may be released to:

Spouse_____

Child(ren)_____

Other_____

Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages may be left:

At my home_____ At my work_____ On my cell_____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

_____

The best time to reach me is (day)_____between(time)_____

Patient's Signature:_____Date:_____