GREGORY HALENDA, M.D., F.A.C.S.
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CARL O. BRUNING, III, M.D
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DONNA M. FINNEGAN, PA-C
KRISTEN N. GREGORY, PA-C
CHELSEA WORKMAN, PA-C

PROSTATE CANCER

BENIGN PROSTATIC HYPERPLASIA

LASER TREATMENT OF PROSTATE

STONE DISEASE
LASER / LITHOTRIPSY

MINIMALLY INVASIVE SURGERY

IMPOTENCE

INCONTINENCE

BLADDER CANCER

MALE INFERTILITY

NO-SCALPEL VASECTOMY

BRACHYTHERAPY

2790 MOSSIDE BLVD.
SUITE G110
MONROEVILLE, PA 15146
(412) 372-6330
FAX (412) 372-3319

575 COAL VALLEY ROAD
SUITE 571
CLAIRTON, PA 15025
(412) 469-7107
FAX (412) 469-8160

Dear:_____

We want to take this opportunity to thank you for choosing our office for your urological care and to welcome you to our practice.

This letter will confirm your appointment on _____.
If you are unable to keep this appointment, please call us as soon as possible and we will reschedule a more convenient time for you.

If your insurance requires a referral for specialist visits, you are responsible for obtaining your referral from your Primary Care Physician. **Please bring your current insurance card (s) with you, along with your driver's license or other valid photo ID. COPAYS WILL BE COLLECTED AT REGISTRATION. YOUR APPOINTMENT MAY BE RESCHEDULED FOR NONPAYMENT OF COPAY. OUR BILLING DEPT WILL VERIFY ELIGIBILITY AND INFORM YOU OF ANY ADDITIONAL AMOUNTS, SUCH AS DEDUCTIBLE AND COINSURANCE, THAT WILL ALSO BE COLLECTED AT THE TIME OF SERVICE. Also, if applicable, please bring all test results and x-rays with you to your visit.**

We have enclosed forms that **must be completed** for your medical record. Please take this opportunity to complete these forms at home and **bring them with you to your appointment**.

We look forward to seeing you and if you have any questions, please feel free to call the office and our staff will be happy to assist you.

Sincerely,

Suburban Urologic Associates

Enclosures

SUBURBAN UROLOGIC ASSOCIATES

Please Print

PATIENT INFORMATION

Patient Name: _____ Birth Date: _____
Last *First* *M.I.*

Address: _____ Age: _____
Street

_____
City *State* *Zip*

SS#: _____ Sex: _____ Marital Status: _____

Home Ph #: _____ Cell Ph #: _____

Occupation: _____ Work Ph #: _____

Employer Name & Address _____

Name of Insurance Co: _____

Name of Insured: _____

Birthday of Insured: _____

Please show your latest insurance card to the receptionist

PRIMARY CARE PHYSICIAN INFORMATION

Name of Primary Care Physician: _____

Address: _____

Phone #: _____

Referring Physician: _____

OTHER INFORMATION

Spouse Name: _____ Spouse Employer: _____

Work Phone: _____ Cell Phone: _____

In Case of Emergency, Contact (*not at same address*)

Name: _____ Relationship: _____

Phone #: _____

IMPORTANT: *All charges and/or co-payments are due at time of service*

Insurance Authorization and Assignments: I request that payment of authorized benefits be made in my behalf to Suburban Urological Associates for any services furnished me by the physician. I authorize release of any medical information necessary to process my claims. I understand that I am responsible for all charges regardless of insurance coverage. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non covered services.

Patient Signature: _____ Date: _____

Updated _____ Initials _____

PATIENT HISTORY FORM #2

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE: _____ / _____ / _____

Last Name: _____ First Name: _____ Middle: _____

DATE OF BIRTH: _____ / _____ / _____ REFERRING MD: _____

PAST MEDICAL & SOCIAL HISTORY

List and Date All Past Surgeries:

_____Date: _____
_____Date: _____
_____Date: _____
_____Date: _____
_____Date: _____

List All Past Chronic Medical Conditions:

_____
_____
_____
_____

Complete the attached medication list or attach your own medication list.

Do you take Aspirin or Blood Thinners every day? Y N Please list _____
Do you take antibiotics prior to dental procedures? Y N
Do you have Latex Allergies? Y N
List ALL Allergies to medication:

_____ _____ _____
_____ _____ _____

Do you use tobacco? Y N If Yes, type and how much _____
Do you drink? Y N If Yes, how much _____
List all serious illnesses in your immediate family (Example: diabetes, tuberculosis, cancer, heart disease, etc)

_____ _____ _____
_____ _____ _____
_____ _____ _____

M.D. Signature: _____

Date	Pt. Init.	Provider Init.	Date	Pt. Init.	Provider Init.
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Patient Name: _____ D.O.B.: _____

MEDICATION LIST

Be sure to include **ALL** prescription drugs, over-the-counter drugs, vitamins, and herbal supplements

WHAT ARE YOU TAKING	DOSAGE	HOW MUCH AND WHEN

Reviewed by: _____/_____ Date: _____

Reviewed by: _____/_____ Date: _____

Reviewed by: _____/_____ Date: _____

Reviewed by: _____/_____ Date: _____

Reviewed by: _____/_____ Date: _____

Reviewed by: _____/_____ Date: _____

Feb 5 2020

SUBURBAN UROLOGIC ASSOCIATES

PATIENT PHARMACY INFORMATION

Today's Date: _____

Patient Name: _____ Birth Date: _____

Name of **Retail** Pharmacy: _____

Street: _____

City: _____

Phone Number: _____

Name of **Mail Order** Pharmacy: _____

If Medco, please list your Medco ID Number: _____

Suburban Urologic Associates

FINANCIAL POLICY

Thank you for choosing our office as your health care provider. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We will submit medical services to your insurance company if you have given us all the required information. We must have the most current copy of your insurance card**.** You must notify us immediately of any charge in your insurance coverage. Please be aware that some, and perhaps all, of the services provided may be considered "non-covered services" according to your policy. You will still be responsible for payment of these services. You are also responsible for obtaining the necessary referrals from your PCP and/or insurance company if applicable. However, authorization from your insurance company does not guarantee payment.

We are participating with most major insurance companies. Please check with your insurance company to determine if we are participating providers. We will collect the current co-payment required for a specialist office at the time of service. All patients are responsible for presenting the most current information and paying the most current specialist co-pay. **COPAY WILL BE COLLECTED AT REGISTRATION. YOUR APPOINTMENT MAY BE RESCHEDULED FOR NONPAYMENT OF COPAY. You will also be responsible for payment of any deductible, co-insurance or non-covered services.**

Deductible and co-insurance responsibilities for select procedures will be determined and collected prior to the service. In this instance, our Billing Department will discuss this with you. These amounts must be paid in full or the procedure and/or office visit will be rescheduled.

BILLING

If you have financial problems, please ask to discuss a payment plan with our Billing Department (proof of income may be required as verification). A billing statement of medical services received will be mailed to you on a monthly basis. If an extended payment plan has been offered to you, we require regular payments or the plan is void. After that, the account may be turned over to our collection agency and a fee will be assessed. We accept cash, checks, Visa, MasterCard or Discover for payment. In the event that a personal check is returned unpaid from your bank for any reason, your account will be charged with a return check fee.

OTHER INSURANCE FORM PREPERATION

If you have insurance forms that need to be prepared by our office (i.e. disability, FMLA), we will do these as quickly as possible but they may take several days for completion. A fee will be assessed and collected prior to completion of these forms. Please provide us with the correct address for the forms' return.

FINANCIAL POLICY

MINOR PATIENT (UNDER 18 YEARS OF AGE)

The parent/guardian/adult accompanying a minor child is responsible for full payment. Any patient 18 or over is legally an adult and responsible for his/her bill (regardless of attending college, living at home or being covered by parent's insurance). We, therefore, cannot release financial or medical information to a parent/guardian without the patient's written permission. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurance. Please check with your insurance policy to determine which company is the primary before your appointment. In divorce cases, the parent who brings the child in for services is the responsible party.

COLLECTION BALANCES

All collection balances transferred to an outside collection agency, will be assessed a collection fee. If you have had a previous collection balance or are presently in collection, it will be required that you pay your previous balance prior to being seen again. If you are seen by the doctor, we must verify current insurance coverage. You will be responsible for payment of co-payment, deductible and any non-covered service prior to appointment.

CANCELLATION POLICY

Please help us provide better service by keeping your scheduled appointment. Notify us at least 24 hours in advance if you are unable to keep your scheduled appointment. Repeated failure to keep appointments may jeopardize your next visit to our office. There is a $100 Cancellation/No Show fee for select office procedures. Our scheduling department will review this with you when the procedure is scheduled.

MEDICAL RECORDS RELEASE

Please contact our office if it becomes necessary for you to obtain a copy of your medical records. We have a standard records release form that must be completed and signed by the patient. An administrative fee may be assessed for this process.

I have read the above financial policy. I understand and agree to this financial policy.

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name

SUBURBAN UROLOGIC ASSOCIATES

ACKNOWLEDGMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: _____ Birth Date:_____

This acknowledgment of notice and consent authorizes Suburban Urologic Associates to use and disclose health information about you for treatment, payment and health care operation purposes.

Notice of Privacy Practices. Suburban Urologic Associates has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent. You may, upon request, receive a copy of our Notice of Privacy Practices.

Amendments. We reserve the right to change our Notice of Privacy Practices and make the terms of any change effected for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Privacy Officer Contact Information. You may contact our Privacy Officer at the following address: Privacy Officer, Suburban Urologic Associates, 2790 Mosside Blvd. #G110 Monroeville, PA 15146

The doctors and staff of Suburban Urologic Associates are dedicated to protecting the privacy of your medical information (including treatment, payment, and health care operations). Therefore, we WILL NOT discuss any of this information with anyone other than yourself There are, however, circumstances where patients may want us to speak with a family member or a friend. If this is your request, please complete the following information;

(Family or Friend) Name: _____

Relationship: _____ Phone Number: ( ) _____

If the above information is not completed, we WILL NOT discuss your medical information with anyone other than yourself.

Confidential information regarding your care will not be left on answering machines, voicemail, or with someone other than yourself.

Acknowledgment and Consent

I acknowledge that I have read Suburban Urologic Associates' Notice of Privacy Practices. I understand my rights regarding my protected health information.

_____ _____

Signature of Patient (or Guardian) Date

SUBURBAN UROLOGIC ASSOCIATES

AUTHORIZATION FOR AND CONSENT TO SPECIAL DIAGNOSTIC/THERAPEUTIC PROCEDURE

I, _____ Give Dr. _____ permission to perform a **BILATERAL VASECTOMY.** I have been informed that this procedure is intended to produce sterility even though the results cannot be guaranteed. I also understand that it is my responsibility to submit a post vasectomy sperm specimen for analysis three months after my vasectomy. I understand that I must utilize another form of birth control until this specimen is received and documented as negative. **Initials:** _____

Any tissue removed in the procedure will be disposed of at the discretion of the pathologist.

I am also aware that if the operation proves successful, the results are expected to be permanent. I have been told the remote possibility that nature may cause the passageways to re-open, thereby defeating the purpose of the operation. Also, I have been informed of the possible risks of the procedure such as: infection, excessive bleeding and chronic pain.

I have received the **VASECTOMY INFORMATION BOOKLET**, read it, and understand what my obligations are regarding the operation and post-operative follow up. I am aware that premature sexual intercourse without using some form of **BIRTH CONTROL** measures may result in an unintended pregnancy. I am also aware of the need to follow these instructions until my physician indicates the probability that the procedure has been a success.

My signature below constitutes my acknowledgment that I have read and agreed to the foregoing, that the operation has been adequately explained to me by my physician and that I have all the information that I desire and that I authorize and consent to the performance of the procedure.

_____ _____

Witness Patient's Signature

_____ AM

Date Time PM

CANCELLATION POLICY FOR ELECTIVE PROCEDURES

You are scheduled for a **BILATERAL VASECTOMY** on _____
If you decide not to proceed, **you are required to notify our office 7 days prior to the date of your procedure.**

If you do not notify our office by _____ of your cancellation, you will be charged a **$100.00 Cancellation / No Show Fee.** Any questions regarding this policy should be directed to our billing office at 412-374-8009.

I understand the cancellation policy regarding my elective procedure. I understand that I will be responsible for the $100.00 fee for not following this policy, should I desire to cancel or reschedule my procedure.

_____ _____

Patient Signature Date

_____

Print Name