PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

I have received a copy of Notice of Privacy Practices from DFW Urology Consultants

_____ _____

Patient Name Printed Patient Signature

_____

Date

IF YOU WOULD LIKE US TO RELEASE INFORMATION ON YOUR HEALTH TO SOMEONE ELSE, PLEASE LIST THEIR NAME AND RELATIONSHIP BELOW.

1.

2.

3.

PLEASE SIGN AND RETURN THIS ALONG WITH YOUR PAPERWORK.

DFW UROLOGY CONSULTANTS
PATIENT INFORMATION

Patient Name/Nombre _____ Date/ fecha: _____
Last/First/Middle

Sex M or F Marital Status S M W D Sep Social Security # _____

DOB/fecha de nacimiento _____ Age/edad _____ E-mail: _____

Address/domicilio _____ City/State/Zip _____

Home Phone/teléfono de casa _____ Work Phone/teléfono de trabajo _____ Mobile _____

Employer/ _____ Occupation _____

Employer's Address _____ City/State/Zip _____

Spouse/Parent's Name _____ Date of Birth _____
(nombre de pareja) (fecha de nacimiento de pareja)

Employer _____ Occupation _____

Employer's Address _____ City/State/Zip _____

Work Phone ( ) _____ Social Security _____

Primary Insurance/nombre de aseguransa _____ Phone ( ) _____

Insured Name _____ ID # _____ Group Name or # _____

Insurance Address _____ City/State/Zip _____

Secondary Insurance Co _____ Phone ( ) _____

Insured Name _____ ID # _____ Group Name or # _____

Insurance Address _____ City/State/Zip _____

PRIMARY CARE PHYSICIAN/ Doctor Primario _____ Phone/teléfono _____

Address/domicilio _____ City/State/Zip _____

Name and phone # of nearest relative not living with you _____

How did you hear about Dr. Hey? _____

FINANCIAL RESPONSIBILITY

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company. I allow electronic transmittal of my medical records as needed. I acknowledge full financial responsibility for services rendered by the physicians at DFW Urology.

I agree to give 24 hour notice to DFW Urology in the event that I should have to cancel an appointment and that I will be charged $50 if I do not notify them with 24 hours. I understand that payment for services rendered (**including co-pays, Medicare co-insurance, deductibles**) are due at the time of service unless other financial arrangements have been made through DFW Urology Billing Department. I agree to pay all reasonable attorney fees and collections costs in the event of default of payment of my charges. I authorize and request that insurance payments be made directly to DFW Urology. **I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.**

_____ _____

INSURED SIGNATURE/ Firma DATE PATIENT SIGNATURE DATE

DFW Urology Consultants

Adult and Pediatric Urology

Wayne A. Hey, D.O., F.A.C.O.S.

Wayne D. Hey, D.O.

4809 Brentwood Stair Rd
Fort Worth, TX 76103
Phone (817) 731-0316
Fax (817) 377-2081

History & Physical

Date:_____ Name:_____ Date of Birth:_____

Primary care doctor's name:_____ Fax number:_____

Preferred pharmacies name:_____ Phone number: _____

Ethnicity/race: _____ Preferred language:_____

Height: _____ Weight: _____

Reason for visit: _____

_____

If you are having any pain, please describe: _____

Does anyone in your family have any urologic problems?_____

Do you have any **medical problems**? Example: high blood pressure

1:_____ 2:_____ 3: _____ 4: _____ 5: _____

6:_____ 7:_____ 8: _____ 9: _____ 10: _____

Please list any **medications** you take:

1:_____ 2:_____ 3: _____ 4: _____ 5: _____

6:_____ 7:_____ 8: _____ 9: _____ 10: _____

11:_____ 12:_____1 3: _____ 14: _____ 15: _____

Please list any **surgeries** you have had:

1:_____ 2:_____ 3: _____ 4: _____ 5: _____

6:_____ 7:_____ 8: _____ 9: _____ 10: _____

Do you smoke or have you smoked? Yes/No

If yes, how much and for how long?_____

Do you have any allergies to any medications? Yes/No If so, please list:

1:_____ 2:_____ 3: _____ 4: _____ 5: _____

OAB – V8
Overactive Bladder – Validated 8-question Screener

DFW Urology Consultants • **Wayne A. Hey, D.O. – Wayne D. Hey, D.O.** • **(817)731-0316**

Patient's Name _____ Date of Birth _____ Date Completed _____

The questions below ask about how bothered you may be by some bladder symptoms. Some people are bothered by bladder symptoms and may not realize that there are treatments available for their symptoms. Please circle the number that best describes how much you have been bothered by each symptom. Add the numbers together for a total score and record the score on the line provided at the bottom.

How bothered have you been by...	Not at all	A little bit	Somewhat	Quite a bit	A great deal	A very great deal
1. Frequent urination during daytime hours?	0	1	2	3	4	5
2. An uncomfortable urge to urinate?	0	1	2	3	4	5
3. A sudden urge to urinate with little or no warning?	0	1	2	3	4	5
4. Accidental loss of small amounts of urine?	0	1	2	3	4	5
5. Night time urination?	0	1	2	3	4	5
6. Waking up at night because you had to urinate?	0	1	2	3	4	5
7. An uncontrollable urge to urinate?	0	1	2	3	4	5
8. Urine loss associated with a strong desire to urinate?	0	1	2	3	4	5

Are you male? _____ if male, add 2 points to your score

Please add up your responses to the questions above: _____

If your score is 8 or greater, you may have overactive bladder. There are effective treatments for this condition. You may want to talk with a healthcare professional about your symptoms.

Note: You may be asked to give a urine sample. Please ask before going to the bathroom.

DFW Urology Consultants

Financial Policies

As a courtesy, DFW Urology will file for your primary and secondary insurance benefits. After your policy(s) has paid you will receive a statement for any balance which is your responsibility. **Payment in full must be made within 30 days of the statement** unless payment arrangements are made with the billing office. **After 90 days your balance is subject to collections** and will be sent to our current collection agency.

You must be prepared to pay **any co-pay, co-insurance or deductible amounts due at the time of your visit**. If this is inconvenient, you may have to be rescheduled for a later date.

Your current insurance card(s) and a picture identification card must be presented at check-in at every visit.

If your policy requires a referral to see a specialist, you must be sure that DFW Urology Consultants has a copy of the current referral on or before your appointment. If your referral is not current, the appointment will be rescheduled.

If you are unable to come to a scheduled appointment, you must notify the office at 817-731-0316 at least 24 hours prior to the schedule appointment time. **Failure to meet the appointment without giving notice will result in a $50.00 No Show fee**. **Missed procedure or surgical appointments without giving notice will have a $100.00 No Show Fee.** This fee will need to be paid before you can schedule your next appointment, procedure or surgery.

Returned checks must be picked-up and paid in full upon notification from our billing office. There is a **return check processing fee of $35.00** which will be due at the time the check is picked up. The return check amount and the return fee will be added to your account and if not paid within 30 days will be subject to collections.

FMLA, Short-term Disability and other forms required by your employer will be completed within 7 working days from the date you present the forms to our office. **The fee for filling out these types of forms is $50.00.**

You may request a complete copy of your medical records. There will be a **processing fee of $25.00.**

I acknowledge that I have received, read and understand the above policies.

Name:_____ Date: _____

ADVANCE BENEFICARY NOICE (ABN)

Patient's Name _____

Please be advised, DFW Urology will file your insurance as a courtesy to you, the patient. If for any reason your insurance plan does not cover services provided by Dr. Wayne Hey or his staff, you the patient are financially responsible. We will do everything within the scope of our responsibility to file and receive payment from your insurance. The patient's responsibility is to make sure we have the correct information at all times; this includes: any preexisting conditions and/or waiting periods, the correct insurance on file (new insurance ID, new group numbers or new insurance policies), your place of residence (are you in a rehab or skilled nursing facility?) correct address and correct contact numbers so you may be reached.

By signing this document you the patient understand and accept patient financial responsibility for services not covered by your insurance.

_____
Signature

_____
Date

Referral Requirement Notice

I, _____, have been informed that my insurance requires a referral from my primary physician to be seen by a specialist. I understand that it is my responsibility to make sure the referral is obtained. My current referral has expired or a referral has not been sent to the physician I am seeing today. I will assure that a referral is sent to DFW Urology Consultants within 5 days. If this is not accomplished, I agree to be responsible for any charges for the services I receive today.

Signed:_____

Date: _____