Gillespie County UROLOGY

Michael C. Speck, M.D. | Jeremy A. Parker, P.A.
1892 W. US Hwy 290, Fredericksburg, TX 78624
Phone: 830-304-1666 | Fax: 830-304-1665

PATIENT INFORMATION

Social Security #: _____-_____-_____ Date of Birth : _____/_____/_____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Sex: †Male †Female Email: _____

Referring Doctor: _____ PCP: _____

Marital Status: †Single †Married †Widowed †Divorced †Separated

---

IF PATIENTS INSURANCE IS NOT THROUGH EMPLOYER OR PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION.

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Sex: †Male †Female Date of Birth : _____/_____/_____ Social Security #: _____-_____-_____

Responsible Party Employer: _____

Relationship to Patient: _____

MEANINGFUL USE DATA *(Please circle)*

Race: †African American †Asian †Caucasian †Hispanic †Native American †Other

Ethnicity: †Hispanic †Non-Hispanic

Preferred Language: †English †Spanish †Other: _____

Prescription Refills

Telephone prescription refills must be requested on Monday – Friday between the hours of 8:30 am and 4:00 pm. Please allow 24 – 48 hours for your prescription to be called in. Prescriptions **will not** be called in after hours or on weekends

Notice of Privacy Practices Acknowledgment- By my signature below, I acknowledge receipt of the Notice of Privacy Practices.
We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Clinic Administrator. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

_____ _____

Patient and /or Guardian Signature Date

Office Use Only *MRN:* _____

Gillespie County UROLOGY

Michael C. Speck, M.D. | Jeremy A. Parker, P.A.
1892 W. US Hwy 290, Fredericksburg, TX 78624
Phone: 830-304-1666 | Fax: 830-304-1665

FINANCIAL/OFFICE AGREEMENT

***You must sign and date the bottom of the page to be a patient at Gillespie County Urology.**

PAYMENT OF BALANCES IS DUE IN FULL AT TIME OF SERVICE unless other arrangements have been made in advance by either you or your health insurance carrier. We accept Visa, MasterCard, Discover, American Express, Checks and Cash.

- I understand that payment of copayments, deductible, and percentages not covered by my insurance carrier are **due upon the receipt of a statement from our office or at time of service,** whichever comes first.
- I understand that the office will copy all my insurances and driver's license. It is my responsibility to notify the office of an insurance coverage change.
- I understand that Michael C. Speck, M.D., P.A. is a Medicare provider and will submit all claims to them.
- **If I am a Medicare recipient, I know I will be responsible for annual deductibles, 20% coinsurance, and any charges the Medicare states that I am responsible for.**
- I understand it is the responsibility of the guarantor to know the details and benefits associated with their insurance plan or coverage and to obtain all referrals and authorizations from the primary care physician, when applicable. **If you do not have a current referral or authorization on file, you may be asked to reschedule your appointment.** Also, if a proper referral is not obtained by the time services are rendered, **I will be financially responsible for those services.**
- Surgery deposits are due **5 business days** prior to surgery. If for any reason surgery needs to be cancelled it must be done **10 business days** in advance or a **$150** cancellation fee may be charged to the patient.
- Vasectomies will be paid in full before the procedure and will be reimbursed based off of insurance payment.
  Vasectomy payment does not cover lab fees. We will submit your insurance information to the lab but you are ultimately responsible for lab fees.
- I understand that Michael C. Speck, M.D., P.A. requires 24-hour cancellation/rescheduling appointment notice. A charge of **$15.00** for office visits and **$100.00** for procedures will apply without proper notice.
- Upon request, our staff provides an **estimate** of costs for services. However, the actual cost of services is established according to the level of care needed as determined by your provider at time of service.
- A **$25** fee is required for forms completed by physicians. (ex. Disability, FMLA, etc.)
- I understand that a **$30** service fee will be applied to all returned checks.
- **$25** Fee for Medical Records.

INSURANCE BILLING:

I hereby authorize Michael C. Speck, M.D., P.A. to furnish my insurance company with all the information that they may request concerning my present illness or injury. I assign Michael C. Speck, M.D., P.A. all money to which I am entitled for medical expenses related to the service reported. I understand that I am financially responsible to Michael C. Speck, M.D., P.A. for charges not covered by this assignment. If I do not pay my balance, I will be sent to collections in 90 days. I understand that I may be eligible to set up a payment plan. I understand that I can be fired from Michael C. Speck, M.D., P.A. for not paying my balance.

I have **read and understand** the above financial policy/office agreement of the practice, and I agree to be bound by **all** its terms. I also understand and agree that the practice may amend such terms from time to time.

SIGNATURE of Responsible Party_____ DATE:_____

If you have questions about your insurance coverage, please call the phone number on the back of your insurance card.

Office Use Only *MRN:* _____

Gillespie County UROLOGY

Michael C. Speck, M.D. | Jeremy A. Parker, P.A.
1892 W. US Hwy 290, Fredericksburg, TX 78624
Phone: 830-304-1666 | Fax: 830-304-1665

HIPAA Acknowledgement

May we disclose your Medical Information to your Emergency Contact listed below? ☐ **Yes** ☐ **No**

- **«PEmergName» «PEmergCTele»**

If **NO**, please list your Authorization for persons to whom information may be disclosed below:
I AUTHORIZE MICHAEL C. SPECK, M.D., P.A. TO DISCUSS AND/OR RELEASE MY PROTECTED HEALTH INFORMATION, INCLUDING LABS, TEST RESULTS, DIAGNOSIS AND TREATMENTS DISCUSSED TO THE FOLLOWING PERSONS:

_____

Print Name of person/organization Relationship to Patient Phone #

_____

Print name of person/organization Relationship to Patient Phone #

Medical Doctor/Primary Care Physician: _____

Why are you seeing the physician today: _____

Pharmacy (Name & City):_____

Allergies: *(Please list all allergies)*_____

_____

Medications: *(please list all medications)* ***Have you had the?*** ☐ **Flu Vaccine** ☐ **Pneumonia Vaccine**

_____

Other: _____

Surgical History *(Please circle all that apply)*

☐ Bladder Surgery ☐ Cystoscopy ☐ Heart Bypass ☐ Hysterectomy
☐ Kidney Stone Surgery ☐ Lithotripsy ☐ Prostate Surgery
Other _____

Medical History *(Please circle all that apply)*

☐ Diabetes ☐ Emphysema ☐ Heart Attack ☐ Heart Murmur ☐ Hepatitis ☐ Hernia
☐ Hypertension ☐ Menopause ☐ Parkinson's ☐ Strokes ☐ Cancer: _____
☐ Other _____ ***Males Only:*** ☐ Prostate Cancer

Family History Do you have a family history of Cancer? ☐ No ☐ Yes Kidney Stones: ☐ No ☐ Yes

Social History (Circle One)

Smoke: *Yes* *Not Anymore* *Never* Drink Alcohol: *Yes* *Not Anymore* *Never* *Socially*

Review of Systems: Urinary Symptom(s) are: *(Please check all that apply)*

☐ Incontinence ☐ Painful Urination ☐ Blood in Urine ☐ Frequency ☐ Urgency
☐ Leakage ☐ Straining ☐ Abdominal Pain ☐ Bladder Pain
☐ Pain in Side R / L ☐ Not Emptying Bladder ☐ Urinating at Night #_____

What is your: Height: _____ Weight: _____

Office Use Only *MRN:* _____

Gillespie County UROLOGY

Michael C. Speck, M.D. | Jeremy A. Parker, P.A.
1892 W. US Hwy 290, Fredericksburg, TX 78624
Phone: 830-304-1666 | Fax: 830-304-1665

Office Use Only

LABS		***IMAGING***	***PROCEDURE***	***LOCATION***
Time Frame: _____		***Time Frame:*** _____	***Time Frame:*** _____	
PSA Total	PTH	CT Stone Protocol	Cystoscopy	Methodist HC
PSA Free	CA	CT Urogram	Prostate Biopsy	Peterson
Total Tetso	PHOS	MRI Prostate	Vasectomy	FBG Clinic
Free Testo	24 Hr Urine	Chest X-Ray	UF/PVR	Good Sam
LFTs	Uric Acid	Renal US	PVR	Cornerstone
CBC	BHCG	KUB	Pelvic Floor Therapy	Outside
Urine C&S	AFP	Bone Scan	UDS	
Cytology	LDH			

BMP ☐ **MS** ☐ **JP** **PSA:** _____ **Testosterone:** _____

Office Use Only *MRN:* _____