UROLOGY SPECIALISTS
OF MILFORD, LLC

Jeffrey Steinberg, M.D.

Dear Patient:

We would like to take this opportunity to welcome you to our practice. We look forward to meeting you and providing the highest quality urologic care.

If you are scheduled for an In-Office appointment, please plan to arrive at the office 10 minutes before your scheduled appointment. Due to precautions we are taking as a result of COVID-19, please remain in your car and call us at 508 473 6333 when you arrive. We will screen you for any COVID symptoms or exposure before bringing you into our office.

If you are scheduled for a Telemedicine appointment, we will call you at your appointment time to begin the visit. While we strive to minimize patient wait times, please allow for a possible delay of 15 minutes in the start of your appointment. Feel free to call the office if you have any concerns about a delay.

To facilitate your appointment, we ask that you please take a few moments to read and complete the enclosed New Patient Information and forms. By doing this prior to your visit, we hope to make your visit as efficient as possible.

If your insurance requires a referral or preauthorization when seeing a specialist, please contact your primary care physician as soon as possible and confirm this has been completed prior to your appointment with us.

Please bring the following items to your appointment:

All Completed Forms
Insurance Cards
Driver's License or Picture ID
Insurance Copay and Coinsurance
A credit card you would like to use to save on file with us
List of medications and allergies

We appreciate your time in helping us to streamline your visit and serve you as efficiently as possible.

If you have any questions or need any assistance, please call our office. We will be happy to help you in any way we can.

We are looking forward to meeting you.

Sincerely,

Donna Jones
Assistant Office Manager
Urology Specialists of Milford

18 Asylum Street, Milford, MA 01757 P 508-473-6333 F 508-634-0570 urologyspecialistsofmilford.com

Excellence. Experience. Compassion.

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2021 STATEMENT OF FINANCIAL POLICY IMPORTANT HIGHLIGHTS

Recent changes in health insurance plans have required us to update our financial policies. Please read the following information carefully as these updates to our financial policy may impact how we collect your patient responsibility at office appointments and for hospital surgical procedures. Please refer to our Certification and Authorization of Financial Policies for more information.

I. Urology Specialists of Milford requires your patient responsibility amount to be paid at the time of your visit.

Prior to your Office visit, our staff will review your insurance benefits and determine if you will be responsible for any co-payment, co-insurance, or deductible for your visit. The amount you will be required to pay will be estimated based upon the information provided to us by your insurance company. Any overpayment made by you will be promptly refunded to you by Urology Specialists of Milford, and you will be billed by Urology Specialists of Milford for any additional balance the insurance company may determine you owe.

II. Urology Specialists of Milford requires all prior account balances to be paid at the time of your visit.

Prior to your Office visit, we will notify you by phone if you have a current or past due balance on your account. At your Office visit, we will collect payment for all account balances. Additionally, if you have an outstanding insurance claim that has not yet been adjudicated, we reserve the right to estimate your patient responsibility for that visit and collect payment at your office visit or prior to your surgery.

III. Urology Specialists of Milford requires payment for your patient responsibility amount prior to all Hospital Surgical Procedures and certain Office Procedures.

Prior to your Office visit, our staff will review your insurance benefits and determine if you will be responsible for any co-payment, co-insurance, or deductible for your Hospital Surgical or Office Procedure. The amount you will be required to pay will be estimated based upon the information provided to us by your insurance company. Any overpayment made by you will be promptly refunded to you by Urology Specialists of Milford, and you will be billed by Urology Specialists of Milford for any additional balance the insurance company may determine you owe.

IV. Urology Specialists of Milford requires patients to save a credit card on file at the time of your visit.

We use PHREESIA, a leading Healthcare Payments network, to securely save your encrypted credit card information, and to process any overdue payment at a later date or set up a payment plan for you. If you do not pay your patient responsibility amount or set up a payment plan with the office within 45 days of your date of service, we will charge to your saved credit card the amount you owe. If your saved credit card is or has been declined, or if you refuse or are unable to save a credit card on file with us, we will ask you to pay your patient financial responsibility at the time of service.

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PATIENT'S CERTIFICATION AND AUTHORIZATION FOR FINANCIAL RESPONSIBILITY

PLEASE CAREFULLY READ THE HIGHLIGHTED INFORMATION BELOW REGARDING HOW WE COLLECT YOUR PATIENT RESPONSIBILITY. THANK YOU.

DISCLOSURE:
Urology Specialists of Milford, LLC is a for-profit professional limited liability corporation solely owned and providing medical services to the community.

I hereby assign to Urology Specialists of Milford, LLC all payments to which I am entitled for medical and/or surgical benefits, relative to the services provided. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment directly to Urology Specialists of Milford, LLC for all medical and/or surgical services rendered to myself and/or my dependents, regardless of insurance benefits, if any, and I understand I am responsible for any amount not covered by insurance.

I hereby authorize Urology Specialists of Milford, LLC to release any information necessary to my insurance carrier regarding my or my dependent's diagnosis, treatment, illness or injury in order to process my claims, secure payment, or for treatment and healthcare operations, and I allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

I agree to respond to any additional information that the insurance company may request in a timely manner. I understand that if the payment of any claim is delayed more than 90 days from the date of service, Urology Specialists of Milford, LLC reserves the right to collect the balance from me.

I understand that I am fully financially responsible for any and all charges incurred for the course of treatment authorized, and all account balances, co-payments, co-insurance, deductibles, and charges for items not covered by my insurance are payable on the date services are rendered. If I have an outstanding insurance claim that has not yet been adjudicated, I understand that Urology Specialists of Milford, LLC may estimate my patient responsibility for that visit and collect payment at the office visit or prior to surgery.

I understand that Urology Specialists of Milford, LLC requires a credit card to be saved on file. I hereby authorize Urology Specialists of Milford to save my credit card on file for future payment of all my patient financial responsibility balances, including any payments or payment plans that I authorize. I further authorize Urology Specialists of Milford to charge the amount owed to my saved credit card on file if I do not pay my patient responsibility balance within 45 days after the date of service. I understand that I may direct Urology Specialists of Milford to process payments using my saved card on file at any time.

I also understand that I will be required to pay my patient responsibility on the date of service if I refuse to save a credit card on file, if my account is or has been delinquent, or if my saved credit card is declined.

I consent to be contacted by Urology Specialists of Milford by phone, text, email or mail regarding any financial or payment information related to my account. I understand that a copy of my payment receipt will be sent to me by email after any transaction is processed.

I understand that Urology Specialists of Milford, LLC requires my financial responsibility to be paid prior to all Hospital Surgical Procedures, and certain Office Procedures. The amount I will be required to pay will be estimated based on my insurance plan and will include all deductibles, copays, and coinsurance. Any overpayments will be promptly refunded to me by Urology Specialists of Milford.

I understand that it is my responsibility to secure referrals and all necessary authorizations under the guidelines of my insurance policy. I understand that certain lab tests may be sent to an outside laboratory that is not affiliated with this practice and I will be billed separately by the laboratory.

I understand that there is an additional charge of $25.00 for any check that is returned by my bank for any reason, and unpaid checks will be reported to the MA Attorney General's office. Delinquent accounts may be listed with local and national credit bureaus.

A photocopy of this assignment is to be considered as valid as the original. This consent shall remain in effect until I give Urology Specialists of Milford written notification of its termination. I further understand that this policy in no way limits my ability to dispute a charge or question my insurance company's determination of payment.

____
Patient Name (Printed) Date of Birth

X____
Patient Signature Date of Signature

UROLOGY SPECIALISTS

OF MILFORD, LLC

Jeffrey Steinberg, M.D.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI)
By my consent, I acknowledge that my protected health information, including all medical records and entire patient file, will be used by Urology Specialists of Milford, LLC or disclosed to others for the purposes of diagnosing or providing treatment, obtaining payment for all healthcare services, or supporting the day-to-day health care operations of the practice, including billing, administration, laboratory and diagnostic centers.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
By my consent, I acknowledge that I have read and reviewed the Notice of Privacy Practices and Patients' Rights pertaining to this office and its affiliated covered entities, and all my questions have been answered to my satisfaction. I understand that I can ask for a copy of this notice at any time and the office will provide it to me upon request.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES
By my consent, I acknowledge that Urology Specialists of Milford, LLC reserves the right to modify the privacy practices outlined in its Notice of Privacy Practices.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION
By my consent, I acknowledge that I may request a restriction on the use or disclosure of your protected health information. Urology Specialists of Milford, LLC may or may not agree to restrict the use or disclosure of your protected health information. If Urology Specialists of Milford, LLC agrees to your request, the restriction will be binding on the Practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION
By my consent, I acknowledge that I may revoke or terminate this authorization by submitting a written revocation to the Practice Manager at Urology Specialists of Milford, LLC.

CONSENT FOR RELEASE OF MEDICAL INFORMATION
By my consent, I acknowledge that Urology Specialists of Milford, LLC may release my protected health information, appointment reminders, account balances and financial information to my immediate family members, care giver, pharmacist and any physician who participates in my care. I also acknowledge that Urology Specialists of Milford, LLC may leave messages on my answering machine or voicemail regarding my protected health information, appointment reminders, account balances and financial information.

I have reviewed this consent form and give my permission to Urology Specialists of Milford, LLC to use and disclose my health information in accordance with the terms specified above.

____

Name of Patient (Print) Date of Birth

x____

Patient Signature Date of Signature

____

Signature of Patient Representative Relationship of Patient Representative to Patient

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NEW PATIENT INTAKE AND HISTORY FORM

Date: ___________________

Name: ____ **Date of Birth:** _____________________

Reason for Today's Visit: ____

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___ Anemia
___ Arthritis
___ Asthma
___ Bleeding Disorder
___ Blood in Stool
___ BPH
___ Cancer
___ Cardiovascular Dis.
___ Cataract
___ COPD
___ Depression
___ Diabetes
___ Digestive Problems
___ Dizzy Spells
___ Eczema
___ Erectile Dysfunction
___ GERD
___ Glaucoma
___ Gout
___ Headache
___ Hearing Loss
___ Heart Attack
___ Hemorrhoids
___ Hepatitis
___ High Blood Pressure
___ High Cholesterol
___ Hypothyroidism
___ Kidney Disease
___ Lung Disorder
___ Memory Loss
___ Mitral Incompetence
___ Seizures
___ Skin Disorder
___ STD
___ Stroke
___ TB
___ Other: ____

FAMILY HISTORY:

Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Father	Mother	Sibling
Prostate Cancer	________	_________	_________
Bladder Cancer	________	_________	_________
Colon Cancer	________	_________	_________
Gynecological Cancer	________	_________	_________
Kidney Cancer	________	_________	_________
Testicular Cancer	________	_________	_________
Bleeding Disorder	________	_________	_________
Coronary Artery Disease	________	_________	_________
Diabetes	________	_________	_________
Gout	________	_________	_________
High Blood Pressure	________	_________	_________
Kidney Stone	________	_________	_________
Respiratory Problems	________	_________	_________
Seizures Disorders	________	_________	_________
Stroke	________	_________	_________
Other:_______________	________	_________	_________

ALLERGY HISTORY:

No Known Allergies **NKDA (No Known Drug Allergies)**

___ Acetaminophen
___ Aspirin
___ Codeine
___ Epinephrine
___ Erythromycin
___ Ibuprofen
___ Latex
___ Lidocaine
___ Metal
___ Penicillin
___ Sulfur
___ Tetracycline

Other: _________________________

PLEASE COMPLETE PAGE 2 ON REVERSE SIDE

SOCIAL HISTORY:

Marital Status: Single Married Separated Divorced Widowed

Most recent primary occupation: None ____

Please describe your current tobacco use? Smoker, current status unknown Current every day smoker Current some day smoker Former smoker Never smoker Unknown if ever smoked

Do you drink caffeinated beverages? Yes No
If yes, please indicate what type of beverage and how many servings per day: ____________________________________

Do you drink alcoholic beverages? Yes No
If yes, please indicate what type of beverage and how many servings per day: ____________________________________

Have you ever used any illicit drugs? Yes No
If yes, please indicate what type of drug and how often: ____

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it.

General: **Normal**
- ❑ Fever
- ❑ Chills
- ❑ Night Sweats
- ❑ Dietary Changes
- ❑ Weight Change

Skin: **Normal**
- ❑ Acne
- ❑ Bruising
- ❑ Dryness
- ❑ Excessive Sweating
- ❑ Hair Loss
- ❑ Itching
- ❑ New Lesions
- ❑ Rash
- ❑ Skin Color Changes

HEENT: **Normal**
- ❑ Blurred Vision
- ❑ Eye Redness
- ❑ Headache
- ❑ Hearing Loss
- ❑ Seasonal Allergies

Neck: **Normal**
- ❑ Neck Mass
- ❑ Swollen Glands

Respiratory: **Normal**
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Wheezing

Breast: **Normal**
- ❑ Breast Mass
- ❑ Breast Pain
- ❑ Breast Swelling
- ❑ Skin Changes

Cardiovascular: **Normal**
- ❑ Heart Stent
- ❑ High Blood Pressure
- ❑ Leg Pain

Gastrointestinal: **Normal**
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting

Genitourinary: **Normal**
- ❑ Blood in Urine
- ❑ Frequency
- ❑ Incontinence
- ❑ Painful Urination

Musculoskeletal: **Normal**
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Swelling of Extremities

Neurological: **Normal**
- ❑ Dizziness
- ❑ Fainting
- ❑ Loss of Consciousness
- ❑ Numbness
- ❑ Seizures
- ❑ Tingling

Psychiatric: **Normal**
- ❑ Anxiety
- ❑ Depression
- ❑ Easily Irritated
- ❑ Memory Loss

Endocrine/Glands: **Normal**
- ❑ Appetite Changes
- ❑ Thyroid Problems

Hematology: **Normal**
- ❑ Anemia
- ❑ Blood Clots
- ❑ Easy Bruising
- ❑ Easy Bleeding
- ❑ Enlarged Lymph Nodes