

Augusta Urology Associates, L.L.C.

Mark L. Cain, M.D.
Charles H. Coleman, Jr., M.D.
Henry N. Goodwin, Jr., M.D.

Michael F. Green, M.D.
J. Benjamin Kay IV, M.D.

J. Douglas Quarles, Jr., M.D.
Richard B. Sasnett, Jr., M.D.
Andrew M. Strang, M.D.

Dear New Patient:

Enclosed is a new patient packet. Please read and complete the information in full. This will tell us about you and your needs. Please bring the completed information along with your insurance card when you come for your appointment.

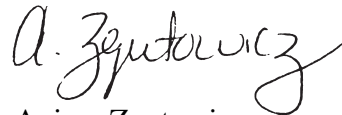
- ▶ It is our practice to collect for services at the time they are rendered.
- ▶ If you are a member of a plan that advises that we are a participating provider, we will be glad to file your charges.
- ▶ If you are part of a PPO or HMO and want to know if we are a participating provider under your plan, please contact your human resource department where you are employed or contact your plan insurance representative prior to your visit.
- ▶ If you participate in a plan that requires prior approval from a primary care physician, please have your primary care physician provide us with the necessary approval prior to your visit in order to prevent an extended wait when you arrive.

Thank you for selecting our practice to handle your medical needs.

Sincerely,

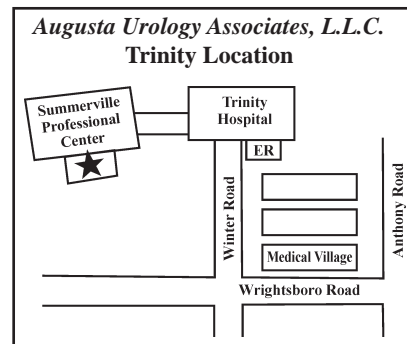
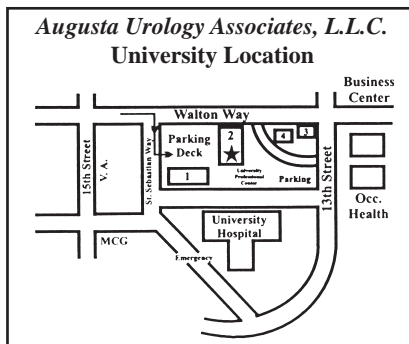


Fran Blocker
Practice Administrator



Anissa Zgutowicz
Financial Administrator

Enclosure: New Patient Packet



Professional Office Building II
818 St. Sebastian Way, Suite 403
Augusta, Georgia 30901
(706) 722-0705

Summerville Professional Center
2258 Wrightsboro Road, Suite 301
Augusta, Georgia 30904
(706) 733-9461

New Patient Information Sheet

Name: _____ Age _____ Date _____

Describe briefly why you are here today: _____

Personal & Family Medical History - Please check all that apply.

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|
| Family | Me | Family | Me | Family | Me |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Anemia | | Heart Attack | | Pelvic Inflammatory |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Arthritis | | Heart Disease | | Prostate Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Bladder Cancer | | Hepatitis | | Prostate Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Cancer, Other _____ | | Hernia | | Psychiatric Difficulties |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Colitis | | High Blood Pressure | | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Diabetes | | HIV Positive | | Sexually Transmitted Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Diverticulitis | | Kidney Disease | | Stomach Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Endometriosis | | Liver Disease | | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Glaucoma | | Lung Disease | | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | Gout | | Ovarian Cysts | | |

Operations & Dates Performed:

List any injuries you have incurred:

List All Medications You Use:

Are You Allergic to Any Drugs: Yes No If YES, please list the drugs you are allergic to:

1. _____ 2. _____ 3. _____
4. _____

Others:

For Women

Are you pregnant? Yes No Not Sure

Date You Began Your Last Menstrual Period _____

Social History - Please Check All That Apply.

1. Do you smoke regularly? Yes No What do you smoke? Cigarettes _____

How Many Per Day ? _____ Packs _____ Each How long ? _____ Years

Have you ever smoked in the past? Yes _____ No _____ For how long? _____ years

2. Do you drink alcohol ? Yes _____ No _____ How often ? Rarely _____ Once a week or more _____ Daily _____
If every day, how much per day ? _____ ounces _____ cans _____ bottles

3. Have you ever used or do you now use illicit drugs ? Yes _____ No _____

Review of Systems

Check All That Apply to You

- **GU**

	<u>YES</u>	<u>NO</u>	<u>No Problem</u>
1. Urination at Night	_____	_____	_____
If yes, how many times:	_____ per night		
2. Difficulty Starting Urine Stream	_____	_____	_____
3. Burning with urination	_____	_____	_____
4. Loss of Control of Urine	_____	_____	_____
5. Blood in Urine	_____	_____	_____
6. Discharge from Penis/Vagina	_____	_____	_____
7. Loss of Sexual Activity	_____	_____	_____

- **Constitutional**: Weight Gain _____ or Weight Loss _____ No Change _____
Tiredness _____ Fever _____

- **Skin**: Rashes _____ or Itching _____ No Problem _____

- **Heart**: Chest Pain _____ Fast Heart Rate _____ or Skipping _____ No Problem _____

- **Respiratory**: Chronic Cough _____ or Hoarseness _____ No Problem _____

- **Neurological:** Seizures ____ or Blackouts ____ No Problem ____
- **Gastrointestinal:** Diarrhea ____ Constipation ____ Blood in Stool ____ No Problem ____
- **Psychological:** Depression ____ Anxiety(Increased Nervousness) ____ No Problem ____
- **Hematology:** Anemia ____ Bleeding Problems ____ No Problem ____
- **Allergies:** _____ None Known ____
- **Musculoskeletal Problems (Joint Problems, Back Aches, Arthritis, etc.)**
 _____ No Problem ____

For Office Use Only

Weight _____ lbs.

Temp. _____ F

Pulse _____

Blood Pressure _____

AUGUSTA UROLOGY ASSOCIATES BILLING & INSURANCE POLICY

You are asked to read and sign the following, indicating that our policies have been fully explained. If there are any questions, please direct them to our business office. Thank you.

INSURANCE: Filing insurance is a service we provide as a courtesy for office visits as well as surgical and diagnostic services. You are asked to assign benefits to us for services rendered. In the event that your insurance company sends you a check for our services, we ask that you immediately forward the check to our business office.

Augusta Urology Associates is a *participating provider* with most insurance companies in this area; however, it is your responsibility to confirm your benefits with your insurance company **BEFORE** seeing one of our physicians. Your medical insurance coverage is a contract between **YOU** and the **INSURANCE COMPANY**. We will assist you in any way we reasonably can but the ultimate responsibility for the payment of our services lies with you. **You** must provide any information that your insurance carrier may request from you (dates of employment, full-time student verification, etc.) in a timely manner to expedite the payment time. If you fail to respond to your carrier within the time-frame your company has established, you may be responsible for the full amount billed if such failure to respond results in the claim being rejected by your insurance company.

MEDICARE : As participating physicians in the Medicare program, by law we are required to file your claim. Medicare typically pays at **80% of the allowable charge**. We will file any secondary insurance coverage you may have for the 20% remaining balance. ANY balance remaining on your account after we have heard from Medicare & your secondary provider (if applicable) is your responsibility.

MEDICAID: We are participating providers for the Georgia Medicaid program. We are required by law to collect a \$2.00 co-pay from all Medicaid patients at the time of your visit. We **DO NOT** participate in the South Carolina Medicaid program.

TRICARE (Champus): We are participating providers in the Tricare program and will file your claims for office visits as well as diagnostic and surgical services.

BILLING: Even though an insurance claim has been filed, you will receive a statement each month reflecting your current balance with us. Often you will receive this statement before your insurance has paid us. Unpaid balances become PAST DUE at 90 days after services are rendered. At this point, we may elect to use a collection agency to assist in the collection of past due balances. A collection fee of 35% of the unpaid balance may be added to your balance in this situation.

If you have a financial situation which causes your medical expense to be a burden, we are willing to discuss a monthly installment plan with you. Please contact our business office.

Our goal at Augusta Urology Associates is to deliver the best urological care available. We appreciate your time in reviewing our policies and hope you understand the need for stating these.

I have read and understand the above policies.

Signed by: _____

Guarantor

Date: _____