**Roscoe S. Nelson, MD, FACS**
Diplomat, American Board of Urology

Dear Patient,

Welcome to our Practice! Thank you for choosing Arizona Urology Specialists for your urologic care, we look forward to meeting you. At Arizona Urology Specialists, we pride ourselves in offering the highest quality urologic care with compassionate, responsive, competent, and excellent customer service. We will make every effort to make your experience with us a positive one. If we fall below this standard, please let us know!

Please take a moment to read the information below to answer frequently asked questions. Most information can be found on our websites at **www.arizonaurologyspecialists.com** and **www.peedoc.com**.

**Office Location and Hours**: Our office is located at 6320 W Union Hills Drive., Suite B-2600, Glendale, AZ 85308. Our office is open Monday thru Thursday 8:00am-5:00pm and Friday until 12:30pm. The phone hours are Monday thru Friday 8:00 to 4:30pm. If you need to speak with your physician urgently after hours please call our main line and you will be transferred to our answering service. We always have a doctor on call 24/7.

**What to Bring to Your Appointment**: If you have x-rays, labs or other pertinent medical records please bring with you to your appointment. To help expedite your appointment, please arrive 30 minutes early (if it's your first appointment). Please print, complete and bring with you to your visit the following forms:

1. Patient Demographic Information and Consents
2. Patient History Form

**Insurance & Billing**: Please bring your insurance card(s) and photo ID with you to your appointment. It is important to bring the correct insurance information and immediately notify our staff of any insurance changes. If a referral is needed from your primary care physician, please ensure they are informed so they may send your referral prior to yours visit. Co-pays, deductibles, and co-insurances are due at the time of service. We accept most credit cards, check, or cash. Payment options are offered for selective treatments to make your treatment affordable and convenient. For billing questions you may contact the business office at (602) 557-0007.

Once again, thank you for selecting our office. We are a referral practice, so many of our patients found us through direct referrals from friends, family, referring physicians or positive online reviews. Please do not hesitate to let us know how we can serve you better.

Sincerely,

Roscoe S. Nelson, MD

6320 WEST UNION HILLS DRIVE
SUITE NUMBER B-2600
GLENDALE, ARIZONA 85308
P 602-942-5600
F 623-825-6386
E DRNELSON@PEEDOC.COM
W PEEDOC.COM

# Arizona Urology Specialists
# New Patient Registration Form

***PLEASE PRINT***

Last Name:_____ First Name: _____ MI: _____

Gender: Male / Female Date of Birth:_____ Age:_____

Race (i.e. Caucasian/Hispanic/Asian):_____Ethnicity (i.e. American/Mexican/German):_____

Primary Language:_____ Last 4 of Social Security #: _____

Address: _____City: _____Zip:_____

(H) Phone:_____ (C) Phone_____(W) Phone:_____

Preferred number to reach you? Home Cell Work OK to leave message at this number? Yes No

In case of emergency number:_____Contact name:_____

E-mail:

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

Preferred Appointment Reminder Method: Phone Mail E-mail

Primary Care Physician (PCP) / Family Doctor:_____ Phone:_____

Referring Physician:_____ Phone:_____

---

***Local Pharmacy Name:_____ Phone:_____**

**Address or Cross-Streets**:_____ **Phone:_____**

***Mail Order Pharmacy Name:_____**

**Primary Insurance Name**:_____

Primary Holder Name:_____ Date of Birth:_____

**Secondary Insurance Name:_____**

Primary Holder Name: _____ Date of Birth:_____

**ASSIGNMENT OF BENEFITS**

I hereby authorize my benefits to be paid directly to Arizona Urology Specialists, LLC and I am financially responsible for non-covered services and/or balances not paid by the insurance carrier. I also authorize release of my information required to process these claims. I authorize you to give me my medical care, including diagnosis and/or treatment.

_____ _____ _____

Signature of the Patient or the Patient's Legal Representative Date Relationship to Patient

**Patient Name:** _____ **DOB:** _____ **Date:** _____

# Arizona Urology Specialists, LLC

## Consents Form

Would you like a copy of the Notice of Privacy Practices? Declined ☐ Accepted ☐

Do you have an Advance Directive? (Legal document expressing your critical care wishes when you are unable to decide for yourself
Yes ☐ No ☐

### Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Arizona Urology Specialists, LLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Arizona Urology Specialists, LLC at any time to obtain a current copy.

**Signature:_____ Date:_____

### Authorization of Release of Health Information:

I authorize the following individual(s) to have access to my personal health information.

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

**Signature:_____ Date:_____

### Notice of Limited English Proficiency:

I have been offered a copy of the Notice of Limited English Proficiency. I understand that if I have Limited English Proficiency, I must provide a reliable, competent and proficient translator. If I cannot provide this translator, I must notify Arizona Urology Specialists, LLC in writing.

**Signature: _____ Date: _____

### Consent to Obtain Electronic Medication History:

To optimize the use of electronic prescribing of medications and coordinate care between my providers, I hereby authorize Arizona Urology Specialists, LLC to access my medication history without limitation or exclusion as is reasonably necessary to disclose, retrieve, and view medications issued by a provider.

**Signature:_____ Date:_____

### Portal Authorization:

The Patient Portal is a secure web-based system that allows for protected communication and transfer of information between the clinic and the patient. By signing below, you agree to the terms and conditions set forth in the Patient Portal Authorization Policy.

**Signature:_____ Date:_____

# Arizona Urology Specialists

Patient History Form

To prevent medical errors it is critical you complete this form completely and accurately!

Patient Name: _____ DOB: _____ Date: _____

Height: _____ ft _____ in Weight: _____ lbs Have you seen another urologist about this same problem? ☐ No ☐ Yes

**How did you hear about us:** ☐ Friend ☐ Internet (which site?) _____ ☐ Insurance Company ☐ Other, How? _____

**CHIEF COMPLAINT** (Why do you want to see the doctor?) _____

_____

How long have you had this complaint? _____

**MEDICATIONS** (List all **Prescription** drugs you are taking with dosage and schedule) ☐ See Attached List

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

List all **Non-Prescription** drugs:

Vitamins: _____ Aspirin / Ibuprofen: _____

Other (including supplements):_____

**ALLERGIES** (List all allergies to drugs or foods): ☐ No Known Allergies ☐ Iodine ☐ Hibiclens ☐ Lidocaine/Marcaine ☐ Latex

_____

_____

**PATIENT MEDICAL HISTORY** (Do you have any of the following:)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Asthma | ☐ Yes | ☐ No | Glaucoma | ☐ Yes | ☐ No | Osteoarthritis | ☐ Yes | ☐ No |
| Atrial Fibrilation | ☐ Yes | ☐ No | Heart Disease | ☐ Yes | ☐ No | Peripheral Vascular Dis. | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Hepatitis | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Type:_____ | | | Hyperlipidemia | ☐ Yes | ☐ No | Thyroid Disorder | ☐ Yes | ☐ No |
| CVA / Stroke | ☐ Yes | ☐ No | **Hypertension** | **☐ Yes** | **☐ No** | Urinary Incontinence | ☐ Yes | ☐ No |
| Depression | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | UTI Recurrent | ☐ Yes | ☐ No |
| **Diabetes** | **☐ Yes** | **☐ No** | Myasthenia Gravis | ☐ Yes | ☐ No | Vascular Disease | ☐ Yes | ☐ No |
| DVT | ☐ Yes | ☐ No | Neurologic Disorder | ☐ Yes | ☐ No | No Medical Problems | ☐ Yes | ☐ No |

Other Medical Problems/Prior Hospitalizations: ☐ No ☐ Yes. If yes, type and date:_____

_____

**PREVIOUS SURGERIES:** ☐ Yes ☐ No (If yes, please complete the below)

| Type | Date | Type | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Patient Name: _____ DOB: _____ Date: _____

**FAMILY HISTORY** (Please fill out as complete as possible – # of children, status, check boxes)

| | Status (Alive/Dead) | Age | Prostate Cancer | Kidney Cancer | Bladder Cancer | Breast Cancer | Diabetes | High Blood Pressure | Heart Disease |
|---|---|---|---|---|---|---|---|---|---|
| Daughters (#) | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sons (#) | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Father | A/D | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mother | A/D | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Grandparent | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sibling | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other Family History?: | | | | | | | | | |

**SOCIAL HISTORY**

Occupation: _____ Retired: ☐ Yes ☐ No Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Current Tobacco use? ☐ Yes ☐ No Prior Tobacco use? ☐ Yes ☐ No Alcohol use? ☐ Yes ☐ No Current Drug use? ☐ Yes ☐ No

Exercise? ☐ Yes ☐ No Type/How Often?:_____ Caffeine use? (Cups / Day): Coffee: _____ Tea: _____ Cola: _____

**REVIEW OF SYSTEMS** (Have you currently or recently had)

**General**
Fatigue ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Weight Gain ☐ Yes ☐ No
Weight Loss ☐ Yes ☐ No

**Allergy**
Drug Allergies ☐ Yes ☐ No
Seasonal Allergies ☐ Yes ☐ No

**Opthalmologic**
Blurred Vision ☐ Yes ☐ No

**ENT**
Dry Mouth ☐ Yes ☐ No
Nosebleeds ☐ Yes ☐ No

**Endocrine**
Cold Intolerance ☐ Yes ☐ No
Excessive Sweating ☐ Yes ☐ No
Heat Intolerance ☐ Yes ☐ No

**Cardiovascular**
Chest Pain ☐ Yes ☐ No
Edema (swelling) ☐ Yes ☐ No

**Respiratory**
Shortness of Breath ☐ Yes ☐ No
Are you on oxygen ☐ Yes ☐ No

**Gastrointestinal**
Constipation ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Nausea ☐ Yes ☐ No

**Hematology**
Bleeding Problems ☐ Yes ☐ No

**Musculoskeletal**
Back Pain ☐ Yes ☐ No
Muscle Pains ☐ Yes ☐ No
History of Gout ☐ Yes ☐ No
Muscle weakness ☐ Yes ☐ No

**Peripheral Vascular**
Blood Clots in Legs ☐ Yes ☐ No

**Skin**
Rashes ☐ Yes ☐ No

**Neurologic**
Leg or Arm Weakness ☐ Yes ☐ No
Balance Difficulty ☐ Yes ☐ No
Headaches ☐ Yes ☐ No

**Psychiatric**
Depressed Mood ☐ Yes ☐ No
Seeing a psychiatrist? ☐ Yes ☐ No

**Urology**
Frequency ☐ Yes ☐ No
Urgency ☐ Yes ☐ No
Nocturia (pee at night) ☐ Yes ☐ No
Burning ☐ Yes ☐ No
Blood in Urine ☐ Yes ☐ No
Hard to start ☐ Yes ☐ No
Leak with Cough etc ☐ Yes ☐ No
Leak with Urge ☐ Yes ☐ No
Start/Stop ☐ Yes ☐ No
Empty Completely ☐ Yes ☐ No
Dribbling After ☐ Yes ☐ No

**Sexual History**
Change in sex drive? ☐ Yes ☐ No
Performance satisfactory? ☐ Yes ☐ No

**Males**
Testicular Pain/Swelling ☐ Yes ☐ No
Discharge from penis ☐ Yes ☐ No
Blood in Semen ☐ Yes ☐ No

**Females**
Mammogram _____
Annual Pap _____

**Date of Last (Mo/Yr):**
Colonoscopy _____
DEXA Scan _____
Pneumonia Vaccine _____

Form Completed By: _____ Date: _____

# Arizona Urology Specialists
## Vasectomy Packet

Welcome and thank your for choosing Arizona Urology Specialists.

Please read the information carefully **before** your vasectomy appointment.

A consent form is in your packet but do **not** sign it until you are in our office for your vasectomy appointment.

To avoid any delay in your procedure and/or discharge teaching, it is recommended that you do **not** bring any young children or infant to your vasectomy appointment.

Make sure you have a driver and a car available. You may be sent to a pharmacy for medications.

Make sure your packet contains the following items:

- How to get ready for your vasectomy
- Patient History Form
- Consent form
- Vasectomy Aftercare Instructions
- Facts about vasectomy
- Welcome Letter, Contacts List, Financial Policy, HIPPA Notice, Notice of Privacy Practices, Maps

If you have any further questions after reading our vasectomy packet, please call us at 602-942-5600 during routine business hours.

The physician will meet with you and your significant other prior to your vasectomy to review the information in this packet and answer any further questions you may have.

Thank you.

# Arizona Urology Specialists
## How to Get Ready For Your Vasectomy

- Our customary charge for a vasectomy is $1,000.00. (Laboratory services (semen analysis), pathology charges, post-vasectomy medical supplies (jock strap) and medications (pain medication, anxiolytics and antibiotics) are not included in this charge).

- If you plan to pay for your vasectomy using your health insurance, you may be responsible for a co-payment. Make sure you bring your insurance card and any referral paperwork for your visit. (Prior authorization may not guarantee that your insurer will pay for your vasectomy. It is your responsibility to check with your insurance provider regarding coverage for your vasectomy)

- Arrange to have someone stay with you at your appointment. You may need a ride to pick up medication and you can't drive after the procedure. If you take pain medication or sedatives prior to your appointment you should have someone drive you to the office.

- **Medications with anti-coagulation (blood thinning) effects such as aspirin**, garlic (ajo), ginko, ginseng, Advil, ibuprofen, Excedrin, Indocin, naprosyn, or any other nonsteroidal ant-inflammatory medication (NSAID's), Coumadin/warfarin, ticlid, plavix, heparin, persantine or lovenox **must be discontinued at least ten (10) days before your vasectomy**. If you are on these medications due to a serious medical condition such as an artificial heart valve, cardiac arrhythmia, or hypercoagulable state, please inform our staff before scheduling your vasectomy. **If these medicines are not discontinued, your vasectomy will be cancelled.**

- Please inform our staff if you have a medical condition such as a heart murmur, artificial heart valve or other internal prosthetic device, which may require prophylactic antibiotic before your vasectomy.

- Shave your scrotum. Concentrate on shaving the front and sides of your scrotum from the level of the penis down before your appointment. Use a razor and do not use any chemical hair remover such as Nair™.

- Bring a scrotal supporter (jock strap) to your procedure. Tight underwear is not acceptable. Loose pants (sweat pants) or shorts may be worn to your appointment. Scrotal supporters are available at the office for $15.00.

- Plan to rest and "take it easy" for at least two days after your vasectomy. Avoid any heavy lifting or strenuous activity (such as climbing ladders) for at least one week. Have ice packs ready at home (frozen corn or frozen peas).

- Complete the history portion of the History & Physical and Procedure form before your appointment.

- Review and sign the financial policy form.

- Read the handouts titled Facts about Vasectomy and Vasectomy Aftercare Instruction.

- BRING YOUR VASECTOMY PACKET TO YOUR APPOINTMENT!

# Arizona Urology Specialists

Vasectomy Consent Form

## Operation or Procedure

I, _____ (patient or guardian), authorize Dr. _____ to perform the procedure known as a **vasectomy.**

I understand the reason for the operation/procedure is to make me sterile.

## Risks and Possible Complications

This authorization is given with the understanding that any operation/procedures involves some risks and possible complications. These risks include but are not limited to: Bleeding, infection, hematoma and/or abscess formation, chronic pain, scar tissue formation, and future pregnancies.

## Alternatives

The following methods of contraception are known alternatives to a vasectomy: use of a condom, birth control pills/patch, tubal ligation, intrauterine device, and abstinence.

## Perfect Results Are Not Guaranteed

I understand that no guarantees have been made as to the results of this operation/procedure, and that it may not completely treat the condition for which it has been recommended.

## Patient's Acknowledgment of Informed Consent for Vasectomy

I have read and fully understand this consent form. I understand that I should not sign below unless all of my questions and concerns have been explained or answered to my complete satisfaction. Given the intent of this procedure, it is strongly recommended that you have discussed your decision to undergo a vasectomy with your spouse or significant other in advance.

_____ **Patient/Responsible Party Signature**

_____ **Witness Signature**

____/____/____ **Date**

____/____/____ **Date**

## Provider Confirmation

I have explained the purpose of this procedure to this patient and have addressed all of his questions and concerns. Risks benefits and alternatives were discussed, and the patient have given me consent to proceed with a vasectomy.

_____ **Physician Signature**

____/___/_____ **Date**

# Arizona Urology Specialists

## Vasectomy Aftercare Instructions

- Plan on minimal activity for forty-eight (48) hours.
- Avoid any strenuous activity (lifting more than 10 lbs) for 1 week.
- Apply an ice pack to the scrotum at thirty-minute intervals for twenty-four (24) to forty-eight (48) hours. Expect to see some swelling and bruising over the scrotum.
- Keep the incision dry by covering it with a piece of gauze or band-aid. Change the dressing a minimum of twice a day.
- Wear a scrotal support for 1 week.
- Do not apply any ointment or cream to the wound unless otherwise specified.
- You may shower after twenty-four (24) hours. No bathing or swimming until the incision has healed.
- Avoid sexual activity for at least two weeks.
- Post-vasectomy semen analysis procedure
    - Perform your post-vasectomy semen analysis after 3 months and at least twenty (20) ejaculations. If there are still sperm present, you will be asked to leave another specimen after 10 more ejaculations.
    - You may leave the specimen cups at the lab during routine business hours. Make sure the lab is authorized by your insurance plan.
    - Semen may be obtained by masturbation or coitus interruptus. Do no use any spermacide cream during this process.
    - It usually takes about two weeks before we receive the results and call you.
    - PROTECTIVE INTERCOURSE IS MANDATORY UNTIL YOUR POST-VASECTOMY SEMEN ANALYSES SHOWS NO SPERM.
- Call our office (602) 942-5600 if you should have any additional questions.

# Arizona Urology Specialists
## Vasectomy Fact Sheet

**What is a vasectomy?**
A vasectomy is surgical procedure designed to permanently disrupt the flow of sperm from the testicles to the prostate gland during ejaculation. After a vasectomy, a patient will still produce semen during ejaculation but it will contain no sperm.

**How soon will I be sterile after a vasectomy?**
The time it takes for someone to become sterile after a vasectomy varies from one individual to another. Protective intercourse is mandatory until your post-vasectomy semen analyses show no sperm.

**Are the effects of a vasectomy permanent?**
For all intensive purposes, a vasectomy should be considered permanent. There is a potential 0.1% (1 in 1000) chance that the vas deferens tube may "grow back together."

**Is this operation reversible?**
Your urologist can reverse a vasectomy in most cases but it is very expensive. Most insurance plans will not cover the cost of a vasectomy reversal. Although the success rate for a vasectomy reversal is relatively high, the chance of an actual full-term pregnancy is less than fifty (50) percent.

**Will a vasectomy affect my sex life?**
A vasectomy should not affect your sex life unless you are undergoing this procedure with significant reservation.

**Will my ejaculate be normal after a vasectomy?**
Yes, although the seminal fluid will eventually contain no sperm, the actual volume of the ejaculate may decrease only by a small amount.

**Are there any long-term complications?**
No long-term complication has ever been proven after a vasectomy. Previous articles suggesting a potential higher risk of prostate cancer associated with patients undergoing a vasectomy have been disproved by recent credible studies. A slightly higher risk of coronary artery disease (CAD) has been reported in laboratory animals have been described. However, no such link could be identified in men.


# No Show Policy

At **Arizona Urology Specialists, we** strive to meet and exceed the expectations of all of our patients and we are dedicated to providing you with the best care and services possible. We also strive to meet your needs by providing appointments times that best fit your schedule.

Time is specifically reserved for you on your schedule when you make your appointment. When sufficient notice is not given to cancel or reschedule your appointment, it does not give us enough time to contact another patient who could come to the office during your assigned time. This results in other patients not getting the care they need, when they need it.

Because of the great need for our services we have implemented the following No-Show policy.

**Arizona Urology Specialists,** has implemented a No-Show policy. A NO-SHOW is when a patient fails to keep a scheduled appointment or without providing 24 hour's cancellation notice. A No-Show will generate a fee of $100.00 and with 3 or more no shows it may require you to seek medical care with another group. If your appointment is a surgery at the hospital/ Surgery Center or in office procedure such as a biopsy, our fee in the event you fail to show for your procedure is $250.00.

In the event that you have a special circumstance regarding your missed appointment, please contact our office. We understand that there may be issues beyond your control and we want to be understanding of special circumstances.

I have read and fully understand the Patient No-Show Policy.

_____ _____

Patient Signature / (Parent or Guardian for Minor Date

ARIZONA UROLOGY SPECIALISTS

*Right for Your Family. Right for You.*

Policy: Prior Authorization Fee
Date 6/9/2016

Dear Patient,

Arizona Urology Specialists providers make every effort to ensure that you receive the safest, most effective and reasonably priced prescription medications, treatments, laboratory tests and imaging studies we feel is best suited for your healthcare. We must also abide by regulations set by your insurance company and government agencies. Over the past year, many health insurance companies or plans are requiring prior authorization or approval for an increasing number of medications, imaging studies and laboratory testing.

As this is additional and labor intensive service that our providers and staff complete, effective July 1, 2016, Arizona Urology Specialists will begin charging a fee of $25.00 per authorization. This cost is an out-of-pocket expense to you and not covered by your insurance.

You can be assured that your provider will take every step necessary to provide you with a cost effective treatment and recommend testing or a medication that does not require prior authorization. In the event our office needs to perform an authorization, our office will reach out to you as soon as possible to see if you would like to proceed with the authorization and to collect the $25.00 fee in advance. Our office is unable to guarantee that your insurance carrier will approve the item(s) being authorized.

Please note that this fee does not apply to surgical authorizations performed in the office, a surgery center or hospital facility. In the event that your procedure is performed in the office and requires a medication such as Botox, your insurance carrier may require additional authorization for the medication and may be subject to this authorization fee.

If you have any questions, please contact the business office at 602-557-0007.

77 E. Thomas Rd., Suite 230, Phoenix, AZ 85012

ARIZONA UROLOGY SPECIALISTS
Right for Your Family. Right for You.

# Patient Financial Policy

We are committed to providing the best possible medical care and patient experience to our patients. Patients knowing and understanding their financial responsibility is a key component to a positive care experience and a successful physician patient relationship.

**Non-Covered Services:** Patients are responsible for knowing their insurance coverage and bringing their insurance cards to their appointments. Please know your insurance benefits before each visit. You will be asked to pay for any services that are not covered by your insurance plan.

**Correct Insurance Information:** You are responsible for providing us with the most correct and update information about your health insurance. It is your responsibility to notify us immediately of a change to your health insurance plan or change in insurance status. If we have incorrect insurance information, outstanding balances will be billed to you directly.

**Payment is required at the Time of Service:** You are responsible for paying deductibles, copayments, coinsurance and other out of pocket expenses at time of service. If we are unable to verify your insurance coverage, you will be asked for payment. In addition to cash payments and checks, we also accept most major credit cards. Patients who are not covered by health insurance are required to pay for the provided services at the time of service.

**Missed Appointments:** Multiple missed or no show appointments will result in a $25 charge per occurrence and the patient may be subject to discharge from the practice.

**Special Insurance Processing Requests:** The Arizona State Constitution permits insured individuals to pay directly for health care services, if they so desire. If you choose to pay for health care services, your health care provider will not submit a claim to your health plan. It is your responsibility for notifying your provider's office when you do not wish a claim to be submitted on your behalf.

**Related Facilities or Services:** AUS Physicians may have a financial interest in where you are referred for treatment. This may include, but not limited to surgery centers, lithotripsy centers, pathology labs, oncology treatment centers, radiation facilities that perform CT and MRI scans and other medical and non-medical related entities.

**Collection Agency Fees:** When patient accounts become extremely delinquent, patients or patient guarantors agree to pay collection agency or attorney fees or not less than thirty five (35) percent. The collection agency fees will be added to the patient's outstanding balance and collected by the collection agency upon referral to the agency.

**Administrative Charges:** Patients may incur, and are responsible for, the payment of additional charges at the discretion of AUS. The charges may include but are not limited to (subject to change at any time).

- Charge for Returned Checks $25.00
- Charge for extensive phone consultations and/or after hour's phone calls requiring diagnosis, treatment, or prescriptions. $100.00
- Charge for copying and distribution of patient medical records. $50.00
- Charge for insurance authorization of prescription medications. $25.00
- Charge for forms completion, including but not limited to disability and FMLA forms. $35.00
- Charges for providing non-English speaking interpreters. Price varies based on language.

**Patient Authorizations:**

By my signature below, I hereby authorize AUS and the physicians, staff, labs, and hospitals associated with AUS to release ALL medical and other information acquired in the course of my examination and/ or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

I have read, understand, and agree to the provisions of this Policy.

_____ _____

Printed Name of Patient Printed Name of Guardian (if Applicable)

_____ _____

Signature of Patient or Guardian Date

Waiver of Patient Authorization

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____ _____

Signature of Patient or Guardian Date