

**CHZ Urology, LLC**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ RECORD NO. \_\_\_\_\_

**ANNUAL PATIENT UPDATE FORM**

**DATE COMPLETED:** \_\_\_\_\_

**LIST CURRENT MEDICAL PROBLEMS: (DIABETES, HIGH BP, HEART DISEASE, ETC)**

- |    |    |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

**LIST ANY OPERATIONS YOU HAVE HAD IN THE PAST YEAR**

- |    |    |
|----|----|
| 1. | 3. |
| 2. | 4. |

**FAMILY HISTORY (ANY SERIOUS ILLNESS IN FAMILY MEMBER)**

<b>ILLNESS</b>	<b>FAMILY MEMBER AFFECTED</b>
1.	
2.	
3.	

**SOCIAL HISTORY:**

DO YOU SMOKE CIGARETTES?	IF YES, FOR HOW LONG?
DO YOU DRINK ALCOHOL?	IF YES, HOW MANY DRINKS/DAY?

**LIST ALL CURRENT MEDICATIONS**

- |    |    |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

**PLEASE LIST ANY OTHER CHANGES IN YOUR HEALTH IN THE PAST YEAR WHICH ARE NOT DESCRIBED ABOVE:**

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**CHZ UROLOGY, LLC**

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, hereby give my consent for CHZ Urology, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (CHZ Urology, LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. CHZ Urology, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to CHZ Urology, LLC Privacy Officer at 7501 Surratts Road, Suite 308, Clinton, MD 20735. A copy of this notice is posted in each office.

With this consent, CHZ Urology, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, CHZ Urology, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to CHZ UROLOGY, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, CHZ UROLOGY, LLC may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

**CHZ UROLOGY, LLC**

**ACKNOWLEDGEMENT OF RECEIPT OF COPY OF OFFICE PRIVACY NOTICE**

By signing this form, I, \_\_\_\_\_, acknowledge that I have received a copy of the **Notice of Privacy Practices** prior to signing this consent. A copy of the Notice is also posted in the office.

CHZ Urology, LLC reserves the right to revise its **Notice of Privacy Practices** at anytime. A revised **Notice of Privacy Practices** may be obtained by forwarding a written request to CHZ Urology, LLC Privacy Officer at 7501 Surratts Road, Suite 308, Clinton, MD 20735.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I revoke my consent, CHZ UROLOGY, LLC may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

## OFFICE POLICIES AND PROCEDURES

The following policies apply to our office, and have been placed in effect to improve our ability to provide care for you, as well as comply with state and federal rules regarding patient information and privacy. Please read carefully and sign at the bottom indicating your understanding.

### BRING XRAYS TO THE OFFICE WITH YOU

We are dedicated to providing you with the best care we can. For that reason, if we order X-rays or ultrasound tests, we make it a habit of personally reviewing all films before making treatment decisions. In many instances we can identify a specific finding that the radiologist or technologist was not looking for.

For this reason, we ask that if you have an X-ray or ultrasound or CAT scan ordered by one of us, that when you return to the office ***you personally bring in those films for our review***. We know that this may be an inconvenience, but we are doing so with your best interest in mind.

### BRING A REFERRAL FROM YOUR PRIMARY CARE PROVIDER

If you belong to an HMO, you are **required by your insurance company** to have a valid referral for all visits to this office. You are responsible for hand-carrying this referral into the office on the day of your appointment or scheduled procedure.

While we apologize for the inconvenience, ***if you do not have a valid referral in hand*** for your appointment you will have the option of choosing one of the following alternatives:

- Reschedule your appointment for another day
- Pay for services out of pocket (*this will require a waiver of insurance benefits*)

### TREATMENT OF CONDITIONS NOT COVERED BY YOUR INSURANCE

Your insurance company may not cover some or all services related to certain diagnoses. The two most common pertain to the diagnoses of Impotence (Erectile Dysfunction) and Infertility. If you are being evaluated in our office for one of these problems, we highly recommend you check with your insurance company regarding their coverage of these diagnoses prior to your visit. Payment for non-covered services will be collected in full at the time of your visit. Should you have any questions, contact our billing department at (301) 645-7735.

### ADMINISTRATIVE FEE FOR MISSED APPOINTMENTS

With the current state of managed health care, it is imperative that we make maximum use of our allotted time schedules, and we cannot afford to have blocks of unused time on our appointment schedules. This is especially important given the long waiting list of patients desiring an appointment. We therefore reserve the right to charge a **\$25 fee** for missed appointments without a 24 hour notice and a **\$250 fee** for missed procedure/surgery appointments without a 48 hour notice.

I have reviewed, understand, and agree to the policies as outlined above:

\_\_\_\_\_  
PATIENT SIGNATURE



Chiaramonte Huisman and Zorn Urology, LLC

**FINANCIAL POLICY FOR PARTICIPATING INSURANCE COMPANIES**

Thank you for choosing us as your health care provider. We are committed to the highest standards of care and the latest technologies in the rapidly advancing field. The following is a statement of our Financial Policy, which we request that you read, agree to, and sign prior to any treatment.

All patients must complete our information and insurance forms and present insurance cards and driver's license or state issued id to be photocopied before seeing the doctor. **Please be prepared to show your insurance and id at every appointment.** As we understand that this may be an inconvenience, this is done for your protection against identity theft

We accept cash, checks, Visa, Mastercard, and Discover. **Office visit co-payments are due at time of visit.** Any balance on your account must be paid in full upon receipt of your statement. If you are unable to pay your account in full, we offer a payment plan that divides your total account balance into 3 even monthly payments. If you are unable to comply with either of these options your account may be sent to a collection agency

\*\*\*\*We are participating with the following insurance companies\*\*\*\*

Medicare, AARP, BCBS, Aetna, Cigna, Mailhandlers, Tricare, US Family Health Plan,, Coventry Plans, Bravo, Wellcare, Elder Health, and Kaiser.

\*\*\*Please note that this list is subject to change at any time\*\*\*

Please be aware that some, and perhaps all, of the services provided may be "non-covered" services and not considered "reasonable" and "necessary" under your insurance coverage based on your diagnosis. We will do our best to advise you in advance of this situation. Any services non-covered by your insurance policy become your financial responsibility.

The charge for cancelling or rescheduling surgical procedures without 48 hours notice is **\$250.00**. We **MUST** charge for appointments not rescheduled or cancelled within 24 hours notice. The charge for broken appointments is **\$25.00**. These are not covered by your insurance carriers and thus become the patient responsibility to pay.

This financial policy is to clarify any questions you may have about your financial obligation to CHZ Urology. If the account becomes delinquent (not paying according to the above-stated policy), the doctor, his assigns or lawful agents may pursue collection procedures. **You will be responsible for any collection, interest and or attorney fees.** Please note that collection fees can range anywhere from 35%-50% of your past due balance.

Thank you for understanding our Financial Policy. If you should have any questions, please ask **before** services are rendered. **I have read and understand and agree to the provisions of this Financial Policy.**

X \_\_\_\_\_  
(Signature of Patient or Responsible Party)

Date: \_\_\_\_\_

X \_\_\_\_\_  
(Signature of co-responsible party)

Date: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I authorize CHZ Urology to request and receive information regarding my insurance coverage and benefits paid. Also, to apply for benefits on my behalf for services rendered to me and request payment from insurance company be made directly to CHZ Urology, LLC. A copy of this authorization may be used in place of the original.

X \_\_\_\_\_  
Signature of Patient or Subscriber

Date: \_\_\_\_\_