Payment Options

1. Enroll in the e-billing process by placing a payment method on file and authorizing a future charge up to a maximum of $250 per visit for amounts owed by me as determined by my insurance company. Amounts owed by me may include (i) copayments, (ii) coinsurance, (iii) deductibles, (iv) non-covered or out-of-network services or (v) fees (if applicable) charged by the practice for forms, medical records, appointment cancellations, NSF fees, credit card charge backs, etc.

   ☐ **I elect to enroll in the e-billing system.**

2. Pay your estimated co-insurance and deductible at the time of service. We have an office visit estimation tool that will allow us to estimate your co-insurance and deductible.

   ☐ **I elect to pay my estimated patient responsibility prior to my visit today.**

3. Opt out of the e-billing system for a fee of $50 per year (due today) which covers the costs our practice incurs to send monthly statements and process manual payments. I understand that if I opt-out of the e-billing process and fail to pay my financial responsibility in a timely manner I will not be allowed to opt-out for future dates of service. Instead, I will be required to pay estimated charges in full prior to services being rendered.

   ☐ **I elect to opt-out of the e-billing process. I'm prepared to pay $50 today to opt-out of the program for the next 12 months or I already paid to opt-out this year. I understand I'm still responsible for balances determined to be my responsibility by my insurance carrier.**

4. Present valid, verifiable insurance information demonstrating 100% coverage for medical services having met all applicable deductibles. These plans are:

   a. Traditional Medicare with Medicaid secondary
   b. Medicaid (Blue Ridge office only)
   c. Traditional Medicare with a Plan F secondary
   d. Traditional Medicare with Tricare secondary
   e. WellCare SNP

   ☐ **I have provided the appropriate insurance information. I understand that if my insurance carrier (s) doesn't pay my entire balance I'm ultimately responsible.**

I have had the opportunity to review the financial policy of Urology of Greater Atlanta, LLC. I confirm that I have received a copy of the policy for my records or that I have declined a copy. I understand that I am ultimately responsible for payment of services rendered to me and/or my dependents. I have indicated my preferred method to handle patient responsibility above.

_____	_____
Patient Name	Patient Birthdate
_____	_____
Patient (Guardian) Signature	Date

UROLOGY OF GREATER ATLANTA, LLC

REVIEW OF SYSTEMS

Check if you are experiencing any of the following symptoms.

GENERAL:
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ None

EYES:
- ☐ Blurred vision
- ☐ Burning
- ☐ Cataract
- ☐ Double vision
- ☐ Glaucoma
- ☐ None

BLOOD/LYMPH:
- ☐ Bleeding
- ☐ Bruising
- ☐ Hepatitis
- ☐ Masses/nodules
- ☐ Wounds won't heal
- ☐ None

SKIN:
- ☐ Color change
- ☐ Hair loss
- ☐ Moles
- ☐ Lesions
- ☐ Rash
- ☐ None

ENT:
- ☐ Discharge
- ☐ Dizziness
- ☐ Hearing loss
- ☐ Ringing
- ☐ Sore throat
- ☐ Voice change
- ☐ None

GASTROINTESTINAL:
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Pain
- ☐ None

PULMONARY:
- ☐ Blood
- ☐ Cough
- ☐ Oxygen Use
- ☐ Severe Snoring
- ☐ Shortness of breath
- ☐ Sleep Apnea
- ☐ Sputum
- ☐ Tuberculosis
- ☐ Wheeze
- ☐ None

NEUROLOGIC:
- ☐ Headache
- ☐ Odd sensations
- ☐ Paralysis
- ☐ Seizure
- ☐ Stroke
- ☐ Weakness
- ☐ None

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss
- ☐ Mood swings
- ☐ None

ENDOCRINE:
- ☐ Appetite change
- ☐ Diabetes
- ☐ Heat/cold intolerance
- ☐ Thirst
- ☐ None

MUSCULOSKELETAL:
- ☐ Joint swelling
- ☐ Muscle loss
- ☐ Pain
- ☐ Stiffness
- ☐ None

GENITOURINARY:
- ☐ Blood in urine
- ☐ Burning with urination
- ☐ Difficulty urinating
- ☐ Discharge
- ☐ Kidney stones
- ☐ Pain when postponing urination
- ☐ Pelvic pain/pressure
- ☐ Sexual problems
- ☐ Sexually transmitted disease
- ☐ Unable to urinate
- ☐ Urinary tract infection
- ☐ None

BREAST:
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Pain
- ☐ Skin changes
- ☐ None

OB/GYN:
- ☐ Abnormal periods
- ☐ Birth control pill use
- ☐ Hot flashes
- ☐ Pregnant
- ☐ None

CARDIOVASCULAR:
- ☐ Chest pain
- ☐ Fainting
- ☐ Palpitations
- ☐ None

_____ Patient or Guardian Name

_____ Relationship if other than self

_____ Signature

_____ Date

_____ Physician Signature

_____ Date