

Dear, \_\_\_\_\_

We welcome you as a new patient and look forward to seeing you on \_\_\_\_\_  
at \_\_\_\_\_.

**Location of appointment:**

\_\_\_\_\_ 2525 Telephone Rd. Pascagoula, MS 39567 Phone: 228-769-2069

\_\_\_\_\_ 1124 Oakleigh Rd. Ocean Springs, MS 39564 Phone: 228-875-3778

\_\_\_\_\_ 147 Reynoir Street Suite 306 Biloxi MS 39531 Phone: 228-432-1116

If you need directions to either office or have questions prior to your visit, please call 769-2069 and press **0** for the operator. If you need to cancel (please give a 24 hour notice if possible) or reschedule your appointment please call 769-2069 and press **212** for the appointment desk.

**The following check list will help you with your first visit to our office:**

1. Please complete all forms and bring them with you to the office on the day of your appointment. Please include this sheet. ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT TIME. PLEASE BE AWARE THAT IF YOU ARE 15 MINUTES LATE FOR A SCHEDULED APPOINTMENT, YOU WILL BE ASKED TO RESCHEDULE.
2. ALL PATIENT'S MUST BE PREPARED TO GIVE A URINE SAMPLE.
3. Bring your insurance card(s) and driver's license and will we make a copy of them for your chart.
4. Bring all of your current medications.
5. Call 1 to 2 days prior to your appointment and the nurse will get a medical history of you over the phone.
6. All patients are required to have a valid photo identification. If patient is a minor, the legal guardian must provide a valid photo identification.
7. ALL PATIENTS ARE REQUIRED TO BRING PROOF OF ADDRESS, EXAMPLE: UTILITY BILL, PHONE BILL, ETC.
8. If the patient is a minor, he or she may be accompanied by the parent (or parents). No other children are allowed in the room at the time of the doctors visit. If patient is a parent with minor children, please do not bring them to the visit. No childcare is provided at the office.

ALL PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN and documentation of guardianship must be provided at the time of the office visit. (Todos los pacientes menores de 18 anos deben ir acompañados por un padre o tutor legal, Y la documentación de la tutela debe ser suministrada en el momento de la visita al consultorio ). Si usted no habla Ingles, usted debe traer un interprete con usted a la hora de su cita.

\*\*\*\*Insurance co-pays must be paid before seeing the doctor\*\*\*\*

\*\*\*\*\$100 deposit is required if you are cash pay, additional charges may be incurred if you have a procedure the same day\*\*\*\*

\*\*\*\*If outpatient surgery is required, you will be asked to pay a surgery deposit\*\*\*\*

---

1124 Oakleigh Rd., Ocean Springs, MS 39564  
2525 Telephone Rd., Pascagoula, MS 39567  
147 Reynoir Street, Suite 306, Biloxi, MS 39531

228-875-3778  
228-762-2069  
228-432-1116

**PATIENT INFORMATION**

REFERRING DR. \_\_\_\_\_ CHOICE OF LANGUAGE \_\_\_\_\_

PHARMACY OF CHOICE / CITY, STATE \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ APT OR LOT \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ APT OR LOT \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

HOME PH \_\_\_\_\_ WORK PH \_\_\_\_\_ CELL PH \_\_\_\_\_

EMPLOYER NAME & ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_ M \_\_\_\_ F \_\_\_\_

MARRIED \_\_\_\_ WIDOWED \_\_\_\_ DIVORCED \_\_\_\_ SINGLE \_\_\_\_ SPOUSE'S NAME \_\_\_\_\_

**EMERGENCY CONTACT (THAT DOES NOT LIVE WITH YOU)**

NAME \_\_\_\_\_ (RELATION) \_\_\_\_\_ (PH) \_\_\_\_\_

**Do we have your permission to:**

Leave a message on your cell phone? Yes: \_\_\_\_\_ No: \_\_\_\_\_ N/A \_\_\_\_\_

Leave a message on your home answering machine? Yes: \_\_\_\_\_ No: \_\_\_\_\_ N/A \_\_\_\_\_

Leave a message at your place of employment? Yes: \_\_\_\_\_ No: \_\_\_\_\_ N/A \_\_\_\_\_

Send emails concerning appointments/ medical condition Yes: \_\_\_\_\_ No: \_\_\_\_\_ N/A \_\_\_\_\_

E-mail address \_\_\_\_\_

Discuss your medical condition w/any member of your household or family? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**If YES, please give the following information:**

NAME(S): \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IF PATIENT IS A MINOR INDICATE RELATIONSHIP:**

PARENT \_\_\_\_\_, GUARDIAN \_\_\_\_\_, OR OTHER \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ HOME( ) \_\_\_\_\_ WORK( ) \_\_\_\_\_

ADDRESS \_\_\_\_\_

**PLEASE PRESENT INSURANCE CARDS & PHOTO ID TO THE RECEPTIONIST SO COPIES MAY BE MADE.**

**\*\*\*INSURANCE OR MEDICARE INFORMATION\*\*\***

MEDICARE#: \_\_\_\_\_ MEDICAID#: \_\_\_\_\_

INSURED: \_\_\_\_\_ RELATION TO PT: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

INS.CO.: \_\_\_\_\_ SS#: \_\_\_\_\_ GRP#: \_\_\_\_\_ POLICY#: \_\_\_\_\_

EMPLOYER NAME & ADDRESS \_\_\_\_\_

**\*\*\*SECOND OR OTHER INS. INFORMATION\*\*\***

INSURED: \_\_\_\_\_ RELATION TO PT: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

INS.CO.: \_\_\_\_\_ SS#: \_\_\_\_\_ GRP#: \_\_\_\_\_ POLICY#: \_\_\_\_\_

EMPLOYER NAME & ADDRESS \_\_\_\_\_

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

---

**FINANCIAL POLICY**

Thank you for choosing South Mississippi Urology as your healthcare provider. We are committed to providing you the best possible service at the lowest possible price. Following is a statement of our financial policy which we require you to read and sign prior to treatment.

South Mississippi Urology accepts payment for professional services in the form of cash, check, credit card or patient financing. All patients will be required to establish a financial arrangement when services are rendered. In addition, we accept insurance from major insurance companies. **PLEASE BE AWARE THAT FEW INSURANCE COMPANIES ATTEMPT TO COVER ALL MEDICAL COSTS. EACH PATIENT IS REQUIRED TO MAKE A DEPOSIT PRIOR TO SURGERY.** Your insurance coverage is a contract between you and your insurance carrier. We will assist you in maximizing your insurance benefits and in obtaining necessary pre-certifications. As a courtesy we will review your insurance coverage, estimate your insurance payment, review your insurance form and file your claim with the carrier. To avoid any misunderstanding, we will require you to assign all insurance benefits for professional services directly to our office. If you request your insurance company to pay you directly, we will require full payment from you at the time of service. You will be notified when the insurance carrier remits payment to our practice. We will apply this payment to your account and refund any credit balance within 30 days.

If an insurance problem occurs you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problem. **YOU WILL BE RESPONSIBLE FOR ANY PORTION OF YOUR BILL WHICH IS DENIED OR NOT PAID BY YOUR INSURANCE CARRIER.**

If this bill is not paid within the ninety (90) day period from demand or billing, South Mississippi Urology, PLLC may add a collection fee of up to 30% or \$10.00 whichever is higher. If the account is turned over to a collection agency or attorney, a 30% fee will be added to the account.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication. Our staff has been instructed to make every effort to clarify any misunderstandings you have concerning your balance. If you have any questions concerning our financial policy or need any assistance, please contact our practice immediately at 769-2069.

**I have read, understand and agree to the financial policy.**

---

Signature of Patient or Responsible Party

---

Date

---

1124 Oakleigh Rd., Ocean Springs, MS 39564  
2525 Telephone Rd., Pascagoula, MS 39567  
147 Reynoir Street, Suite 306, Biloxi, MS 39531  
Revised: 2/11/2013 JS

---

228-875-3778  
228-762-4483  
228-432-1116

**CONSENT FOR TREATMENT**

This consent is **not** to be used or considered an informed consent for operation or surgical procedures. This is to certify that the undersigned authorizes the examination and/or treatment as may be necessary or advisable completed within the office of South Mississippi Urology, PLLC (SMU).

I consent to my photograph to be taken by South Mississippi Urology, PLLC for identification purposes.

1. The undersigned as the patient or his/her authorized legal representative do hereby authorize South Mississippi Urology, PLLC to release to my insurance company or other appropriate agencies, information necessary to validate this claim for billing purposes.
2. South Mississippi Urology, PLLC is also hereby authorized to release to any other physicians or medical entity information as needed for treatment, care of the insured.
3. I hereby authorize any medical and/or health insurance company to pay the proceeds of any benefits due me directly to South Mississippi Urology, PLLC. A copy of this form can be considered as an original for insurance purposes. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or the indicated person for whom I am financially responsible. Although I have requested the doctors to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt payment of the bill.
4. **I have read this agreement and understand the contents.**

PATIENT'S NAME (print)	Date	PATIENT'S NAME (signature)
------------------------	------	----------------------------

Responsible Party NAME (print)	Relationship	Responsible Party NAME (signature)
--------------------------------	--------------	------------------------------------

**5. STATEMENT TO PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO SOUTH MISSISSIPPI UROLOGY, PLLC**

Medicare#: \_\_\_\_\_ and/or Medicaid#: \_\_\_\_\_

BENEFICIARY: \_\_\_\_\_

I request that payment of authorized MEDICARE/MEDICAID benefits be made on my behalf to South Mississippi Urology, PLLC for services furnished me by physicians associated with South Mississippi Urology, PLLC. I authorize South Mississippi Urology, PLLC to release Health Care Financing Administration/ or Medicaid and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Patient/Responsible Party Signature

---

**Authorization to Obtain Medication History**

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Address: \_\_\_\_\_

By signing below, I hereby authorize South Mississippi Urology to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Patient/Legal Representative or Parent/Legal Guardian Print Name

\_\_\_\_\_  
Patient/Legal Representative or Parent/Legal Guardian Signature

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. South Mississippi Urology may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

---

**PATIENT INFORMATION CHECKLIST**

INCOMPLETE

UPDATED

- |  |       |
|--|-------|
| ___ 1. Completed Patient Information Sheet                           | _____ |
| ___ 2. Signed Insurance Authorization Consent Form                   | _____ |
| ___ 3. Signed Financial Policy                                       | _____ |
| ___ 4. Photo ID/Picture  | _____ |
| ___ 5. Copy of Current Insurance Card (s)                            | _____ |
| ___ 6. Confirm Emergency Contact Name, Relation and Number           | _____ |
| ___ 7. Patient has completed section for permission to leave message | _____ |
| ___ 8. Correct Year Label  | _____ |
| ___ 9. Signed Notice of Privacy Practices Secured in Back of Chart   | _____ |
| ___ 10. Authorization to Obtain Medication History                   | _____ |

CHECK OFF, INITIAL AND DATE WHEN INFORMATION IS VERIFIED. KEEP FORM IN CHART AT ALL TIMES IN FRONT OF PATIENT INFORMATION SHEET.