WAYNE B. GLAZIER, M.D., P.C. *UROLOGY*

MAIN OFFICE: 85 PRESCOTT STREET, SUITE 403, WORCESTER, MA 01605
PHONE: 508-753-7259 FAX: 508-753-9577

PATIENT INFORMATION FORMS UPDATED 8/1/2018

(THIS LINE FOR OFFICE USE ONLY: RETURN FORMS TO:_____page 1 of 6

PATIENT: date that you filled out these 6 pages _____

Name:_____DOB:_____GENDER: MALE or FEMALE

LAST 4 numbers of Social Security# ____ _____ _____ _____ Language:_____

Race: CIRCLE ONE: Hispanic * Caucasian * Asian * African American * Native American * Other

Ethnicity: CIRCLE ONE: Hispanic Non-Hispanic MARITAL STATUS:_____

Preferred Contact Method:_____
(example: home phone, cell phone or regular mail)

Home Address: _____
(street, city, state & zip code)

Home Phone#_____Work# _____Cell#_____

PATIENT Employer Name:_____ Occupation:_____

EMERGENCY Contact Name & Phone _____

EMERGENCY Contact's Relationship to patient:_____

Can your emergency contact make or change appointments for you?_____

Can we discuss your medical information with your emergency contact?_____

~~~~IF YOU WOULD LIKE TO SIGN UP FOR OUR ONLINE PATIENT PORTAL,
PLEASE PROVIDE YOUR EMAIL ADDRESS HERE_____

*****Our office uses an electronic system to submit your non-narcotic prescription requests directly to your pharmacy. Do we have your permission to enter your prescriptions and obtain your medication history through this system?_____**

What is your * PHARMACY* name & ADDRESS (STREET # & TOWN):

_____

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BE SURE THE PRIMARY CARE PHYSICIAN WE HAVE ON FILE MATCHES THE PRIMARY CARE PHYSICIAN THAT YOUR *INSURANCE* HAS LISTED FOR YOU*

Primary Care Physician Name & Phone #:_____

#1 Insurance Name:_____

#2 Insurance Name:_____

IF YOU HAVE ANY HEALTH CARE DIRECTIVES, FOR EXAMPLE: Power of Attorney, Health Care Proxy, Do Not Resuscitate Orders, No Blood Transfusions allowed etc., please list them below *AND ALSO PROVIDE OUR OFFICE WITH A LEGAL COPY OF THAT DIRECTIVE, OTHERWISE WE CANNOT HONOR THOSE REQUESTS*

_____

PERMISSION TO TREAT & DISTRIBUTE INFORMATION

Do you grant your Health Care Provider permission to treat you for the urological condition(s) you are being seen for? ☐ YES ☐ NO **If no, please be sure to let the receptionist know. THE PROVIDER MAY DETERMINE THAT HE/SHE WILL NOT BE ABLE TO SEE YOU UNDER THAT RESTRICTION

Do you grant your permission for your Health Care Provider to forward your information as needed to outside facilities such as hospitals and/or laboratories if he/she deems it is in the best interest of your urological health?

☐ YES ☐ NO (If no, please be sure to let the receptionist know.
THE PROVIDER MAY DETERMINE THAT HE/SHE WILL NOT BE ABLE TO SEE YOU UNDER THAT RESTRICTION

INSURANCE REFERRALS

IF YOUR INSURANCE REQUIRES REFERRALS FOR SPECIALIST VISITS, IT IS YOUR RESPONSIBILITY TO OBTAIN THAT REFERRAL PRIOR TO YOUR VISIT. IF THE REFERRAL IS NOT ON FILE AT THE TIME OF THE VISIT, WE WOULD HAVE TO RESCHEDULE YOUR VISIT.

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PRIVACY POLICIES STATEMENT

By signing this form, you acknowledge that this medical practice has informed you of its privacy practices information. The complete policy is posted in a binder on the table to the left of the reception room window. This notice explains how health information is handled. A federal law about medical privacy called "HIPAA" requires that all medical offices inform their patients of their privacy policies. An abbreviated version of that policy is listed below:

****Please note, our office routinely sends notices to patients regarding lab results, appointments and billing issues. We also make phone calls to the numbers you have given us regarding the same issues. If you have any restrictions or exceptions on how we communicate with you, please explain those restrictions below:**

****If you have Restrictions regarding WHO we may COMMUNICATE with about your appointments, lab results or billing issues, list those restrictions here:**_____

_____

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STANDARD PATIENT PAYMENT RESPONSIBILITIES:

You WILL BE RESPONSIBLE FOR PAYMENT OF TODAY'S SERVICES :

1) IF THE INSURANCE ON FILE FOR YOU AT THIS OFFICE REJECTS TODAY'S CHARGES BECAUSE YOUR COVERAGE HAS BEEN DEACTIVATED. * OR*

2) IF THE INSURANCE ON FILE FOR YOU AT THIS OFFICE REQUIRES INSURANCE REFERRALS FOR SPECIALIST VISITS AND THE CURRENT REFERRAL ON FILE IS NOT VALID *OR*

3) IF YOU HAVE **NO** INSURANCE FOR TODAY'S VISIT, YOUR PAYMENT IS REQUIRED **PRIOR** TO SERVICES BEING PROVIDED.

DISMISSAL FROM PRACTICE REASONS:

- CHRONIC NON-PAYMENTOF BALANCES DUE
- REPEATED MISSED OR CANCELLED APPOINTMENTS
- ANY INAPPROPRIATE BEHAVIOUR TOWARDS PROVIDERS OR STAFF
- CHRONIC REFUSAL TO FOLLOW CARE PLANS RECOMMENDED BY YOUR PROVIDER

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PATIENT FINANCIAL POLICIES

OUR OFFICE IS DEDICATED TO PROVIDING THE BEST POSSIBLE CARE & SERVICE TO YOU. WE REGARD YOUR UNDERSTANDING OF OUR FINANCIAL POLICIES AS AN ESSENTIAL ELEMENT OF YOUR CARE. AS A COURTESY, OUR OFFICE WILL BILL YOUR INSURANCE COMPANY FOR SERVICES PROVIDED TO YOU.

**ALL COPAYS & PRIOR BALANCES DUE ARE PAYABLE AT THE TIME OF CURRENT SERVICES.

ADDITIONAL FINANCIAL POLICY INFO EXPLAINED BELOW:

- **IF YOUR INSURANCE COMPANY DOES NOT REIMBURSE OUR OFFICE WITHIN A REASONABLE AMOUNT OF TIME (TWO MONTHS IS CONSIDERED THE MAXIMUM PROCESSING PERIOD), YOU WILL BE BILLED FOR THE VISIT(S). IF, AT A LATER DATE, WE RECEIVE PAYMENT FROM YOUR INSURER WE WILL REFUND ANY OVERPAYMENT DIRECTLY TO YOU.**
- **IF YOUR INSURANCE COMPANY REQUIRES COPAYMENTS FOR OFFICE VISITS, THAT PAYMENT IS DUE AT THE TIME OF YOUR VISIT. IF OUR OFFICE HAS TO BILL YOU FOR THAT COPAY, PLEASE BE ADVISED THAT THERE WILL BE A $10.00 BILLING FEE ATTACHED TO EACH PATIENT BILL SENT.**
- **IF OUR OFFICE SENDS MORE THAN 1 STATEMENT FOR ANY PATIENT DUE BALANCE, THERE WILL BE A $10 BILLING FEE ADDED TO EACH STATEMENT SENT**

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NONCOVERED SERVICES & BALANCES

- **NOT ALL SERVICES PERFORMED BY THE DOCTOR ARE GUARANTEED TO BE COVERED BY YOUR INSURANCE COMPANY. IT IS YOUR RESPONSIBILITY TO VERIFY COVERAGE FOR SERVICES EXPECTED TO BE PERFORMED BY YOUR DOCTORS.**
- **IF A CHARGE IS REJECTED BY YOUR INSURANCE, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THAT CHARGE.**
- **IF YOUR INSURANCE DOES NOT COVER 100% OF YOUR CHARGES, YOU ARE RESPONSIBLE FOR ANY BALANCE DUE.**
- **IF YOU HAVE ANY QUESTIONS REGARDING YOUR BILL, PLEASE CALL OUR OFFICE AND ASK FOR ANJI.**
- **IF OUR OFFICE HAS TO SEND ANY PATIENT DUE BALANCES ON YOUR ACCOUNT TO OUR ATTORNEY FOR COLLECTION, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS AND ACTUAL ATTORNEY FEES.**
- **PLEASE NOTE***WE CHARGE A $75 *NEW PATIENT APPOINTMENT* NO SHOW/LATE CANCELLATION FEE FOR FAILURE TO GIVE 48 HOURS NOTICE OF CANCELLATION* WE ALSO CHARGE A $25.00 NO SHOW/LATE CANCELLATION FEE FOR *EXISTING* PATIENT APPOINMENTS FOR FAILURE TO GIVE 48 HOURS NOTICE OF APPOINTMENT CANCELLATIONS.**

**** SOME appointments may require longer notifications of cancellations & carry a higher no show fee depending on the type of appointment that was on file for you.**

****My signature below confirms that I have read & understand the policies of this office**

_____ _____

Patient Signature **date signed**

****IF ANOTHER PERSON FILLED OUT THESE FORMS FOR YOU, WE NEED THAT PERSON'S INFORMATION & RELATIONSHIP TO YOU LISTED BELOW.**
****ALSO IF PATIENT IS UNDER 18, LEGAL GUARDIAN MUST SIGN BELOW:**

_____**(Guardian or interpreter signature)**

Print Legal Guardian OR INTERPRETER'S name here: _____

RELATIONSHIP TO PATIENT:_____PHONE NUMBERS:_____

BELOW INFO IS FOR OUR OFFICE USE ONLY: *IF PT DIDN'T SIGN FORMS, EXPLAIN WHY*

_____*EMPLOYEE NAME WHO DID FIRST STEPS ***(MARLBORO OFFICE DOES 1 & 2)*

_____*EMPLOYEE NAME WHO DID *SECOND* STEPS & SCANNING ****