PATIENT INFORMATION SHEET

SOUTHERN UROLOGY, LLC / SOUTHERN SURGICAL & MEDICAL SPECIALISTS

Please complete every section. If something is not applicable, please write "NA" rather than leaving blank

Patient Name Last: First: Middle:		Date of Birth: / /	Social Security # - -
Other Known Name (If Any) Last: First: Middle:		Other local Urologist(s) seen (if any):	
Primary Language: ☐ English Other:	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	Race:	Sex: ☐ M ☐ F
Marital Status: ( )Single ( )Married -how long?:_____ ( )Life Partner -how long?_____ ( )Divorced ( )Widowed ( )Separated			
Home Street Address:	City:	State:	Zip:
Mailing Street Address (If Different Than Above):	City:	State:	Zip:
Home Phone Number:	Work Phone #:	Other / Cell #:	Additional Contact #:
Nearest relative not living with you (Emergency Contact):	Contact Phone #:		Relationship to Pt.:
Employer Name:	Your Occupation:	Status: ☐ Full-Time ☐ Part-Time	Employment Location (City/State):
Your Primary Care Physician:	Preferred Pharmacy:	Pharmacy Location (Street, City): Pharmacy Phone Number:	
Email Address:			

INSURANCE INFORMATION

PRIMARY	***SECONDARY***
Primary Insurance Co.:	Secondary Insurance Co.:
Member ID#:	Member ID#:
Group #:	Group #:
If Policy Holder is not Patient (through spouse's employer, etc):	**If Policy Holder is not Patient** (through spouse's employer, etc):
Policy Holder Name:	Policy Holder Name:
Policy Holder SS#:	Policy Holder SS#:
Policy Holder Address:	Policy Holder Address:
Policy Holder Phone:	Policy Holder Phone:
Policy Holders Date of Birth:	Policy Holders Date of Birth:
Is this Policy through COBRA or Other Temporary Continuatiom of Benefits?	

LEGAL / WORK COMP / OTHER FACILITY

Is your visit related to a pending legal case? ☐ Yes ☐ No	If Yes, Attorney Name:
Is your visit related to a work-related injury? ☐ Yes ☐ No	If Yes, Date of Injury:
Are you currently a Hospice or Home Health Care Patient? ☐ Yes ☐ No If Yes, Provider Name:	Are you currently in a Nursing Home or Skilled Nursing Facility? ☐ Yes ☐ No Location Name:

MINORS ONLY

Father's Name:	Phone # (If different):	Father's Occupation:	Father's Employer / Location:
Mother's Name:	Phone # (If different):	Mother's Occupation:	Mother's Employer / Location:

REFERRAL INFORMATION

Referring Physician's Name:	Referring Physician Specialty:
If not referred by a physician, how did you find us?	

OFFICE STAFF USE ONLY

Appt Date:	Acct / MRN#:	Dx / Reason for Visit:
Other Ref MD or Pre-Cert Info:		

Patient Name (Last, First)_____ Appt Date:_____

PAST MEDICAL HISTORY FORM
SOUTHERN UROLOGY, LLC

PLEASE CHECK NEXT TO ANY OF THE FOLLOWING CONDITIONS IF EVER DIAGNOSED:

CARDIOVASCULAR

- ☐ Anemia
- ☐ Aneurism
- ☐ Arrhythmia (Irregular Heart Beat)
- ☐ Atrial Fibrillation (Afib)
- ☐ Congestive Heart Failure (CHF)
- ☐ DVT (Blood Clot)
- ☐ High Blood Pressure (Hypertension)
- ☐ Mitral Valve Prolapse
- ☐ Sickle Cell Anemia
- ☐ Other_____

ENDOCRINE

- ☐ Diabetes ☐ Insulin ☐ Non-Insulin
- ☐ Hypogonadism (Low Testosterone)
- ☐ Gout
- ☐ Thyroid ☐ Hyper- ☐ Hypo-
- ☐ Other_____

GENERAL

- ☐ High Cholesterol
- ☐ Obesity

GASTROINTESTINAL

- ☐ Gallstones
- ☐ Crohns' Disease / Colitis
- ☐ Diverticulitis
- ☐ Hepatitis, Type _____
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Stomach Ulcer
- ☐ Other_____

GENITOURINARY

- ☐ AIDS / HIV
- ☐ BPH
- ☐ Epididymitis
- ☐ HPV
- ☐ Impotence
- ☐ Interstitial Cystitis
- ☐ Kidney Stones
- ☐ Polycystic Kidney Disease
- ☐ Prostatitis
- ☐ Other_____

HEAD, EARS, EYES, NOSE, THROAT

- ☐ Blind
- ☐ Cataracts
- ☐ Deafness
- ☐ Glaucoma ☐ Open Angle ☐ Closed
- ☐ Sinusitis
- ☐ Tinnitus (Ringing in ear(s))

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Carpel Tunnel
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Other_____

NEURO / PSYCH

- ☐ ADD
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Spina Bifida
- ☐ Spinal Cord Injury
- ☐ Stroke (CVA)

Other_____

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Pulmonary Emboli (Blood Clot in Lung)
- ☐ Sleep Apnea
- ☐ TB
- ☐ Other_____

TUMORS / CANCER

- ☐ Bladder Cancer
- ☐ Brain Tumor
- ☐ Breast Cancer
- ☐ Cervical / Uterine Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Ovarian Cancer
- ☐ Pancreatic Cancer
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Renal Cancer - Kidney
- ☐ Sarcoidosis
- ☐ Skin Cancer
- ☐ Stomach Cancer
- ☐ Testicular Cancer
- ☐ Throat Cancer

Patient Name (Last, First)_____ Appt Date:_____

PAST SURGICAL HISTORY

List ALL surgeries, dates of surgery, and whether it was on your right or left side (if applicable)

Type of Surgery	Date	Side
Example: Knee replacement	*Oct 2007*	*left*

SBE PROPHYLAXIS

Do you have to take antibiotics prior to dental or surgical procedures due to a heart condition?

☐ No ☐ Yes If yes, please specify_____

OB / GYN HISTORY *(Men skip to next section)*

Last Menstrual Period_____ Have you had a Mammogram? __Yes __No

Prior Abnormal Pap Smear?_____ If so, Date of Last Mammogram _____

Date of last Pap Smear_____

Age of 1st Period_____ Hysterectomy? Date_____

Do you have regular periods ☐ Yes ☐ No

Age of Menopause_____

Are You Pregnant Now? ☐ Yes ☐ No

Number of Pregnancies_____ Number of Premature Deliveries_____

Number of Deliveries_____ Number of Vaginal Deliveries_____

Number of Full Term Deliveries_____ Number of C-Section Deliveries_____

SEXUAL HISTORY

Are you sexually active?

☐ Yes ☐ No If Yes: ☐ Single or ☐ Multiple Partners

Birth Control?

☐ None
☐ Birth Control Pill
☐ Condom / Diaphragm
☐ Other: _____

Sexually Transmitted Diseases

☐ None
☐ Gonorrhea
☐ Syphilis
☐ HPV / Genital Warts

OTHER PROCEDURE HISTORY

Ever had a colorectal cancer screening? ( ) Yes ( ) No If yes, date of last:_____

If Yes, was it: ( ) Colonoscopy ( ) Flexible Sigmoideoscopy ( ) Fecal occult blood test (FOBT)

Ever had a bone mineral density scan? ( ) Yes ( ) No If Yes, date of last:_____

Ever had a blood transfusion? ( ) Yes ( ) No If Yes, date of last:_____

Taking baby aspirin or any other anti-platelet daily? ( ) Yes ( ) No

Date of last pneumonia vaccine:_____

Date of last influenza vaccine:_____

Patient Name (Last, First)_____ Appt Date:_____

SOCIAL HISTORY

CHILDREN

☐ Yes how many?_____
☐ No

ALCOHOL CONSUMPTION

Do you drink alcohol?
☐ Yes
☐ No

If yes, how often?
☐ Occasionally / socially
☐ Daily, How many?_____

If yes, what?
☐ Beer
☐ Wine
☐ Liquor

SMOKING HISTORY

Do you currently smoke?
☐ Yes
☐ No

If yes, how many packs a day? _____
How many years have you smoked?_____

Do you use smokeless tobacco:
☐ Yes
☐ No

If Yes, how many years?_____

Did you smoke in the past?
☐ Yes
☐ No

How many packs a day?_____
For how many years did you smoke?_____
Number of years since you quit?_____

DRUG USE

Do you use recreational drugs?
☐ Yes
☐ No

If yes, what type?_____

CAFFEINE

Do you drink caffeinated beverages?
☐ Yes
☐ No

If yes, what type?_____
How many (cups, cans, etc.) a day?_____

FOREIGN TRAVEL

Have you traveled to a foreign country recently?
☐ Yes
☐ No

If yes, where?_____

FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No

Does anyone in your family have the following conditions?

If so, indicate if applies to your father, mother, brother, sister, grandfather, grandmother, aunt or uncle

☐ BPH (Enlarged Prostate)_____
☐ Bedwetting_____
☐ Bladder Cancer_____
☐ Breast Cancer_____
☐ Cervical Cancer_____
☐ Colon Cancer_____
☐ COPD (Lung Disease)_____
☐ Diabetes_____
☐ Heart Attack_____
☐ High Blood Pressure_____
☐ Kidney Cancer_____
☐ Kidney Disease (what type?)_____
☐ Kidney Stones_____
☐ Lung Cancer_____
☐ Ovarian Cancer_____
☐ Pancreatic Cancer_____
☐ Parkinson's Disease_____
☐ Prostate Cancer_____
☐ Stroke_____
☐ TB_____
☐ Uterine Cancer_____
☐ Other_____

Spouse:	Age_____ ☐	Deceased at age_____	Children?_____
Father:	Age_____ ☐	Deceased at age_____	How Many?_____
Mother:	Age_____ ☐	Deceased at age_____	
Siblings:	Age_____ ☐	Deceased at age_____	

Patient Name (Last, First)_____ Appt Date:_____

DRUG ALLERGIES

Drug Name	Type of Reaction
Example: Penicillin	*rash*

MEDICATIONS (List all Prescription and Over-the-Counter drugs you are taking)

Medication Name & Strength	How Many/Much	How Often?
Example: Testosterone 200mg/ml	*1 cc*	*Every Month*

Patient Name (Last, First)_____ Appt Date:_____

REVIEW OF SYSTEMS

Please check next to any of the following symptoms you are CURRENTLY experiencing

CONSTITUTIONAL

- ☐ Appetite Change
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Weakness
- ☐ Weight Change
- ☐ Weight Loss

EYES

- ☐ Blind
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye Pain
- ☐ Worsening Eyesight
- ☐ Glaucoma

ALLERGIES

- ☐ Animal
- ☐ Drug
- ☐ Environmental
- ☐ Food
- ☐ Seasonal

NEUROLOGICAL

- ☐ Balance Problems
- ☐ Disoriented
- ☐ Dizzy
- ☐ Headache
- ☐ Leg/arm weakness
- ☐ Memory Loss
- ☐ Numbness/Tingling
- ☐ Speech Problems
- ☐ Tremors

ENDOCRINE

- ☐ Sugar Diabetes
- ☐ Thirsty
- ☐ Thyroid Problem
- ☐ Tired/sluggish
- ☐ Too hot/cold

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Abdominal cramps
- ☐ Reflux
- ☐ Bloody Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/vomiting
- ☐ Hemorrhoids
- ☐ Indigestion/Heartburn

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Dyspnea on exertion
- ☐ Edema
- ☐ Irregular Heart Beat

SKIN / INTEGUMENTARY

- ☐ Acne
- ☐ Boils
- ☐ Moles
- ☐ Itching
- ☐ Rash

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle cramps
- ☐ Muscle weakness

ENT

- ☐ Ear Infections
- ☐ Sinus trouble
- ☐ Sore Throat
- ☐ Deafness

GENITOURINARY

- ☐ Bedwetting
- ☐ Blood in urine
- ☐ Burning on urination
- ☐ Erection problems
- ☐ Bladder stones
- ☐ Leaking urine
- ☐ Penis Pain
- ☐ Curved Penis
- ☐ Scrotal Pain
- ☐ Scrotal Swelling
- ☐ STD
- ☐ Vaginal Discharge
- ☐ Incontinence
- ☐ Weak Stream
- ☐ Nocturia
- ☐ Urgency
- ☐ Frequent Urine
- ☐ Painful Ejaculation

RESPIRATORY

- ☐ Asthma Attack
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

HEMATOLOGIC / LYMPHATIC

- ☐ Swollen Glands
- ☐ Blood Clotting Problem
- ☐ Bleeding problems
- ☐ Bruising
- ☐ HIV / AIDS

PSYCHOLOGICAL

- ☐ Do you feel anxious?
- ☐ Do you feel depressed?

NOTICE OF PRIVACY PRACTICES
SOUTHERN SURGICAL & MEDICAL SPECIALISTS
(Includes Southern Urology, LLC, Surgical Specialists of Lafayette, LLC, and Lafayette Diagnostic & Radiation Treatment Center)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA), requires all health records and other Protected Health Information ("PHI") used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice in its currently in effect was updated on 03/26/13 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the Company Contact information listed at the end of the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: Without specific written authorization, we are permitted to use and disclose your healthcare records for the purpose of TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, and OTHER REASONS REQUIRED BY LAW:

TREATMENT: This means providing, coordinating, or managing health care and related services by one or more healthcare providers/physicians. For example, if your specialist asks your primary care doctor to share PHI related to any physical exams or diagnostic procedures done.

PAYMENT: This means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be billing your insurance company or Medicare for services rendered.

HEALTH CARE OPERATIONS: This is the business aspect of running our practice, such as conduction quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be a periodic quality review/assessment of our documentation protocol, etc.

PUBLIC HEALTH, ABUSE or NEGLECT, HEALTH OVERSIGHT, and OTHER REASONS REQUIRED BY LAW: We will use and disclose your PHI when we are required to do so by federal, state or local laws. We may disclose your PHI to public health authorities that are authorized by law to collect information, or to a health oversight agency for activities included but not limited to: response to a court order or administrative order; if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute-- but only if we made an effort to inform you of the request or obtain an order protecting the information the party has requested. We may release your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death or if you are an organ donor. We may release your PHI to the tumor registry. We may use and disclose PHI when necessary to reduce or prevent a serious threat to your health and safety, of another individual or to the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PHI if you are a member of the U.S. or foreign military (including veterans) when required for appropriate intelligence or national security activities authorized by law. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care services to you, for the safety and security of the institution, and to protect your health and safety or that of other individuals or the public. We may release your PHI for worker's compensation and similar programs.

In addition, your confidential information may be used to remind you of an appointment (electronically, by mail, letters, voicemail messages, or postcards) or provide you with information about treatment options or other health related services including release of information to friends or family members that are *directly* involved in your care or assist in taking care of you.

PATIENT RIGHTS

AUTHORIZATION: Any uses or disclosures of your PHI *not* addressed above may only be made with your authorization. You may revoke such authorization in writing and we are required to honor and abide that written request, except to the extent that we have already taken actions relying on your authorization.

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to your physician to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies, electronic media storage, and staff time.

RESTRICTIONS: The following uses and disclosures will be made only with your authorization: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for fundraising or marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this NPP.

ADDITIONAL RESTRICTIONS: You have the right to request additional restrictions on our use or disclosure of your health information. This must be made in writing, and must identify: (i) the information to be restricted; (ii) the type of restriction being requested (i.e. on the use of information, the disclosure of information, or both); and (iii) to whom the limits should apply. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

RESTRICTING DISCLOSURE TO YOUR INSURANCE COMPANY: We must comply with your restriction request if you have paid for your services out-of-pocket, in full, and you are requesting that we not disclose your PHI related solely to those services to your health plan. This request must be made in writing prior to or on the date of the service to allow our office to provide you with the information on your out of pocket cost, collect necessary fees for service, obtain a signature of this request, and avoid filing to your insurance.

DISCLOSURES OF ACCOUNTING: You have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes other than treatment, payment, healthcare operations and other reasons required by law herein, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Your request must be in writing and specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our Website, you are entitled to receive this Notice in written form.

BREACH: We are required to notify you if there is a breach and/or unauthorized use of your PHI.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information, you may contact the person below. You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your rights to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACTS:

Company's Contact:
Mark Eldredge
120 Rue Louis XIV
Lafayette, LA 70508
PHONE: 337-769-7779
FAX: 337-769-7788

Government Contact:
U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C. 20201
Toll Free 877-696-6775

Revised on 04/26/2013

Southern Surgical & Medical Specialists
Includes:
Southern Urology
Surgical Specialists of Lafayette
Lafayette Diagnostic & Radiation Treatment Center

PRIVACY NOTICE ACKNOWLEDGMENT

I hereby acknowledge that I have been given the opportunity to read and review our Notice of Privacy Practices, located on our web site and in the lobby of our office. I understand that a copy of this Notice will be made available to me, for my personal use, if requested.

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient/Representative **Signature** Date of Signature

_____
Representative's Relation to Patient, If Applicable

Documentation of Good Faith Effort

(To be completed by our staff if a signature is not obtained by patient or representative)

A good faith effort has been made to obtain a written acknowledgement of the Notice of Privacy Practices made available to the patient, provided in the lobby of our office. An Acknowledgement has not been obtained because:

☐ Patient refused to sign the Acknowledgement despite having opportunity to read and review.

☐ Other: Patient was unable to sign the acknowledgement because:_____
_____

_____ _____
Employee Signature Date

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

As required by HIPAA, you have a right to request that communications concerning your personal health information be made through confidential channels. Periodically, we will need to contact you for appointment reminders, to give test results, or to speak with you regarding any insurance/billing concerns. Please assist us in providing the proper means to contact you, and if you are not available, the name(s) of those you give permission to speak to.

---

*I hereby authorize **Southern Urology** (DBA Southern Surgical & Medical Specialists) to leave detailed messages regarding my personal health information via:*

Home Telephone Number Yes No Phone #_____

Cell Phone Number Yes No Phone #_____

Written (mailed) Communication
To my home address on file Yes No
To another address only Yes No
Other address: _____
_____

I hereby request and authorize my Southern Urology physician to disclose any medical information relating to diagnoses, care, treatment, test results and prognosis concerning myself to the individuals listed below. (*This may include spouses, relatives, children, friends, etc*.). I understand information may be either obtained in person, in writing or by telephone. (*Write "None" in the space provided below if you do not want anyone to have access to your medical information.*). This consent is valid until revoked in writing.

Name	Relationship to Patient	Telephone (if different than the Home Number above)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Patient Name (Printed) Signature of Patient / Legal Guardian

_____ _____
Legal Guardian Name (If applicable) Date

PATIENT NOTIFICATION OF OUR FINANCIAL POLICY

Southern Surgical & Medical Specialists – which includes the divisions of Southern Urology, Surgical Specialists of Lafayette, and Lafayette Diagnostic & Radiation Treatment Center -- is committed to providing the highest quality of healthcare available while maintaining a financial policy that is fair to our patients. First and foremost, it is important for you to understand that, regardless of your insurance status, you are ultimately responsible for payment of your account.

We accept cash, checks, and major credit cards. We accept Medicare assignment and are participating providers for many managed care plans. We are obligated to follow their guidelines related to billing, collections and allowable pricing on "covered" services. However, each policy is written differently and it is the patient's responsibility to be aware of what their own policy does and does not cover. Some other key points to know:

- If insured, we ask that you present your insurance card at each visit. It is your responsibility to ensure that the card (and your coverage) is current and correct. Please let us know whenever any demographic information (address, phone numbers, etc.) has changed.
- If we are "participating providers" with your insurance company, we will collect co-pays, deductibles, co-insurance and other out-of-pocket expenses your insurance company does not cover at the time of service.
- For our private pay patients, we offer a 25% "prompt pay" discount from our charge schedule when paying in full.
- For private pay patients and those with insurance plans with whom we do not participate, your payment is due at the time of service. If we do not participate with your insurance plan, we can file your claims and refund you any portion your insurance plan covers.
- If the assignment of benefits is rejected or if your insurance fails to pay on a claim according to our contractual terms within 60 days after it has been filed (unless there is a valid reason for denial), it will be your responsibility to pay the charges in full.
- We send statements and bills to patients on unpaid amounts owed. At the discretion of our billing department, we may agree to an installment payment plan. However, lacking any agreed-upon payment arrangement with you (or failing to make payment on such agreed-upon amount) we may turn your account over to an outside collection agency. *If at any time you cannot pay your bill, please contact our billing office to discuss possible payment arrangements.*
- Certain diagnostic tests may be performed that require an "outside" physician's professional services (example: a pathologist's interpretation/report on a biopsy sample). Be aware that you may receive a separate bill from a physician or lab for services not performed by Southern Urology. Please inquire with our physician or nurse should you have questions about whether of your particular tests are sent to outside providers.
- For commercial insurance patients, a deposit may be required for any outpatient or inpatient hospital procedures to cover your deductible, unless we can verify that your deductible has been met.
- Non-Medical Charges: Special medical forms and record copying is charged at a variable rate depending on number of pages. $25 is charged on all NSF checks.
- You may be referred to certain services (diagnostic CT, radiation oncology, certain lab testing) at Lafayette Diagnostic & Radiation Treatment Center. This facility is part of the Southern Urology, wholly owned and part of our Group Practice. Bills for these tests will come from Southern Urology, but show as a separate practice location.
- Several Southern Surgical & Medical Specialists physicians are also partners and/or have a financial interest in other local healthcare organizations. At some point during your care with Southern Surgical & Medical Specialists you may be referred to and receive services by one of these entities. The following table provides a list of those organizations by physician.

Table of Ownership Interest in other Healthcare Organizations by our physician members:

Frank Baque', M.D.	Southern Lithotripsy; Southern Laser, UMS MR Fusion Services
Thad Bourque, M.D.	Lafayette Surgical Specialty Hospital, Southern Lithotripsy, Southern Laser, UMS MR Fusion Services of Louisiana
Edward Breaux, M.D.	Park Place Surgical Hospital; Southern Lithotripsy, Southern Laser, UMS MR Fusion Services of Louisiana
Jeannette Chassaignac, M.D.	Park Place Surgical Hospital; Southern Lithotripsy, Southern Laser, UMS MR Fusion Services of Louisiana
Christopher Fontenot, M.D.	Lafayette Surgical Specialty Hospital, Southern Lithotripsy, Southern Laser, UMS MR Fusion Services of Louisiana
Marcellus LaHaye, M.D.	Southern Lithotripsy; Southern Laser, UMS MR Fusion Services of Louisiana, UMS MR Fusion Services of Louisiana
Scott Neusetzer, M.D.	Park Place Surgical Hospital; Southern Lithotripsy, Southern Laser, UMS MR Fusion Services of Louisiana
William Roth, M.D.	Lafayette General Surgical Hospital; Southern Laser; HealthTronics Lithotripsy, UMS MR Fusion Services of Louisiana
Samuel Shuffler, M.D.	Lafayette General Surgical Hospital; HealthTronics Lithotripsy, UMS MR Fusion Services of Louisiana
Jeremy Speeg, M.D.	Park Place Surgical Hospital; Southern Lithotripsy, Southern Laser, UMS MR Fusion Services of Louisiana
Jeffrey Thibodeaux, M.D.	Lafayette Surgical Specialty Hospital, Southern Lithotripsy, Southern Laser, UMS MR Fusion Services of Louisiana
John Vallee, M.D.	Opelousas General Hospital Imaging; Southern Lithotripsy, Southern Laser, UMS MR Fusion Services of Louisiana
Jason Breaux, M.D.	Park Place Surgical Hospital
Henry Kaufman, M.D.	Park Place Surgical Hospital
Jacob Landry, M.D.	Park Place Surgical Hospital
Andre Broussard, M.D.	UMS MR Fusion Services of Louisiana
Jason Bourque, M.D.	
Lauran Owens, M.D.	

Southern Surgical & Medical Specialists is the Doing Business As ("DBA") name for Southern Urology, LLC and Surgical Specialists of Lafayette, LLC. We participate with insurance companies under this original entity name. Southern Urology currently has contracts to participate with many major health plans. We can confirm whether we participate with your health plan when you make your appointment, or any time thereafter. Please be aware, however, that some insurance companies add "sub-networks" (PPO, POS, Medicare Advantage, etc.) that may not be part of our agreement.

Patient Acknowledgement of Financial Policy & Assignment of Benefits

By signing below, I certify that I have read this Financial Policy and understand its terms and conditions. I authorize the release of any medical information necessary to process my insurance claims, and request that payment of insurance benefits be made directly to Southern Urology. I also authorize the release of financial information relating to my account through direct phone calls and mailings as necessary to collect on all claim balances. I understand that I am responsible for my own bill in the event that my insurance company does not pay or pay within a timely fashion.

Signature of Patient / Responsible Person: _____
Printed Name:_____
Relationship to Patient (if Responsible Party):_____
Date: _____/_____/_____