Urology Clinic of Hanford

www.urologyhanford.com
Seetharaman Ashok, M.D.
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Welcome to Urology Clinic of Hanford. It is our goal to provide superb urological care, and for you to understand the nature of your problem, the reasons for investigational tests, and the treatment plan to promote and protect your urological health. In order to minimize your waiting time and provide efficient service to all our patients, we request your assistance with the following things.

Your First Appointment

We ask that you fill out and sign the attached forms and insurance information documents prior to your first appointment. Please bring your current **insurance card(s)**, **x-ray films**, and a list of your **current medications**. (included on last page)

Appointments

We recognize the value of your time, and will do our best to see you as promptly as possible. Please make sure to **check in** with the receptionist when you arrive. We will contact you 2 days prior to your appointment as a reminder, and we ask that you contact our office to reschedule and appointments at least **24 hours** in advance. Our waiting list for appointments is lengthy, and missing an appointment deprives someone else of the opportunity to be treated in a timely fashion. For this reason, repeated no-shows and same day cancellation may result in a **$25.00 charge** for office visits or a **$100.00 charge** for a procedure or surgery.

(Turn Over)

Medications

We ask that you please contact your pharmacy directly if you need any prescription refills. Please allow at least **72 hours** for medication refills. In case of a presumed **urinary tract infection**, we may prescribe antibiotics without an appointment. However, we ask that you **obtain a urine sample** prior to starting antibiotics therapy to allow better long-term management of your problem. If this request is ignored, prescription of antibiotics without an appointment will no longer be available to you.

Emergencies

Our office is not open on weekends. The only location where an on-call physician can see you is in the **emergency room** or the **hospital**.

Surgery

Payment arrangements for elective surgery need to be made **in advance**. The amount required in advance as a down payment will depend on both your insurance coverage and the type of surgery performed.

Co-Pays

Co-pays are required at the time of service without exception. For our Medicare patients, please recognize that, although Medicare does not require a co-pay, your secondary insurance often does.

Payments

Payment arrangements need to be made **at the time of service**. We are happy to file the forms necessary for you to receive insurance benefits. Your insurance policy is an agreement between you and your insurance company. It states what is and is not covered. This means that **you** are ultimately responsible for all charges.

(Turn Over)

Payment plans are available for those who require financial assistance. Patients with delinquent accounts will be seen only on a cash basis payable at the time of service.

Signatures

The affixed "New Patient Information Sheet" contains a signature area. It is required by law that this section is filled out prior to the billing of your insurance. In addition, there is a copy of the HIPAA (Health Insurance Portability and Accountability Act of 1996) handout posted in the reception area. If you would like a copy of this handout, please notify the receptionist.

Conclusion

Welcome again to Urology Clinic of Hanford, and thank you for choosing us. We look forward to providing you with optimal urological care.

Dr. Seetharaman Ashok M.D. and staff

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New Patient Information Sheet

Name:(First)_____**(Middle)**_____**(Last)**_____
Mailing Address:_____**City**_____**Zip**_____
Primary Phone #:_____ **Secondary Phone #:**_____
Social Security #:_____
Date of Birth:____/____/_____ **Age:**____ **Sex:** Male / Female
Maritial Status: S / M / W / D
Referring Physician:_____
Primary Care Physician:_____
Emergency Contact (Not Living With You):_____
Phone #:_____
Pharmacy Name:_____ **City:**_____
Email Address:_____

Primary Insurance Information
(Circle "Self" If Secondary Insurance Information Is Same As Patient, And Go On To Next Section)

Insurance Company:_____
Relationship to Patient: Self / Spouse / Dependent
Name of Insured:_____
Social Security # of Insured:_____
Date of Birth:____/____/_____

Secondary Insurance Information
(Circle "Self" If Secondary Insurance Information Is Same As Patient, And Go On to Next Section)

Insurance Company:_____
Relationship to Patient: Self / Spouse / Dependent
Name of Insured:_____
Social Security # of Insured:_____
Date of Birth:____/____/_____

Financial Agreement And Authorization For Treatment:

I authorize treatment of the named patient and agree to pay for all fees and charges related to medical care received by Seetharaman Ashok, M.D.

(Turn Over)

I agree to pay resonable attorney fees for any legal action taken to collect such charges.

It is agreed that payments will not be delayed or withheld because of insurance coverage of pending claims; all proceeds are assigned to Seetharaman Ashok, M.D., without assuming responsibility of collection. I authorize the release of my medical information needed to determine payable benefits or further diagnosis and treatment of medical conditions.

Assignment of Benefits

I hereby direct all payments of benefits otherwise payable to me to Seetharaman Ashok, M.D. I understand I am financially responsible for charges not covered.

No-Show Fees

I hereby acknowledge that I am aware of any and all no-show fees. If I do not give 24-hour notice to cancel my appointment with Seetharaman Ashok, M.D., I will be charged $25.00 for office visits and $100.00 for procedures or surgeries.

Radiology

Copies of patients' films obtained from other facilities will be destroyed in accordance with HIPAA (Health Insurance Portability and Accountability Act of 1996) and radiologic regulations unless the patient requests to keep the films at the time of their appointment. Original films from other facilities will be returned. Original films taken in this office will be stored as required by law.

Privacy Practices

I hereby acknowledge that I am aware of the HIPAA (Health Insurance Portability and Accountability Act of 1996) Notice of Privacy Practices of Seetharaman Ashok, M.D. and that I may receive a copy upon request. I further acknowledge that a copy is posted in the reception area at all times.

(Turn Over)

Responsible Party's Signature:_____
Date:____/____/_____ **Print Name:**_____
Relationship to Patient:_____

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Disclosure of Information

If You Wish Us To Disclose Any Of Your Information To A Friend/Family Member, Please List Their Information Below

Name:_____ **Relationship to Patient:**_____
Name:_____ **Relationship to Patient:**_____
Name:_____ **Relationship to Patient:**_____

I hereby authorize Seetharaman Ashok, M.D. and/or staff to disclose any of my medical information to the person(s) listed above.

Patient Signature:_____
Date:____/____/_____
Print Name:_____
Relationship to Patient:_____

If You DO NOT Wish To Disclose Information To Anyone, Please Sign And Date Below

Patient Signature:_____
Date:____/____/_____
Print Name:_____
Relationship to Patient:_____

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Medical History

Name:_____ **Date of Birth:**____/____/_____
Are You Allergic to Anything? Yes / No **If Yes, Please Specify:**
_____
_____

In The Past, Have You Had These Conditions? (Mark If Yes)

- **Prostate Problems:**__
- **Bladder Problems:**__
- **Kidney Problems:**__
- **Kidney Stones:**__
- **Hypertension (High Blood Pressure):**__
- **Cholesterol:**__
- **Diabetes:**__

Have You Ever Had A Blood Transfusion? Yes / No
If You Found Yourself Needing A Blood Transfusion, Would You Accept It? Yes / No
Have You Had A Pneumonia Vaccine? Yes / No
Date of Injection:____/____/_____ **(65 Years and Older)**
Have You Had A Colonoscopy In The Last 9 Years? Yes / No
Have You Had Colorectal Cancer Screening?
Date of Screening:____/____/_____ **(50-75 Years Old)**
Have You Had Any Past Surgeries? Yes / No **If Yes, Please Explain:**
_____
_____
_____

Family History

Does Anyone In Your Family Have/Has Had These Conditions? (Mark If Yes)

1. **Prostate Cancer:**__
2. **Testicular Cancer:**__
3. **Kidney Cancer:**__
4. **Bladder Cancer:**__
5. **Hypertension (High Blood Pressure):**__
6. **Cholesterol:**__
7. **Diabetes:**__

Social History

Do You Smoke? Yes / No **Are You A Former Smoker** Yes / No
When Did You Quit? _____ **Do You Drink Alcohol?** Yes / No
If Yes, How Often Do You Drink? _____
Are You A Former Drinker? Yes / No **When Did You Quit?** _____

(Turn Over)

Do You Drink Caffeinated Drinks (Coffee, Soda, Tea, etc.) Yes / No

If Yes, How Many Cups A Day?_____

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Medication List

Please Print

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____

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Payment Agreement

Please Sign and Date the Following

I, (Print Name)_____ understand that…

- My co-pay is due at the time of service; this is an agreement with my insurance company that I am responsible for fulfilling.
- We DO NOT carry change. Any cash payment MUST be EXACT CHANGE.
- I am responsible for any fees incurred due to forms being filled out by office staff. These include disability, prior authorization, etc. This fee is CASH ONLY.

Patient Signature:_____

Date:____/____/_____

Accepted Payment Types

- Visa
- MasterCard
- American Express
- Cash
- Checks (Make all checks payable to "Urology Clinic of Hanford")

Accepted Payment Methods

- Magstripe
- EMV (Chip)
- Contactless (Apple Pay, Google Pay, etc.)