Western Michigan Urological Associates
A Holland Hospital Physician Office

PATIENT INFORMATION

(PLEASE PRINT)

APPT DATE/TIME:	APPT DR:	PCP:	ACCOUNT NO:

DEMOGRAPHIC INFORMATION

Last Name:	First Name:	Mi:		
Address:		Date of Birth:	Age:	Sex:
City, State, Zip Code:				
Social Security #:		Marital Status:		
Home Phone:		Work Phone:		
Cell Phone:		Email:		
Preferred Pharmacy:	Address:	Phone#:		
Race: ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other ☐ Do not wish to report		Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Do not wish to report		
Language:				

INSURANCE INFORMATION

(Please give your insurance card(s) to the person at the front desk)

Person Responsible for the Bill:	Address (if different from patient):	Home Phone:

Is this person a patient here? ☐ Yes ☐ No

Primary Insurance:			Employer:	
Subscriber's Name:	Subscriber's Date of Birth:	Policy #:	Group #:	Co-pay:
Patient's Relationship to subscriber:				

Secondary Insurance:			Employer:	
Subscriber's Name:	Subscriber's Date of Birth:	Policy #:	Group #:	Co-pay:
Patient's Relationship to subscriber:				

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship to Patient:	Contact Phone:

How did you hear about our office? ☐ Doctor ☐ Family/Friend ☐ Health Seminar ☐ Website ☐ Yellow Pages ☐ Other

(Turn over to complete)

Holland Hospital
PHYSICIAN OFFICES

Financial Policy

Insurance
We will bill your insurance carrier according to our contract or as a courtesy to you, however payments for deductibles and copays are due at the time of service. This includes all office visits, procedures, and injections. If you do not have your copay with you, your appointment may be rescheduled. Please remember…your insurance coverage is a contract between *you* and *your insurance company* and **not** a substitute for payment. Failure to provide us with your Social Security number may make it impossible for us to speak to your insurance regarding your claim.

Prior Authorizations
Some insurance plans require prior authorization for procedures done in the office, this will be the patient's responsibility to check with their insurance prior to their visit to avoid possible higher deductible and copay charges.

Self-Pay Accounts / Plans We Don't Participate With
Self-pay accounts are patients that have no insurance coverage, have not met their deductible or are covered by insurance plans we do not participate with. Payment must be made at the time of service. If this is not possible, please discuss the situation with the billing department **before** your scheduled appointment.

No-show/Cancellation policy
We kindly ask that you provide 24 hours' notice if you are unable to keep a scheduled appointment. Failure to do so may result in a "No Show" fee charged to your account. Payment of this fee will be required prior to the rescheduling of a new appointment. Multiple missed appointments may result in discharge from our practice. Exceptions will be made on a case by case basis. Thank you in advance for your cooperation.

Collections
In the unlikely event that we require the services of a collection agency, a 25% surcharge will be added to your account.

Payment Methods
For your convenience, we accept the following methods of payment: Cash, Personal Check, Visa, MasterCard, Discover.

Authorization and Release

I authorize payment of medical benefits be made directly to Lakeshore Health Partners, Holland Hospital or its related entities. I understand the financial policy and accept the personal responsibility for payment of covered and non-covered services. I authorize the release of any medical or other information necessary to process my claims.

_____ _____
Patient/Guardian Signature Date

Medicare Information / Authorization		
Number	Primary? ☐Yes ☐No	Medicare Part B? ☐Yes ☐No

I request that payment of authorized Medicare benefits be made to Lakeshore Health Partners, Holland Hospital or its related entities. I authorize any holder of medical information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Centers for Medicare and Medicaid Services or its agents. I also authorize Medicare to send Explanation of Medicare Benefits information to my Medicare supplement and benefits to be paid to Lakeshore Health Partners, Holland Hospital or its related entities for any services furnished to me until further notice. I authorize any holder of information about me, needed to determine those benefits or the benefits payable for related services, to be released to the Centers for Medicare and Medicaid Services, or its agents.

_____ _____
Signature Date