

Bay Area Urology Medical Group Information for Patients

The doctors and staff at Bay Area Urology Medical Group are committed to providing you with quality and efficient urological care in a safe, comfortable environment. Please take a moment to read the following information regarding our practice and policies.

Locations and Office Hours:

50 So. San Mateo Dr., #120
San Mateo, CA 94401
Mon-Fri 8:30 a.m.-5:30 p.m.

1301 Shoreway Road Suite 100
Belmont, CA 94002
Wed and Fri 1:00-5:00 p.m.

Appointments for both offices can be made by calling 650-348-7770. If your condition is ever life-threatening call 911 or go to the nearest emergency room.

When our staff is not in the office, you will be able to reach an on-call physician through our answering service. Please use this service if your call is urgent and you need to speak to the doctor right away. If your call is a non-urgent matter, please leave a message in our voice mail system and your call will be returned the next regular working day.

Cancellations: Our office requests 24 hours notice to cancel an appointment and reserves the right to assess a \$25.00 charge for each missed or late cancelled appointment. Surgical procedures (vasectomies, prostiva treatments, biopsies) require that we reserve equipment and extended physician and staff time. 48 hour notice is required for these cancellations to avoid a \$100-\$200 late cancellation fee (depending on procedure).

Prescription refills: Patients that need their prescriptions refilled should call their pharmacy. The pharmacy will send a fax to our office if there are no refills remaining. Refills will not be issued to patients who have not been seen in the last year or to patients that do not return as instructed. Follow-up visits are scheduled to ensure quality of patient care. We charge a \$10 fee for the paperwork and time involved when our office must contact your insurance company for prior authorization for your medication.

Paying for your Visit: Our practice accepts payment from a number of medical insurance plans.. If we are a participating provider with your plan, we will accept your insurance card (and referral if HMO) as payment for the services we provide you. Patients will be responsible for any co-payments, out of network fees, deductibles, and any treatment not covered by your insurance company **at the time of service.** Co-payments that are not paid at the time of service and balances due not paid within 30 days of receiving a statement will be charged an additional \$10 fee. We accept credit card payments for amounts over \$50.00

If you do not have insurance, forgot your insurance card, or arrive without a necessary referral, you will be considered "Self-Pay" and must pay for the medical services you receive at the time of the visit.

Questions regarding claims or statements can be directed to our **billing department at 650-356-8204.**

Our staff realizes that your time is valuable and attempts to see patients as scheduled. Please understand that certain unexpected emergencies call our doctors out of the office and occasionally surgeries are delayed and disrupt our schedule. We apologize in advance for these inconveniences to you. If you are unable to wait to see the doctor, please speak to our receptionist so that she can schedule a more convenient time.

Bay Area Urology Medical Group

Patient Name: _____ **Patient DOB** _____

Patient Social Security # _____

I hereby authorize direct payment of my insurance benefits to Bay Area Urology Medical Group for services rendered to my dependents or me by the physician or under his supervision. I understand that it is my responsibility to know my insurance benefits, whether or not the services I receive are a covered benefit, and provide referrals from my PCP if necessary.

I understand and agree that I will be responsible for any balance due that Bay Area Urology is unable to collect from my insurance carrier for whatever reason and agree to remit payment for balances billed to me within 30 days of receipt. I am responsible for any collection fees due to non-payment, including late fees of \$10 per month for non-payment. I certify that I have read and agree to both the Bay Area Urology Medical Group's Patient Privacy Policies and Information for Patients.

I authorize BAUMG to release any of my or my dependent's medical information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefit. I am aware Bay Area Urology uses a MPMG shared Electronic Medical Record that allows both MPMG personnel and MPMG participating physicians and their staff access to each patient's health information. The purpose is to expedite the referral of patients within the MPMG system and to assist in managing their care in a coordinated way. Information in your Electronic Medical Record can be released outside the MPMG system only with your express written authorization or as otherwise specifically permitted or required by law.

I authorize BAUMG to leave messages for me regarding my appointments at the phone numbers provided I authorize them to discuss my condition and treatment with the following people that assist me with my healthcare needs.

Name	Phone Number	Relationship

I understand that if my insurance requires prior authorization for medication, I must provide this office with the necessary forms and pay a \$10 fee before an authorization will be requested on my behalf.

I agree to pay a "no show" or late cancellation fee if I fail to give 24 hours notice to cancel an appointment (\$25.00) or 48 hours notice to cancel a scheduled surgery or procedure(\$100-\$200).

I understand that I will be provided with test results either by telephone or a scheduled follow up visit. If results have not been communicated to me within three days of testing, I agree to call BAUMG to obtain these results.

I hereby consent to evaluation, testing, and treatment as directed by my Bay Area Urology Physician.

Patient's Signature _____ **Date** _____

Guardian's Signature _____ **Date** _____
(if different from patient)

Guardian's Name _____

Patient Name _____ Date _____

Please list any prescription medications you are taking:

Name of Medication	Dose	When do you take it? (times/day)	Purpose/Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please circle any prescriptions above that you need refilled today.

Please list Over the Counter Medications you take, including vitamins and herbals:

Please list any ALLERGIES you have to Medication/Food/Environment and the reaction experienced:

Please provide your Preferred/Contracted:

Pharmacy: _____ Street _____ City _____

Laboratory: _____

What is the one thing that you want to make sure you have taken care of during your visit today?

Please list all other concerns you would like the doctor to address:

Please list other doctors or health providers you've recently seen or test you've had done.

**Bay Area Urology Medical Group
Patient Information**

Name Last _____ First _____ Middle _____

Date of Birth _____ Social Security No. _____

Driver's License No. _____ State Issued _____

Marital Status _____ Languages Spoken _____

Local Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ Primary Care Provider _____

Employer _____ Work Phone _____

Emergency Contact Name _____ Phone Number _____

Primary Insurance Company Name _____

Insurance ID Number _____ Group Number _____

Subscriber _____ Subscriber's Date of Birth _____

Relationship to Patient _____

Secondary Insurance Company Name _____

Insurance ID Number _____ Group Number _____

Subscriber _____ Subscriber's Date of Birth _____

Relationship to Patient _____

How were you referred to our office? _____

