MISSISSIPPI
UROLOGY CLINIC, PLLC

PATIENT INFORMATION

Social Security #: _____-_____-_____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Sex: □ Male □ Female DOB: _____ Email: _____

Referring Doctor: _____ PCP: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

---

PRIMARY INSURANCE: _____

Subscriber Name (Full Name): _____ Relationship to Patient: _____

Subscriber SSN: _____ Subscriber DOB: _____

Insurance ID # _____ Group Number #: _____

SECONDARY INSURANCE: _____

Subscriber Name (Full Name): _____ Relationship to Patient: _____

Subscriber SSN: _____ Subscriber DOB: _____

Insurance ID # _____ Group Number #: _____

MEANINGFUL USE DATA

Race: □ African American □ Asian □ Caucasian □ Hispanic □ Indian □ Native American □ Pacific Islander

Ethnicity: □ Hispanic □ Non-Hispanic Preferred Language: □ English □ Spanish □ Other: _____

IN CASE OF EMERGENCY

Relative/Friend: _____ Relationship: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Authorization To Release Medical Information and Payment of Insurance Benefits

I hereby authorize Mississippi Urology Clinic, PLLC or my attending physician to release or disclose to insurance companies and/or outpatient benefits programs information from my medical record pertaining to my treatment as needed to process insurance claims. Furthermore, I hereby assign payment directly to Mississippi Urology Clinic, PLLC benefits wherein specified and otherwise payable to me but not to exceed Mississippi Urology Clinic, PLLC regular charges for medical treatment. I understand that I am financially responsible for charges not covered by this authorization.

PATIENT SIGNATURE: _____ DATE: _____

Office Use Only: MRN: _____ Provider: _____

MISSISSIPPI UROLOGY CLINIC, PLLC

Care Provisions Policies 2022

We appreciate the opportunity to serve you and pledge to provide you our best medical care, with compassion, in a safe environment. In order to make our relationship with you the best it can possibly be, please be familiar with and agree to the following policies:

Administrative Policies

- We promise to value your time, and we will inform you as soon as possible if your provider is running late or has been called to surgery. In return, we expect you to arrive on time for your appointments, with all necessary information needed to complete your encounter.
- Many appointments require collection of a urine sample, so please check with the front desk upon arrival before going to the bathroom.
- To respect other patients, we ask that cell phones be turned on vibrate mode while in our office. Please refrain from using verbally abusive language, threatening any employee, provider, patient, or otherwise hostile behavior. Using such is cause for immediate termination from this practice.
- In-office procedures require extra supplies and time. No-showing or canceling a vasectomy, Urolift, SpaceOAR, or Urodynamics test within 24 hours will result in a $25.00 cancellation fee.
- Missing or no-showing your appointment creates an undue burden and increases the cost of care to other patients. Missing three appointments without notice will result in dismissal from this practice.

Insurance & Billing Policies

- If you want us to bill insurance, please bring your card to every appointment; without it we cannot bill your carrier. We are required to collect co-payments and co-insurance and reserve the right to re-schedule or cancel appointments to comply with insurance company agreements.
- Health insurance is an agreement between you and your insurance carrier. You are responsible for understanding your own coverage. Your insurance company makes the determination of your eligibility. You authorize your insurance benefits to be transferred directly to the rendering provider and acknowledge you are financially responsible for paying any co-insurance amounts. You agree to pay for services rendered within the limits of this care provisions policy.
- If you do not have insurance, wish not to provide your social security number, or choose not to file a visit with your insurance, a minimum payment of $195 at time of service is required. The remaining balance for services received will be addressed in our billing statement.
- Many insurance companies have lists of approved drugs they cover. Your provider will prescribe the medication they feel will best address your needs. We will do our best to respond to prior-authorization requests from your insurance company, but this process may delay your prescription. You are responsible for contacting your insurance provider with any questions or requests concerning approved medications.
- Disability, FMLA, and other form completion requests will be processed after a form fee of $25.00 is received.
- We accept cash, check, credit card, and Care Credit. Payment in full is due within 30 days of your first statement unless other arrangements have been made. We send two statements at 30-day intervals. You understand and agree that if we send your account to collections for non-payment, a fee of 35% of the unpaid balance will be added. This amount shall be in addition to any other cost incurred directly or indirectly to collect amounts owed under this agreement.
- If you need a surgical procedure, our surgery coordinator will assist you in scheduling. Although we seek prior authorizations, insurance carriers state they are not a guarantee of payment. You must call your insurance carrier to verify they will cover your procedure.
- If you get lab or imaging tests as part of your appointment, remember some tests/labs are performed by outside parties; in such cases they bill separately. If you know your insurance carrier only covers certain labs or facilities, please notify our office in advance.

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

_____ _____

Print Name of person/organization **Relationship to Patient**

_____ _____

Print name of person/organization **Relationship to Patient**

By signing below you agree to the terms of service provided herein.

_____ _____

Signature of Patient Date

Office Use Only: MRN: _____ Provider: _____

Mississippi Urology Clinic, PLLC and Mississippi Urology Outpatient Surgery Center, LLC Clinic
Physician – Patient Arbitration Agreement

«PName» ("Patient"), engages Mississippi Urology Clinic, PLLC or Mississippi Urology Outpatient Surgery Center, LLC and any employees thereof individually or collectively referred to as ("Clinic"), and each Physician affiliated with the clinic ("Physician" or "Physicians") that renders medical care and services to perform services in conjunction with Patient's medical care. For and in partial consideration of the rendition of any and all present and future medical care and services, Patient agrees that in the event of any dispute, claim or controversy arising out of or relating to the performance of medical services, including but not limited to patient fees, informed consent, negligence or medical malpractice, between Patient (whether a minor or an adult) or the heirs-at-law or personal representative of Patient, as the case may be, and the Clinic and each Physician individually, where the claim or the amount in controversy exceeds $5,000, such dispute or controversy shall be submitted to JAMS, or its successor, on an arbitration form for final and binding arbitration. All claims for unliquidated damages shall be deemed claims for in excess of $5,000. This agreement further applies to any claim that derives or arises from a claim that the patient or someone on the patient's behalf asserts against the Clinic, its employees, or agents, and/or the Physicians.

Either party may initiate arbitration of any matter subject to arbitration by filing a written demand for arbitration at any time. Patient shall be entitled to an in person hearing in the county where the care at issue occurred, in accordance with the Federal Arbitration Act. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures and Minimum Standards of Procedural Fairness, and all parties are bound by the arbitrator's decision. Any decision by the arbitrator(s) shall be accompanied by a reasoned opinion. Judgment may be entered on the arbitrator's award, if any, by any court having jurisdiction of the subject matter.

All parties agree that their relationship affects interstate commerce and that this Agreement shall be governed by the Federal Arbitration Act, and, if not, by Mississippi law. The party requesting arbitration shall bear all costs of the arbitration, except the Patient is not required to pay any more than $125.00, with the Clinic bearing the other arbitration costs. However, each party is solely responsible for their own attorney, expert, and other associated costs, expenses, and litigation fees on their behalf.

The arbitration proceedings and any award from such proceedings are confidential. Any award that is filed for confirmation must be filed under seal and remain confidential if not satisfied within the later of twenty (20) days from filing or twenty (20) days from the end of JAMS Optional Arbitration Appeal Procedure, if applicable.

If you are not willing to submit to binding arbitration, the Clinic and/or Physicians may perform the services or refer you to another health care provider capable of rendering the medical care or services which you require (although Physician assumes no responsibility for the quality of care or service rendered by any other health care provider). Such referral will not occur if you are in need of emergency care or in immediate distress. Please inform a Clinic representative immediately if you do not agree to binding arbitration and desire such referral.

This Agreement may be rescinded by written notice by either party within fifteen (15) days of signature. However, any claim or dispute related to medical services rendered after execution of this Agreement and prior to the date of such written notice of rescission shall be subject to the terms of this Agreement. Written notice of such rescission may be given by any person with authority to act for the patient, including a guardian or conservator of Patient if Patient is a minor or incapacitated. This agreement may be modified only by signed agreement by each party or its authorized representative. If any portion of this Agreement is found unenforceable, that portion shall be stricken and the remainder of this Agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where services are rendered.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL.

If a person is signing this Agreement on behalf of another individual who is the actual patient, such person signing this Agreement hereby attests that he or she has full legal authority to execute this Arbitration Agreement on behalf of the patient. Further the person signing this Agreement hereby agrees to indemnify and hold harmless Clinic and/or Physician(s) from any claim, demand, or loss which may occur in the event said person does not, in fact, have such legal authority.

A photo static or electronic copy of this authorization shall be considered as effective and as valid as the original.

SIGNATURE OF PATIENT/GUARDIAN

By: _____ Date: _____

For Office Use Only

Witness Signature: _____ Date: _____

Office Use Only: MRN: _____ Provider: _____

Mississippi Urology Clinic, PLLC and Mississippi Urology Outpatient Surgery Center, LLC ("Clinic") Clinic Physician – Summary of Patient Arbitration Agreement

SUMMARY OF ARBITRATION AGREEMENT FOR PATIENT:_____

Medical staff must carefully explain the Agreement to each Patient. Have the Patient initial bedside each of the following points after you explain to them.

	Explain:	**Patient Initials in Each Box**
1.	Before signing the Agreement the Patient may make written changes in the Agreement if they so desire and present to Clinic for approval. The Clinic has the right to refuse to accept any such changes.	
2.	You are agreeing to arbitrate any disputes above $5,000. You are agreeing not to sue the Clinic, any Physicians, or employees in a court of law.	
3.	You are waiving his or her constitutional or statutory right to a jury trial.	
4.	Arbitration will be performed by JAMS. This is a national association of neutral arbitrators. They do not work for the Clinic, Physicians, or for the Patient. The Clinic or the Physicians will pay the Arbitrator's costs, except for the first $125.00. Each side will pay for their own attorneys, other litigation costs and expenses, including experts.	
5.	This Agreement is effective from the date of this Agreement.	
6.	You can can rescind this Agreement within 15 days, but must still arbitrate any claim arising before the Agreement is rescinded.	
7.	If the Patient does not agree to arbitrate, or if Agreement is rescinded, the Clinic will either treat the patient or immediately refer them to another doctor or group who can provide the medical care they need, provided the Patient is not in need of emergency care or under immediate stress.	
8.	If a court rules that a dispute must be litigated and not arbitrated, any lawsuit must be filed in where services were rendered.	
9.	In arbitration each side will have a fair opportunity to present their evidence, but court rules do not necessarily apply. There is no right of appeal except in limited circumstances. An arbitrator's award can be vacated only in limited circumstances such as fraud or undisclosed conflict of interest.	
10.	Any claim by you, Physician(s), or Clinic will be waived and forever barred if, on the date of the demand for arbitration, the claim would be barred by the applicable statute of limitations.	
11.	If you still have any questions, you should consult an attorney before signing.	
12.	You and UAM (including its physicians) each have the right to terminate the doctor-patient relationship at any time, but the terms of the Agreement still apply to the care that was provided.	
13.	The arbitration proceedings and any award are confidential. If the award is filed in court for any reason, it shall be filed under seal and will remain sealed unless timely satisfied as previously described.	
14.	This Agreement is binding on you as well as anyone claiming by or through you, including your spouse or any type of estate, heirs, or beneficiaries and applies to any claim that arises from care provided to the patient.	
15.	To the extent this Agreement is being signed on behalf of another individual who is the actual patient, you acknowledge you have authority to enter this Agreement on their behalf.	
16.	I have read and understand both the Agreement and the summary.	

I hereby confirm that I have explained the agreement to the Patient, and the Patient has affirmed his or her understanding of the Agreement by initialing or signing beside each of the foregoing provisions.

Signature of Patient: _____

Office Use Only: MRN: _____ Provider: _____

MISSISSIPPI
UROLOGY CLINIC, PLLC

MRN: **«*PNumber*»** | Patient Name*: «Pname»*	Date of Birth*: «Pdob»*

Who referred you to this office? _____ **Medical Doctor/PCP:** _____

Why are you seeing the physician today: _____

When did your problem start: _____ **Pharmacy (Name & Number):**_____

My Main Problems are:

❑ Enlarged Prostate ❑ Blood in urine ❑ High PSA ❑ Bladder Infection ❑ Kidney Stones
❑ Prostate Infection ❑ Urinary Incontinence ❑ Bladder Cancer ❑ Prostate Cancer ❑ Erectile Dysfunction
❑ Overactive Bladder ❑ Infertility ❑ Lump in Testicle ❑ Interstial Cystitis ❑ Leak Urine
❑ Curvature of Penis ❑ Urethral Stricture ❑ Other _____

Allergies ❑ None Please list all allergies: _____

Medications ❑ None Please list all medications: _____
_____

Surgical History ❑ Appendectomy ❑ Back/Hip/Knee ❑ Cystoscopy ❑ Gallbladder ❑ Heart Bypass
❑ Kidney Stone Surgery ❑ Lithotripsy ❑ Prostate Biopsy ❑ Prostate Seed ❑ Prostate Surgery ❑ Colonoscopy
❑ Other _____ ❑ **No Changes**

Medical History ❑ Diabetes ❑ Emphysema ❑ Heart Attack ❑ Heart Murmur ❑ Hepatitis ❑ Hernia
❑ Hypertension ❑ Parkinson's ❑ Strokes
Cancer: ❑ Prostate ❑ Kidney ❑ Testis ❑ Other _____ ❑ **No Changes**

Family History ❑ Prostate Cancer ❑ Kidney Cancer ❑ Kidney Stones ❑ Heart Disease

Social History (Circle One)

Marital Status: *Single Married Divorced Widowed* Smoke: *Yes Not Anymore Never*
Drink Alcohol: *Yes Not Anymore Never Socially* Daily Caffeine Intake: *0 1 2 3 4+*
Blood Transfusion: *YES NO*

Recent Immunizations: ❑ Yes ❑ No If yes, list name & date: _____

My Symptom(s) are:

General/Constitutional	❑ Fever	❑ Weight Loss	❑ Chills
Eyes	❑ Blurry Vision	❑ Double Vision	❑ Cataracts
Ears, Nose, Mouth, Throat	❑ Hearing Loss	❑ Nasal Stuffiness	❑ Sore Throat
Cardiovascular	❑ Chest Pains	❑ Swollen Ankles	❑ Irregular Heartbeat
Respiratory	❑ Shortness of Breath	❑ Wheezing	❑ Chronic Cough
Gastrointestinal	❑ Abdominal Pain	❑ Nausea/Vomiting	❑ Change In bowels
Genitourinary	❑ Incontinence	❑ Painful Urination	❑ Blood in Urine
Musculoskeletal	❑ Chronic Back Pain	❑ Chronic Neck Pain	❑ Sore Muscles
Integumentary/Skin	❑ Rash	❑ Persistent Itching	❑ Skin Cancer History
Neurologic	❑ Numbness	❑ Tingling	❑ Dizziness
Hematologic/Lymphatic	❑ Swollen Glands	❑ Abnormal Bleeding	❑ Transfusion History

My Urinary Symptom(s) are:

❑ Incomplete Emptying ❑ Frequency ❑ Intermittency ❑ Weak Stream ❑ Straining
❑ Testicle Pain ❑ Pain in Side Right / Left ❑ Urinating at Night # _____

Office Use Only: MRN: _____ Provider: _____