Shreveport Urology

ELIZABETH HARREL, MD
8001 Youree Drive, Suite 820
Shreveport, LA 71115-2352
(318) 212-3569

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE English	SEX F
LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)			ETHNICITY Not Hispanic or Latin	
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	SECONDARY HOME PHONE	RACE White	
PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	EMERGENCY CONTACT NAME	CONTACT HOME PHONE		
SEXUAL ORIENTATION Heterosexual	PREFERRED PRONOUN HE	GENDER IDENTITY FEMAL	MARITAL STATUS UNKNOWN	OCCUPATIONAL/STUDENT STATUS Student	Full-time

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE English	SEX F

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	SECONDARY HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT $
CITY, STATE ZIP			DEDUCTIBLE $
RELATIONSHIP TO PATIENT			EFFECTIVE DATE | EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN

DATE

WILLIS-KNIGHTON HEALTH SYSTEM

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x−ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient’s doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient’s consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient’s hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third−party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third−party payors for the purpose of performing pre−certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital’s electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis−Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness’’). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co−insurance, non−covered charges and other items not paid by insurance or other third−party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third−party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third−party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient’s authorized representative to file any necessary claim appeal(s) on Patient’s behalf. In consideration for this appointment. WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor’s obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys’ fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date:

Admission Time:

AD0005

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one−third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis−Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis−Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

Signature of Patient/Guardian	Date/Time	Guarantor	Date/Time	Witness	Date/Time
Print Name	Date of Birth	Print Name		Print Name	

If Patient/Guarantor is unable to sign, I, ________________________________ , do hereby state that I have been given the authority to sign for

____ , either expressed or implied and that he or she is fully aware of this authority.

Signature of Authorized Party	Authorized Party's Relationship to the Patient	Date/Time	Witness	Date/Time

Admission Date:

Admission Time:

AD0005

WILLIS-KNIGHTON HEALTH SYSTEM

Payment Policy
Willis−Knighton
Network Physicians

Payment arrangements are understood and agreed upon by the patient and provider prior to services being rendered.

Willis−Knighton Health System participates with and accepts most insurance plans. **Patients are required to furnish proof of insurance at the time of service.** As a courtesy to our patients, we will be happy to file the insurance claim(s) for services rendered by any of the 80+ providers participating within the Willis−Knighton Physician Network.

Monthly statements are generated and mailed to patients/guarantors to make them aware of any outstanding balance after insurance coverage has been exhausted. **Any outstanding balance is considered the guarantor's responsibility regardless of insurance coverage.**

An account will be deemed delinquent after 90 days from the date of service or from the date services were denied or paid by the insurance carrier.

Annual deductible amounts will be the obligation of the guarantor. If the patient has met his/her deductible for the current year and can verify this with an Explanation of Benefits from his/her insurance carrier, the remainder of the patient responsibility (such as 20% for most insurance plans) will be due at the time of visit.

Co−payments for HMO's, PPO's, and other managed care plans must be paid at the time of service. Balance billing patients for their co−pays is a violation of many managed care contracts and will not be allowed. **Co−payments will be collected at check−in before the physician sees the patient.** If the patient does not have the co−pay at the time of visit, the patient may reschedule the appointment in order to meet the co−pay requirement.

Should the patient or responsible party express an inability to pay, alternate payment plans and assistance are available upon request. The physician and/or clinic manager must approve monthly payment plans and discounts. Patients must agree in writing to the payment plan prior to seeing the physician.

My signature below verifies that I have read and understand the payment policy outlined above.

Patient (if over 18 years of age)	Date
Guarantor (if patient is under 18 years of age)	Date

Appointment Policy

Effective January 1, 2014

Your time is valuable to us. We will strive to be an "on time" clinic, but in order to do so, we ask that you follow these guidelines:

All NEW PATIENT PAPERWORK must be filled out completely before your appointment time, or we may need to reschedule. We know this is a laborious process, but we also have to factor in time to enter this into the computer. If you anticipate difficulty in achieving this, we can schedule a nurse visit in person or by phone before you appointment to get this completed.

For each follow-up visit, you will be asked to update your PREFERRED PHARMACY, review your MEDICATION LIST and make appropriate changes, and fill out a brief SYMPTOM UPDATE. You may also be asked to sign paperwork that must be updated annually. Failure to do this COMPLETELY will result in a delay in seeing the doctor, not only for you, but patients scheduled after you.

If you are going to be late for your appointment, please call and notify the office.

If you are more than 15 minutes late for an office visit, your appointment will need to be rescheduled.

If you are more than 5 minutes late for a scheduled procedure (cystoscope, urodynamics, vasectomy, etc.), your appointment will need to be rescheduled as it takes time (as long as **45 minutes**) to reprocess and sterilize our instruments.

Failure to notify Shreveport Urology of the cancellation of your appointment at least 24 hours in advance will result in a fee of $35-$50 being billed to your account. This fee is not covered by insurance and you will bear complete financial responsibility. Repeated "no shows" may result in termination from the practice.

We will do our best to apprise you of any delays. If your schedule is unable to accommodate our delay, please notify the receptionist and we will be happy to reschedule your appointment.

Your cooperation is appreciated. You will be provided a copy of this policy upon request.

I have read and understand the above policy:

______________________________ ______________

Patient Signature Date

WILLIS-KNIGHTON HEALTH SYSTEM

Alternative Contact/Preferred Method of Communication Form

Patient Name______________________________ Date of Birth______________

We at Shreveport Urology take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

☐ I do NOT authorize anyone to receive information regarding my medical care.

☐ I authorize my physician and the employee of this clinic to speak with:

1. Person:______________________________ Relationship: RELATIONSHIP

Phone number(s):______________

☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

2. Person:______________________________ Relationship: wife

Phone number(s):______________

☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

3. Person:______________________________ Relationship: wife

Phone number(s):______________

☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

Please check your primary and secondary preferred methods of communication:

_____ Home Phone/Answering Machine _____ Mail _____ Work Phone

_____ Cell Phone (voice mail) _____ Cell Phone (text message)

_____ Email and email address ______________________________

Electronic Communication is my preferred method ☐ **yes** ☐ **no**

(In order to electronically communicate to you or anyone you designate, we are required to have your written permission).

This authorization will remain in effect unless changed by me while I am a patient at this office.
It is my responsibility to notify this office of changes and to complete a new form.

Any problems and/or questions concerning this form are to be referred to the Willis−Knighton Health Systems Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

PATIENT SIGNATURE:______________________________

PARENT/GUARDIAN SIGNATURE:______________________________

WITNESS SIGNATURE:______________________________

DATE:__________ TIME:__________

Shreveport
Urology

MEDICATIONS

NAME	DOSE	FREQUENCY	CONDITION
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼
		once daily ▼	Hypertension ▼

ALLERGIES

MEDICATION/FOOD	REACTION	SEVERITY
	Anaphylaxis ▼	UNKNOWN ▼
	Anaphylaxis ▼	UNKNOWN ▼
	Anaphylaxis ▼	UNKNOWN ▼
	Anaphylaxis ▼	UNKNOWN ▼
	Anaphylaxis ▼	UNKNOWN ▼
	Anaphylaxis ▼	UNKNOWN ▼
	Anaphylaxis ▼	UNKNOWN ▼
	Anaphylaxis ▼	UNKNOWN ▼

DOB:

DATE:

Shreveport Urology

MEDICAL/SURGICAL HISTORY

CONDITION/PROBLEM	TREATMENT/PROCEDURE	MONTH/YEAR
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	
Hypertension ▼	Tonsillectomy ▼	

SOCIAL HISTORY

OCCUPATION	MILITARY SERVICE	TOBACCO HISTORY
	NONE ▼	NEVER ▼ *Year quit?*
	Airforce ▼	*How much, how often?* 1/2 pack/day ▼

FAMILY HISTORY

CANCER	FAMILY MEMBER	CANCER	FAMILY MEMBER
KIDNEY Cancer	NONE ▼	Breast Cancer ▼	mother ▼
BLADDER Cancer	NONE ▼	Breast Cancer ▼	mother ▼
PROSTATE Cancer	NONE ▼	Breast Cancer ▼	mother ▼
Breast Cancer ▼	mother ▼	Breast Cancer ▼	mother ▼

CONDITION	FAMILY MEMBER	CONDITION	FAMILY MEMBER
KIDNEY STONES	NONE ▼	Hypertension ▼	mother ▼
Hypertension ▼	mother ▼	Hypertension ▼	mother ▼
Hypertension ▼	mother ▼	Hypertension ▼	mother ▼
Hypertension ▼	mother ▼	Hypertension ▼	mother ▼

DOB:

DATE: