Sunrise Urology, PC
3303 S. Lindsay Rd, Suite 121
Gilbert, AZ 85297
Voice: (480) 507-9600
Fax: (480) 507-9610

John C. Lin, M.D.
Board-Certified Urologist

www.sunriseurology.com

Thank you for choosing Sunrise Urology for your urologic needs.

In order to help make your upcoming office visit as easy as possible, we have enclosed necessary forms which should be completed **prior** to your arrival. We recommend that you personally deliver, fax, or mail the forms back to us.

Please also bring:

- **Insurance cards**
- **Photo identification**
- **Form of payment** (we accept cash, debit card, MasterCard™, and VISA™)
- A list of all the **medications** you are currently taking
- Any medical records, blood lab work, **diagnostic testing** in actual film format or on CD (**CD is preferred**) that you may have had done as it pertains to your visit. Feel free to drop these off at the office prior to your visit.

If you are bringing records in-person, **please give all of the records to the check-in staff upon arrival and do not hold on to these records**. We will electronically scan these records and return them to you. Following these instructions will greatly facilitate your visit.

We very much value our patients' time and will work to minimize your wait in our office. To ensure that all patients maximally optimize their time with us, please note that you may be rescheduled if you arrive late to your appointment. Please also refrain from emptying your bladder right before your visit, as we will likely need a urine sample from you.

Our hours of operation, map to our office, and other useful information are available on our web site at **www.sunriseurology.com** and by calling our friendly staff.

We look forward to meeting you soon, and thank you for choosing us for your urologic care!

Sincerely,

Your urologic team at Sunrise Urology

Location and Directions

We are conveniently located north of I-202 (Santan) freeway, on S. Lindsay Road, at the southeast corner of S. Lindsay Road and E. Pecos Road.

- From I-60 (Superstition Freeway), exit on Val Vista Dr and travel south approximately 6 miles. Turn right on E. Pecos Rd, and then turn left on S. Lindsay Rd. We are on your immediate left.
- From the south loop of I-202 (Santan Freeway), exit on Gilbert Road and travel north. Turn right on E. Pecos Rd and then turn right on S. Lindsay Rd. We are on your immediate left.
- You can find us on Facebook under “Sunrise Urology”
- We are on the web: www.sunriseurology.com

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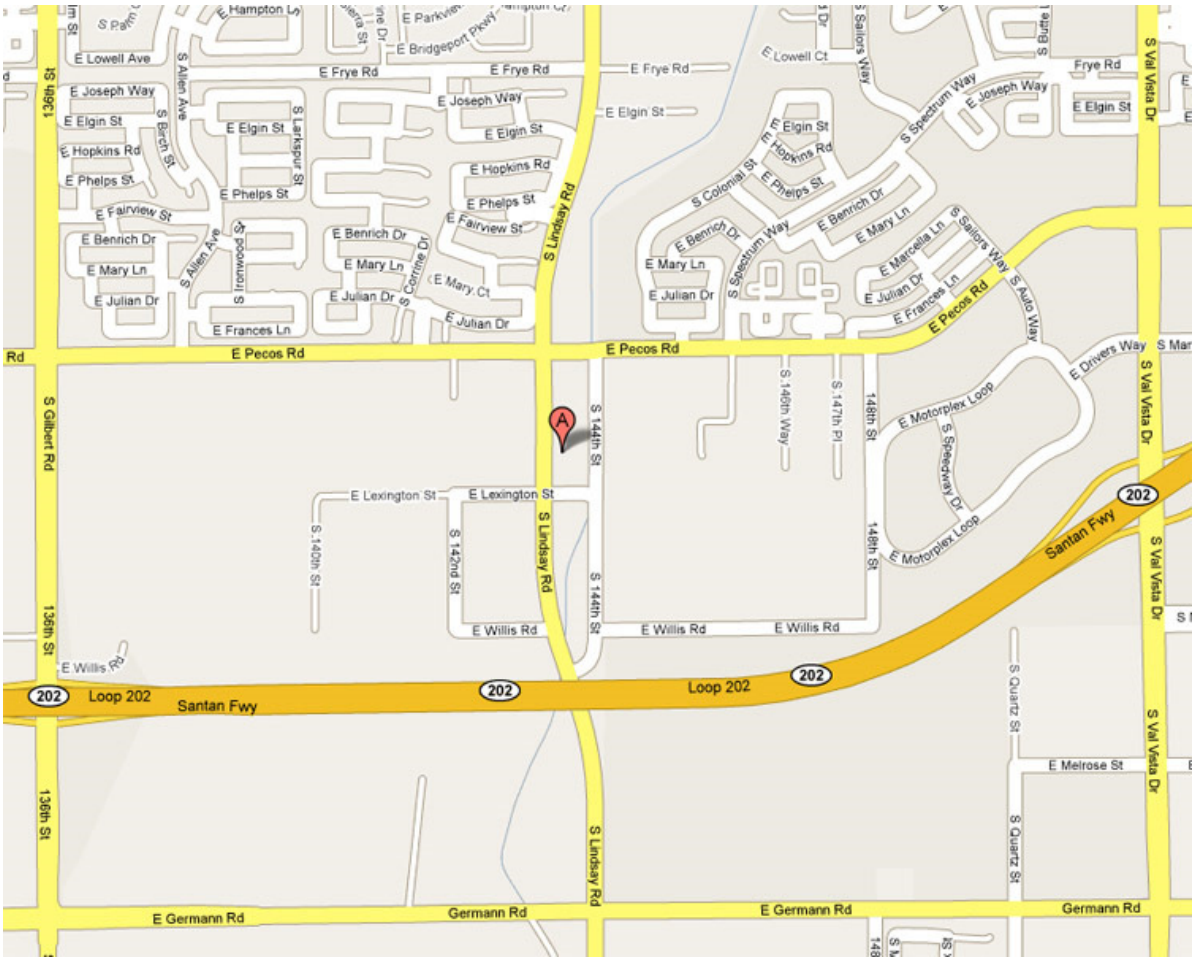

Sunrise Urology, PC
Patient Financial Policy

The following financial policy is being provided to avoid any future misunderstanding. If you have any questions regarding this policy, please discuss them with our staff prior to your appointment. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of our professional relationship.

- We have made prior arrangements with many health plans to accept an "assignment of benefits". As a courtesy, we will bill those plans with which we have an agreement and will require you to pay any copayment, deductible, and co-insurance at the time of service. We will collect the copayment as soon as you arrive for your appointment as required by your health plan. Failure to provide necessary copayment will necessitate rescheduling of your appointment.

- If you have a health plan with which we do not have a prior agreement, you will be seen on an "unassigned" basis. This means that your carrier will send the payment directly to you. In this instance, our charges for your care and treatment will be due at the time of service.

- Your health insurance policy is a contract between you and your insurance company. In many instances, the doctor is not involved. Unless either you or your health coverage carrier have made other arrangements in advance, full payment is due at the time of service.

Please initial where indicated *to signify that you have read and understood the following items:*

_____ In order to provide the best possible care and to ensure availability of our services to patients, please call **as soon as possible** if you know you will need to reschedule or cancel your appointment. **If you miss your office visit appointment without notifying us 24 hours (during business days) prior to your appointment, you will be charged $25.00 for that missed appointment. Similarly, if you do not cancel or reschedule an appointment for a procedure, surgery, or diagnostic imaging study 24 business hours prior to the scheduled procedure or surgery, you will be billed $100 per occurrence.**

_____ In the event that your health plan determines that a service or supply is "**not covered**", you will be financially responsible for that particular service or supply. Payment is due upon receipt of a statement from our office. Payment for certain services / supplies may be required at the time of the visit.

_____ Charges will apply for the processing of disability forms, life insurance policy application forms, FMLA, and other related forms at $25 per form (up to 3 pages, with $5 per each additional page) and for copying / preparing medical records ($15). Forms will need to be picked up **personally**; we will **not** fax or mail these forms.

_____ There will be a $40.00 charge for **each** insufficient-fund check you issue.

_____ If your account is turned over to a Collection Agency, a $100 collections processing fee will be added to any outstanding balance.

I have read and understand the financial policy of Sunrise Urology, PC, and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by Sunrise Urology, PC, without notice.

_____ _____ _____
Signature Print Name Date

Insurance and Payment Options

PAYMENT AND INSURANCE

- Please contact your insurance company to obtain a "preferred provider" list to make sure Sunrise Urology is a "participating provider" on your plan prior to scheduling an appointment. Some plans may require you to obtain a "referral" from your primary care provider prior to seeing a specialist.
- We can still help you if we are not on your "preferred provider" list. Your insurance coverage will be determined by any "out of network" benefits you may have as dictated by your plan.
- As a courtesy to you, we verify insurance benefits and eligibility prior to your visit.
- Applicable copayments will be collected at the time of service. This arrangement is part of your contract with your insurance company, and our failure to collect copayment from you may be considered fraud.
- We will collect any unmet deductible and applicable patient payment responsibility at the time of your visit.
- Fees for services not covered by insurance are collected at the time of visit.
- Patients who do not have insurance coverage or have a Health Savings Account / Health Reimbursement Arrangement will be required to pay in full at every visit.
- For your convenience, our office accepts cash, debit cards, credit cards (MasterCard™ and VISA™) and personal checks.
- Please contact your insurance plan representative if you have questions regarding coverage for your visit or procedure. Insurance companies are responsible to you, the policyholder, not to the physician. As a courtesy to you, our office will file your claims to your insurance company as long as we are "contracted" with your insurance company. However, we do not determine the amount of coverage you will receive. Your insurance company determines the amount of your coverage and you should be aware of your benefits prior to all office visits and procedures. Any questions you may have concerning your insurance benefits should be directed to your insurance plan representative.

INSURANCE COMPATIBILITY

- Some insurance plans may not be fully compatible with reimbursement for services provided by Sunrise Urology. It is recommended that patients contact their insurance carriers to verify benefit and eligibility for services to be provided by Sunrise Urology.

Patient Registration Form

PATIENT INFORMATION:

Name: _____ Gender: Male / Female Marital Status: _____

Date of Birth: _____/_____/_____ Race: _____ Ethnicity: _____

Social Security No: _____ - _____ - _____ Preferred Language (if other than English): _____

Mailing Address:_____

Home Address:_____

2nd / Seasonal Adds:_____

Home Phone: ( ) _____-_____ E-mail: _____

Cell Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Patient's Employer (if applicable): _____

Employer Address: _____

Employer Phone Number: ( ) _____-_____

Referring Doctor:_____ Phone #: ( ) _____-_____

Primary Care Doctor & Phone # (if different than referring doctor): _____

Emergency Contact: _____ Home Phone: ( ) _____-_____

Work Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Local Pharmacy _____ Adds: _____ Phone: ( ) _____-_____

(**Your care may be delayed if you do not provide your pharmacy information!** We ***electronically prescribe*** your medications to the pharmacy. **We do not usually handwrite or fax prescriptions**.)

You authorize us to share your Protected Health Information with the following person(s) (until you notify us otherwise):

Name: _____ Relationship: _____ DOB: _____/_____/_____

Name: _____ Relationship: _____ DOB: _____/_____/_____

Primary Insurance: _____	**Secondary** Insurance: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
DOB: _____/_____/_____ SS#: _____-_____-_____	DOB: _____/_____/_____ SS#: _____-_____-_____
Relation to Patient:_____	Relation to Patient:_____

I have been given the opportunity to obtain a copy of the HIPAA privacy rules from this provider (available online at www.sunriseurology.com and at Sunrise Urology in Gilbert, AZ). I hereby authorize Sunrise Urology to apply for benefits for services rendered.

Signature: _____ Date: _____

Sunrise Urology, P.C.
Patient History Questionnaire

Gilbert, Arizona ● (480) 507-9600
www.sunriseurology.com

Name: _____ Age: _____ Today's Date: _____

Medication or Food **Allergy**: No _____ Yes _____ Please list _____

Do any of these types of cancers run in the family? Yes / No If Yes, please **indicate below**.

Adrenal / Bladder / Kidney / Prostate / Testis / Urethra Cancer

*Past **Surgeries** / **Medical Diagnoses** / **Hospitalizations*** (Use separate sheet if needed) Month & Year

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Social History

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

Do you smoke / use cigarettes / pipes / other tobacco products?

YES → How much do you smoke? _____ pack(s) per day. ***When*** did you start? _____ (indicate year)

NO → If you quit already, ***how much*** did you smoke ***before*** you quit? _____ pack(s) per day

How long did you smoke before you quit? _____ years. ***When*** did you quit? _____ (indicate year)

Do you drink alcohol? No ____ Yes ____ If **YES**, how much do you drink? _____

What kind of work do you do now? _____ Full Time ___ Part Time ___

If retired or not currently working, what type(s) of work did you do in the past?

_____

***Current Medications**:(Please include all **PRESCRIPTION, HERBAL,** and **OVER THE COUNTER** drugs)*

	Name	**Dose (ie. mg, ml)**	**How Often** do you take it?	**WHY (Diagnosis)** are you taking this med?
1.				
2.				
3.				
4.				
5.				
6.				

WOMEN ONLY: Number of pregnancies ____ No. of deliveries ____ Complications? _____

Do you have now or have you experienced the following?
*If answer is **YES** for a particular item, **please elaborate**.*

Gen:	No	Yes
History of Malignant Hyperthermia	___	___
Trouble with anesthesia?	___	___
Artificial Hip or Joint?	___	___
Weight Loss (unintentional)?	___	___
Chills?	___	___
HEENT:		
Glaucoma?	___	___
Uncontrolled, severe headaches?	___	___
Double vision?	___	___
Neck:		
Neck mass?	___	___
Swollen glands?	___	___
Resp:		
Short of breath?	___	___
Coughed up blood?	___	___
Obstructive sleep apnea	___	___
CV:		
Had Rheumatic Fever	___	___
Mitral valve prolapse?	___	___
Artificial heart valves?	___	___
Congenital heart disease (this is **NOT** congestive heart failure)	___	___
Pacemaker?	___	___
Irregular heart beat?	___	___

GI:	No	Yes
Nausea?	___	___
Vomiting?	___	___
Heartburn?	___	___
Musculosk:		
Joint swelling?	___	___
Joint pain?	___	___
Neuro:		
Dizziness?	___	___
Fainting spells?	___	___
Stroke or “mini stroke”?	___	___
Psych:		
Suicide attempts?	___	___
Hearing voices?	___	___
Feeling down?	___	___
Nervous breakdown?	___	___
Endocr:		
Diagnosed with diabetes?	___	___
Change in hair texture?	___	___
Heme:		
Abnormal bleeding?	___	___
On a “blood thinner”?	___	___
Have “thick blood”?	___	___
Bruising easily?	___	___

Issues you wish to discuss with us on your visit:

1. _____

2. _____

3. _____

I certify that preceding information is accurate to the best of my knowledge and that incomplete or wrong information may negatively impact on my health care.

Signature:_____

Date: _____