Caleb J. Fleming, MD
Certified, American Board of Urology

1445 Sheldon Rd, Suite 101
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Phone: 616.604.8363
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Lakeshore Urology, PLC

www.lakeshore-urology.com

Thank you for choosing Lakeshore Urology, PLC for your urological needs. For your convenience we have enclosed our pre-registration forms. Please bring the following with you to your appointment:

Please bring the following to your appointment. Please do not mail.

1. **Completed** registration forms.
2. **Completed** annual authorizations form.
3. **Completed** Health history forms.
4. A list of medications you are currently taking.
5. Driver's license / Photo ID and insurance card (present at each visit).
6. Please be prepared to leave a urine specimen if needed.

A $25.00 administrative fee will be charged in the event you fail to give 24-hour advance notice of cancellation. Please plan to arrive early. If you are more than 15 minutes late, we may be forced to reschedule your appointment and charge a $25.00 administrative fee for your missed appointment. Please note we do not guarantee a reminder call regarding your appointment date and time.

Per your insurance contract, any co-payments are required to be paid at the time of your appointment. We accept cash, personal checks, debit cards, and credit cards.

Our Grand Haven office hours are: Monday, Tuesday, Wednesday, Thurs 8:00AM-4:00PM Friday 8AM-12:00 PM

Please do not hesitate to contact us if you have any further questions. We look forward to meeting you!!

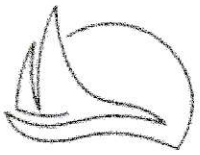
APPOINTMENT DATE: _____ Time:_____

***** Please Arrive 15 minutes prior to your scheduled time*****

HARBOR DUNES MEDICAL CENTER

1445 SHELDON RD. STE. 101

GRAND HAVEN, MI 49417



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Patient Name:_____ **Date of Birth:**_____

ANNUAL AUTHORIZATIONS

[ ] I request that no information be released. _____(initial here)
[ ] I authorize my verbal or written information be released to:
Name:_____, Relationship_____
Name:_____, Relationship_____

Notice of Privacy Practices: I have been notified of and provided access to a copy of the Lakeshore Urology, PLC Notice of Privacy Practices.

Payment Agreement: I understand Lakeshore Urology, PLC will bill for most services provided to me. If I do not have insurance, I agree to pay Lakeshore Urology, PLC for all charges for services provided to me as requested. If I have health insurance which covers services I received, I understand I am responsible if for some reason Lakeshore Urology, PLC is not paid by an insurer for services received unless the insurer has an agreement with Lakeshore Urology, PLC which prohibits billing me for services. I agree to pay Lakeshore Urology, PLC the amount of any charges not covered by or disputed by the insurance, worker's compensation carrier or employer. I understand that for any unpaid balance, Lakeshore Urology, PLC will use the services of a third party collection agency to collect any outstanding balance. I authorize Lakeshore Urology, PLC to research my ability to pay.

Medical Release: I hereby authorize Lakeshore Urology, PLC to disclose any medical records or other information pertaining to my treatment, hospitalization or outpatient care to my insurance company, employer or acting intermediary. Photocopies of this authorization shall be valid as the original.

Insurance Authorization: I authorize payment of medical benefits to be sent directly to Lakeshore Urology, PLC (Tax ID#46-1710531) for any services rendered. I have read this form (or had it read to me) and I understand it. I agree that by signing this form, I am bound by what it says whether I am the patient or someone acting on the patient's behalf.

HIV/Hepatitis Testing: For the protection and proper treatment of patients, medical staff and healthcare personnel, I consent to be tested for human immunodeficiency virus (HIV) and Hepatitis in the event where a healthcare worker or office associate sustains an exposure to my blood or other bodily fluids.

Patient or Responsible Party Signature:_____ Date:_____

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Please fill in all of the blanks, -- if none, please write "none".

Patient Information:	
Last Name	
First Name	
M. Name + Suffix	
Sex	
Prev Last Name	
DOB	
Soc Sec No	
Address	
Address 2	
Zip	
City	
State	
Home Phone	
Work Phone	
Mobile Phone	
Email	
Contact Preference	[ ]Home [ ]Work [ ]Mobile [ ]Mail [ ]Portal
Usual Provider	[ ]Caleb Fleming, MD [ ]Clay Reeves, NP-C
Preferred Office	[ ]Grand Haven [ ]Muskegon [ ]Shelby
Language	[ ]English [ ]Spanish [ ]Other:_____
Race: The Federal Government requires physician groups to collect certain information. This information is about your Race and Ethnic background. You are NOT required to provide this information and you MAY DECLINE to answer	[ ]DECLINE [ ]American Indian [ ]Asian [ ]Asian Indian [ ]Black/African American [ ]European [ ]Filipino [ ]Japanese [ ]Korean [ ]Hawaiian/Pacific Islander [ ]White/Caucasian [ ]Arab [ ]Chinese [ ]Vietnamese [ ]Other:_____
Ethnicity:	[ ]DECLINE [ ]Hispanic/Latino [ ]Not Hispanic/Latino
Marital Status:	[ ]Unknown [ ]Married [ ]Single [ ]Divorced [ ]Separated [ ]Widowed [ ]Partner
Homebound?	[ ]YES [ ]No

Date:	
Guardian Information:	
Last Name	
First Name	
M.Name + Suffix	
Emergency Contact Information	
Name	
Relation	
Emergency Phone	
Mobile Phone	
Next of Kin	
Name	
Relationship	
Phone	
Employer Information	
Name	
Address	
City/State/Zip	
Phone	
Occupation	
Guarantor Information	
Guarantor (name to whom statements are sent)	
Relationship to Pt	
Last Name	
First Name	
M. Name + Suffix	
DOB	
Mailing Address:	
Same as Patient's?	
Address	
Address 2	
Zip	
City	
State	
Soc Sec No	
Phone	
Email	
Employer	

How did you hear about us?

How do you want your Patient Care Summary Delivered?

[ ]Portal [ ]Paper

OFFICE USE:	[ ]Privacy Notice [ ]Release of Billing Information [ ]Assignment of Benefits

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Name	Birth Date:	Today's Date:
Who is your Primary Care Provider	Preferred Pharnacy Name/Location:	

Allergies: **[ ]Latex [ ] Penicillin [ ]Sulfa [ ]Cephalosporins(Keflex) [ ]Contrast Dye**

[ ]Other (specify):

Reason for Today's Visit:

Review of Systems

Y	N	**Constitutional**
		Chills
		Fever
		Weight Loss
Y	N	**Cardiovascular**
		Chest Pain
		Heart Murmur
		Palpitations
Y	N	**EEMT**
		Vision Changes
		Hearing Loss
		Sore Throat
Y	N	**Hematologic/Lymphatic**
		Easy Bleeding
		Swollen Lymph Nodes
		Bruising
Y	N	**Respiratory**
		Cough
		Shortness of Breath
		Wheezing
Y	N	**Endocrine**
		Excessive Thirst
		Fatique
		Hot Flashes
		Decreased Libido

Y	N	**Urinary**
		Dysuria (burning)
		Hematuria (Blood in urine)
		Flank Pain
		Feeling of Incomplete Emptying
		Urinary Frequency
		Urine Stream Stops and Starts
		Urinary Urgency
		Weak Stream
		Straining to Urinate
		Nocturia (up several times/night)
		Hesitancy with Urination
		Retention (unable to urinate)
		Stream Sprays or Splits
		Loss of Control (incontinence)
		Nighttime Bedwetting
Y	N	**Male Genital**
		Erectile Dysfunction (ED)
		Penile Discharge
		Penile Swelling
		Testicular Pain
		Testicular Lump
		Scrotal Pain
		Scrotal Lump/Swelling
Y	N	**Female Gynecologic**
		Pelvic Pain
		Pelvic Pressure
		Vaginal Itching/Burning
		Abnormal Periods
		Post Menopausal

Y	N	**Gastrointestinal**
		Abdominal Pain
		Blood in Stool
		Constipation
		Diarrhea
		Heartburn
		Loss of Appetite
		Nausea
		Vomiting
Y	N	**Musculoskeletal**
		Bone Pain
		Back Pain
		Arthralgias/Joint Pain
		Swelling of Extremities
Y	N	**Neurologic**
		Difficulty Walking
		Headache
		Memory Loss
		Seizures
		Tremors
Y	N	**Psychiatric**
		Anxiety
		Depression
		Insomnia
Y	N	**Skin (Integumentary**
		Itching Skin
		Rash
		Hives
		Jaundice

	Medication	Dosage	Frequency	Medication	Dosage	Frequency
	Aspirin					
	Coumadin.Warfarin					
	Plavix(clopidogrel)					

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Name:	Birthdate:	Today's Date:

Past Medical History

Year	Disease	Year	Disease
	Asthma/COPD/Emphysema		Heart Disease
	Back Pain		Hepatitis
	Bleeding Disorders		Hypertension (High Blood Pressure)
	Blood Clots/DVT		Hyperthyroidism
	Cancer, Bladder		Hypothyroidism
	Cancer, Breast		IBD/Crohn's/Ulcerative Colitis
	Cancer, Colorectal		Kidney Disease
	Cancer, Lung		Liver Disease
	Cancer, Ovarian		MRSA/Antibiotic Resistant Infection
	Cancer, Prostate		Osteoporosis
	Cancer, Renal (Kidney)		Other- Specify:
	Cancer, Testicular		Peripheral Vascular Disease
	Cancer, Uterine		Polycystic Ovary/Menstrual Problems
	Chronic Pain		Pulmonary Embolism
	Dementia (Alzheimer's)		Pyelonephritis
	Diabetes		Seizures
	Diverticulosis/Diverticulitis		Sexually Transmitted Infections
	Fibromyalgia		Sleep Apnea
	Glaucoma		Stroke
	Gout		Tuberculosis
	HIV/AIDS		

Surgical History

Year	Type
	Amputation
	Angioplasty
	Aortic Aneurysm
	Appendectomy
	Back Surgery
	Bariatric Surgery
	Caesarean Section
	Cancer Surgery
	Carotid Endarterectomy
	Cataract Surgery
	Cholecystectomy
	Circumcision
	Colostomy/Ileostomy
	Feeding Tube
	Heart Bypass (CABG)
	Hernia Repair
	Hysterectomy
	Joint Replacement
	Other Abdominal Surgery
	Prostate Surgery
	Suprapubic Tube
	Vasectomy

Family History

Father	Mother	Sibling	Grand Parent	Disease
				Bladder Cancer
				Bleeding Disorders
				Cancer
				Diabetes
				Kidney Disease
				Kidney Stones
				Prostate Cancer
				Renal (Kidney) Cancer
				Sleep Apnea

Social History

Smoking Status?

[ ]Never
[ ]Daily
[ ]Some Days
[ ]Unknown Current Status
[ ]Unknown if Ever Smoked

Smoking-How Much?

[ ]One pack per week (PPW)
[ ]Two PPW
[ ]1/4 Pack/Day (PPD)
[ ]1/2 PPD
[ ]One PPD
[ ]1 1/2 PPD
[ ]2 PPD
[ ]3+ PPD

Tobacco Years of Use?

Alcohol Intake?

[ ]None
[ ]Occasional
[ ]Moderate
[ ]Heavy

Caffeine Intake?

[ ]None
[ ]Occasional
[ ]Moderate
[ ]Heavy

Illicit Drugs?

[ ]Yes [ ]No

Gynecologic History

Last Menstrual Period

If Post Menopausal, at what Age?

Lakeshore Urology, PLC

FINANCIAL POLICY LAKESHORE UROLOGY,PLC

Payment/Insurance Policy
We recognize the need for a definite understanding between you and your physician concerning healthcare and the financial concerns. Our commitment is to provide the very best healthcare to our patients while recognizing the need to limit services to only those medically necessary. The responsibility for payment of fees for these services is the direct obligation of the patient.

Updating Information:
Please be sure we have the most current demographic and insurance information at all times. It is your responsibility to provide us with this information. The information you provide us must match the information you provide the insurance carrier. Filing insurance claims with the wrong information delays processing and increases patient's financial responsibility.

Insurance:
You must realize, however, that your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. While we will try to be helpful, and we may participate in the plan, your health benefit plan determines your coverage, any requirements for prior authorizations or referral and establishes the limit on your coverage for medical services. We cannot know the benefits and exclusions of each patient's policy. **It is the patient's responsibility to know and understand your coverage and benefits**

It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from primary care physicians, pre-certification, limits on outpatient charges, specific physicians and/or hospitals to use. **You should be knowledgeable of any deductibles, co-payments and/or coinsurance.** You agree to accept responsibility for co-payments, deductibles, and medical care and other services that are provided to you which are not specifically covered by your insurance plan or not covered due to the absence of authorizations/referrals you are obligated to obtain under your insurance plan. The services, plans, and benefits under your insurance plan may be subject to and governed by applicable contracts and government regulations.

You are required to present your insurance card **every** visit.

Bills from Hospital and Labs:
When you have certain laboratory testing collected in our office,, the specimen is generally sent to an outside lab or hospital for analysis. When this occurs you may receive a separate bill from that entity.

Payment Policy Schedule:*

Co-payments	Full payment at the time of service
Deductibles and Coinsurance	Full payment at the time of service
Non-covered service	Full payment at the time of service.
Self pay Surgeries	Payment is handled on a case-by-case basis. Generally, a 50% deposit is required 10 days prior to surgery with the balance due at the time of the surgery.
Surgery Cancellations	Any cancellation or rescheduling of a scheduled surgical procedure without a valid medical reason less than 5 business days prior will incur a $100.00 cancellation fee. This fee is not covered by insurance.
Referrals/Authorizations	Should your insurance carrier require a referral or authorization, it is your responsibility to obtain or request one prior to your appointment. The office will not issue a referral or authorization for a service already performed or back date a referral or authorization.
Returned checks	If you make a payment by check to the office and it is returned to us for any reason, you will incur a $25.00 fee. Additionally, no appointments or services will be provided for non-emergent care, until the balance is paid in full.
Past Due Accounts	It is our intention to collect all payments for services rendered on time. Our policy is to send three statements should there be

an existing balance, however if your account becomes past due the office will take the necessary steps to collect this debt. Any and all additional costs associated with the collection of the debt may become your financial responsibility.

* The fees/charges quoted above are subject to change at any time.

We realize that temporary financial problems may affect timely payments on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any further questions about the information above or any uncertainty regarding our financial policy, please do not hesitate to ask us. We are here for you.

I have read and understand the financial policy.

_____ _____

Signature (Patient, Guardian or power of Attorney) Date

_____ _____

Witness Date