Jonathan N. Lazare, M.D.

First name: __________________________ Initial: _____ Last Name: ________________________________

Address: ____

City: _________________________________ State: _____________ Zip: _____________

Phone: (   ) ________________________ Cell Phone: (   ) ________________________

Email Address: ____

Date of Birth: _____/_____/_____ Social Security No: ____________________________

Circle One- Sex: Female/Male Marital Status: Single/Married/Widow/Partnership/Divorced

Race: Caucasian (White) ___ African American (Black) ___ Hispanic___ Other __________________

Employer: ____________________________Work Phone: (   ) ___________________

Work Address: ____

Work City: ________________________________ State: ________ Zip: __________

Spouse or Parent's Name: _________________________________ Phone: (   ) ______________________

Primary Care Physician: _________________________________ Tele#_______________________

Name of Doctor who referred you? ____

How did you hear about the practice? ____

Are you allergic to any medications, if so please list the medications?

Please list all medications you are currently taking (include aspirin daily)?

Describe the reason for your visit? ____

____

Is your visit related to **Infertility** or **Erectile Dysfunction**? Yes or No

Specify____________________________________

Are you or think you are pregnant? Yes or No

Date of last menstrual period? _______________________

Primary Insurance: ___________________________Policy Number: __________________________

Secondary Insurance: _________________________ Policy Number: __________________________

Emergency Contact: _______________________________ Relationship: _____________________

Telephone Number: _______________________________

Dr. Lazare Does Not Give Test Results Over The Phone.
All Results Are Discussed With the Patient
Face - To - Face During The Follow - Up Visit.
If This Is Not Acceptable To You –
We Suggest You Seek a Different Urologist.

We have instituted this policy because discussing results over the phone is dangerous for several reasons. First, there is the potential for miscommunication and misunderstanding over the telephone. Secondly, you may require additional tests based upon your initial test results. Arrangements and scheduling of these tests require your presence in the office. Finally, during a face-to-face follow-up visit, you have the chance to think and ask Dr. Lazare questions about your test results and your condition. This is usually not possible over the telephone.
Thank you.

Signature: ____ Date: ____________________________

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

The medical services you seek imply an obligation on your part to ensure payment in full is made for services received. This Statement and/or by receipt of from Jonathan N Lazare MD you agree:

1. You acknowledge and agree to all FINANCIAL POLICIES of Jonathan N Lazare MD that you are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier, which are not otherwise covered by your insurance.

2. **You are responsible for knowing your insurance policy.** For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services by Jonathan N Lazare MD and are responsible to obtained such authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received by Jonathan N Lazare MD are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services by Jonathan N Lazare MD; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.

3. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be considered a **self-pay patient**. As a self-pay patient, our fee is expected to be paid at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may rescheduled.

4. We may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary.

5. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a submitted claim. You must notify us of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact the Billing Department to address the problem or to discuss a workable solution.

6. Whether or not you have insurance or are self-pay, payment of any account balance is due within thirty (30) days of receipt of your billing statement. If you need to make special arrangements for payment, you may contact our Billing Department to determine on an agreeable payment plan. Partial payments may be accepted and applied, without waiver, at the discretion of Jonathan N Lazare MD. Acceptance of any partial payment shall not extend any time period, cure any default, or be deemed to satisfy any remaining balance due. If any balance on your account is over thirty (30) days past due, your account will be in default and may be referred to a collection agency.

7. We accept payment by check, cash, money order, debit cards or credit cards (Visa, MasterCard or Discover).

a. **Payment by Check.** If payment is made by check and it is returned or declined for any reason, your account will be charged a return fee of $30.00. Check should be made to Jonathan N Lazare MD.

b. **Payment by Credit Card/Credit Card on File.** When you pay by credit card to be held on file, you agree to keep the credit card information current, and you authorize Jonathan N Lazare MD to securely store your credit card information, and only charge it should you have an outstanding balance or any leftover balance from a

processed claim in the future **WE WILL CONTACT YOU BEFORE CHARGING ANY BALANCES TO YOUR CREDIT CARD.**

8. **Additional Charges.** Patients may incur and are responsible for the payment of additional charges at the discretion of Jonathan N Lazare MD including but not limited to: (i) charges for a missed appointment without **24 hours** advance notice will be subject to a fifty dollar no show fee; (ii) we send our urine specimens to an outside lab. If you have a specific lab you want our office to send your urine specimen to please let the front desk know so we may give you a prescription to go to your desired lab. (iii) charges for copying and distribution of patient medical records; (iiii) charges for extensive forms preparation or completion is subject to a charge of .75 per page plus postage ; or (v) any costs associated with collection of patient balances, all as allowed by law.

9. **Self-pay Patients**: The fee of 380.00 is due at the time services are render in full. This covers the initial Consultation up to 45 minutes, up to two ultrasounds and the collection of a urine specimen. **Please be Advised that the urine collected is sent to an outside lab and that is a separate charge from the lab.**

____ _______ _________

10. **Authorization to Contact.** You authorize Jonathan N Lazare MD and or personnel to communicate by mail, telephone, cell phone and/or e-mail according to the information provided in your patient registration information. Jonathan N Lazare MD, or staff may use any information you have provided to contact you for purposes related to your account, including debt collection.

I have read and understand the financial and office policies described above.

Patient Signature: ______________________________

Date: ____________________

Pharmacy Information

Name of Pharmacy: ____

Address: ____

City: _______________________________ State: _________ Zip: ___________

Telephone: __________________________ Fax: _________________________

Credit Card on File Authorization

Please complete for the office of Jonathan N Lazare M.D to keep your credit card on file for any balances incurred due as described above.

The undersigned agrees and authorizes Jonathan N Lazare MD to charge the credit card for any outstanding balances. We will contact you before any charges are made to your credit card.

Cardholder Name ____

Circle one – Visa MasterCard Discover

Card Number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date __ __ / __ __

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare Operations.
The practice reserves the right to change the privacy policy as allowed by law.
The practice has the right to restrict the use of the information but the practice does not have to agree To those
The patient has the right to revoke this consent in writing at any time and all full disclosures will then Cease restrictions.
The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

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This consent was signed by: ____

(PRINT NAME PLEASE)

Signature: ____ Date: ________________