Barnes Urology
William F. Barnes, MD PC
4200 S. Douglas Ave. Suite 104 OKC, OK 73109
Phone: (405)644-5175 Fax: (405)644-5176
Email: fax@wfb-md.com

NEW PATIENT PAPERWORK

IF YOU DO NOT HAVE INSURANCE: A MINIMUM DEPOSIT OF $200.00 IN THE FORM OF CASH, MONEY ORDER OR CREDIT CARD IS REQUIRED AND WILL BE DUE AT THE TIME OF YOUR APPOINTMENT TO SEE OUR PHYSICIAN. WE DO NOT ACCEPT PERSONAL CHECKS FROM NEW PATIENTS.

IF YOU DO HAVE INSURANCE: YOUR COPAY, CO-INSURANCE OR DEDUCTIBLE MUST BE PAID IN FULL WITH CASH, MONEY ORDER OR CREDIT CARD, PLEASE KEEP IN MIND WE DO NOT ACCEPT PERSONAL CHECKS FROM NEW PATIENTS.

Your appointment is scheduled for: _____ all new patients can expect to be in our office for 1–2 hours during their initial visit. WE ASK ALL NEW PATIENTS TO SEND THEIR PAPERWORK TO US BEFORE YOUR SCHEDULED APPOINTMENT DATE. IF YOU CANNOT GET IT BACK TO US BEFORE YOUR APPOINTMENT PLEASE BRING IT THE DAY OF YOUR APPOINTMENT. **ALL NEW PATIENTS MUST BE IN OUR OFFICE AT LEAST 30 MINUTES BEFORE YOUR APPOINTMENT TIME.** IF YOU SHOW UP AT YOUR SCHEDULED APPOINTMENT TIME WITHOUT YOUR PAPERWORK IN HAND YOU MAY BE ASKED TO RE-SCHEDULE YOUR APPOINTMENT. ANY PATIENT WHO IS MORE THAN 15 MINUTES LATE FOR ANY SCHEDULED APPOINTMENT WILL BE RE-SCHEDULED.

Please bring the following to your scheduled appointment.

- ***Completed paperwork** (if you have not already sent it to us) (REQUIRED)
- ***Photo ID (Required)**
- ***Insurance Card (Required). If you have insurance but do not have an insurance card, please obtain one before your appt. If you cannot provide your card at the time of your office visit, please call and re-schedule your appointment**
- ***All current medications or list of medications with dosage**
- ***Please be prepared to give a urine specimen upon arrival. If you arrive and need to use the restroom, please advise the front desk immediately. We require a urine sample on all patients.**

Our office is located North of SW 44th street on Douglas Ave in Oklahoma City in the Medical Office Building at Southwest Integris Medical Center 1st floor Suite 104. We are located in the 3-story white building north of the Emergency Room.

WE ARE NOT IN MIDWEST CITY

IMPORTANT INFORMATION FOR NEW PATIENTS

We ask that all new patients please mail, fax or hand deliver this paperwork to us before your scheduled appointment. ALL NEW PATIENTS ARE TO BE IN OUR OFFICE 30 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME. Your photo ID & Insurance card(s) are required when you check in. If you do not have these you will be re-scheduled.

As a courtesy to you Barnes Urology will be happy to file your insurance for you. We will file claims with up to 3 insurance companies for you. We require that you pay your co-pay and any deductible(s) that you might have at the time of check-in with the receptionist. If you are uncertain as to what these may be please contact your insurance company and they can give you this information. If you are unable to pay your co-pay and/or deductible on the day that you are to be seen please call our office and we will be happy to re-schedule your appointment for another day.

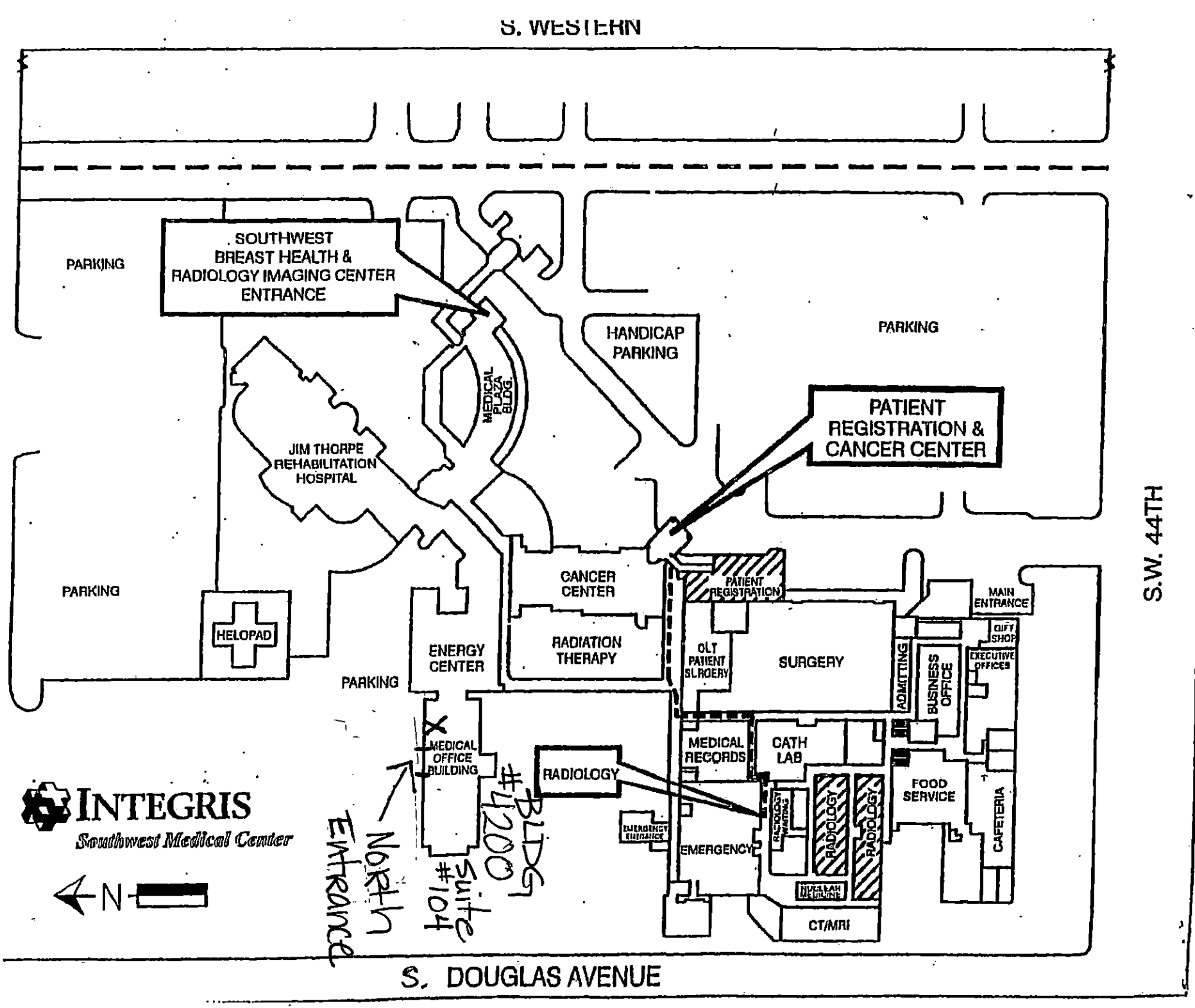
Cancellation Policy

Our office requires a 24 hour notice for all cancellations. We understand that sometimes there are circumstances beyond your control and our office will work with you.

NO SHOW POLICY

If you have no showed an appointment twice a no show fee of $25.00 will be required before any future appointments are scheduled. A no show appointment is an appointment that you do not show up for and have not called to cancel.

PLEASE NOTE WE ARE IN OKLAHOMA CITY ON DOUGLAS AVENUE BEHIND SOUTHWEST INTEGRIS MEDICAL CENTER AT SW 44TH & WESTERN. WE ARE LOCATED IN THE MEDICAL OFFICE BUILDING A/K/A MOB BUILDING BEHIND THE EMERGENCY ROOM.


S. WESTERN
SOUTHWEST BREAST HEALTH & RADIOLOGY IMAGING CENTER ENTRANCE
PARKING
HANDICAP PARKING
PARKING
MEDICAL PLAZA BLDG.
JIM THORPE REHABILITATION HOSPITAL
PATIENT REGISTRATION & CANCER CENTER
PARKING
CANCER CENTER
PATIENT REGISTRATION
MAIN ENTRANCE
HELOPAD
ENERGY CENTER
RADIATION THERAPY
OLT PATIENT SURGERY
SURGERY
ADMITTING
BUSINESS OFFICE
GIFT SHOP
EXECUTIVE OFFICES
PARKING
MEDICAL OFFICE BUILDING
MEDICAL RECORDS
CATH LAB
RADIOLOGY
FOOD SERVICE
CAFETERIA
EMERGENCY ENTRANCE
EMERGENCY
RADIOLOGY WAITING
RADIOLOGY
RADIOLOGY
NUCLEAR MEDICINE
CT/MRI
INTEGRIS
Southwest Medical Center
N
North Entrance
#4200 BLDG Suite #104
S. DOUGLAS AVENUE
S.W. 44TH

Barnes Urology
William F. Barnes, MD PC

4200 S. Douglas Ave. Suite 104 OKC, OK 73109
Phone: (405)644-5175 **Fax:** (405)644-5176 **Email:** fax@wfb-md.com

Patient Name: _____ **Today's Date:** _____
First MI Last

SS #: _____ **Date of Birth:** ____/____/____ **Age:** _____ **Sex:** M _____ F _____

Home Address _____ **Apt #** _____

City: _____ **State:** _____ **Zip Code:** _____

Cell #: _____ **Home #:** _____ **Work #:** _____

Please circle the best method for contacting you: **CELL** **HOME** **WORK**

May we leave a message on your Cell phone or Answering Machine? **Yes** **No**
(medical information, appointment dates and times, labs, results of labs or scans, etc.)

Provide your Email address for the Patient Portal: _____
(Patient Portal will allow you to view your medical records on-line. You will be the only one to have access to your records)

Employer: _____ or **Retired** **Student** **Disabled** **Unemployed**

Responsible Party name: _____
If Patient is Minor First MI Last

Primary Insurance Company _____ **Policy Number:** _____

Policy Holder Name _____ **Date of Birth** ___/___/___ **SSN #:** _____

Employer Name/ Address / Phone #: _____

Secondary Insurance Company _____ **Policy Number:** _____

Policy Holder Name _____ **Date of Birth** ___/___/___ **SSN #:** _____

Employer Name/ Address / Phone #: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION

Whom May we thank for referring you to our office? _____

Name and Number of your Primary Care Physician: _____

Name and Number of Other Physicians _____

Name, Number and Location of your Pharmacy: _____

Signature _____ **Date** _____

THIS FORM MUST BE SIGNED AND DATED BY PATIENT OR LEGAL GUARDIAN OF A MINOR

Barnes Urology
William F. Barnes, MD PC

4200 S. Douglas Ave. Suite 104 OKC, OK 73109
Phone: (405)644-5175 **Fax:** (405)644-5176 **Email:** fax@wfb-md.com

PATIENT MEDICAL HISTORY QUESTIONAIRE

NAME: _____ AGE: _____

Marital Status: Married Single Divorced Widowed Height: _____ Weight: _____

Race: American Indian/Alaska Native Asian Black or African American Caucasian Eskimo

Hispanic or Latino Native Hawaiian or Pacific Island Unknown

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Why are you seeing the Doctor today? _____

Please List all Allergies: _____

List All Current Medications with dosage: _____

_____

_____

_____

List All Surgeries/Hospitalizations & years performed: _____

_____

_____

List all of your Current Medical Conditions & onset dates: _____

_____

_____

Family History of Illness or Disease _____

_____

Do you or have you used tobacco products: Cigarettes Cigars Smokeless Tobacco Pipe

How long have you been using the above? _____ How much per day? _____

If you no longer use tobacco products, when did you quit, how long & how much per day? _____

Do you consume alcohol? No Yes What type of Alcohol? Wine Beer Liquor

How much and how often do you consume alcohol? _____

Do you consume caffeinated products? Coffee Tea Soda How much per Day? _____

Any Other pertinent information we should be made aware of? _____

_____

Signature _____ Date _____

THIS FORM MUST BE SIGNED AND DATED BY PATIENT OR LEGAL GUARDIAN OF MINOR

PLEASE CIRCLE IF YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS:

General/Constitutional:	Fever	Weight Loss	Chills
	Weight Gain	Fatigue	
Eyes:	Blurry Vision	Double Vision	Cataracts
Ears, Nose, Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat
Cardiovascular:	Chest Pains	Swollen Ankles	Irregular Heartbeat
Respiratory:	Shortness of Breath	Wheezing	Chronic Cough
Gastrointestinal:	Abdominal Pain	Diarrhea	Constipation
	Nausea	Vomiting	
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

BARNES UROLOGY

4200 S. DOUGLAS AVE. SUITE 104 OKC, OK 73109

PHONE: (405)644-5175 FAX: (405)644-5176 EMAIL: FAX@WFB-MD.COM

PATIENT AGREEMENTS AND ACKNOWLEDGEMENT

AUTHORIZATION FOR MEDICAL TREATMENT

Barnes Urology and its personnel are hereby authorized to administer any medical, diagnostic or therapeutic treatment as may be deemed necessary or advisable. I represent to Barnes Urology that I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that insurance or medical benefits for Barnes Urology charges otherwise payable to me are to be made payable to Barnes Urology. Any payment received for services may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.

PRECERTIFICATION

I understand that Barnes Urology will assist with insurance precertification requirements which are the responsibility of the policyholder and/or physician, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided me, payment is guaranteed for any amount due for such services provided by Barnes Urology. Charges for services and goods shall be at Barnes Urology billed charges rates unless otherwise agreed to in writing by Barnes Urology. Barnes Urology requires that a minimum of 25% of the patient balance is to be paid per month. Barnes Urology will impose a fee of $25.00 for more than one no show appointment.

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of the Notice of Privacy Practices and this Patient Agreement and Acknowledgement. I further certify that I am the patient or duly authorized by the patient to accept the terms of the Patient Agreement and Acknowledgement. A photocopy of this document has the same effect has an original.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by Barnes Urology and are accessible to Barnes Urology personnel as needed to perform their respective job duties. Barnes Urology personnel in attendance may use and disclose medical information for operational purposes and to any other physician or health care provider involved in my continuum of care. Safeguards are in place to discourage improper access to my protected health information. Barnes Urology and its personnel are authorized to disclose all or part of my medical record to any insurance carrier or health plan, workers compensation carrier, or self-insured employer group liable for any part of Barnes Urology charges and to any health care provider who is or may become involved with my care.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

A complete description of how your medical information will be used and disclosed by Barnes Urology is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this agreement. A copy is available to you upon registration and is posted in Barnes Urology facilities.

By signing this agreement I acknowledge receipt of Barnes Urology Notice of Privacy Practices and authorize the use and disclosure of my medical information as described in the Notice of Privacy Practices.

Signature of Patient or Responsible Party	**Relationship to Patient**	**Date**

BARNES UROLOGY

4200 S. DOUGLAS AVE. SUITE 104 OKC, OK 73109

PHONE: (405)644-5175 FAX: (405)644-5176 EMAIL: FAX@WFB-MD.COM

PATIENT AGREEMENTS AND ACKNOWLEDGEMENT

Barnes Urology may furnish my Medical Information (appointment date and time, labs, results of labs or scans, etc.) to the following Person(s): This includes: Spouse, child(ren), other relatives, or friends.

The first person listed will be the emergency contact person

Name	Relationship	Phone Number

Signature:_____ **Date:**_____

(Staff only) Basis for refusal, if refused: _____

BARNES UROLOGY

4200 S. DOUGLAS AVE. SUITE 104 OKC, OK 73109

PHONE: (405)644-5175 FAX: (405)644-5176 EMAIL: FAX@WFB-MD.COM

PATIENT FINANCIAL POLICY AND RELEASE FOR TELEHEALTH

Patient Name: _____

Date of Birth: _____

Thank you for choosing us as your health care provider. The following provides an explanation of the additional disclosures and requirements applicable to the delivery of Telehealth services. This document does not replace our Financial Policy and Agreement, which must be read and signed prior to any current and future medical evaluation or treatment in this office.

Many insurance carriers provide coverage for Telehealth or Telemedicine care allowing your care givers to interact with you from a remote location. However, this coverage does vary by insurance carrier. In addition, each insurance carrier typically has a different level of coverage that will vary from plan to plan. With this wide range of coverage and benefits, it is not possible for our staff to know what your plan covers. Therefore, you must contact your insurance plan in order to determine the exact coverage your policy provides.

Please Read and acknowledge the following:

While I know that it is my responsibility to understand my health insurance policy's benefits and coverage, I am requesting a remote appointment regardless of my coverage and benefits provided by my insurance plan. If my insurance plan does not pay for my Telehealth encounter, I understand that it is my responsibility to pay for the appointment.

BARNES UROLOGY uses technology compliant with current HIPAA guidelines. In order to use Telehealth services, I understand that I must have an internet accessible device with a microphone, speaker and video capabilities. Most modern mobile phones meet these criteria. If I do not have a device that meets these criteria, I understand that I will receive my Telehealth encounter using only a voice-only phone call which may change my insurance plan's coverage.

I have read this document and agree to the terms of this policy.

Patient/Parent/Guardian/Patient Rep. Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Rep. Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____

BARNES UROLOGY

4200 S. DOUGLAS AVE. SUITE 104 OKC, OK 73109

PHONE: (405)644-5175 FAX: (405)644-5176 EMAIL: FAX@WFB-MD.COM

CONSENT TO OBTAIN TELEHEALTH SERVICES

- I understand that to fulfill my request for a remote visit, my health care provider wishes me to engage in a telemedicine encounter using **I-PHONE OR I-PAD FACETIME OR FACEBOOK MESSENGER.**
- My health care provider has explained to me that the **I-PHONE OR I-PAD FACETIME OR FACEBOOK MESSENGER** will be used to effect the telemedicine encounter and that such an encounter will not be the same as a direct patient encounter due to the fact that I will not be in the same room or location as my provider.
- I understand that there are risks to this technology including interruptions, unauthorized access and technical issues. I understand that my health care provider and I can discontinue the telemedicine encounter if it is felt the **I-PHONE OR I-PAD FACETIME OR FACEBOOK MESSENGER** connections are not adequate for the situation.
- I understand that if others are present during the encounter other than my healthcare provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the encounter and thus will have the right to request the following:
    - Written documentation of the care I receive via telehealth;
    - Ask non-medical personnel to leave the telehealth encounter room; and/or
    - Terminate the telehealth encounter at any time.
- I have had the alternatives to a telehealth encounter explained to me, and I am choosing to participate in a **I-PHONE OR I-PAD FACETIME OR FACEBOOK MESSENGER** telehealth encounter.
- In an emergency, I understand that the responsibility of the provider engaged in the telehealth encounter is to advise my local practitioner, and that the specialists' responsibility will conclude upon the termination of the **I-PHONE OR I-PAD FACETIME OR FACEBOOK MESSENGER** telehealth encounter connection.

I give permission for you to provide care using a telehealth encounter as described above:

Patient/Parent/Guardian/Patient Rep. Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Rep. Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____