Pediatric Associates of University of Iowa Stead Family Children's Hospital

Monday – Thursday 7:00 am – 8:00 pm **Friday 7:00 am – 5:00 pm** **Saturday 8:00 am – 12:00 pm** **Sunday 12:00 pm – 4:00 pm**

Urine Specimen Information

Patient Name: _____ Date of Birth: _____

Primary Physician: _____ Phone Number: _____

What is the urine specimen for?

☐ Physical Examination ☐ Recheck Urinary Tract Infection

☐ Symptoms of Urinary Tract Infection – if so, have you spoken to a nurse? ☐ Yes ☐ No

Any changes since you spoke with a nurse? ☐ Yes ☐ No

What phone number can you be reached at? _____ Who should we ask for? _____

I understand that Pediatric Associates of University of Iowa Stead Family Children's Hospital, LLC will file my insurance, but that I am responsible for all charges. I authorize Pediatric Associates of UI Stead Family Children's Hospital, LLC to release needed information to the insurance company and the insurance company to pay Pediatric Associates of UI Stead Family Children's Hospital, LLC for the charges incurred. I further understand that it is my responsibility to pay for all charges if my insurance company does not do so.

Signature: _____ Date: _____

* There will be a charge for urine specimen drop-off. You will be charged one or all of the following: a minimal problem charge of $30, a urinalysis charge of $15, and/or a urine charge of $25. These charges are subject to deductible, co-pay and/or insurance depending on your insurance benefits.

For office use only: *Patient Account Number* _____ *Date of Service* _____