UROLOGICAL CONSULTANTS, PA

For Office Use Only
PATIENT
ACCOUNT #

Referring / Primary Doctor ______________________________

Doctor's Phone # ______________________________

PATIENT INFORMATION

Patient's Name: ______________________________
Last First Middle

Patient's Address: ______________________________
Street Apt # City State Zip

Home Phone: ______________ Cell Phone: ______________

Sex: ________ Marital Status: (please circle one) S M D W

Patient Occupation: ______________ Employer: ______________

Employer's Address: ______________________ Work Phone: ______________

Date of Birth: ______________ Age: __________ SS#: ______________

Spouse's Name: ______________ Work Phone: __________ Cell Phone: ______________

INSURANCE INFORMATION

Primary Insurance: ______________________ Policyholder: ______________________

Policy ID #: ______________________ Group #: ______________________

Policyholder Soc. Sec. #: ______________________ Policyholder Date of Birth: ______________________

Relation to Policyholder: ______________________

Seondary Insurance: ______________________ Policyholder: ______________________

Policy ID #: ______________________ Group #: ______________________

Policyholder Soc. Sec. #: ______________________ Policyholder Date of Birth: ______________________

Relation to Policyholder: ______________________

AUTHORIZATION

ASSUMPTION OF RESPONSIBILITY

Your insurance policy is a contract between you and your insurance company. As a courtesy to you, we will bill all charges to the insurance company indicated above. We appreciate prompt payment from you of the balance after your insurance company pays.

AUTHORIZATION TO RELEASE INFORMATION / ANNUAL AUTHORIZATION

The undersigned hereby authorizes Urological Consultants, PA to release all information pertaining to patient's treatment to his/her insurance company or companies.
(I permit a copy of this authorization to be used in place of the original)
I request the payment of authorized benefits for any services furnished to me by Urological Consultants, PA be made directly to Urological Consultants, PA.
I have read, understood and approved all of the above information.

MEDICARE PATIENTS ONLY - CMS ASSIGNMENT / ANNUAL AUTHORIZATION

I request payment of authorized Medicare benefits be made on my behalf to Urological Consultants, PA for any services rendered to me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE: ______________________________ DATE: ______________________

Urological Consultants, P.A.

Receipt of Notice of Privacy Practice

I, ____ , have received a copy of Urological Consultants Privacy Notice.

* ____ * _______________________________
Signature of Patient/Legal Guardian Date

_______ Patient Refused to Sign Employee Signature ________________________________

Request for Protected Health Information

Who may we release your personal and medical information to, other than yourself and medical professionals
Please include the relationship to the patient.

____

____

____

Please indicate where it is OK to leave you a ***detailed message***:

HOME WORK CELL (Please circle all that apply)

* ____ * _______________________________
Signature of Patient/Legal Guardian Date

(For Use by Employees of UCPA Only)

Indicate which Photo ID has been checked:

Driver's License _____ **State:** _____________________ **Date Checked:** _____________
State ID _____ **State:** _____________________ **Employee Initials:** __________
Military ID _____
Other _____ **Specify:** ___________________

Urological Consultants, P.A.

Privacy Notice

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, (The Health Insurance Portability and Accountability Act of 1996)(HIPAA), mandates that we issue this new revised Privacy Notice to our patients. This notice to our patients meets all current requirements as it relates to Standards for Privacy of Individually Identifiable Health Information (IIHI); affecting our patients. You are urged to read this notice.

Our Privacy Notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: “any information, whether oral or recorded in any form or medium, that created or received by a covered entity, that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual that identifies the individual or, with respect to which there is reasonable basis to believe that the information can be used to identify the individual.”

Our office will use or disclose your PHI for purposes of treatment, payment and other healthcare operations. It is our policy to control access to your PHI to only those who have a need to know; and even in cases where access is permitted, we exercise a “minimum necessary information” restriction to that access. Our practice may contact you to provide appointment reminders or to discuss treatment options or alternatives.

An Authorization differs from a Privacy Notice in that it is very specific with respect to the information allowed to be disclosed or used, the entity to which the information may be disclosed, the intent for which it may be disclosed, and the time frame of the authorization and used only for one specific request for information. In the event of a non-healthcare related request for personal health information this office will insist that the requestor have you complete an authorization form.

You, as our patient, may restrict the use or disclosure of an Authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke an Authorization you must provide this office with a written request with your signature and date and provide instructions regarding the existing Authorization or consent. Any revocation will not apply to information already used or disclosed. If you had a “personal representative” initiate an Authorization you may revoke that authorization at any time.

You may request to examine your healthcare information, may request copies of your information, and may request amendments to your information. The physician or principal will exercise professional judgement with regard to requests for amendments and by law may reject the request. If we agree with the request to amend the information, we will abide by the changes.

In limited circumstances, the Privacy Standard permits, but does not require, covered entities to continue certain existing disclosures of health information without the individual authorization for specific public responsibilities. These permitted disclosures include: identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research; generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

There are specific state laws that require the disclosure of heatlh care information related to communicable disease like Hepatitis C, and AIDS. Where the state laws are more stringent than the HIPAA Privacy Standard, the state laws will prevail.

All of these disclosures could occur previously under former laws or regulations however; The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgement to decide whether to disclose any information, reflecting our own policies and ethical principles.

On occasion we may furnish your PHI to a third party. this could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a "chain of trust" contract with our business associates, we cannot absolutely guarantee that they will not use or disclose your PHI in a way that is not permitted by the HIPAA Privacy Standard. It is our practice to retain information about non-healthcare related requests for your health care information for a period of six years.

The law requires us to obtain your signature on this Privacy Notice to indicate only that have received it. It is the law that your rights are communicated in this manner.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IIHI. this office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law. You have the right to file a complaint if you believe that your Privacy rights have been violated. Your complaint must be submitted in writing. Our practice is able to supply you with a "patient complaint form" if requested.

Effective Date: April 14, 2003

UROLOGICAL CONSULTANTS, P.A.
Comprehensive Urological Care for Montgomery County

Name:
Date:

CHIEF COMPLAINT

What is the **main problem** that brings you to see us today?

ALLERGIES

Are you allergic to any of the following? Please check **Yes** or **No** for each.

☐ Check here if you have **NO** known allergies

Allergen	Yes	No	Reaction
Penicillin	☐	☐	
Sulfa	☐	☐	
Latex	☐	☐	
IV Contrast Dye	☐	☐	
Cipro / Levaquin	☐	☐	
Macrobid / Nitrofurantion	☐	☐	
Others (please list):	☐	☐	

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MEDICATIONS

Please list the **name and dosage** of all medications you are taking (include regularly used over-the-counter medications/supplements). **IF YOU HAVE A MEDICATION LIST WITH YOU, PLEASE SUBMIT IT WITH THIS FORM.**

☐ Check here if you are currently taking **NO** medications

Medication	Dose

SURGICAL HISTORY

Have you ever had any of the following **surgeries or procedures**? Please check **Yes** or **No** for each.

☐ Check here if you have had **NO** surgeries or procedures

Urogological Surgeries	Yes	No	Date
Kidney surgery	☐	☐	
Bladder or Incontinence surgery	☐	☐	
Prostate surgery	☐	☐	
Scrotal/Testicle surgery	☐	☐	
Penis surgery	☐	☐	
Other:	☐	☐	

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Abdominal Surgeries	Yes	No	Date
Appendix removal	☐	☐	
Gallbladder removal (cholecystectomy)	☐	☐	
Hernia surgery	☐	☐	
Groin (inguinal)? Side?	☐	☐	
Navel (umbilical)?	☐	☐	
Removal of bowel	☐	☐	
Bag for drainage of stool (ostomy)?	☐	☐	
Aneurysm repair	☐	☐	
Other:	☐	☐	

Gynecological Surgeries	Yes	No	Date
Hysterectomy	☐	☐	
C-section	☐	☐	
Other:	☐	☐	

Brain, Head or Neck Surgeries	Yes	No	Date
Cartoid surgery	☐	☐	
Other:	☐	☐	

Chest Surgeries	Yes	No	Date
Heart bypass	☐	☐	
Artificial heart valve	☐	☐	
Other:	☐	☐	

Joint or Bone Surgeries	Yes	No	Date
Artificial joint / replacement? Which one?	☐	☐	
Other:	☐	☐	

Other Surgeries (Please List):	Date

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PAST MEDICAL HISTORY

Have you ever been treated for any of the following **medical problems**? Please check **Yes** or **No** for each.

Condition	Yes	No
Adrenal Problems	☐	☐
Asthma / Emphysema	☐	☐
Blood Clots / Bleeding Problems / Deep Vein Thrombosis / Pulmonary Embolus	☐	☐
Cancers (please list):	☐	☐
Cataracts	☐	☐
Congestive Heart Failure	☐	☐
Diabetes	☐	☐
Gastrointestinal bleeding	☐	☐
Glaucoma	☐	☐
Gout	☐	☐
Heart Attack / Stroke	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
HIV / AIDS	☐	☐
Irregular Heart Beat	☐	☐
Kidney Failure	☐	☐
Kidney Stones	☐	☐
Sleep Apnea	☐	☐
Thyroid Disease	☐	☐
Urinary Infections	☐	☐
Other (please list):	☐	☐

FAMILY HISTORY

Do you have **close relatives** with any of the following conditions or do any of the following conditions **run in your family**? Please check **Yes** or **No** for each.

Condition	Yes	No
Prostate Cancer	☐	☐
Bladder Cancer	☐	☐
Kidney Cancer	☐	☐
Kidney Stones	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐
Other Cancers	☐	☐
Other (please list):	☐	☐

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SOCIAL HISTORY

Please check or fill in the appropriate answer for each question.

Question	Answer		
What is your marital status?	☐ Married ☐ Divorced	☐ Single ☐ Separated	
Do you smoke?	☐ Yes, Daily ☐ Not anymore	☐ Yes, Not Daily ☐ Never Smoked	
How long have you smoked?			
How many packs per day?			
When did you quit?			
Do you drink alcohol?	☐ Yes	☐ Not Anymore	☐ Never Drank
How much do you drink per week?			
What do you drink?	☐ Beer	☐ Wine	☐ Liquor
When did you quit?			
How many caffeinated beverages do you have per day?			
Have you ever had a blood transfusion?	☐ Yes	☐ No	
What is your primary language?	☐ English ☐ German ☐ Chinese ☐ Other:	☐ Spanish ☐ Portuguese ☐ Japanese	☐ French ☐ Russian ☐ Italian
What is your race?	☐ White ☐ Hispanic/Latino ☐ American Indian / Alaskan Native ☐ Native Hawaiian / Pacific Islander ☐ Unknown	☐ Black/African American ☐ Asian ☐ Other:	
What is your ethnicity?	☐ Hispanic or Latino ☐ Non-Hispanic or Latino		
What do you do for a living (occupation)?			
Who is your employer?			

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REVIEW OF SYSTEMS

Do you have any problems related to the following? Please check **Yes** or **No** for each.

Constitutional	Yes	No
Fever	☐	☐
Chills	☐	☐
Weight Loss	☐	☐

Eyes	Yes	No
Blurry Vision	☐	☐
Double Vision	☐	☐
Cataracts	☐	☐

Ears, Nose, Mouth, Throat	Yes	No
Hearing Loss	☐	☐
Nasal Stuffiness	☐	☐
Sore Throat	☐	☐

Cardiovascular	Yes	No
Chest Pains	☐	☐
Swollen Ankles	☐	☐
Irregular Heart Beat	☐	☐

Respiratory	Yes	No
Shortness of Breath	☐	☐
Wheezing	☐	☐
Chronic Cough	☐	☐

Gastrointestinal	Yes	No
Abdominal Pain	☐	☐
Nausea / Vomiting	☐	☐
Change in Bowel Habits	☐	☐

Musculoskeletal	Yes	No
Chronic Back Pain	☐	☐
Chronic Neck Pain	☐	☐
Sore Muscles	☐	☐

Integumentary, Skin	Yes	No
Rash	☐	☐
Persistent Itching	☐	☐
Skin Cancer History	☐	☐

Neurological	Yes	No
Numbness	☐	☐
Tingling	☐	☐
Dizziness	☐	☐

Hematologic, Lymphatic	Yes	No
Swollen Glands	☐	☐
Abnormal Bleeding	☐	☐
Bruise Easily	☐	☐

Endocrine	Yes	No
Chronic Fatigue	☐	☐
Chronically Too Hot / Cold	☐	☐
Excessive Thirst	☐	☐