Urology Associates, Inc.

Patient Information

First Name_____ Last Name_____ M.I._____

Street Address_____ City_____ State_____ Zip_____

Social Security #_____ Gender assigned at birth: Male__ Female__ Current Gender: Male__ Female__

Date of Birth_____ E-mail address_____

Marital Status (circle one): Single Married Divorced Widowed Partner

Race (circle one): White Black Hispanic Native American Asian Other (please specify)_____
Preferred Language (if other than English) _____

Home Phone _____ Work Phone_____ Cell/Other_____

Would you like to receive text message appointment reminders instead of calls? Yes or No (circle one)

Employer Name_____ Employer Phone_____ Occupation_____

Employer Address_____ If Student: Full Time___ Part Time___

Spouse/Nearest Relative

Name_____ DOB_____ Relationship to patient_____

Address_____ Employer_____

Home Phone_____ Work Phone_____ Cell/Other_____

Emergency Contact (if not the person listed above)

Name_____ DOB_____ Relationship to patient_____

Home Phone_____ Work Phone_____ Cell/Other_____

Insurance Information

Primary Insurance_____ ID#_____ Group#_____

Subscriber Name_____ Subscriber DOB_____ Relationship to patient_____

Secondary Insurance_____ ID#_____ Group#_____

Subscriber Name_____ Subscriber DOB_____ Relationship to patient_____

Authorization: I certify that the information on this form is true and accurate to the best of my knowledge. I also understand that this information may be used by Urology Associates to establish primary insurance coverage and to answer questions the insurance carriers listed may have regarding pre-existing conditions. I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to Urology Associates, Inc. or any individual provider it may designate for services rendered.

Privacy Notice Acknowledgement: I understand that Urology Associates, Inc. has a published Privacy Policy and that I am entitled to a copy at my request.

Financial Policy Acknowledgement: I have been provided a copy of Urology Associates' Financial Policy including the No Show Policy. I have read and agree to the terms of the policy.

Signature of Patient or
Parent/Guardian of Minor_____Date_____

Urology Associates, Inc.

In the event that a patient wishes another individual to receive medical information such as test results, etc., or in the event that the patient is unable to receive those results, the patient may choose to designate persons who are authorized to receive that information.

I hereby authorize the release of my medical health information to the following designated persons:

( ) Spouse Name_____

( ) Son Name_____

( ) Daughter Name_____

( ) Parent Name_____

( ) Other Name_____
Relationship_____

****Permission to leave lab/test results on my answering machine or voice mail:**
(Please circle) Yes No

<u>Patient Portal Access</u>: Please provide your email address below to receive an invitation to access our Patient Portal. The portal allows you to see upcoming appointments, update demographic information, view lab results, and send messages to our office.

If you prefer to have someone else access the portal on your behalf (authorized representative), please provide their email address, and indicate their name, phone number, and relationship to patient.

Email Address: _____

Name (if other than patient)_____Phone_____
Relationship to Patient_____

I understand that if I wish to revoke these authorizations at any time, the request for revocation must be made in writing to Urology Associates, Inc.

If I do not indicate a designated person to receive information, I am requesting that medical information be released only to me.

Patient Signature _____

Printed Name _____

Date _____

Name: _____ **Date:** _____ **DOB:** _____

Referring Doctor: _____ **PCP:** _____

Cardiologist: _____ **Pulmonologist**:_____

Why are you seeing the doctor today? _____ How long have you had this problem? _____

ALLERGIES – **Please list ALL types (Drug, seasonal, pets, environmental foods):**

_____

****Pharmacy Name:** _____ **Phone #:** _____

REVIEW OF SYSTEMS: Please mark if you have *recently* experienced any of the following:

Constitutional
- ☐ Fever
- ☐ Fatigue
- ☐ Generalized Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Eyes
- ☐ Blurred Vision
- ☐ Glasses
- ☐ Worsening Eyesight

Allergic/Immunologic
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies

Neurological
- ☐ Disoriented
- ☐ Dizzy Spells
- ☐ Headache
- ☐ Memory Loss
- ☐ Tremors

Endocrine/Metabolic
- ☐ Excessive thirst
- ☐ Tired/Sluggish
- ☐ Too hot/Too cold

Gastric/Intestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion/Heartburn
- ☐ Nausea/vomiting

Heart/Cardiovascular
- ☐ Chest Pain/Angina
- ☐ Difficulty breathing w/exertion
- ☐ Irregular Heart Beat

Skin
- ☐ Acne
- ☐ Persistent Itch
- ☐ Skin Rash

Musculoskeletal
- ☐ Arthritis
- ☐ Back Pain
- ☐ Muscle Weakness

Ear/Nose/Throat
- ☐ Ear Infection
- ☐ Sinus Problem
- ☐ Sore Throat

Respiratory (Lungs)
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Blood/Lymph System
- ☐ Blood clotting problem
- ☐ Bleeding Problem
- ☐ HIV (AIDS)

Psychological
- ☐ Anxiety
- ☐ Depressed
- ☐ Generally dissatisfied with life

SURGICAL HISTORY **Please mark if you have had any of the following surgeries and date of surgery:**

Cardiovascular
Type of Surgery: _____
Date(s):_____

Type of Surgery: _____
Date(s):_____

GENERAL
Type of Surgery: _____
Date(s):_____

Type of Surgery: _____
Date(s):_____

Gastric/Intestinal
Type of Surgery: _____
Date(s):_____

Type of Surgery: _____
Date(s):_____

Genitoutinary
Type of Surgery: _____
Date(s):_____

Type of Surgery: _____
Date(s):_____

Gynecological
Type of Surgery: _____
Date(s):_____

Type of Surgery: _____
Date(s):_____

Head/Ear/Nose/Throat
Type of Surgery: _____
Date(s):_____

Type of Surgery: _____
Date(s):_____

Musculoskeletal
Type of Surgery: _____
Date(s):_____

Type of Surgery: _____
Date(s):_____

SKIN
Type of Surgery: _____
Date(s):_____

Type of Surgery: _____
Date(s):_____

SOCIAL HISTORY

Marital Status: Please indicate years

_____ Single _____Married _____Separated _____Divorced _____Widowed _____Life Partner ____Common Law Spouse

Occupation: _____ **Number of Pregnancies:**_____ **Live births:**_____

Alcohol Consumption: _____None _____Yes ____Occasional/Social # of drinks per day _____

Tobacco per day: _____None _____Yes #_____Packs/day _____Cigarettes/day _____Smokeless Tobacco

If you previously smoked, when did you quit? _____**Caffeinated beverages:** None Low Moderate Excessive

PAST MEDICAL HISTORY Please mark if you have or have had any of the following diseases or conditions:

Cardiovascular	Current	Past	Family Hx
Angina (Chest Pain)	❒	❒	❒
Aortic Aneurysm	❒	❒	❒
Arrhythmia (Irregular Heartbeat) - AFIB	❒	❒	❒
Atherosclerotic Heart Disease	❒	❒	❒
Congestive Heart Failure	❒	❒	❒
Deep Vein Thrombosis (Blood clots)	❒	❒	❒
Heart Attack (MI)	❒	❒	❒
Heart Murmur	❒	❒	❒
Hypertension	❒	❒	❒

Any other heart problems

Endocrine/Metabolic	Current	Past
Diabetes Mellitus, non-insulin dependent	❒	❒
Diabetes Mellitus, insulin dependent	❒	❒
Gout	❒	❒
Hyperthyroidism	❒	❒
Hypothyroidism	❒	❒
Rheumatoid Arthritis	❒	❒

Any other metabolic conditions:

General	Current	Past
AIDS	❒	❒
Allergies - Seasonal	❒	❒
Anemia	❒	❒
Hypercholesterolemia (High cholesterol)	❒	❒
Obesity	❒	❒
Sleep Apnea	❒	❒

Any other general disease:

Gastric/Intestinal	Current	Past
Gall stones	❒	❒
Hepatitis	❒	❒
Colitis	❒	❒
Constipation	❒	❒
Crohn's Disease	❒	❒
Diarrhea	❒	❒
GERD (Acid Reflux)	❒	❒
Ulcers (specify location)	❒	❒

Any other GI issues:

Genitourinary	Current	Past
Bladder Infection	❒	❒
Blood in urine	❒	❒
Chronic Renal Disease	❒	❒
Erectile Dysfunction	❒	❒
Hemorrhoids	❒	❒
Kidney Cancer	❒	❒
Kidney Infection	❒	❒
Kidney Stones	❒	❒
Penile Discharge	❒	❒
Polycystic Kidney Disease	❒	❒
Recurrent UTI	❒	❒
Testicular Cancer	❒	❒
Transplant Recipient	❒	❒
Venereal Disease	❒	❒

Any other Genital/Urinary Conditions:

Gynecological	Current	Past
Endometriosis	❒	❒
Menopause	❒	❒
Menstrual Disorder	❒	❒
Uterine Fibroids	❒	❒
Polycystic Ovaries	❒	❒

Any other GU conditions:

Head/Ear/Nose/Throat	Current	Past
Blindness	❒	❒
Cataracts	❒	❒
Deafness	❒	❒
Glaucoma	❒	❒
Menniere's	❒	❒
Sinusitis	❒	❒
Tinnitus (Ringing in ears)	❒	❒
Vertigo/Dizziness	❒	❒

Any other head, ears, nose or throat conditions:

Musculoskeletal	Current	Past
Arthritis	❒	❒
Carpal Tunnel Syndrome	❒	❒
Fibromyalgia	❒	❒
Osteoporosis	❒	❒

Any other dieases/condition of other musculosketal system:

Neuro/Psych	Current	Past
ADHD	❒	❒
Alcoholism	❒	❒
Alzheimer's disease	❒	❒
Anxiety	❒	❒
Dementia	❒	❒
Depression	❒	❒
Migraine	❒	❒
Multiple Sclerosis	❒	❒
Parkinson's	❒	❒
Seizures	❒	❒

Spinal Cord Injury	❒	❒
Stroke	❒	❒

Any other Neurological disease or conditions:

Respiratory	**Current**	**Past**
Asthma	❒	❒
Bronchitis	❒	❒
COPD	❒	❒
Pneumonia	❒	❒
Pulmonary Embolism	❒	❒
Tuberculosis (TB)	❒	❒

Any other respiratory diseases or conditions:

Tumors/Cancers	**Current**	**Past**	**Family Hx**
Bladder Cancer	❒	❒	❒
Brain Cancer	❒	❒	❒
Brain Tumor	❒	❒	❒
Breast Cancer	❒	❒	❒
Cervical Cancer	❒	❒	❒
Colon Cancer	❒	❒	❒
Fibrocystic Breast Disease	❒	❒	❒
Gastric Cancer	❒	❒	❒
Laryngeal (Throat) Cancer	❒	❒	❒
Leukemia	❒	❒	❒
Lung Cancer	❒	❒	❒
Lymphoma	❒	❒	❒
Melanoma	❒	❒	❒
Ovarian Cancer	❒	❒	❒
Pancreatic Cancer	❒	❒	❒
Prostate Cancer	❒	❒	❒
Rectal Cancer	❒	❒	❒
Renal Cell Cancer	❒	❒	❒
Sarcoidosis	❒	❒	❒
Testicular Cancer	❒	❒	❒
Ureter Cancer	❒	❒	❒
Ureteral Cancer	❒	❒	❒
Uterine Cancer	❒	❒	❒

Any other tumors/ Cancer:

CURRENT MEDICATIONS – **List ALL medications you are currently taking, including over the counter meds & supplements. (Attach list or write on back of sheet if necessary)**

Drug Name:	**Dosage:**	**Directions/How you take it:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

UROLOGY ASSOCIATES, INC.
FINANCIAL POLICY

PLEASE READ CAREFULLY:

The physicians and staff of Urology Associates, inc., are committed to providing you with the best possible care. In order to help you receive your maximum allowable benefits from your insurance coverage, we need your assistance as well as your understanding of our financial policy.

Insurance Patients:

- Payment of co-pay and deductible is due in full at the time of your appointment. We accept cash, checks, MasterCard, Visa and Discover.
- We must emphasize that as medical providers, our relationship is with **you**, not your insurance company. Your insurance is a contract between you, your employer, and the insurance company. While the filing of claims is a courtesy that we extend to our patients, all charges are **your** responsibility from the date the services are rendered.
- Some insurance plans require referrals or pre-authorization. ***You*** will need to obtain authorization prior to your appointment date. We **cannot** treat you without an authorization if it is required.
- Not all services are a covered benefit, depending on your individual insurance policy. It is your responsibility to familiarize yourself with your benefit coverage. This includes knowing which facilities are in-network for lab, radiology, and surgical procedures in the event that we need to refer you for additional services.
- Some services provided by the clinic are not billable to your insurance and will be your responsibility. This includes charges for completing paperwork that is not directly related to your treatment (i.e., cancer policy paperwork, DHS applications, etc.) as well as after-hours phone calls and copying medical records.
- If surgery is required, you will be contacted prior to your procedure to collect the estimated deductible and coinsurance amounts. Payment for your portion is due two days prior to the surgery date.

Medicare Patients:

- We will file Medicare and any supplemental insurance for your services. Any coinsurance or deductible that remains will be billed directly to you.
- Some services provided by the clinic are not billable to your insurance and will be your responsibility. This includes charges for completing paperwork that is not directly related to your treatment (i.e., cancer policy paperwork, DHS applications, etc.) as well as after-hours phone calls and copying medical records.
- If the doctor plans to run a test or perform a procedure that may not be covered by Medicare, you will be informed in advance and asked to sign a waiver for these services.

NO SHOW POLICY:

It is our policy to charge a $35 fee if you miss your appointment and do not call to cancel. To avoid this fee, please call our office prior to your appointment date if you need to cancel or reschedule.

Continued on Reverse

For those patients without insurance:

OFFICE CHARGES:

- Payment in full is due at the time of your appointment.
- Payment can be made by cash, Visa, MasterCard, or Discover only.

SURGERY CHARGES:

- In the event your doctor determines that surgery is necessary, a down payment of at least 50% of your *estimated* charges is due two days prior to the date of surgery. Arrangements to pay the balance of your account must also be made with our billing office at that time.
- Minimum monthly payment amounts must be approved by the billing office to assure the account is paid in a timely manner. Payments must be received every month in order to keep the account in good standing.
- Surgical procedures that are considered to be elective (i.e., vasectomies, circumcisions, etc.) must be paid *in full* prior to the date of the surgery.
- For your convenience, we do accept credit card payments by phone.

We realize that medical costs can sometimes create a financial hardship. We are eager to help patients settle their accounts in a manner that is agreeable and manageable for both parties. Please contact our billing office with any questions.

MEDICATION REFILL POLICY

Medication questions and requests for additional medication from our patients are important issues that are taken very seriously by our physicians and staff. Please adhere to this policy so that we may give you the best care possible.

HOW TO REQUEST A REFILL:

-Contact your pharmacy and request a refill.
-Give your pharmacy our fax number: 405-749-1001. They will fax us an authorization.
-Allow 2 business days to process your request.
-Your physician must approve the refill before it can be completed.

MEDICATIONS WILL NOT BE REFILLED:

-After 12:00 (noon) on Fridays. Please plan ahead if you will run out over the weekend.
-On weekends, holidays, or after hours.
-If you continue to miss scheduled appointments.
-Within two (2) days of a scheduled office visit. Ideally, refills should be discussed with your physician at regularly scheduled appointments.

Thank you for your assistance in helping to meet your medication refill needs.

DRUG SCREENING: The physicians at Urology Associates may perform urine drug screens when deemed necessary for patient care and management.