Patient Information Form

Date_____ Patient's SSN:_____

Patient's Name_____
Last Name First Name Initial

Street Address_____

City_____ State_____ Zip Code_____

Home Phone _____ Cell Phone_____ Email_____

Birthdate_____ ☐M ☐F ☐Single ☐Married

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unreported/Refuse to report

Race: ☐ White ☐ Black/African-American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander

Language: _____

Patient Employed By_____ Business Address:_____

Business Phone: _____ Occupation: _____
May we contact you at work? _____ YES _____ NO

Spouse's Name_____ Spouse's Phone_____
Leave a message at home with other residents? ☐ YES ☐ NO Answering machine/Voicemail? ☐ YES ☐ NO

Name of Primary Insurance Co._____

Policy Holder Name _____ Policy ID # _____
Policy Holder SSN _____ Group #_____
Copay Amount: _____ Policy Holder DOB _____
Please note your copay must be paid prior to seeing the physician at each visit

Name of Secondary Insurance Co._____

Policy Holder Name _____ Policy ID # _____
Policy Holder SSN _____ Group #_____
Policy Holder DOB _____

IF PATIENT IS A MINOR:

Father's Name:_____ Mother's Name: _____
Address: _____ Address: _____
Phone: _____ Phone: _____
DOB: _____ DOB: _____
SSN: _____ SSN: _____

Referring Physician: _____Primary Care Physician:_____

Pharmacy Name: _____ Pharmacy Address/Phone#: _____

In case of emergency, who should be notified?_____ Phone_____

Kindly provide 24 hours cancellation notice to avoid a cancellation/no-show fee – see financial policy for details

URO PARTNERS

New Patient Form

Last Name_____First Name_____

Date of Birth_____MRN_____

What is the reason for your visit today? (Circle all that apply)

- ☐ Blood in Urine
- ☐ Erectile Dysfunction
- ☐ Incontinence (leakage of urine)
- ☐ Enlarged Prostate
- ☐ Urinary Tract Infection
- ☐ Elevated PSA
- ☐ Kidney Stones
- ☐ Urinary Problems
- ☐ Infertility
- ☐ Other_____

Do you have or have had any of the following medical problems

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Asthma
- ☐ Hypothyroidism
- ☐ Cancer (please specify type)
- ☐ Diabetes
- ☐ Heart Attack
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ Depression
- ☐ Gout
- ☐ Bleeding disorder

Any other Medical Problems you are being treated for or have?

_____

_____

_____

_____

Please circle any of the surgeries listed below you have had with the approximate year.

- ☐ Hysterectomy _____
- ☐ Heart Valve Replacement _____
- ☐ Hip Replacement _____
- ☐ Hernia Repair _____
- ☐ Appendectomy _____
- ☐ Cardiac Bypass _____
- ☐ Knee Replacement _____
- ☐ Colon Resection _____
- ☐ Cholecystectomy _____
- ☐ Gastric Bypass _____

Are there any other surgeries you have had? Please list with the year

_____

_____

_____

_____

Last Name_____ **First Name**_____

Date of Birth_____ **MRN**_____

Are you allergic to any of the following? (Please list the nature of the allergic reaction)

- ☐ **Penicillin**_____
- ☐ **Shellfish**_____
- ☐ **Ciprofloxacin**_____
- ☐ **Sulfa**_____
- ☐ **Iodine**_____
- ☐ **Other** _____

Do you have any other food or drug allergies please list them below

1_____
2_____
3_____
4_____

Do you smoke? NO YES
If yes how many cigarettes do you smoke each day? _____ **Did you ever smoke? NO YES If YES when did you quit?**_____ **Do you drink alcohol? NO YES If YES how many drinks per day?**_____
What is your occupation? _____

FAMILY HISTORY(parents, grandparents, siblings):

Has anybody in your family had cancer? NO YES | If Yes, who: _____
Has anybody in your family had prostate cancer? NO YES | If Yes, who: _____
Has anybody in your family had kidney cancer? NO YES | If Yes, who: _____
Has anybody in your family had bladder cancer? NO YES | If Yes, who: _____
Has anybody in your family had kidney stones? NO YES | If Yes, who: _____

What is your height?____**ft.** ____**in.**
What is your weight? _____**lbs.**

Are there any other serious medical conditions members of your family have had?

1_____
2_____
3_____
4_____

Please list any medications you take along with the dosages and how it is taken (*for example Aspirin 325 mg once daily at bedtime.* Include any over the counter medications, vitamins, or supplements you regularly take.

1_____ 4_____
2_____ 5_____
3_____ 6_____

Patient Name: _____ **Date of Birth:** _____

FollowMyHealth® Universal Health Record

UroPartners now offers our patients the opportunity to join FollowMyHealth, a patient portal that will give you online access to your health information including summaries of your office visits, test results and immunizations. Please provide us with your email address and an invitation to join will be emailed to you.

Email Address: _____

•Must be 18 years or older to join. Please note that parents can obtain access to their child's records from birth to age 15. From age 15 to 18 all access is blocked. Please contact the office if records are needed during this blocked period.

☐ -I **want** to join FollowMyHealth and have my office visit summaries sent to my secure account.

☐ -I do **not want** to receive office visit summaries.

Signature: _____ **Today's Date:** _____

If you are the patient's parent please print your name: _____

Manage Your Health Online!

UroPartners is excited to bring our patients the latest advance in personal health care management - and YOU'RE in the driver's seat. Welcome to the FollowMyHealth (FMH) patient portal, the next big leap in health technology.

FollowMyHealth is a secure patient portal where you can schedule, change, or cancel an appointment, view your health history, lab results, medication lists and allergies. It provides prescription renewal and pre-registration services and allows you to communicate securely with your doctor. But more than that, it's your own personal record of your health, making it easier for you to be more actively involved in managing your own care.

How do I sign up for FollowMyHealth?

- Patients may sign up to use the patient portal during an office visit.
- The receptionist will verify your identity (photo ID required) and ask for your email address.
- Within 5 business days, you will receive an invitation via email to activate your FMH account.
- The email invitation will include a link to access your online health record.
- You can create your own username and password using the FMH Secure log on method. None of your private health information is held or accessible on any public network
- You will be required to enter a 4 digit INVITATION CODE.

Your Invitation Code is: _____

Powered by FollowMyHealth

The next generation universal health record, FollowMyHealth, combines patient-provider communication with a patient-managed personal health record.

One of the most prestigious features of this technology is the seamless combination of information from multiple health care organizations which creates the potential to house all of your health care information in one easy-to-access location.

UroPartners Financial Policy

UroPartners welcomes you to our practice. We work hard to provide the highest quality care to you. Your clear understanding of our Financial Policy is important to our professional relationship. **Please remember that our contract for services is with you, and it is our policy that you are responsible for our fees regardless of insurance coverage.**

CO-PAYS: ALL APPLICABLE COPAYS ARE DUE AT THE TIME OF SERVICE.

Commercial Insurance Patients: We submit claims for those patients enrolled in a participating HMO, PPO, EPO and POS provided you have furnished us with **all** the necessary insurance information. This must be furnished at your appointment and include **policy and group numbers and the address of the claims office where your completed insurance form is to be mailed. If you do not provide us with your insurance card, you will be held responsible for the charges at the time of service.** You will receive an explanation of benefits from your insurance carrier determining your financial responsibility as well as receive a billing statement from us when your insurance has paid their portion.

Managed Care Contracts: It is the patient's responsibility to call their insurance carrier to obtain pre-certification if required. If you are unsure whether pre-certification is a requirement, please contact your insurance carrier. In addition, many managed care contracts require a referral from their primary care physician prior to seeing our physician. It is the patient's responsibility to obtain the necessary referral and bring it with them to the visit. If you do NOT have this information before the visit, you may be responsible for some or all of the visit charges that your insurance does not cover.

Medicare Patients: UroPartners accepts assignment on Medicare insurance claims. The administrative staff will submit all claims for you and Medicare will pay their portion of your bill directly to the office. Please remember Medicare pays 80% of what they approve and you are responsible for the remaining 20% coinsurance as well as any yearly deductible and/or non-covered services. If you have secondary insurance which may cover this 20%, please submit to us a copy of the card at the time of your appointment so that we may file a claim for you. If you do not have secondary insurance, you may be responsible for the 20% coinsurance amount at the time of service.

Non-contracted and out-of-network managed care plans: Patients who have insurance plans that do not have an existing contract with UroPartners are expected to pay in full at time of service.

Self Pay: All self-pay patients are expected to pay at the time of the visit. We accept several different credit cards, checks or cash.

Account Statements: Statements are mailed out monthly to patients who have a balance due on their account. Payment of this balance is expected on receipt of the statement. Any payment plans must be arranged with our billing department. Accounts overdue by more than 90 days may be referred to a collection agency.

Returned Checks: There will be a $25 fee for a returned check.

Missed Appointments: We reserve the right to charge a $35 missed office appointment fee and a $100 missed procedure/surgery fee to patients who don't show for a scheduled office visit. We may require this fee to be paid prior to making another appointment.

Cancellations: We understand due to different circumstances, patients must cancel appointments from time to time. Please give us 24 hours notice when canceling your appointment. You may always leave a message with our answering service. We reserve the right to charge a cancellation fee for patients who do not cancel their appointment more than 24 hours prior to that appointment. We also reserve the right to charge a cancellation fee for hospital surgeries cancelled within one week of the surgical date.

Patient Name: _____

_____	_____	_____
Signed (patient or parent if minor)	Patient Date of Birth	Date

Permissions, Consents, and Responsibilities

Patient Name: _____

Consent to Treat: I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

Release of Information and Assignment of Benefits: I understand that I am responsible for any fees for service rendered for myself and/or for my children (if applicable). I hereby authorize UroPartners to release any medical information to my insurance carrier concerning all conditions including those that may reference drug abuse, alcohol abuse or mental illness in order to process any claims on my behalf. I hereby assign to UroPartners payments made by my insurance carrier.

Contracted Laboratory: UroPartners will send lab tests to the UroPartners Laboratory and several other local labs. I understand that if my insurer mandates that I use a contracted lab, I must supply UroPartners with the name of that lab. If the contracted lab name is not supplied by me, my benefit level may be reduced when the test is submitted to UroPartners or an undesignated lab. If our UroPartners office does not work with the lab required by your insurer, it may be necessary to have your labs drawn at the outside lab. I also understand that it is my responsibility to notify UroPartners of any changes in my contracted laboratory.

Name of Laboratory: _____Initials/Date: _____

Authorization to Discuss My Account: I hereby authorize the staff of UroPartners to discuss appointment information, test results and financial information with the following named person: _____

Commitment to Your Care: I understand that in order to have an effective doctor-patient relationship it is my responsibility to be compliant with the physician's treatment recommendations and office policies. I understand that I may terminate this relationship at any time and request my records to transfer my care to another urologist. I further understand that the UroPartners' physicians may terminate the doctor-patient relationship at any time by giving 30-day written notice.

Privacy Notice: I hereby give my consent to UroPartners to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my patient record. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has al- ready relied on it to use or disclose my health information. I acknowledge that I have received the UroPartners Notice of Privacy Practices brochure or have received it on a prior visit.

_____	_____	_____
Signed (patient or parent if minor)	Patient Date of Birth	Date

Authorization for Use or Disclosure of Protected Health Information for Release of Medical Records

Please complete the following information:

Date of Birth _____

Patient Name: _____ SSN: _____

Address: _____ Phone: _____

_____

These Records are needed for an appointment on: _____/_____/_____

I authorize Uropartners, LLC to release/disclose the following information to _____for the above patient:

☐ All Records ☐ Laboratory/Pathology Records ☐ X-ray/Radiology Records

☐ Billing/Financial Records ☐ Other (describe specifically)_____

Dates of Treatment being disclosed: From: _____ To: _____

Copied Medical records are to be sent to:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

The information may be used/disclosed for each of the following purpose:

☐ At my request (only the patient can check this box) ☐ For employment purposes

☐ For my health care ☐ For payment/insurance ☐ Other: _____

This authorization shall expire no later than: _____/_____/_____ and may not be valid for greater than one year from the date of signature below for the release of medical records to the above named company/person.

I understand that with signing this release, I am allowing Uropartners, LLC to disclose my health information, which may include: HIV/AIDS status, cancer diagnosis and treatment, drug/alcohol abuse, or sexually transmitted diseases. I further understand that this authorization is voluntary and I may refuse to sign this authorization. My refuse to sign will not affect my ability to obtain treatment from Uropartners, LLC. By signing below, I am authorizing the use or disclosure of protected health information and that a fee will be assessed for photocopying and shipping.

_____ _____

Signature of patient or legal guardian Date

_____ _____

Printed name of patient or legal guardian Relationship to patient

Release Date: _____/_____/_____ #Pgs: _____ Certified: Y N Via: Mail Fax Pick-up Completed by Initials: _____

Fee Assessed for Photocopies: $_____ Paid by: Cash Check Credit Card