UrologyAustin

PATIENT REGISTRATION – DEMOGRAPHICS

Assigned UA Physician

PATIENT INFORMATION

Last Name	First Name	M.I.	Nickname

SSN	Sex ☐ Female ☐ Male	Date of Birth	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race/Ethnicity ☐ I decline to answer ☐ African-Amer. ☐ Asian ☐ Caucasian ☐ Hispanic or Latino ☐ Native Amer. ☐ Pacific Islander ☐ Other

Preferred Language ☐ English ☐ Spanish ☐ Other:

Street Address	Apt #

City	State	Zip

Preferred Contact: ☐ Home # ☐ Work # ☐ Cell # ☐ Email	Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )	Email Address

Referring Physician	Referring Physician Phone ( )	Primary Care Physician	Employer Name ☐ n/a

EMERGENCY CONTACT INFORMATION

Name	Relationship to Patient: ☐ Spouse/Partner ☐ Friend ☐ Parent ☐ Other:	Phone ☐Home ☐Cell ☐Work ( )	Phone ☐Home ☐Cell ☐Work ( )

GUARANTOR (Financially-responsible party)

Name (☐ same as patient)	Relationship to Patient: ☐ Parent/Guardian ☐ Power of Atty. ☐ Other:	Phone ☐Home ☐Cell ☐Work ( )	Phone ☐Home ☐Cell ☐Work ( )

Street Address	Apt #

City	State	Zip

INSURANCE INFORMATION

Primary Insurance ☐ no insurance or wish to self-pay	*Secondary* Insurance ☐ none
☐ Private Policy ☐ Group Policy (Employer) ☐ TriCare (ChampUS) ☐ Medicare (Part B) ☐ Medicaid ☐ Indemnity Plan ☐ Worker's Comp ☐ Other	☐ Private Policy ☐ Group Policy (Employer) ☐ TriCare (ChampUS) ☐ Medicare (Part B) ☐ Medicaid ☐ Indemnity Plan ☐ Worker's Comp ☐ Other
Insurance Name/Plan	Insurance Name/Plan
Insurance/Member ID #	Insurance/Member ID #
Group # ☐ n/a	Group # ☐ n/a
Claim # ☐ n/a	Claim # ☐ n/a
Subscriber Name ☐ patient = subscriber	Subscriber Name ☐ patient = subscriber
Subscriber DOB / Subscriber SSN	Subscriber DOB / Subscriber SSN

OTHER INFORMATION

Are you a resident of a nursing home facility? ☐ Yes ☐ No (If Yes, patient must be accompanied by an informed caregiver)	Are you registered for Home Health Care? ☐ Yes ☐ No
Facility Name	What is your preferred pharmacy for prescriptions?
Facility Phone ( )	Do you have a mail order or second pharmacy for prescriptions? Please provide name.

Patient/Guardian Signature: _____ Date Signed: _____

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Baker, Brett W MD
Bischoff, Carl J MD
Bonsall, Diane MSN,APRN,ACNS-BC
Bruce, R Grady MD
Cuellar, David C MD
Desireddi, Naresh V MD
Floyd, Michael K MD
Freidberg, David W MD
Garza, Richard P MD
Greenwell, David P MD
Horan, John J MD
Kocurek, Jeffrey N MD
Long, Jack C MD
Maloney, Shaun A MD
McClelland, Michael L Jr, MD
Northway, Robert O III MD
Patel, Monica L MSN, APRN
Phillips, David L MD
Pickett, Steven H MD
Putzi, Mathew J MD
Ruff, Peter A MD
Singh, Herb MD
Williamson, John C MD

FINANCIAL POLICY NOTICE

Please read carefully. Initial where indicated and then sign at the bottom.

_____ (Initial) Insurance co-pays are due **at the time of service** and before you see the doctor. **If you are unable to pay your co-pay you may be asked to reschedule your appointment.** Due to the fact that Urology Austin physicians are specialists, higher co-pays may be indicated (consult your policy benefits for clarification).

_____ (Initial) CT scans and in-office surgical procedures are typically applied by your insurance company towards your deductible, co-insurance or other out-of-pocket expense. **All fees are due in advance of the CT or surgical procedure performed** unless an alternate arrangement is made *prior to* your appointment date. **Outside radiologist fees usually apply for your scan. Please pay close attention to your CT information.**

_____ (initial) If at any time you have a credit on your account, refunds may only be remitted to you *after* all pending insurance claims have been finalized by your insurance company and reported to us.

_____ (Initial) Many insurance plans cover ancillary services (labs, x-rays, CT scans, etc.) under alternate benefits, such as higher deductible or co-insurance amounts, even additional co-pays. These additional out-of-pocket expenses are not associated with our contract/participation with your insurance company. Instead, it is simply a matter of your plan benefits. Urology Austin must comply with both contractual obligations and government regulations, **thus we cannot alter your insurance plan benefits and will bill you accordingly**.

_____ (Initial) It is the patient's responsibility to know from whom your insurance company requires that you to obtain any labs, x-rays, or any other ancillary services. Please let your doctor's medical assistant or nurse know so that they may schedule these services accordingly.

_____ (Initial) It is the patient's responsibility to obtain all referral certifications from the primary care or referring physician when required by your insurance plan. **If you do not have a current referral on file, you will be asked to reschedule your appointment.**

_____ (Initial) Laboratory services cannot be billed until the date the test is performed which may be a different day than when you came to give your sample. Thus, the date on your billed statements (from Urology Austin or your insurance company) may be different from the actual date you were in the office. **Outside laboratory charges may also apply—ask an associate for more info if you will be having lab services.**

_____ (Initial) If we do not participate with your insurance company, and your insurance plan does not provide out-of-network benefits, you will be considered a "self-pay" patient. See the Self-Pay Patient policy below. As a courtesy, we shall provide you with the information necessary to bill your insurance company.

SELF-PAY PATIENTS

_____ (Initial) If you (1) do not have insurance coverage, (2) choose not to use your insurance coverage, or (3) are seeking treatment/services that are not covered by your insurance plan, you are a "self-pay" patient. Upon arrival at your visit you are required to provide a $250 deposit. As you leave, you must pay for any remaining balance for the services provided. A 30% discount of our regular fees will be applied. Alternate payment arrangements are available at the discretion of the site manager (30% discount may be forfeit).

Urology Austin accepts cash, checks, MasterCard, VISA, Discover Card and American Express. Additional fees may apply to special financing arrangements and bad debt collections.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept the above financial policy. (Additional financial obligations may apply to special services. You will be presented more information as they apply to your treatment plan.)

Guarantor Signature: _____ Date: _____

Name of Guarantor (if different from patient): _____

Patient name: _____ DOB_____ Date_____

Medical History Form

Reason for Visit Today: _____

MEDICAL ALLERGIES (include dye, etc): _____

CURRENT MEDICATIONS (If additional → Complete on back)

Name	Dose	How often per day	Reason for taking	Name	Dose	How often per day	Reason for taking

PAST MEDICAL HISTORY (Urologic) - Please circle as appropriate

Erectile Dysfunction Elevated PSA Enlarged prostate (BPH) Hypogonadism – "Low T"

Kidney stones Urinary retention Blood in urine (hematuria) Urinary Tract Infections

Prostate Cancer Bladder Cancer Kidney Cancer Testicular cancer

Renal Failure Incontinence (leakage of urine) Pelvic prolapse(cystocele, rectocele)

Other: _____

PAST MEDICAL HISTORY (Non-urologic) – Please circle as appropriate

Head, Ears, Eyes, Nose, Throat: Blindness Cataracts Deafness Glaucoma
Cardiovascular: Heart attack (MI) Hypertension Atrial Fibrillation
Congestive Heart Failure Angina
Respiratory: Asthma COPD Emphysema Pulmonary Embolism(PE)
Gastrointestinal: Crohn's Disease Diverticulitis Hepatitis GERD (reflux)
Endocrine: Diabetes Gout Hypothyroidism Hyperthyroidism
Neurological: Alzheimer's Dz Stroke Parkinson's Dz Multiple sclerosis
Cancer: Breast Colon Lung Lymphoma Ovarian
Other cancer diagnosis: _____
Infectious/Hematologic: Anemia HIV/AIDS Tuberculosis Deep venous thrombosis (DVT)

Other medical conditions

PAST SURGICAL HISTORY (Urologic and Gynecologic) - Please circle as appropriate

Robotic Prostatectomy Open Radical Prostatectomy
Nephrectomy – Open or Laparoscopic Partial Nephrectomy – Open or Laparoscopic
TURP (surgery for enlarged prostate) TURBT (removal of bladder tumor)
ESWL (sound wave treatment of kidney stones) Ureteroscopy – laser or basket removal of stones
Orchiectomy (removal of testicle) Pyeloplasty (for UPJ obstruction)
Prostate Needle Biopsy Endoscopic treatment of urethral stricture
Pelvic Prolapse repair (cystocele, enterocele, rectocele repair – with or without mesh)
Bladder sling for incontinence Bladder suspension for incontinence Hysterectomy
Dates of Surgery/Procedure circled above: 1) _____
(or other surgeries) 2) _____

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Patient name: _____ DOB_____ Date_____

PAST SURGICAL HISTORY (Non-Urologic):

Type of surgery	Date (approximate)	Hospital or City

FAMILY HISTORY: (Please check where appropriate)

	Father	Mother	Brother	Sister	Grandparent	Son	Daughter	Runs in Family
Prostate Cancer								
Kidney stones								
Heart Disease								
High Blood pressure								
Diabetes								
Other: _____								

SOCIAL HISTORY: (Please circle the appropriate response)

Marital Status: Married Single Divorced Widowed Separated Unknown
Smoking status: Current every day smoker Current some day smoker Former smoker
Never smoker
Do you drink alcohol: Yes Not anymore Never Drank
How many caffeinated drinks do you drink per day: _____
Have you had a blood transfusion: Yes or No
Language: English Spanish French German Portugese Russian Chinese Other _____
Race: White Black or African American American Indian/Alaska Native Hispanic/Latino Asian
Other _____

REVIEW OF SYSTEMS:

(Please circle any medical problems listed below you have)

Constitutional:	NONE	Fever	Weight Loss	Chills
Eyes:	NONE	Blurry vision	Double Vision	Cataracts
Ears, Nose, Throat	NONE	Hearing Loss	Nasal Stuffiness	Sore throat
Cardiovascular:	NONE	Chest pain	Swollen ankles	Irregular heart beat
Respiratory:	NONE	Shortness of breath	Wheezing	Chronic cough
Gastrointestinal	NONE	Abdominal Pain	Nausea/Vomitting	Constipation
Genitourinary	NONE	Incontinence	Painful urination	Blood in urine
Musculoskeletal:	NONE	Arthritis	Chronic back pain	Sore muscles
Integumentary/Skin	NONE	Rash	Persistent itching	Skin cancer history
Neurological	NONE	Numbness	Tingling	Dizziness
Hematological	NONE	Abnormal bleeding	Transfusion history	Swollen glands

Other complaints: _____

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Horan, John J MD FACS
Kocureck, Jeffrey N MD
Maloney, Shaun A MD
McClelland, Michael L Jr MD
Northway, Robert O III MD
Phillips, David L MD
Pickett, Steven MD PhD
Putzi, Mathew J MD
Ruff, Peter A MD
Singh, Herb MD
Williamson, John C MD

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION & ASSIGNMENT OF BENEFITS

_____ (Initial) I have read and acknowledge Urology Austin's Notice of Privacy Practices. Urology Austin complies with all regulatory guidelines with regard to safeguarding your protected health information (PHI). For example, sharing of my PHI may only occur between authorized entities such as my insurance company and my physician, but not with my spouse. These guidelines and our policies are published in this Notice. A copy for my records will be provided at my request.

_____ (Initial) I authorize my primary care physician, referring physician and other care providers to furnish any and all information concerning my present illness or injury to Urology Austin.

_____ (Initial) I authorize Urology Austin to leave information and appointment reminders at the following:

☐ Home Phone: _____ ☐ Work Phone: _____

☐ Cell Phone: _____ ☐ Email Address: _____

Please list any authorized entities with whom we can share your PHI: ☐ None

Name: _____Relationship_____

Name: _____Relationship_____

Name: _____Relationship_____

ASSIGNMENT OF BENEFITS

I authorize assignment of my insurance plan benefits directly to Urology Austin for services provided. I understand that I am financially responsible to Urology Austin for all cost-share expenses (co-pay, co-insurance and deductible), as well as any services not covered by my insurance plan.

_____ Patient Name

_____ Patient DOB

_____ Patient Signature

_____ Date Signed

_____ Guarantor Signature (if different than patient)

_____ Date Signed