UrologyAustin

PATIENT REGISTRATION – DEMOGRAPHICS

Assigned UA Physician

PATIENT INFORMATION

Last Name	First Name	M.I.	Nickname

SSN	Sex	Date of Birth	Marital Status
	☐ Female ☐ Male		☐ 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 Name	Referring Physician Phone # ( )	Primary Care Physician Name	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, if different from patient)

Name	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: _____

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

HEENT: 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) _____

UrologyAustin

Patient name: _____ DOB_____ Date_____

PAST SURGICAL HISTORY (Non-Urologic):

Type of surgery	Date (approximate)	Hospital or City

FAMILY HISTORY: (Please check where appropriate and specify approximate age of diagnosis)

	Father	Mother	Brother/Sister	Aunts/Uncles	Grandparent	Children	First Cousins	Runs in Family (Specify)
Prostate Cancer								
Breast Cancer (Age 50 or <)								
Colon Cancer								
Ovarian Cancer								
Pancreatic Cancer								
Kidney stones								
Heart Disease								
High Blood pressure								
Diabetes								
Other: _____								

*If Prostate Ca, Breast Ca, Ovarian Ca, or any combination of at least two of these, patient may be eligible for hereditary cancer testing - MyRisk.

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: _____

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 deposit ($250 for new patients and $150.00 for already established returning patients). As you leave, you must pay for any remaining balance for the services provided. A 30% discount of our regular fees will be applied.

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): _____

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

Urology Austin now offers convenient and secure access to your personal health record, the Patient Portal (the "Portal") through Healthtronics. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so. The Patient Portal is designed to further improve communication between the patient and the treating physician. This form is intended to inform you of the facts and risks surrounding the use of the Patient Portal. Please ensure to notify Urology Austin if you identify a discrepancy on your record immediately.

Policies, Usage, and Limitations:

Urology Austin reserves the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal. Also, the following policies and limitations apply:

1. **Do not use portal communication if there is an emergency, please dial 911 or go to the Emergency Room.**
2. **Do not use the portal as internet based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules and sees a provider.**
3. **Use the Portal to request prescription refills, which will be filled according to our regular clinic policy.**
4. **No request for narcotic pain medication will be accepted through the portal.**
5. **No request for re-fill medication not currently being treated by our providers.**
6. **After you agree to the Policy and Procedures and sign the Authorization Form, we will attempt to send a "welcome message" email to you. This will provide a link to the Portal login screen. **If you have not received an email from us within 3 working days, please CALL the office. We will not respond directly to your email. All electronic communications must be through the Portal e-mail system.***
7. **We will normally respond to non-urgent email inquires within 24hrs but no later than 3 business days after receipt. **If you have not received an email from us within 3 working days, please CALL the office.***

Security Guidelines

Urology Austin offers secure viewing and communication as a service to our patients who wish to view parts of their records and communicate with our staff. All new and established patients have signed Urology Austin's HIPAA Consent form and have been given a copy of the UA Notice of Privacy Practices. You may request a copy of the forms either at the office or by visiting our website at www.urologyaustin.com. The Portal offers a secure messaging system, which can be a valuable communications tool; however, there are potential risks associated with this system. In order to manage these risks, Urology Austin will impose some conditions of participation. By signing the Authorization Form you accept the risks and agree to the conditions of participation. Once this form is agreed to and signed, we will send you an email notification that tells you how to log in for the first time. Please keep this email in a safe place for future reference. Following the instructions on the email, you should be able to login using the user name and password provided. Once logged into the portal, you should go to "My Account" on the top right of the page. Here you can change your password to something only you will know. *This is essential to make sure your information remains secure and private!*

Your Private Health Information Protection and Risks

While we try and ensure that all communication through the portal is secure, keeping it secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are present. **We need you to make sure we have your correct email address and you MUST inform us if it ever changes.** If you think someone has learned your password, you should promptly go to the Patient Portal and change it. If you forgot your password please use the "forgot password" option on the portal or call our office. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible. We will never sell or give away any private information, including your email addresses.

Patient Portal Authorization Form

Patient Portal: Urology Austin/Healthtronics

Urology Austin now offers convenient and secure access to your personal health record, the Patient Portal (the "Portal") through Healthtronics. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so. Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others. If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from Patient Portal Healthtronics promptly after submitting this form**. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust. If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

The patient portal is provided as a courtesy to our patients. We reserve the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal. Also, the following policies and limitations apply:

1. **Do not use portal communication if there is an emergency, please dial 911 or go to the Emergency Room.**
2. **Do not use the portal as internet based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules and sees a provider.**
3. **Use the Portal to request prescription refills, which will be filled according to our regular clinic policy.**
4. **No request for narcotic pain medication will be accepted through the portal.**
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7. **We will normally respond to non-urgent email inquires within 24hrs but no later than 3 business days after receipt. **If you have not received an email from us within 3 working days, please CALL the office.***

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this Patient Portal Authorization Form. **Please print all information clearly.**

Patient Full Name:_____ Date of Birth:_____

Confidential e-mail address:_____
(The information and link for user access will go to this address; call us with changes)

Patient Signature:_____ Date:_____

For Office Use Only

I have authenticated the identity of the person named on this form:

_____ _____
Staff Signature Date

_____
Print Name
