ADVANCED UROLOGY INSTITUTE

ADMINISTRATIVE OFFICES
12109 COUNTRY RD. 103
OXFORD, FL 34484

Florida Care Centers

Blountstown

Carrabelle

Daytona Beach

DeLand

Homosassa

Inverness

Leesburg

Marianna

New Smyrna Beach

Ocala

Orange City

Oxford

Palm Coast

Panama City

Perry

Port Orange

St. Augustine

Tallahassee

Let us take this opportunity to welcome you as a new patient to our practice.

We are enclosing patient history and information forms for you to complete. Some of these questions may seem unrelated to your problem. However, your cooperation in completing the history form will help us in diagnosing and treating your illness, as well as understanding the relation to other problems you may have had. Please answer ALL questions and bring these completed forms with you when you come in for your appointment.

It is important to bring your insurance card on the day of your appointment.

We accept Medicare assignment; however, you are responsible for any deductible and the 20% difference between the Medicare allowable and the Medicare payment. Payment of your portion is expected at the time services are rendered. If your insurance plan requires a co-pay, please be prepared to pay it at the time services are rendered.

If you are unable to keep your scheduled appointment, for any reason, please call us immediately so we may give this time to someone else.

PLEASE BRING A LIST OF YOUR CURRENT MEDICATIONS WITH YOU.

Thank you,

The Physicians and Staff
Advanced Urology Institute

Advanced Urology Institute, LLC
Patient Information Sheet

Date: _____ SS # _____

Date of Birth_____ Age____ Sex: ___ M___ F Ethnicity __Hispanic/Latino ___ Not Hispanic/Latino

Race: ___White ____Black or African American ___American Indian/Alaskan ___ Asian ___Native Hawaiian ___

Primary Language_____ Marital Status___ Single___ Married___ Divorced___ Widowed___ Separated

Pt. Name _____
Last Name First Name MI

Address: _____City_____St _____ Zip_____

Summer/Winter Address: _____City_____St_____Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

*Email _____ Employer Name_____

Primary Physician: _____ Referring Physician: _____

*Pharmacy:*_____ *Location:* _____ *Phone No.* _____

Emergency Contact _____ *Address* _____ *Phone #*_____

Spouse's Name _____ DOB _____ SS #_____

Address: If different than above _____City_____St _____ Zip_____

Home # _____ Cell # _____ Work # _____

Financially Responsible Party: _____Relationship_____

Primary Ins. Co. _____ Phone _____
Policy Subscriber Name _____ DOB _____
Relationship to Pt._____SS # _____Policy # _____ Group # _____

Secondary Ins. Co. _____ Phone _____
Policy Subscriber Name _____ DOB _____
Relationship to Pt._____SS # _____Policy # _____ Group # _____

Third Ins. Co. _____ Phone _____
Policy Subscriber Name _____ DOB _____
Relationship to Pt._____SS # _____Policy # _____ Group # _____
_____ Phone _____

Authorization to Release Medical Information
I hereby authorize the above physician to release any information Necessary to process my insurance claim.

Authorization to Pay Benefits.
I hereby authorize lifetime payment of medical benefits to The above named physician/medical group

Payment for services is expected at the time of service, unless advance payment arrangements have been made. Insurance is filed as a courtesy, It does not eliminate the patient's responsibility for payment. I certify the information I have provided is correct.

_____ _____
Patient Signature Date

Advanced Urology Institute, LLC

Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

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

Advanced Urology Institute, LLC is authorized to release protected information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information: Please mark each person/entity that you approve to receive any personal or medical information	**Description of Information to be Released:** Please mark each area of information that may be given to the person/entity listed on the left in the same section.
o Answering Machine	o Messages regarding appointments, lab tests/ x-rays or procedures o Any other information regarding treatment o Any information regarding Medications
o Spouse (Provide Name and DOB) _____	o Billing Information o Financial / Insurance Information o Medical Information (treatments, results, etc)
o Parents/Children (Provide Name and DOB) _____ _____ _____ _____	o Billing Information o Financial / Insurance Information o Medical Information (treatments, results, etc)
o Other (Provide Name and DOB) _____	o Billing Information o Financial / Insurance Information o Medical Information (treatments, results, etc)

EXPIRATION DATE: Provide an expiration date that this authorization will expire. _____

If no expiration date is given, this authorization will expire 1 year from the below signature date!

RIGHTS OF THE PATIENT: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Advanced Urology Institute, LLC. I understand that revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority: _____

_____

ACKNOWLEDGEMENT OF PRIVACY NOTICE

In compliance with HIPPA regulations, I have been given the opportunity to review the Joint Privacy Notice for Advanced Urology Institute, LLC. I understand a copy of this policy is available for me to take home for my records.

_____ _____

Signature of Patient or Personal Representative Date

ADVANCED UROLOGY INSTITUTE

545 Health Blvd.
Daytona Beach, FL 32114
(386) 239-8500

Date: _____ Name: _____

Age: _____ Referring Physician: _____

Have you ever been seen by a urologist? ☐yes ☐no Urologists name? _____

Symptoms or problems which lead you to seek help: _____

_____

_____

How many times is your sleep interrupted to urinate? _____

Do you have pain during urination? _____

When awake do you urinate:
☐ an appropriate frequency
☐ more often then usual, but not a problem
☐ enough to be a problem

When you need to urinate do you feel:
☐ you can wait if necessary
☐ you can wait a brief time
☐ you must urinate immediately

How long do you have to wait to start urination after you reach a bathroom:
☐ not at all
☐ some delay but not a problem
☐ enough to be concerned

Do you notice slowing or weakness of your urinary stream:
☐ not at all
☐ some but not a problem
☐ enough to be concerned

Any abnormality in urine such as:
☐ blood
☐ cloudy urine
☐ strong odor to urine

Please complete reverse side

Any pain felt related to urinary tract?
☐ yes ☐ no
location:_____ describe pain(e.g. burning, sharp, ache, etc.):_____
_____
_____

Do you have: ☐ fever ☐ chills

Any incontinence (urinary leakage) enough to be a problem?
☐ yes ☐ no
☐ get warning but can't wait
☐ leak without warning (e.g. with coughing, sneezing, laughing)

Check any of the following that apply:
☐ must strain or bear down to start your urinary stream
☐ intermittent urinary stream
☐ must return to the bathroom to completely empty your bladder
☐ a history of kidney stones
☐ a history of urinary tract infections
☐ a history of sexually transmitted disease

Have you ever had a catheter or a cystoscopy (procedure where a scope is passed to look at your bladder) performed?
☐ yes ☐ no If yes, when _____

FEMALES ONLY (check all that apply)

☐ Menstrual irregularities ☐ Post menopausal bleeding
☐ Vaginal discharge ☐ Pain with intercourse
☐ Urinary symptoms after intercourse

MALES ONLY (check all that apply)

☐ Pain in testes ☐ Swelling of testes ☐ Pain with ejaculation
☐ Blood in semen ☐ Difficulty obtaining erection, maintaining erection or both

ADVANCED UROLOGY INSTITUTE

545 Health Blvd.
Daytona Beach, FL 32114
(386) 239-8500

Date:_____ Name:_____ Age:_____

GENERAL REVIEW OF PERSONAL HISTORY: (a copy of this may be added to your hospital record)

Describe any non-urologic symptoms you presently have:

Depression or anxiety:_____

Neurologic (e.g. weakness, numbness, dizziness, seizures):_____

Eyes (glaucoma, double vision):_____

Ears, nose, throat, sinuses:_____

Endocrine (e.g. diabetes, thyroid trouble):_____

Respiratory (e.g. shortness of breath, asthma, bronchitis, bloody sputum):_____

_____

Cardiovascular (e.g. angina, palpitations, congestive failure):_____

_____

Gastrointestinal (e.g. stomach, intestines, gallbladder, liver):_____

_____

Other:_____

_____

Are you an "easy bleeder" ❒ yes ❒ no Have you ever had a blood transfusion ❒ yes ❒ no

List any past operations and approximate dates:

Operation:_____ Date:_____ Operation:_____ Date:_____

Operation:_____ Date:_____ Operation:_____ Date:_____

Operation:_____ Date:_____ Operation:_____ Date:_____

List any past serious illnesses and approximate dates:

Illness:_____ Date:_____ Illness:_____ Date:_____

Illness:_____ Date:_____ Illness:_____ Date:_____

Illness:_____ Date:_____ Illness:_____ Date:_____

Please complete reverse side

List all present medications, dosages and reasons for use (include non-prescriptions drugs taken frequently also (e.g. Aspirin):

Drug:_____ Dose:_____ Reason:_____

Drug:_____ Dose:_____ Reason:_____

Drug:_____ Dose:_____ Reason:_____

Drug:_____ Dose:_____ Reason:_____

Drug:_____ Dose:_____ Reason:_____

Drug:_____ Dose:_____ Reason:_____

List all allergies, particularly medication and food allergies:

Allergic to iodine? ❒ yes ❒ no Reaction:_____

Allergic to seafood? ❒ yes ❒ no Reaction:_____

Allergic to:_____ Reaction:_____

Allergic to:_____ Reaction:_____

Allergic to:_____ Reaction:_____

Do you smoke cigarettes? ❒ yes ❒ no How much per day?_____ How many years?_____

Did you ever smoke a pack or more a day? ❒ yes ❒ no How many years?_____

Do you drink alcohol? ❒ yes ❒ no Type ❒ wine ❒ beer ❒ liquor How much a day?_____

What is your present or former occupation?_____

FAMILY HISTORY

Cancer:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
Diabetes:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
Nephritis (Bright's disease):	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
Kidney Stones:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
Bleeding Tendencies:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
Heart Trouble:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather
High Blood Pressure:	❒ mother	❒ father	❒ brother	❒ sister	❒ grandmother	❒ grandfather

Other:_____

_____

Mother: ❒ living age:_____ ❒ deceased/age of death:_____ cause of death:_____

Father: ❒ living age:_____ ❒ deceased/age of death:_____ cause of death:_____

Sister(s): number living:_____ age(s):_____

number deceased:_____ age(s) at death:_____ cause of death:_____

Brother(s): number living:_____ age(s):_____

number deceased:_____ age(s) at death:_____ cause of death:_____

Children: number living:_____ age(s):_____

number deceased:_____ age(s) at death:_____ cause of death:_____

ADVANCED UROLOGY INSTITUTE

Check the Facts

ABOUT YOUR URINARY ACTIVITIES

NAME _____ AGE _____

Circle your score for each below.

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always
1 Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2 Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3 Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
4 Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5 Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6 Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5

	None	1 time	2 times	3 times	4 times	5 or more times
7 Over the last month or so, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

From the American Urological Association (AUA) Symptom Index for BPH.

Total Symptom Score = Sum of Questions 1 to 7 = ____

SYMPTOM SCORE = 1-7 Mild 8-19 Moderate 20-35 Severe

Quality of Life How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
	0	1	2	3	4	5	6

ADVANCED UROLOGY INSTITUTE

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT §164.510 §164.514

USE AND DISCLOSURE REQUIRING THE OPPORTUNITY TO AGREE OR OBJECT

Patient Name: _____ ID Number: _____

SECTION A: FACILITY DIRECTORIES

Medical facilities where I may be a patient create and maintain facility directories for the purpose of identifying and locating patients within that facility. I understand that I have the right to agree, object or restrict any or all of the items listed below from being added to that directory.

I understand that I have the right to agree, object or restrict release of the information to the following entities:

____ FAMILY MEMBERS (ALL OR INDIVIDUAL) ____AGREE ____OBJECT ____RESTRICT

____ OTHER FRIENDS, ACQUAINTANCES, ETC. ____AGREE ____OBJECT ____RESTRICT

(LIST OF INDIVIDUALS)

_____ _____ _____

_____ _____ _____

This opportunity is authorized for the following facility(ies):

_____

_____

_____

SECTION B: EMERGENCY CIRCUMSTANCES

In the event of an emergency situation, in case of disaster or in an attempt to identify or locate relatives, care givers or others involved in my well-being, whereby I am unable to communicate these conditions,

____ My provider may provide the information.
____ My provider may not provide the information.
____ My provider may use his/her best professional judgment on my behalf.

I understand that I have the right to alter or terminate this agreement at any time. I understand that this authorization is voluntary.

_____

Signature of patient or patient's representative **Date**

(Form must be completed before signing.) Printed name of patient's representative: _____

I want to terminate my agreement beginning on _____, 200__.

_____

Signature of patient or patient's representative **Date**

ADVANCED UROLOGY INSTITUTE

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverages, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

ADVANCED UROLOGY INSTITUTE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ADVANCED UROLOGY
INSTITUTE

FINANCIAL POLICY

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, personal checks, MasterCard, Visa and Discover.

Returned checks are subject to a service charge of $25.00 and you may lose your privilege to write checks in our office.

PRIVATE INSURANCE COMPANIES THAT WE "ARE" A PROVIDER WITH. Co-payment and deductible must be paid at the time of service. If we are unable to verify your insurance coverage, you may be responsible for full payment at the time of the service. Because we are under contract with the insurance company, we will file your insurance claim. If payment is not received from your insurance company within a reasonable time, the full balance will be transferred to the responsibility of the patient (or guardian).

If you provide us with incorrect or invalid insurance information and we need to re-enter and resubmit your corrected insurance information, there may be a $20.00 administrative charge for each claim that has to be refiled.

PRIVATE INSURANCE COMPANIES THAT WE "ARE NOT" A PROVIDER WITH. You will be responsible for payment in full at the time of service and our office will file the claim form as a courtesy with your insurance company.

MEDICARE. Your deductible and 20% of the allowable charges are due at the time of service. Since we are a Medicare provider, we will file your Medicare. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare processes the claim. If you have a secondary insurance policy, we will file the claim as a courtesy.

CHILDREN OF DIVORCED PARENTS. Payment will be due from the person who is with the child today no matter who is responsible by divorce decree.

MISSED APPOINTMENTS. We ask for 24 hour's notice to cancel an appointment. Patients who do not call to cancel an appointment may be charged $25. A third no-show may result in the patient being discharged from the practice.

FORMS AND RECORDS. For completion of disability and cancer policy forms, there will be a $10 charge for a one-sided form and a $15 charge for a two-sided form. Medical records requested will have a charge of $1 per page for the first 25 pages, and twenty-five cents for every page thereafter. Forms and records will be released only after the payment has been collected.

FINANCIAL AGREEMENT. We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (such as elective sterilization, infertility evaluation, screening lab tests, etc.).

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account after 90 days, including those that your insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our billing department at (386) 274-1947.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the Financial Policy.

_____ _____

Signature (Patient, Guardian, or Power of Attorney) Date