ADVANCED UROLOGY INSTITUTE
240 SOUTHPARK CIRCLE EAST
ST. AUGUSTINE, FL 32086
904-824-1450
HOWARD B. EPSTEIN, MD, FACS

FILL OUT ALL ATTACHED PAPERS AND BRING THEM TO YOUR APPOINTMENT:
ALL PAPERS MUST BE FILLED OUT

APPOINTMENT TIME: _____

APPOINTMENT DATE: _____

On behalf of our entire staff, we would like to take this opportunity to welcome you to our practice and thank you for selecting our office to meet your health care needs. We appreciate the trust you have placed in us.

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 have had.

PLEASE ANSWER ALL QUESTIONS AND BRING THESE FORMS WITH YOU WHEN YOU COME IN FOR YOUR APPOINTMENT.

If you have had any test ordered by another physician (blood work, x-rays, etc.) it is helpful for you to bring the results with you to your appointment. Or, if you prefer, you can call your physician and ask them to fax us a copy of these reports to 904-824-1490. This is important at the time of your initial office appointment as well as for all return visits. Frequently, we can avoid duplicating tests or use the results for comparison. Having the results with you, or having them faxed to us, can save you time and money.

If your insurance plan requires an authorization or referral from you Primary Care Physician, you will be responsible for obtaining this prior to your visit. Co-Payments are due at the time of visit. We accept Medicare assignment; however, you are responsible for any deductible and the difference between Medicare allowable and Medicare payment. We accept most major insurances, but we suggest that you contact your insurance company to verify that our office is a provider for your plan.

A 24-HOUR ADVANCE NOTICE IS REQURED FOR ALL APPOINTMENT AND CANCELLATIONS. FAILURE TO PROVIDE THIS NOTICE MAY RESULT IN A $25.00 FEE.

For your comfort, we suggest you bring a sweater or jacket as our office is sometimes cool. Please bring your insurance card and proof of identification to your appointment.

Thank you for choosing Advanced Urology Institute as part of your health care team.

Advanced Urology Institute, LLC

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

PATIENT INFORMATION SHEET

Name *(Last, First, M.I.):*		**Sex:** ☐ M ☐ F	**Date of birth:**
Age:	**Primary Language:**	**Ethnicity:** ☐ Hispanic/Latino	☐ Not Hispanic/Latino
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			**SS#:**
Race: ☐ White ☐ Black or African American ☐ American Indian/Alaskan ☐ Asian ☐ Native Hawaiian			
Permanent Address:	**City:**	**Street:**	**ZIP:**
Summer/Winter Address:	**City:**	**Street:**	**ZIP:**
Home Phone:	**Cell Phone:**	**Work Phone:**	
***Email:**	**Employer Name:**		
Primary physician:	**Referring physician:**		
Pharmacy:	**Location:**	**Phone:**	
Emergency Contact:	**Address:**	**Phone #:**	
IF MARRIED:			
Spouse's Name:	**DOB:**	**SS#:**	
Address *(If different from above):*	**City:**	**Street:**	**ZIP:**
Home Phone:	**Cell Phone:**	**Work Phone:**	

INSURANCE INFORMATION

Financially Responsible Party:		**Relationship:**	
Primary Insurance Co.:		**Phone:**	
Policy Subscriber Name:		**DOB:**	
Relationship to Pt.	**SS#**	**Policy#**	**Group#**
Secondary Insurance Co.:		**Phone:**	
Policy Subscriber Name:		**DOB:**	
Relationship to Pt.	**SS#**	**Policy#**	**Group#**
Third Insurance Co.:		**Phone:**	
Policy Subscriber Name:		**DOB:**	
Relationship to Pt.	**SS#**	**Policy#**	**Group#**

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/group medical.

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:**

AUI
ADVANCED UROLOGY INSTITUTE

240 Southpark Circle East
St. Augustine, FL 32086
Phone: (904) 824-1450
Fax: (904) 824-1490

Name:	**Date:**	**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:**

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?**
Do 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:**

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Phone: (904) 824-1450
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Name:		**Date:**
Age:	**Referring Physician:**	
Have you ever been seen by a urologist? ☐ Yes ☐ No	**Urologist's 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 than 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	
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 system ☐ 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 through your bladder) performed? ☐ Yes ☐ No		
If yes, when:		
FEMALES ONLY (check all that apply) ☐ Menstrual irregularities ☐ Vaginal discharge ☐ Urinary symptoms after intercourse ☐ Post-menopausal bleeding	**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, LLC

Authorization for Release of Information

Name *(Last, First, M.I.):*	**Date of birth:**

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

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

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 HIPAA regulations, I have been given the opportunity to review the Join 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:**

NEW PATIENT OR ANNUAL FEMALE SURVEY

How many times do you typically wake up at night because you have to urinate? _____

Do you typically urinate more frequently than every 2-3 hours during the day? ☐ Yes ☐ No

Do you experience a sudden urge to urinate? ☐ Yes ☐ No

If yes, how often? ☐ Rarely ☐ Occasionally ☐ Frequently

If you postpone urination, will you experience pain? ☐ Yes ☐ No Leakage? ☐ Yes ☐ No

Do you leak urine when you: ☐ Laugh ☐ Cough ☐ Sneeze

If yes, do you wear panty protection? ☐ Yes ☐ No

If yes, what type? ☐ Panty liner ☐ Pad ☐ Undergarment

If yes, typically, how many per day? _____

Is your urine stream typically: ☐ Strong ☐ Weak ☐ Intermittent

Do you have to wait for your stream to start, even though you feel the urge to urinate? ☐ Yes ☐ No

Do you experience pain in your: ☐ Flank area ☐ Lower pelvis

When was your last gynecological exam? _____

Were you told there were any abnormal findings after your exam? _____

Are you currently using any female hormones or creams ☐ Yes ☐ No

REVIEW OF SYSTEMS. DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? PLEASE CHECK THE SYMPTOMS YOU ARE HAVING.

☐ Fever
☐ Chills
☐ Weight Loss
☐ Blurry Vision
☐ Glaucoma
☐ Cataracts
☐ Hearing Loss
☐ Sinus/Congestion
☐ Sore Throat
☐ Chest Pains
☐ Irrregular Heart Beats
☐ Swollen Ankles
☐ Shortness of Breath
☐ Wheezing
☐ Cough
☐ Oxygen Use
☐ Nausea/Vomiting
☐ Diarrhea
☐ Abdominal Pain
☐ Urinary Leakage
☐ Constipation
☐ Blood in Urine
☐ Decreased Libido
☐ Erectile Dysfunction
☐ Chronic Back Pain
☐ Joint Pain
☐ Walks with Cane/Walker
☐ Rashes
☐ Skin Cancer
☐ Current Skin Lesions
☐ Numbness
☐ Tingling
☐ Dizziness
☐ Depression
☐ Panic Attacks
☐ Headaches
☐ Poor Memory

Smoking:

☐ Current Everyday Smoker ☐ Current Somedays Smoker ☐ Former Smoker ☐ Never Smoked

Quit Date: _____

Language: _____

Race: _____

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

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, 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. Your 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 hours' notice to cancel an appointment. Patients who do not call 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 $15 charge for a two-sided form. Medical records requested will have a charge of $1.00 per page for the first 25 pages, and twenty-five cents for every page thereafter. Forms and records will be released only after payment has been received.

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 test, 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 over 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 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.

_____ _____

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

_____

Signature (Patient, Guardian, or Power of Attorney)

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information

For more information about HIPAA
Or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775