# ADVANCED UROLOGY INSTITUTE

**ADMINISTRATIVE OFFICES**
12109 COUNTY RD. 103
OXFORD, FL 34484
352-391-6000

*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 completeing 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 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, Daytona
545 Health Blvd
Daytona Beach, FL 32114

Advanced Urology, Port Orange
900 N. Swallow Tail Dr. #106
Port Orange, FL 32127

**ADVANCED UROLOGY INSTITUTE**
**DAYTONA DIVISION**

**PATIENT NAME:** _____ **DATE OF BIRTH:** _____

**TODAY'S DATE:** _____ **REFERRED BY:** _____

**MAIN SYMPTOM (main reason you came to see the urologist and how long you have had the problem:** _____

_____ **PHARMACY:** _____

SEVERITY QUALITY LOCATION DURATION TIMING CONTEXT
ASSOC. SYMPTOMS MODIFYING FACTORS

**Do you suffer from any of the following:**
**(Please circle one response)**

| | | |
|---|---|---|
| Urinate very frequently | YES | NO |
| Strong urge to urinate | YES | NO |
| Unable to control the urge and leaked | YES | NO |
| Leak with coughing, sneezing, or strenuous activity | YES | NO |
| Have to wait too long to start | YES | NO |
| Takes a long time to empty bladder | YES | NO |
| Poor flow of urine | YES | NO |
| Slow stream of urine | YES | NO |
| Dribbling after urination | YES | NO |
| Interrupted, stop and go stream | YES | NO |
| Do you strain to urinate | YES | NO |
| Feeling of incomplete emptying and need to go again | YES | NO |
| How many times do you urinate: Day: _____ Night: _____ | | |
| Do you pass blood in the urine | YES | NO |
| Pain while passing blood in the urine | YES | NO |
| History of pelvic infection | YES | NO |
| Problem with sexual function | YES | NO |
| Have you had recurrent urinary tract infections | YES | NO |

**PAST UROLOGICAL HISTORY:**

| | | |
|---|---|---|
| Have you had VD, Gonorrhea, Chlamydia, or Herpes | YES | NO |
| Kidney stones/urinary stones | YES | NO |
| If so, when: | | |
| Any surgery for urinary stones | YES | NO |
| Cancer of urinary bladder or kidney | YES | NO |
| Ever had kidney x-rays (IVP) | YES | NO |
| When: _____ Where: _____ | | |
| Any history of cancer | YES | NO |
| If so, what type of cancer: _____ | | |
| If so, when were you diagnosed: _____ | | |
| **ARE YOU ALLERGIC TO IODINE, SEAFOOD, OR X-RAY DYE?** | **YES** | **NO** |

**PAST MEDICAL HISTORY**
any history of:
heart disease angina stroke
diabetes high blood pressure
high cholesterol acid reflux COPD

**PAST ILLNESS/INJURIES with dates:**
_____
_____
_____

**PAST SURGERIES with dates:**
_____
_____
_____

**ARE YOU CURRENTLY ON:**
blood thinners (Coumadin, Plavix (Clopidogrel) Eliquis, Pradaxa, Xarelto, Brilinta, Aggrenox, etc)
Aspirin Vitamin E steroids
insulin

**ALLERGIES: List all medications that you are allergic to:**
_____
_____

**MEDICATIONS that you are taking daily with strength and how often**
_____
_____
_____
_____
_____
_____
_____

**SOCIAL HISTORY:**

Major Occupation (current or previous)_____

Are you retired YES NO

Are you disabled YES NO

Do you smoke YES NO

If yes, how many packs per day_____How many years_____

If quit, how many years ago?_____

Do you drink alcoholic beverages YES NO

If yes, how much_____

If quit how many years ago _____

Do you drink caffeinated beverages YES NO

If yes, how many per day_____

Do you use recreational drugs YES NO

Have you ever had a blood transfusion YES NO

**FAMILY HISTORY:**

Kidney stones YES NO

Prostate cancer YES NO

Heart disease YES NO

Diabetes YES NO

Other:_____

**REVIEW OF SYMPTOMS: Do you have any of the following symptoms? Please circle any symptoms that you have**

| | | |
|---|---|---|
| Fever | Chills | Cataracts |
| Blurry vision | Glaucoma | Sore throat |
| Hearing loss | Sinus problem/congestion | Swollen ankles |
| Chest Pains | Irregular heartbeats | Cough |
| Shortness of breath | Wheezing | O2 use |
| Abdominal pain | Nausea/vomiting | Diarrhea |
| Hematuria (blood in urine) | Decreased libido | Constipation |
| Erectile dysfunction | Joint pain | Urinary leakage |
| Chronic back pain | History of skin cancer | Walk with cane or walker |
| Rashes | Tingling | Current skin lesions |
| Numbness | Panic attacks | Dizziness |
| Depression | Weight loss | Headaches |
| | | Poor memory |

Did you receive the flu shot this year? YES NO

| | | | |
|---|---|---|---|
| Have you had the pneumonia vaccine within the last 10 years? | YES | NO | Approximate date: _____ |
| Have you had a colonoscopy within the last 10 years? | YES | NO | Approximate date: _____ |

ADVANCED UROLOGY INSTITUTE

# Patient Information Form

7-1

Please Print

Appointment Date: _____

| | | | | |
|---|---|---|---|---|
| Minor or Dependent Patient: Name (Last/First/Middle) | Sex | Date of Birth | Age | |
| Adult Patient: Name (Last/First/Middle) (Or Parent/Guardian of Dependent Named Above)<br>Mr. Ms. Mrs. | | | Age | Social Security Number |
| Address (Street - City - State - Zip) | | Marital Status<br>☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated | | |
| | | Driver's License Number<br>State | | |
| If P.O. Box, Give Street Address | | Home Phone No.<br>( ) | Cell No.<br>( ) | |
| Local Address | | Local Phone No.<br>( ) | | |
| Name of Employer | | Work Phone No. Is this visit worker's compensation? If yes, date of accident.<br>( ) | | |
| Employer's Address (Street - City - Zip) | | | | |
| Name of Spouse (Last/First/Middle) | | Date of Birth | Age | Social Security Number |
| Spouse's Employer | | Spouse's Work Phone No.<br>( ) | | |
| In Case of Emergency, Notify | | Emergency Contact's Phone No.<br>( ) | | |
| Whom May We Thank For Referring You To Us?<br>Yellow Pages: MD Referral Line: Friend: | | Pharmacy Name<br>Phone No. ( ) | | |
| Family Physician | | Phone No.<br>( ) | | |
| Have you seen a urologist before? If yes, please give name and address. | | Phone No.<br>( ) | | |

I will be paying today by:

☐ Check ☐ Cash ☐ Visa ☐ MasterCard ☐ Extended Payment Plan (Prior Approval Required)

**Insurance Information**

| | | | |
|---|---|---|---|
| Primary Insurance Name | Address (City-State-Zip) | | Phone No.<br>( ) |
| Name of Insured | Relationship | I.D. No. | Group No. |
| Secondary Insurance Name | Address (City-State-Zip) | | Phone No.<br>( ) |
| Name of Insured | Relationship | I.D. No. | Group No. |

I understand and agree that I am ultimately responsible for payment. I certify this information is true and correct to the best of my knowledge. **I CERTIFY THAT MY INSURANCE IS IN FORCE AS OF THIS DATE.** I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO **UNDERSIGNED** PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

_____ DATE: _____

Signed (INSURED OR AUTHORIZED PERSON)

ADVANCED UROLOGY INSTITUTE

# FINANCIAL POLICY OF ADVANCED UROLOGY INSTITUTE

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 any forms ie., Disability, Cancer Policies, FMLA, etc. there will be a $25 charge. For records, the fee is $1 per page for the first 25 pages and .25 thereafter. Records will also require a records release signed prior to release. Forms and records will only be released 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 _____

# 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:**<br>Please mark each person/entity that you approve to receive any personal or medical information | **Description of Information to be Released:**<br>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<br>o Any other information regarding treatment<br>o Any information regarding Medications |
| o Spouse (Provide Name and DOB)<br>_____ | o Billing Information<br>o Financial / Insurance Information<br>o Medical Information (treatments, results, etc) |
| o Parents/Children (Provide Name and DOB)<br>_____<br>_____<br>_____<br>_____ | o Billing Information<br>o Financial / Insurance Information<br>o Medical Information (treatments, results, etc) |
| o Other (Provide Name and DOB)<br>_____ | o Billing Information<br>o Financial / Insurance Information<br>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