Main Urology Associates, P.C.
Brompton Professional Park
6645 Main Street
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----------Practice Limited to Urology*Office Hours by Appointment----------

Appt. Date:

Location:

WELCOME TO MAIN UROLOGY

Thank you for calling our office for an appointment. In order to serve you more efficiently on the day of your appointment we ask that you:

1) **Fill out the enclosed patient information forms.**

2) **Bring the completed forms with you on your appointment date.**

3) **Bring your insurance cards. If your insurance requires a referral, you must have it on the day of your appointment, or your appointment will be rescheduled.**

4) **Be prepared to pay a co-pay if your insurance so requires**

5) **Failure to complete the patient information forms will cause a delay in your appointment time.**

6) **If you have been referred for physical therapy with Jill Franz, PT by a physician outside of Main Urology, please bring a prescription for physical therapy from the referring physician dated within 30 days of your first appointment. Failure to bring this prescription may cause your appointment to be rescheduled.**

We are looking forward to participating in your good health.

ACCT#_____ Telephone: 631-0932
Main Urology Associates, P.C. Fax: 631-2826

Name _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

Sex _____ Marital Status _____ Race _____ Soc. Sec. No. _____

Referring MD _____ Family MD _____
MD Address: _____Phone number: _____

Employer Name, Address and Telephone _____

_____

Emergency Notification

Name _____ Relation to patient _____

Telephone: Work: _____ Home _____

Insurance Information

Type of Insurance _____ ID# _____

Policy Holder _____ D.O.B. _____

Place of Employment of Insured _____

It is necessary for us to have written consent in your medical file if you want us to be able to communicate any medical information about yourself to another individual. If you want us to release information to a family member, such as a spouse, significant other, a parent or a sibling, or any other individual, you must indicate the name of the person(s). WE WILL BE UNABLE TO RELEASE ANY INFORMATION TO ANYONE OTHER THAN WHO IS INDICATED ON THIS FORM.

I, _____, hereby give my permission for the staff of
(Your Name)

Main Urology Associates to release medical information about myself to:

_____
(Name of person you are authorizing) (Relationship)

_____
(Name of person you are authorizing) (Relationship)

I may cancel this authorization at any time by written notification.

Signature _____ Date Signed _____ Acct# _____

NEW PATIENT HISTORY – ACCT #_____

The reason you are seeing the doctor today: _____

Allergies: Drug or Environmental "Example"- Shellfish or IVP Dye

None: ____ List: _____

Medications (Including Aspirin/Vitamins Etc.): _____

_____

Pharmacy name and telephone#: _____

Personal Medical History (please circle any of the following which you have)

AIDS	Emphysema	Meningitis
Anemia	Epilepsy	MI
Angina	Genital Herpes	Mitral Valve Prolapse
Arthritis	Glaucoma	Parkinson's
Asthma	Heart Disease	Peptic Ulcer
Cancer	Heart Murmur	Pneumonia
Cataract	Heart Valve Replacement	Radiation Therapy
Chemotherapy	Hemophilia	Sickle Cell Disease
Cholesterol (Elevated)	Hepatitis	Sinus Pain
Depression/Anxiety	High Blood Pressure	Stroke
Diabetes	Joint Replacement (hip/knee)	Thyroid Disease
Diverticulosis	Kidney Stones	Tuberculosis
Venereal Disease		

Other: _____

Do you wear glasses or contacts? Yes No

Are you hard of hearing? Yes No

Do you smoke? Yes No #PPD _____ #Years _____

Do you drink alcohol? Yes No Occasionally Rarely

Do you take antibiotics before dental work/or do you have an artificial implant? Yes No

Women: Are you pregnant? Yes No #Weeks _____
Last Menstrual Period? _____
Number of Pregnancies? _____
Number of Deliveries_____

Patient's Name _____ Acct# _____ D.O.B._____

NEW PATIENT HISTORY (CON'T)

Family history of prostate/bladder/kidney cancer? Yes No

Sexual function: Difficulty obtaining erection; Difficulty maintaining erection;
Erection inadequate for intercourse? Yes No

List all past surgery with approximate date or age and any other medical/surgical history NOT otherwise listed: _____

_____

Patient's Name _____ Acct# _____ D.O.B._____

Main Urology Associates, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU CAN BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of urology procedures will be available in your medical record to all health professionals who may provide treatment to you or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payments from your health plan, from other sources of coverage such as an auto insurer or from credit card companies that you may use to pay for services.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the public health department.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Other disclosures of your health information or for uses other than those listed above, requires your specific written authorization. If you change your mind after authorizing, you may submit a written revocation of the authorization. However, your revocation will not affect or undo any use or disclosure that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION: Your health information will be used by our staff to send any appointment reminders deemed necessary.

INDIVIDUAL RIGHTS: You have certain rights under federal privacy standards including:

* The right to request restrictions on the use and disclosure of your health information
* The right to receive confidential communications concerning your medical condition and treatment
* The right to inspect and copy your health information
* The right to request an amendment or submit a correction request to your health information
* The right to receive an accounting of how and to whom your health information was disclosed
* The right to receive a printed copy of this notice

MAIN UROLOGY DUTIES: We are required to maintain the privacy of your health information and to provide you with this notice of privacy practices. We reserve the right to amend or modify our privacy policies and practices. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

* You may generally inspect or copy your health information. As permitted by federal regulation, we require that such request must be submitted in writing to the attention of: The Practice Administrator or Compliance Officer at Main Urology Associates, P.C. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny your request.
* If you would like to submit a comment or complaint about your privacy practices (you will not be penalized or otherwise retaliated against for filing), you may submit a letter outlining your concerns to: The Practice Administrator or Compliance Officer at Main Urology Associates, P.C. at 6645 Main Street, Williamsville, NY 14221.

The effective date of this notice is: APRIL 14, 2003

ACKNOWLEDGMENT OF RECEIPT OF
Main Urology Associates, P.C.
Notice of Privacy Practices

I, ____ was provided by

Main Urology Associates, P.C. Notice of Privacy Practices either:

________ Upon my first visit for treatment.

________ Via e-mail with my permission before my first visit for treatment.

________ In an emergency situation, as soon as possible after the emergency treatment situation.

__________________________________ __________________________________

Print Patient's Name   Patient's Signature

____

Date

* *

If the patient did not sign the Acknowledgment, please state:

Efforts made to obtain Acknowledgment: _____________________________________

____

____

Reasons for not obtaining Acknowledgment:

__________ Patient or Patient's Representative refused to sign.

__________ An emergency situation prevented patient from signing Acknowledgment.

__________ Other: ____

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