Abraham S. Hawatmeh, MD, FACS
Frederick P. Walters, MD
Salim I. Hawatmeh, MD

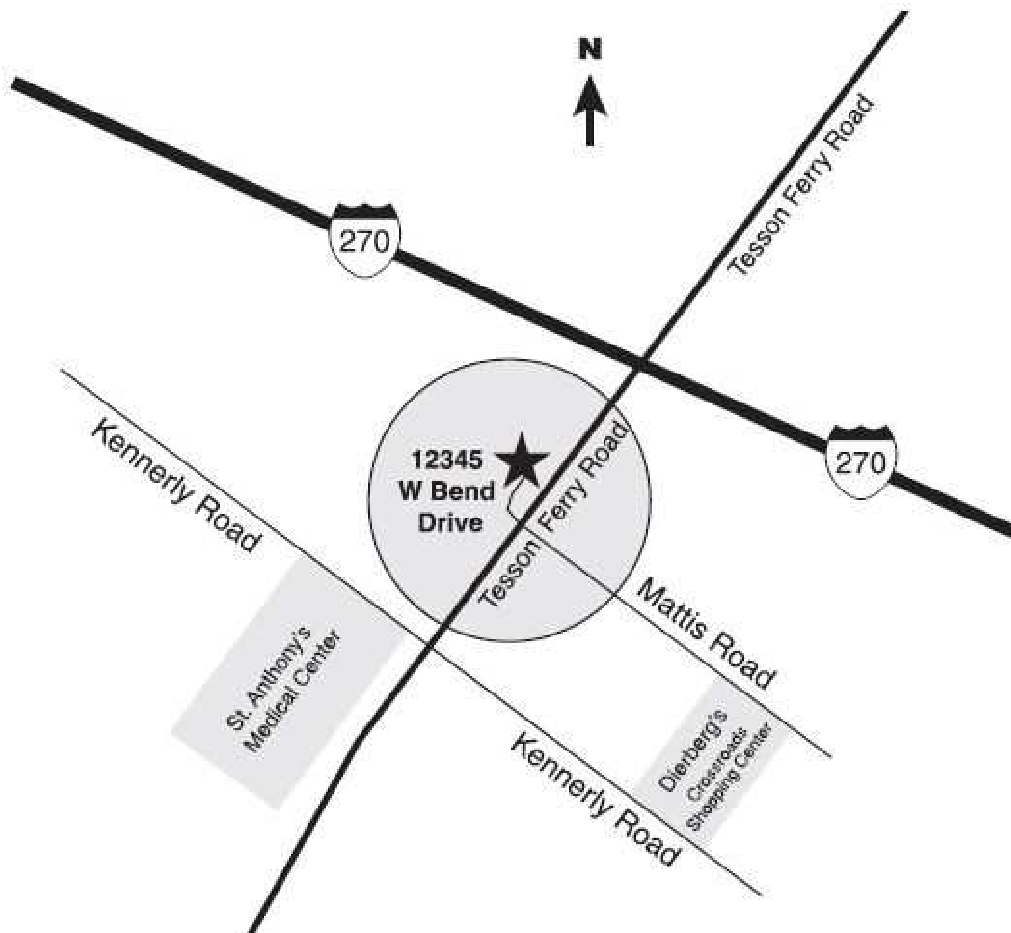
WE HAVE MOVED!

To better accommodate our patients, we have moved to a larger office and new building.

Our new address is: **12345 West Bend Drive, St. Louis, Missouri 63128**

Our new building is just around the corner from our old office, and is located at the west corner of Tesson Ferry Road (Highway 21) and Mattis Road, across from Dierberg's Crossroads Center.

For your convenience, our telephone and doctor's exchange phone number remain the same:



Name ____ **Date** ___________________________

Date of Birth ___________________________________

By what method did you choose our practice: Referring Physician: ____

_____Friend _____Yellow Pages _____Insurance Company _____TV Ad _____Newspaper Ad _____Internet

Other (Please explain) ____

Why are you seeing the doctor today? ____

Have any tests been performed for this problem? **Yes** or **No** What was done ___________________________________

Where and when where these tests performed? ____

How long have you had this problem? ____

What improves or worsens the problem/pain? ____

Are there any symptoms that go along with the problem/pain? ____

Is the problem/pain continuous or does it come and go? ____

Describe the pain (sharp/dull, etc.) ____

Have you tried any medicine/treatment for this problem/pain? ____

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following diseases or conditions:

ADD
ADHD
Alcoholism
Allergies
Alzheimer's Disease
Anemia
Aneurysm
Angina
Anorexia
Anxiety Disorder
Arthritis
Arrhythmia
Aortic aneurysm
Aortic Stenosis
Aortic Insufficiency
Asthma
Aerial fibrillation
Back pain
BPH
Bi-polar disorder
Bladder Cancer
Bleeding Disorder
Blindness
Brain tumors
Breast Cancer
Bronchitis
Cataracts
Cerebrovascular Disease
Cholecystltis
Cholelithiasis
Chronic fatigue syndrome
Chronic liver disease
Chronic lung disease
Chronic renal insufficiency
Chronic Renal Failure
Colitis
Constipation
Colon Cancer
Colon Condition
Congenital Heart Disease
Congenital Heart Failure
Crohn's Disease
Deafness
Deep vein thrombosis
Depression
Diabetes-non ins dependent
Diabetes-insulin dependent
Diabetes-uncontrolled
Diarrhea
Eating Disorder
Ear Infections
Elevated PSA
Emphysema
Enlarged Heart
Epilepsy
Fibrocystic Breast Disease
Fibromyalgia
Gastric Cancer
GERD
Glaucoma
Goiter
Gout
Hay Fever
Heart Attack
Heart Disease
Heart Valve Problem
Heart Murmur
Hemorrhoids
Hepatitis
Herniated Disc
Hiatal Hernia
High Cholesterol
High Blood pressure
Impaired Glucose tol.
Infertility
Irritable Bowel Disease
Inflam. Bowel Disease
Kidney Disease
Kidney Infection
Kidney stones
Infectious Disease
Laryngeal Cancer
Leukemia
Liver Disease
Lung Disease
Lung Cancer
Lymphoma
Malaise
Melanoma
Mental Illness
Migraine
Mitral stenosis
Mitral insufficiency
Mitral Valve Prolapse
Mumps
Nervous Breakdown
Obesity
Osteoporosis
Pancreatitis
Pancreatic Cancer
Peptic Ulcer
Phlebitis
Polio
Prostate Cancer
Prostatitis
Pulmonary embolism
Rectal Fissure
Rectal Cancer
Rheumatic Fever
Sexually Trans. Disease
Sickle Cell Anemia
Stroke
Suicide Attempt
Testicular Cancer
Thyroid Disease
Tuberculosis

Other: ____

____

Name ______________________________ **Date** ____________________

Date of Birth ________________________

SURGICAL HISTORY

Please CIRCLE if you have had any of the following surgeries and date of surgery:

Amputation
Angioplasty
Aortic Aneurysm Repair
Appendectomy
Arthroscopic Surgery
Back Surgery
Bariatric Surgery
Bladder Surgery
Bowel Resection
Brachytherapy
Brain Surgery
Breast Surgery
Biopsy of Prostate
CABG
Carotid Artery Surgery
Carpal Tunnel Surgery (R or L or both)
Cataract Surgery (L or R or both)
Cervical Spine Surgery
Cholecystectomy
Circumcision
Colon Resection
Colonoscopy
Corneal Surgery (L or R or both)
Cystoscopy
Cysto-TUR Fulguration
Cyst Removal
Deliveries (Vaginal or C-Section)
Ear Surgery (L or R or both)
EGD
Epididymectomy
ESWL
Eye Surgery (L or R or both)
Facial Surgery
Foot Surgery (L or R or both)
Gastric Surgery
Hand Surgery (L or R or both)
Heart Surgery
Heart Transplant
Hemorrhoidectomy
Herniorrhaphy
Hip Surgery
Hydrocelectomy
Ilioconduit
Ileostomy
Indigo Laser Surgery
Inguinal Herniorrhaphy
Knee Surgery (L or R or both)
Laminectomy
Laparoscopy
Laparatomy
Leg Surgery (L or R or both)
Liver Surgery
Lumpectomy
Lung Surgery
Lymphatic Node Dissection
Lysis Adhesions
Mastectomy
Mastoid Surgery
Meatotomy
Nasal Surgery
Needle Biopsy
Nephrectomy
Nephrolithotomy
Orchiectomy
Pacemaker Insertion
Parathyroidectomy
Penile Implant
PEG
PE Tubes
Pilondial Cyst Incision
Radical Prostatectomy
Renal Transplant
Rotator Cuff Surgery
Septoplasty
Sinus Surgery
Skin Grafting
Spermatocelectomy
Splenectomy
Stomach Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery
TUMT Prostate
TUR Prostate
Umbilical Hernia
Ureteroscopy
Varicocelectomy
Vasectomy
Vein Stripping
Ventral Hernia Repair
VLAPP

Other: ______________________________

FAMILY HISTORY

Please list which family member has/had any of the following: (Mother. Father. Siblings. Grandparents)

	WHO		WHO		WHO
Arthritis		Gout		Multiple Sclerosis	
Bedwetting		Heart Attack		Laryngeal Cancer	
Bladder Cancer		Hypertension		Pancreatic Cancer	
Cancer (site unknown)		Kidney Disease		Prostate Cancer	
Crohn's Disease		Kidney Stones		Stroke	
Depression		Leukemia		Thyroid Disease	
Diabetes		Malignant Melanoma		Tuberculosis	

Other: ______________________________

Name ____ **Date** ____________________

Date of Birth __________________________

REVIEW OF SYSTEMS: PLEASE CIRCLE ALL THAT APPLY

Constitutional
Aches/Pains
Appetite Changes
Bruises easily
Fever
Chills
Hot Flashes
Night Sweats
Fatigue
Generalized Weakness
Insomnia
Swollen Glands
Anorexia
Weight loss
Weight gain
Other

Eyes
Blindness
Blurred Vision
Double Vision
Eye Pain
Other

Allergic/Immunologic
Seasonal
Drug
Animal
Environmental
Other

Neurological
Stroke
Headache
Dizzy spells
Balance problems
Numbness/Tingling
Tremors
Leg or Arm Weakness
Memory Loss
Speech Problems
Other

Endocrine
Diabetes
Pituitary Disease
Thyroid Disease
Excess thirst
Tired/Sluggish
Heat/Cold Intolerance
Other

Gastrointestinal
Acid Reflux
Indigestion/Heartburn
Nausea/Vomiting
Abdominal Pain
Bloody Stools
Abdominal Cramps
Diarrhea
Constipation
Change in Bowel Habits
Hemorrhoids
Flatulence
Gas
Rectal Bleeding
Tarry stools
Other

Cardiovascular
Chest pain/angina
Dyspnea on exertion
Edema
Hardening of the arteries
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart beat
Low exercise tolerance
Mitral valve Prolapse
Orthopnea
Pain/cramps w/exercise
Palpitations
Skipped Heart beats
Swelling
Other

Skin
Acne
Boils
Persistent Itch
Skin rash
Changing moles
Pigment changes
Other

Musculoskeletal
Back Pains
Joint Pains
Neck pain/stiffness
Muscle Cramps
Arthritis
Muscle Weakness
Other

Ears/Nose/Throat
Ear Infection
Sinus Problems
Sore Throat
Other

Genitourinary
Back Pain
Bedwetting
Blood in urine
Dribbling
Burning on Urination
Erection Problems
Premature Ejaculation
Flank Pain
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Nocturnal Enuresis
Nocturia
Prostate Infection
Sexual Dysfunction
Low desire
Sexually Transmitted Diseases
Stranguria
Suprapubic Pain
Testes/Scrotal Swelling
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine Retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge/Problems
Weak Stream
Other

Respiratory
Asthma
Tuberculosis
Emphysema-Bronchitis
Environmental Allergies
Frequent Cough
Shortness of Breath
Wheezing
Other

Hematological/Lymphatic
Swollen Glands
Blood clotting problems
Bleeding Problems
Hepatitis
HIV (AIDS)
IV Drug Use
Sickle Cell
Other

Psychological
Not satisfied with life
Anxious
Depressed
Considered Suicide
Other

Patient Signature ____ **Date** ______________

Name ____ **Date** _________________

Date of Birth _______________________________

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years __________

_____Single _____Married _____Separated _____Divorced _____Widowed _____Life Partner _____Common Law Spouse

Dependants: Please indicate # of each, if you have:

_____ Sons _____Daughters _____Stepchildren _____Adopted _____Foster _____Parents _____Grandparents

Occupation: Please circle one that applies:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, Other

Hobbies: Please circle any that apply to you:

None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball

Alcohol Consumption: Do you drink alcohol? ______**Yes** ______**No**

If Yes: Occasionally/Socially _________ # of drinks per week __________ How long?__________

Tobacco: Do you smoke?______ #______Packs/day ______Cigarettes/day ______Smokeless Tobacco

Have you ever smoked? _______ #______Packs/day ______Cigarettes/day ______Smokeless Tobacco

If you previously smoked, When? ___________________________ **How long?** ___________________________

Recreational Drugs: ____None **If yes**, please list: ____

Caffeinated beverages: None Low Moderate Excessive

ALLERGIES - Please list ALL types (Drug, seasonal, pets, environmental, foods)

____

____

Recent Foreign Travel: None Americas ________________________ Worldwide ________________________

CURRENT MEDICATIONS - Please list ALL medications you are currently taking including over the counter meds

Drug Name:	Strength:	Directions/How you take it:
__________________________	______________	____________________________________
__________________________	______________	____________________________________
__________________________	______________	____________________________________

Attach list if necessary

Pharmacy Name:_____________________________________ **Phone #** _________________________________

South County Urological INC.

Please Print the following information:

Today's Date: ________________________________ **SS#:** __________________________________

Patient Name: ____ **Birth Date:** ________________

Home Address: ____

City: ______________________________________ **State:** _________ **Zip Code:** _________________

Mailing address if different than above: ____

Home Phone: (   ) ______________ **Primary Doctor:** ____

Who referred you to our office?: ____

Employer: ____ **Phone:** _____________________________

Employer's Address: ____

Spouse's Name: ____________________________________ **Spouse's SS#:** ______________________

Spouse's Employer: ________________________________ **Phone:** ____________________________

Spouse's Birth Date: _________________________________

Insurance Information

Primary Insurance: ____

Subscribers Name: __________________________________ **Subcribers DOB:** ____________________

ID#: ____ **Group#:** __________________________________

Secondary insurance: ____

Subscribers Name: __________________________________ **Subscribers DOB:** ___________________

ID Number: __________________________________ **Group #:** __________________________________

Emergency Contact: _________________________________ **Phone:** ____________________________

Relationship to the above Contact: ____

AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Patient Name: ____________________________________ Social Security Number: ____________________

Persons/organizations providing the information:
South County Urological, Inc.

Persons/organizations receiving the information:
Please list the name and relationship to you of family, members and friends with whom we may discuss your protected health information:
Name: _______________________________ **Relationship to you**: _______________________________
Name: _______________________________ **Relationship to you**: _______________________________
Name: _______________________________ **Relationship to you**: _______________________________
Name: _______________________________ **Relationship to you**: _______________________________
Name: _______________________________ **Relationship to you**: _______________________________

Specific description of information:
Information contained in all billing and medical records.

Purposes of Use or Disclosure: **Treatment, administrative operations of South County Urological, Inc. or answering inquiries by the parties listed above.**

SECTION B

Please read carefully:

1. I understand that this authorization will expire when a time period of two (2) years has run without me receiving treatment from this practice.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, except the extent the organization has taken action in reliance on the consent.

_____________________________________ ______________________
Signature Patient/Patient's Representative Date

____
Printed Name of Patient's Representative

Basis of representative's authority to act for patient: ____

____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

NOTICE OF PRIVACY PRACTICES OF SOUTH COUNTY UROLOGICAL, INC.

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. .

Uses and Disclosures of Health Information:

Without your consent, we may use health information about you for treatment (such as sending your medical record information to a specialist physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), and for administrative purposes (such as comparing patient data to improve treatment methods.)

We may also use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, research studies, coroners, funeral arrangements and organ donation, workers' compensation purposes, judicial/administrative proceedings/specialized governmental functions to relatives/friends involved in your treatment and payment for your treatment if you do not object, and in emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also contact you about treatment alternatives or we may contact you about appointment reminders. If we cannot reach you regarding appointment reminders we may leave a limited message on your answering machine or with the person who answers your telephone. **Please inform us if you do not want to receive appointment reminders in any of these** ways. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at anytime. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area, in each examination room, and on our Web site. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights:

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about your care. An example of when you may not have access to your health information is when you are participating in a research study. You may receive access after the research study is complete. You also have the right to receive a limited list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.

You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes. We will consider your request but are not legally required to accept it.

Complaints:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. Under no circumstances will you be retaliated against for filing a complaint.

Our Legal Duty:

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints regarding privacy, please contact:

Theresa Hammack

Title: **Privacy Official**

Telephone: **(314) 843-8000**

Effective Date: **April 14. 2003**

RECEIPT ACKNOWLEDGED: ___________________________________

Printed Patient Name: ____

Date: ______________

Thank you for choosing South County Urological, Inc. as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

ALL COPAYS AND COINSURANCE ARE DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISAIMASTERCARD, AND DISCOVER.
THERE WILL BE A $25.00 PROCESSING FEE FOR ALL RETURNED CHECKS.

FINANCIAL POLICY - PROFESSIONAL FEES

1. The patient or guardian (if patient is a minor) is responsible for the account regardless of insurance coverage.
2. In order to keep our fees down, payment is expected at each office visit. Patients who have a coinsurance or a copayment are expected to pay this at the time of the office visit. This is part of your contract with the insurance company anal noncompliance may result in your insurance company canceling your policy. We do report non-payment of coinsurance and copayments if they cannot be resolved within 30 days of the date of the first statement:
3. Accounts with a balance due over 30 days will be assessed a processing fee of $5.00 for every 30 days it is past due. This may or may not apply to those who have payment arrangements.
4. There may be a $25.00 charge assessed to any account for appointments that are not canceled within 24 hours of the appointment time.

INSURANCE AND INSURANCE FORMS

1. Please remember that insurance is considered a method of reimbursing you, the patient, for fees paid to the doctor and is not a substitute for payment. The patient is responsible for payment of health care regardless of the status of his/her claim. Reduction or rejection of your claim by your insurance company does not relieve you of the financial obligation incurred for medical services rendered. It is your responsibility to obtain benefit information and to pay all deductibles, coinsurances, or other balance not covered by your insurance.
2. We are Medicare participating and therefore accept assignment from Medicare. We do not accept assignment from other insurance companies unless we are contracted with them: We will, however, be happy to assist you in filing claims for reimbursement from other insurance companies.
3. South County Urological, Inc. is a provider for many managed care plans. However, it is the responsibility of the patient to obtain a referral for each visit if it is required by the insurance. Failure to obtain a referral may result in non-payment of the claim by the insurance company and the patient will be responsible for payment at the time of service.
4. It is the patient's responsibility to inform the office staff if a precertification, authorization, or second surgical opinion is required by your insurance before admission to the hospital. It is also the responsibility of the patient to inform the office staff if your insurance required you to utilize a specific hospital for medical services rendered or ordered by this office.
5. It is the responsibility of the patient to inform the office staff of any changes in insurance coverage and to provide the necessary information to file a claim with the insurance. If this information is not provided the balance of the account will be the responsibility of the patient.

ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim and request payment of insurance benefits be made to the physician for services described on the insurance form. I understand that I am financially responsible for all charges whether or not paid by said insurance. A photo copy of this assignment is to be considered as valid as the original.

I have read in full, understand, and agree to comply with the financial policies of South County Urological, Inc.

Signature. ____ Date: ____________________