UROLOGY TEAM P.A. **NEW PATIENT INFORMATION**

Today's Date:	Account number:	MD #:

DEAR PATIENT: We have made every attempt to reduce the amount of paperwork that you need to fill out and also make the process more efficient. Your cooperation and correct completion of the information below will assist us in obtaining the information correctly the first time. Please provide a copy of your primary and secondary (if applicable) insurance card to the front desk with your paperwork. THANK YOU

Is your condition a result of a work injury?_____ Or related to an auto accident?_____

PATIENT INFORMATION: **SS #:_____ DL #:_____**

Last name: _____ First name:_____ MI:_____

Address: _____ City: _____ State:_ Zip:__

_____ Phone #: _____ Cell #: _____ Email:_____ DOB:_____

_____ AGE: _____ M: ___ F: ___ Marital Status:_____

Your Employer: _____Occupation:_____

Work Address: _____ City:_____

State/ Zip: _____Work #: _____ Work Email: _____

Emergency Contact: _____ Phone #: _____ Cell #: _____

Patient relationship to primary cardholder: Self:_____ Spouse: _____Other:_____

If you are not the primary cardholder please complete next box.

PRIMARY AND SECONDARY CARDHOLDER INFORMATION: Please complete this section if the patient is not the primary cardholder for their primary and secondary insurance. This information is REQUIRED BY YOUR insurance company for identification of policyholder and correct billing.

Cardholder's name:_____Cardholder's Occupation:_____

Cardholder's Employer: _____Cardholder's work #:_____

Cardholder's SS #: _____Cardholder's DOB: _____

PATIENT REFERRAL INFORMATION: Your insurance company and Urology Team REQUIRE this information. The Urology Team MD utilizes this information to send communication about your care to your referring and primary care physician (if appropriate).

Referring MD: (full name)_____Phone #:_____

Primary care physician: _____Phone #: _____

For office use:

- ❑ **Copy of primary card attached**
- ❑ **Copy of secondary card attached**
- ❑ **Waiver signed and attached**
- ❑ **Referral obtained and attached**
- ❑ **Demographic entered and attached**
- ❑ **Employee Initials _____**

PATIENT HISTORY FORM

TODAY'S DATE _____/_____/_____

LAST NAME _____

FIRST NAME: _____

DATE OF BIRTH: _____

Chief Complaint or the main reason for your visit today? (Describe your in detail)

_____

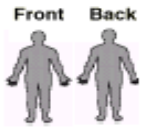
_____

_____

_____

History of Present Illness (Please answer the following questions completely or write N/A)

Location of the problem
Abdomen Back Leg
Other _____
_____
_____



Is anything else occurring at the same time?
YES NO If yes, please explain.
Nausea Rash Headaches
Other

AT ITS WORST…….On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago

Does anything make the problem better?

Does anything make the problem worse?

How long does the problems last? _____

Is the problem constant or variable?
Dull then Sharp Very sharp then leaves Always there
Other

Does the problem interfere with your normal functions?
Yes ☐ No ☐ If yes, please explain

MD ONLY: (COMMENTS/ NOTES)

# ANSWERS	LEVEL
1-3	1 OR 2
4 +	3-5

Past Medical, Family & Social History

(List all serious illnesses in your immediate family. Please fill in every box with information or N/A)

DISEASE	PARENTS	BROTHERS /SISTERS	CHILDREN	DISEASE	PARENTS	BROTHER/ SISTERS	CHILDREN
DIABETES				BLEEDING			
CANCER				KIDNEY PROBLEM			
HEART DISEASE				OTHER			
HIGH BLOOD PRESSURE				OTHER			

Do you smoke? ☐ Yes ☐ No
If yes, how much? _____

Do you drink? ☐ Yes ☐ No
If yes, how much? _____

Do you exercise regularly? ☐ Yes ☐ No
If yes, how much? _____

Married: # of Children:

Past Illness and Dates

Illnesses	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgeries and Dates

Surgeries	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Comments:

MD ONLY: (COMMENTS/ NOTES)

# ANSWERS	LEVEL
0	1 or 2
1-2	3
3	4 or 5

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other _____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other _____

Allergic / Immunologic

Hay Fever	Y	N
Drug allergies	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other _____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other _____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other _____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other _____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other _____

Ear / Nose / Throat / Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N

Other _____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other _____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other _____

Hematologic / Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other _____

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other _____

Patient/family signature:_____ Date:_____

Physician use only: Comments/Notes

# ANSWER	LEVEL
0-1	1 OR 2
2-9	3
10+	4 OR 5

Modified 5/6/02

XX MD SIGNATURE: _____ **Date:** _____

Medication Record

Patient: _____ **DOB:** _____ **UTPA MD:** _____

★**Medication Allergies:** _____

★**Other Allergies: (foods, latex, betadine etc.)** _____ **Posted on Chart:** _____

★**Significant Health Conditions:** _____

Primary Care Physician: _____ **Phone Number:** _____

_____ **Care Physician:** _____ **Phone Number:** _____

_____ **Care Physician:** _____ **Phone Number:** _____

Pharmacy: _____ **Phone Number:** _____

MEDICATIONS: LIST ALL CURRENT MEDS & SUPPLEMENTS.

Rx Start Date	MEDICATION OR DRUG SUPPLEMENTS	Dos-age	How often	✓if OTC	✓ if Prescription	If Prescription please list name of Prescribing Physician	RX Stop Date UTPA only

Notice of Privacy Practice; 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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill & collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, "we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law." Or "we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that this practice provides only the best health care." For further information on "health care operations" see the definition in the regulation at 45 CFR§164.501. A link to the regulation is available on the TMA website.]

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, 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, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using. Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled. We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed. If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation
We may disclose your medical information as required by workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information when the disclosure is required by law.

Your Rights Under Federal Law

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances. You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care. To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document. We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies. We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access. Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures
HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12- month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government. The contact information for the United States Department of Health and Human Services is**: Office for Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, Texas 75202, (214) 767–4056, TDD (214) 767–8940.**

Our Promise to You
We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests
If you have any questions or want to make a request pursuant to the rights described above, please contact**:**
Practice Manager, 11410 Jollyville Road #1101, Austin Texas 78759, Phone: 512.231.1444, Fax: 512.231.1470 or via contact on our website: www. Urologyteam.com. This notice is effective 04/04/05

Acknowledgement of Review of Notice of Privacy Practices
I acknowledge I have received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____ _____
Signature of Patient or Personal Representative` Date

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority

Financial Responsibility and Policy Sheet

Printed Patient Name:_____

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following policies. If you have any questions regarding these policies, please discuss them with our Account manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

INSURANCE: We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment/co-insurance at the time of service. This office's policy is to collect this co-payment/co-insurance when you arrive for your appointment

HMO: The co-payment made at the front desk is for the **visit only** and often considered the time you spend with the physician. If an HMO patient follows the **referral or authorization guideline** before their visit to a specialist, medical necessity and service is a covered service as determined by your insurance company.

All other Insurances: The co-payment made at the front desk is for the visit only often considered the time you spent with the MD. If you have any procedures performed during your visit to Urology Team, the procedure co-payment, deductible and or co-insurance (most-likely) is not covered in the co-payment made at the front desk. Unless otherwise stated by your insurance company, all other insurances have –CO-PAYMENTS & OR CO-INSURNCE, ENCOUNTER FEES, YEARLY DEDUCTIBLES, MUST MEET MEDICAL NECESSITY AND BE A COVERED SERVICE. ***In other words, the amount you pay during your visit may not be all you owe. Your final responsibility will be determined after your insurance company has received a bill for all services rendered, process and paid your claim.***

Miscellaneous:

- You acknowledge that the insurance card and information provided each visit is the correct and current information. You understand that it is your responsibility to inform the Urology Team PA if a change in your insurance coverage occurs
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. SERVICES MOST OFTEN DENIED BY INSURANCE COMPANIES: FERTILITY AND RELATED WORKUP TO INCLUDE MESA AND VASECTOMY REVERSALS, SEXUAL DYSFUNCTION AND RELATED WORKUP MOST OFTEN ERECTILE DYSFUNTION, SOME LAPAROSCOPIC PROCEDURES. Please call your insurance company to verify coverage of these services. The customer service number is located on your card.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office. You understand that should a Urology Team physicians visit you in the hospital or perform surgery, that these physician fees are separate than surgical assists, hospital, anesthesia, lab or pathology fees.

Private Pay Patients: As a private pay patient you will be asked to make a deposit prior to seeing the doctor. It is very important that you ask about the cost of care or services that your physician is recommending prior to the service being performed. At the end of my visit, I understand that I will receive a refund or expected to pay for additional charges.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **THE UROLOGY TEAM PA** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Consent for Treatment:

I understand my right to participate in my treatment process. I am mentally competent and do hereby consent to necessary examination, procedures and or treatments prescribed by my physician, his/her assistants or designee as is necessary in his/her judgment.

Authorization to Release Information

I hereby authorize **THE UROLOGY TEAM PA** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **THE UROLOGY TEAM PA** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. In the event of default, I understand that the Urology Team may use an outside collection company and or report returned checks to the Attorney General office for the State Of Texas.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I understand that our records contain protected health information about you and as such are highly confidential. When appropriate, this office may use medical records for non-treatment purposes (research, public health, and some operational activities).

_____Initials acknowledge receipt of this office's **Notice of Privacy Policy.**

_____Initials acknowledge receipt of this office's **New patient folder** including insurance responsibility.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

_____ / / _____

Signature of Patient or Responsible Party if a Minor Date Relationship to Patient

06/03/05 asj