FRANCIS A. GAROFALO, M.D., F.A.C.S.
Diplomate of the American Board of Urology

30 Stevens Street, Suite 3G
Norwalk, CT 06856

203-852-2003
Fax 203-852-2919

Thank you for choosing Dr. Garofalo for your urology health care needs.

Your appointment is scheduled on _____ _____@_____

Enclosed you will find a **New Patient Questionnaire**. Please take a few minutes to fill out this information prior to coming in for your visit. This will help us to provide you with better and faster service. Please visit our website for any further information at, **www.cturology.urologydomain.com**

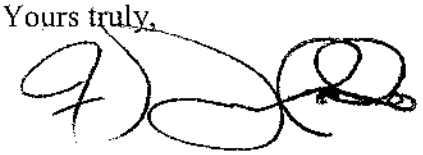
Please bring in your **insurance card** if you have insurance. If your insurance requires a referral to see a specialist, please obtain it with you or make arrangements to have it sent here. The **referral** is your responsibility, *(it is required by your insurance company)* if it is not here on the date of visit, your appointment will be rescheduled. Co-pay is expected at time of visit. If your co-pay is not paid on the date of visit a **$15 processing fee** will be charged to your account, and **$5 each additional month** that we have to bill you. If you do not have insurance coverage, payment is expected at the time of visit. We reserve the right to reschedule your appointment if you are more than ten minutes late.

Please bring a list of **current medications** and any **reports or tests** from your doctor that may have been done, which are pertinent to your visit. Lastly please remember that Dr. Garofalo is a urologist and we require you to give a **urine sample** in the office.

We require **24 hours** notice to cancel or reschedule an appointment. **We charge $50** for no shows and without 24 hours notice to cancel or reschedule. We charge **$50.00** for a bounced check.

If a **spouse or family** member has questions about your health care and would like to speak with Dr. Garofalo they must **come in to the office** with you.

Yours truly,



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First_____Middle_____Last_____
Home Address_____
City_____State_____Zip_____
Home #_____Work#_____Other#_____

Date of Birth_____Sex male female S.S.#_____
Marital Status Married Single Other Ethnicity_____

Employer (Name of Company)_____
Address_____City_____State____Zip_____

Primary Care Doctor_____Phone #_____
Referring Doctor_____Phone #_____

Financially Responsible Party **(If child is the Patient/Parents or Legal Guardians)**
Name_____Relationship_____Home#_____Work#_____
Name_____Relationship_____Home#_____Work#_____

Primary Insurance Policy Holder (If not patient)
Name_____Date of Birth_____SS#_____
Employer_____
Address_____City_____State_____Zip_____

Secondary Insurance Policy Holder
Name_____Date of Birth_____SS#_____
Employer_____
Address_____City_____State_____Zip_____

Emergency Contact Name_____Home #_____Work#_____

Francis A. Garofalo, M.D., F.A.C.S

# Office Financial Policy

Revised April 15, 2003

Thank you for choosing us as your health care provider. We are committed to providing you with exceptional healthcare. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to sign. At each visit you will be expected to bring your photo ID and your insurance cards, which we will copy and file in your chart. We require you to sign-in at each and every visit. All patients must complete all forms prior to seeing the Doctor.

**FULL PAYMENT IS DUE AT TIME OF SERVICE.**

**WE ACCEPT CASH, CHECKS, DEBIT, VISA, MC & AMEX.**

## Contracted Insurance Companies

All co-pays and deductibles are due at the time of treatment. For patients with Medicare, you are required to pay the 20% that Medicare states you are responsible for. Also be aware that Dr. Garofalo must apply for benefits on your behalf to receive payment for services rendered. In doing so, we must release any medical information to process your claims. In the event that your insurance coverage changes to a plan we do not participate with, please refer to the following paragraph.

## Regarding Indemnity Insurance/Private Insurance/Self-pay

Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. We require payment in full at time of service for office visits. For patients having procedures in the hospital, 50% of the total charge is due at the time of the pre-operative appointment. The balance is then due at your post-operative appointment.

## Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

## Minor Patients

Parents or legal guardians accompanying a minor are responsible for payment on date of service.

## Fees

Unless canceled, at least 24 hours in advance, our policy is to charge $50 for missed appointments. Please help us to serve you better by keeping scheduled appointments. A $15 processing fee will be applied to your account if a co-pay is not received on the date of service and each month thereafter. Please remember to bring your co-pay for each visit so as to avoid any fees. We also reserve the right to charge $50 for any check returned for insufficient funds. If your insurance requires you to have a referral to see a specialist, it must be at the office at the time of service. If no referral is obtained, the patient is expected to pay in full for all services rendered.

If you are completely unable to make payments, you will be referred to the Americares clinic in Norwalk.

I understand that I am responsible for services rendered, including attorney's fees and cost of collections in the event of default due to incorrect or improper insurance information. I further understand that if a payment becomes 90 days past due, I will make payment to Dr. Francis Garofalo for the visit. The information I have given is true to the best of my knowledge.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

PLEASE FILL OUT OTHER SIDE

# PATIENT HISTORY FORM

Note: This is a confidential record and will be k… your doctor's office. Information contained here will not b… released to anyone without your authorization to do so.

TODAY'S DATE____/____/____ DATE OF LAST PHYSICAL EXAM____/____/____

LAST NAME_____ FIRST NAME_____ MIDDLE_____

Social Security No. _____ DATE OF BIRTH____/____/____

**CHIEF COMPLAINT**

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

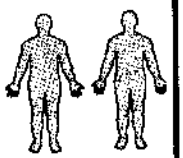
_____

## History of Present Illness

Please answer the following questions

**Location of the problem**

Front Back



Abdomen Back Leg

Other_____

_____

_____

**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

Other_____

**Does anything help or make the problem worse?**

Moving around Standing Up Lying on my side

Other_____

**How long does the problem last?**

30 minutes 1 hour It is always there

Other_____

**Is anything else occurring at the same time?**

YES No If yes, please explain.

Nausea Rash Headaches

Other_____

**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_____

_____

**Physician use only: (Comments/Notes)**

| # Answers | Level of Service |
|---|---|
| 1 - 3 | 1 or 2 |
| 4+ | 3 - 5 |

## Past Medical & Social History

**List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)**

_____ _____ _____

_____ _____ _____

_____ _____ _____

**List any personal past illnesses and/or surgeries and when they occurred.**

**Illness or Surgery Date**

_____

_____

_____

**Do you smoke? Y N**

**If yes, how much?** _____

**Do you drink? Y N**

**If yes, how much?** _____

**Are you on any medications? Y N (If yes, list all.)**

_____ _____

_____ _____

**Are you on a special diet? Y N (If yes, please explain)**

_____

**Do you have allergies? Y N (If yes, Please explain.)**

_____

_____

**Physician use only: (Comments/Notes)**

| #Answer | Level of Service |
|---|---|
| 0 | 1 or 2 |
| 1 - 2 | 3 |
| 3 | 4 or 5 |

PLEASE USE INK

Pharmacia&Upjohn

PLEASE FILL OUT OTHER SIDE

**(OVER)**

USX 9787.00

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# Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**.

**Please explain any Yes answers in space provided**

**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 problems | 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_____

**Physician use only: (Comments/Notes)**

| #Answer | Level of Service |
|---|---|
| 0 - 1 | 1 or 2 |
| 2 - 9 | 3 |
| 10+ | 4 or 5 |

Physician: _____ Date: _____/_____/_____



PLEASE USE INK