UROLOGIC ASSOCIATES OF ALLENTOWN

ADULT UROLOGY
1240 SOUTH CEDAR CREST BLVD. – SUITE 310
ALLENTOWN, PENNSYLVANIA 18103-6218
610-437-9988 • FAX 610-437-4320

PATIENT INFORMATION

ALL MINORS (18 YRS. OR YOUNGER) MUST BE ACCOMPANIED BY A PARENT DATE:_____

NAME: _____ PHONE (HOME): _____

ADDRESS: _____ (WORK): _____

CITY: _____ STATE:_____ ZIP _____

AGE: _____ DATE OF BIRTH: _____ SEX:_____ SOCIAL SECURITY #: _____

OCCUPATION:_____ MARITAL STATUS:_____ SPOUSE'S NAME: _____
(IF RETIRED, FORMER OCCUPATION)

POWER OF ATTORNEY: _____ PARENT/LEGAL GUARDIAN: _____

REFERRING PHYSICIAN:_____ PHONE: _____

ADDRESS: _____

FAMILY PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

MEDICARE PATIENTS:
I request payment of authorized Medicare benefits to be made either to me or on my behalf to Urologic Associates of Allentown, PC for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

PATIENT SIGNATURE:_____

COMMERCIAL INSURANCE PATIENTS:
I authorize the release of any medical information necessary to process all claims and I also authorize payment of medical benefits to Urologic Associates of Allentown, PC.

PATIENT SIGNATURE:_____

INSURANCE INFORMATION

PRIMARY COVERAGE

☐ Medicare ☐ B/S ☐ MA ☐ Other ☐ Self

INSURANCE ID #: _____

INSURANCE GROUP #:_____

INSURANCE COMPANY: _____

EMPLOYER NAME:_____

ADDRESS: _____

POLICY HOLDER

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT:

☐ SELF ☐ SPOUSE ☐ PARENT OF CHILD

SECONDARY COVERAGE

☐ Medicare ☐ B/S ☐ MA ☐ Other ☐ Self

INSURANCE ID #: _____

INSURANCE GROUP #:_____

INSURANCE COMPANY: _____

EMPLOYER NAME:_____

ADDRESS: _____

POLICY HOLDER

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT:

☐ SELF ☐ SPOUSE ☐ PARENT OF CHILD

Please complete other side ➡

INSURANCE AND PAYMENT AGREEMENT

I have read and fully understand the financial policy and procedure of Urologic Associates of Allentown, PC. I acknowledge receipt of a copy of this policy. I agree to be financially responsible for services rendered.

_____ _____

Signature of Patient and/or Guardian Date

IMPORTANT NOTICE TO PATIENTS WITH MANAGED HEALTH CARE PLANS

Some patients' insurance programs fall in the category of "Managed Care" or "HMO" (Health Maintenance Organization). In most cases, these insurance plans require that you have a written or electronic referral from your primary care physician in order to be treated by one of our physicians. We are not permitted to treat the patient without this referral. This applies to repeated visits as well as most diagnostic x-rays and tests and to surgical procedures.

We will assist you with your insurance needs as best we can. Please recognize, however, that we must follow these insurance guidelines regarding your care.

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received a copy of the Privacy Notice for Urologic Associates of Allentown, PC. I have read the notice an hereby give my consent to release protected health information about me under the circumstances expressed in the written privacy notice.

_____ _____

Signature of Patient and/or Guardian Date

RELEASE OF INFORMATION DIRECTIVES

May we communicate information concerning your:

APPOINTMENTS

On your answering machine? Y N Phone: _____

On your voice mail? Y N Phone: _____

By mail? Y N Address: _____

To another person? (eg. Family Member, Doctor, etc.) Y N Name(s): _____

MEDICAL INFORMATION

On your answering machine? Y N Phone: _____

On your voice mail? Y N Phone: _____

By mail? Y N Address: _____

To another person? (eg. Family Member, Doctor, etc.) Y N Name(s): _____

I specifically do not want information released to:

_____

_____

Patient Signature: _____ Date: _____

UROLOGIC ASSOCIATES OF ALLENTOWN, PC

FINANCIAL POLICY

We are committed to providing our patients with quality health care. If a patient has health insurance, we will work to assist them in receiving the maximum allowable benefit and to fulfill their personal financial obligation to pay for co-pays, deductibles and non-covered, remaining balances. If a patient does not have health insurance, we will work with that patient with sensitivity and fairness to receive payment for our services. A system of assistance based on income and corresponding payment arrangements will be utilized to support our patients facing financial hardship meet their financial obligation to our medical practice.

PROCEDURE

Payment for services is due and expected at the time services are rendered. Questions regarding our fees and the charges associated with a patient's past, present or future care will be directed to a billing representative. We accept cash, checks, MasterCard or Visa. Patients with insurance will be asked for current and applicable insurance information each time services are performed. Our billing department staff will be available to discuss the contractual aspects of patient insurance coverage as it pertains to any remaining balance financial responsibility. Patients with insurance and facing financial hardship are encouraged to discuss terms of payment with our billing staff. Likewise, patients without insurance and facing financial hardship are encouraged to discuss terms of payment with our billing staff.

Outstanding balances that have reached 90 days past due will be turned over to a collection agency unless prior arrangements for payment have been made with our billing department. Finance charges on balances past 90 days may be applied. All collection fees and legal fees will become the responsibility of the patient. Once a patient's account is turned over to collection, a determination by the practice will be made as to whether or not the patient will be discharged from the practice and be informed to seek medical treatment elsewhere. Once informed of the decision to discharge, the patient will have 30 days to make other arrangements for continued medical care with another physician.

PATIENT COPY – PLEASE KEEP FOR YOUR RECORDS

Date _____

PATIENT MEDICAL HISTORY

UROLOGIC ASSOCIATES OF ALLENTOWN

Name _____ **Date of Birth**_____

1. WHAT IS THE REASON FOR YOUR VISIT?

_____

2. HOW LONG HAVE YOU HAD THIS CONDITION?

_____

3. WHAT TREATMENT HAVE YOU HAD FOR THIS?

_____

MEDICAL HISTORY

1. WHAT MEDICAL CONDITIONS DO YOU HAVE NOW?

_____

2. WHAT MEDICAL CONDITIONS HAVE YOU HAD IN THE PAST?

_____

_____

3. HAVE YOU EVER HAD SURGERY OR BEEN HOSPITALIZED? ☐ YES ☐ NO IF YES, LIST BELOW.

SURGERY & HOSPITALIZATIONS	FACILITY & PHYSICIAN NAME	DATE

PLEASE LIST OR PROVIDE A LIST OF YOUR CURRENT MEDICATIONS

NAME OF MEDICATION	DOSE	TIMES PER DAY

4. LIST MEDICATION ALLERGIES

_____

_____

_____

5. DO YOU SMOKE? ☐ Yes ☐ No How much?_____ (pack per day)

Have you smoked in the past? ☐ Yes ☐ No

How long? _____ The year you quit

6. DO YOU USE ALCOHOL? ☐ Yes ☐ No

If yes, how much in an average week?_____

7. DO YOU DRINK CAFFEINATED BEVERAGES? ☐ Yes ☐ No

Please complete other side ➡

FAMILY HISTORY

Has a member of your family (not related by marriage) ever had any of the following diseases? If yes, state relation to you.

1. Kidney Stone ☐ Yes ☐ No _____
2. Prostate or other Urologic Cancer ☐ Yes ☐ No _____
3. Chronic Kidney or Urinary Tract Problems ☐ Yes ☐ No _____
4. Colon or Rectal Cancer ☐ Yes ☐ No _____
5. Other Family Diseases ☐ Yes ☐ No _____

FEMALE MEDICAL HISTORY

OBSTETRICAL HISTORY: Number of pregnancies:_____ Living children:_____

GYNECOLOGICAL HISTORY:

Date of last menstrual period:_____

Are you sexually active at the present time? ☐ Yes ☐ No

Do you a cystocele/rectocele (dropped bladder/organ)? ☐ Yes ☐ No

Are you presently taking (or have in the past) estrogen hormone replacement? ☐ Yes ☐ No

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

Join 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 problems	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 _____		

UROLOGIC ASSOCIATES OF ALLENTOWN, PC

PRIVACY NOTICE

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

PLEASE READ IT CAREFULLY

Effective Date: February 1, 2003

Once you sign the consent form for Urologic Associates of Allentown, PC, we may use and disclose medical information about you in order to complete your treatment, to obtain payment for services rendered to you and to perform the operations of the practice.

Examples of how we may use and disclose information are as follows:

Uses and disclosures for treatment

- If a nurse practitioner, physician or physician assistant at the practice refers you for a cardiac stress test and needs to call the cardiologist for results, the clinician may give your name and reason for ordering the test to the cardiologist's office.
- A nurse practitioner, physician or physician assistant at the practice may call you from time to time to advise you of new alternatives to your treatment.

Uses and disclosures to obtain payment

- The practice's billing staff may submit a claim form containing your name, address, social security number, diagnoses and procedures performed in our office or other inpatient or outpatient settings to your insurance company.

Uses and disclosures to perform the operations of the practice

- The practice's nurse practitioners, physicians and physician assistants may audit (read and comment upon) your chart in order to track and improve our performance in assuring that screening test and immunizations are done on time.
- The practice's staff may mail you notices of upcoming appointments.
- We may leave a message at a telephone number you provide, asking you to return our call.

The practice may use or disclose protected health information about you for other purposes, without your consent, if we are required by law to disclose to government authorities. Examples of such uses or disclosures may include suspected domestic abuse or documented communicable diseases.

You may revoke your consent authorizing disclosure of your protected health information.

You have rights regarding your protected health information. You may:

- Request restrictions on certain uses and disclosures of protected health information, but we are not required to agree to a requested restriction.
- Request that you receive confidential communication of protected health information.
- Request to inspect and to receive a copy of your own protected health information.
- Request that your information be amended.
- Request an accounting of disclosures of protected health information made by the practice in the past six years.
- Request a paper copy of this notice.

This practice is required to act on your request within 60 days.

The practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. This practice is required to abide by the terms of this notice and to provide individuals with revisions to it.

You may complain to this practice or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint to this practice by writing to: Practice Administrator, Urologic Associates of Allentown, PC, 1240 South Cedar Crest Boulevard, Suite 310, Allentown, PA 18103.

No one will attempt to retaliate against you for filing a complaint.

For more information about this privacy notice, please contact: Compliance Officer, Urologic Associates of Allentown, PC, 1240 South Cedar Crest Boulevard, Suite 310, Allentown, PA 18103, Phone: 610-437-9988.

I have reviewed this notice and believe I understand my right to privacy as it pertains to this practice.

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