PLEASE BRING YOUR INSURANCE CARD(S) AND PICTURE ID TO BE COPIED

# Urology Specialists, P.C.

William Chapman, M.D.    Michael Brown, M.D.    James Flatt, M.D.    Keith Jiminez, M.D.

## Urochart Update

Name______________________________ Age______ Date of Birth___/___/_____ Today's Date ____/___/_____

Address_____________________ ________________ City ___________ ST_________ Zip ______________

Home Phone _________________ Cell ________ ______________ Email ____________________

Current or Former Occupation: ______________________ Retired Full Time Part Time

Primary Insurance ________________________ Holder Name __________________ Holder DOB ______________

Secondary Insurance ______________________ Holder Name __________________ Holder DOB ______________

Gender M or F    Primary Care Physician ______________________ Referring Physician ________________

Pharmacy Name: ________________________ Street Address: ________________________________

City:____________________________________ Phone Number: ________________________________

**List your MEDICATIONS & dosages.**
(including over the counter, such as aspirin):
1.____________________________________
2.____________________________________
3.____________________________________
4.____________________________________
5.____________________________________
6.____________________________________
7.____________________________________
8.____________________________________
Coumadin    Plavix

**Medication Allergies**
1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________
6. ________________________________
7. ________________________________
8. ________________________________

**Past Surgical History:** Check all operations you have had:

Cystoscopy by urologist    Hernia repair    Cancer surgery (list )
Hysterectomy - ovaries removed'    Colon removal    ____________________
Heart valve replaced    Appendectomy    ____________________
Heart bypass    Joint replacement    ____________________
Kidney stone removal    Any blood transfusions?
Other surgery (list ) ____________________________________________________

**Medical history:** Please check all conditions you have been diagnosed with and/or treated for. Give any necessary details or discuss any other conditions not listed on the following lines **OR** I have no serious medical conditions.

Diabetes    Liver disease (cirrhosis, hepatitis, etc.)    Sleep Apnea
High blood pressure    Lung disease (emphysema, bronchitis, etc.)
HIV/ AIDS    Heart disease (heart attack, congestive heart failure, etc.)
Anemia    Stroke or other vascular diseases (poor circulation, blood clots, etc.)
Cancer: Type: ______________    Sexually transmitted disease (herpes, gonorrhea, condyloma, etc.)
Kidney disease(stones,failure)    Other (Please explain) ________________________________________

**Family History:** Does anyone in your family have or previously had:
Heart disease; Diabetes; Kidney Stones; Kidney disease
Prostate cancer; other cancer, please explain:_______________

**Social History**:
Marital Status : M D S W How much alcohol do you drink? None; ____ drinks/week;
Do you smoke? No; Yes, ___ packs/day for ____ years; Smokeless Tobacco? Yes No
Quit How long did you smoke? ____ years. How much a day did you smoke? ____ Pack(s)
How much caffeine do you drink a day? ___ coffee; ___ soda; ___tea
Language: English Spanish Other ______________________
Race: White Black/African American Other______________________________
Ethnicity: Hispanic/Latino Other____________________________

Urology Specialists, P.C.

| | |
|---|---|
| William R Chapman, M.D. | James A Flatt, M.D. |
| Michael W. Brown, M.D. | V. Keith Jiminez, M.D. |

Receipt of Privacy Practices: Consent for Use/Disclosure of Protected of Health Information (PHI)

I, ______________________________________________was provided a copy of Urology Specialists' Privacy Practices Notification. Urology Specialists may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand, and agree to the terms of this consent. Further, I hereby consent and authorize Urology Specialists to use or disclose my PHI in conjunction with Urology Specialists' treatment, payment or healthcare operations in accordance with the terms of this consent.

➔ ________________________________________ ___________________________

Signature of Patient/Guardian Date

Further, I hereby authorize and give my consent to Urology Specialists to leave messages on my answering machine/voicemail/e-mail for the following: (*check all that apply*)

| | | | |
|---|---|---|---|
| Appointment Reminders | _____ | Prescription Refills | _____ |
| Medical Information | _____ | Test Results | _____ |
| Insurance/Payment Issues | _____ | Mail | _____ |

I further authorize and give consent to Urology Specialists to communicate any of my PHI to the following person/persons:

| Name | Relationship |
|---|---|
| ________________________________________ | ___________________________ |
| ________________________________________ | ___________________________ |
| ________________________________________ | ___________________________ |
| ________________________________________ | ___________________________ |

➔ ________________________________________ ___________________________

Signature of Patient/Guardian Date

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## Unpaid Co-Payment Process Fee Acknowledgment and Appointment Authorization Agreement

Our physicians hold a responsibility to recommend what treatment you may need. Any recommendations are based off of your history, any testing, labs and office exam by our office. Your physician and nurse will give you any options available for the treatment and thoroughly answer any questions you may have.

This form serves as notification of a specialist co-pay that each insurance REQUIRES Urology Specialists to collect at the time of service in the amount of _________. If you feel that this amount is incorrect and/or has changed, it is the responsibility of the patient to provide Urology Specialists' staff with the correct amount and insurance information. This co-pay amount is an estimated cost and may be more or less as will be determined by your insurance company. Also, there is no guarantee of payment for procedures and visits performed. Any denial of this will result in financial responsibility of the office visit and any procedures to fall upon the patient and will require payment of the amount in its entirety.

IF you are unable to pay Urology Specialists the co-pay as listed in your individual insurance policy today, you claim awareness to be billed for the co-pay plus an additional processing fee of $15.00* as specified in our billing process. If chronic non-payment occurs it will constitute a hold on the account and pre-payment to the account before the next visit will be scheduled.

Some insurance require a prior-authorization from the insurance company itself and the lack the authorization or referral required as noted in the individual policy will result in non-payment from the insurance company. If your insurance requires an authorization or a referral, it is THE PATIENT'S responsibility to ensure this is received in a timely fashion. Stating this, financial responsibility of the office visit and any procedures will fall upon the patient and will require payment of the amount in its entirety if a denial is received for lack of authorization. If any questions arise regarding a bill, contact Urology Specialists' billing department at 256-882-3626.

I authorize the release of any medical information necessary to process any insurance claim on my behalf. A photo-stat of this authorization shall be considered as valid as the original.

We are not part of the relationship you have with your insurance company. If your insurance company denies coverage for your benefit for any reason, you will obtain responsibility to become financially responsible for the amount due.

I understand that I am financially responsible for a fee if I no show for my appointment or cancel without giving a minimum of a business day (24 hours) notice. I also agree and understand that should I fail to give notice as instructed that the account may be subject to a $25.00 charge* for a regular appointment and $50.00 charge* for a procedure appointment. Multiple no-show or cancellations may result in dismissal from the practice.

Patients are seen in order of appointments, as much as possible. Occasionally, it may appear that someone is being seen "out of turn". This occurs because the doctors, of necessity, must spend more time in consultation with new patients, and this may affect the normal patient flow. We will try to make your wait as short as possible and your understanding is appreciated.

➔ ______________________________ ______________________
Signature of Patient/Guardian Date

*This is subject to the change and is at the discretion of the office.

Urology Specialists, PC

Michael Brown, MD ~ William Chapman, MD ~ James Flatt, MD ~ Keith Jiminez, MD

# Patient Portal

To participate, please fill out this form.

Name: ________________________________________

Date of Birth: ____________________

Email address: ________________________________

We will email you with further instructions to complete this system.

4704 Whitesburg Drive, Ste 100 Huntsville, AL 35802 256.882.3605

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Phone (256) 882-3605 Fax (256) 880-1272
Michael W Brown, M.D., F.A.C.S James A. Flatt, M.D., F.A.C.S
William R, Chapman , M.D. V. Keith Jiminez, M.D., F.A.C.S

______________________
Name of Patient

# Extra Visit History

Have you had a colonoscopy within the last 9 (nine) years? YES or NO

If so, when was it (PLEASE FILL OUT DATE) ______________

Have you ever had a pneumonia shot? YES or NO

If so, when was it (PLEASE FILL OUT DATE) ______________

I acknowledge that the above is filled out to its entirety and holds true for my medical and surgical history. If the above differs in the future, I will make the office aware at my next office visit so the appropriate changes can be made.

______________________________ ______________
Signature of Patient Date