

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

### Urology Specialists, P.C.

Michael Brown, M.D., James Flatt, M.D., Keith Jiminez, M.D., Daniel Osula, M.D., Tyler Wood, 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:** Circle 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 circle 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, PC**  
**4704 Whitesburg Drive, Suite 100**  
**Huntsville AL 35802**

**Phone (256) 882-3605**

**Fax (256) 880-1272**

**Michael W Brown, M.D., F.A.C.S**  
**M. Tyler Wood, M.D.**

**James A. Flatt, M.D., F.A.C.S**  
**V. Keith Jiminez, M.D., F.A.C.S**  
**Daniel Osula, M.D.**

\_\_\_\_\_  
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

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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 photostat 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.

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## 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.

## Urology Specialists, PC Notice of Privacy Practices

**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**

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment who may be consulted by staff members.

**Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of Urology Specialists, PC. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

**Law enforcement.** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Appointment reminders.** Your health information will be used by our staff to send you appointment reminders.

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

## **Individual Rights**

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

## **Urology Specialists, PC Duties**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

## **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

## **Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we required that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Urology Specialists, PC. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

## **Complaints and Contact Person**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address below. You will not be penalized or otherwise retaliated against for filing a complaint. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the same address. The name and address of the person you can contact for further information concerning our privacy practice is:

**Julie Hovey, Practice Manager**  
**Urology Specialists, PC**  
**4704 Whitesburg Dr S, Ste 100**  
**Huntsville, AL 35802**  
**256-882-3603**

**This notice effective September 29, 2014**