UROLOGY SPECIALISTS, P.C.

Michael W. Brown, M.D.
M. Tyler Wood, M.D.

James A. Flatt, M.D.
V. Keith Jiminez, M.D.
Daniel Osula, M.D.

NEW PATIENT INFORMATION (PLEASE PRINT & COMPLETE IN FULL) **DATE**____________

LAST NAME____________________ FIRST NAME____________________

ADDRESS____

CITY__________ STATE______ ZIP________ PHONE__________

REFERRING PHYSICIAN_______________ FAMILY PHYSICIAN_______________

BUSINESS PHONE________ CELL PHONE________ SPOUSE'S NAME__________

DATE OF BIRTH_______ SEX____ MARITAL STATUS_____ SS#__________

RACE________ ETHNICITY______________ LANGUAGE__________

E-MAIL ADDRESS____________________ EMPLOYER_______________

Name of nearest relative, <u>outside</u> your home to notify in case of emergency:

________________________ Relationship________ PHONE__________

PRIMARY MEDICAL INSURANCE CO._______________ POLICY #____________

NAME OF POLICYHOLDER_______________ RELATIONSHIP TO YOU__________

INSURED DATE OF BIRTH________ INSURED SS#__________ GROUP #__________

SECONDARY MEDICAL INSURANCE CO._______________ POLICY #____________

NAME OF POLICYHOLDER_______________ RELATIONSHIP TO YOU__________

INSURED DATE OF BIRTH________ INSURED SS#__________ GROUP #__________

PHARMACY____

***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.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

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.

SIGNED: ______________________________

I authorize payment to Urology Specialists, P.C. benefits otherwise payable to me. I understand that I am financially responsible to those indicated above for charges not covered by this authorization. I also agree that, should I fail to assume this financial responsibility and credit action is necessary. I will pay for these costs in addition to the amount of the doctor's charges.

I acknowledge and agree that Urology Specialists, P.C. and any affiliates or vender thereof, including collection or billing companies, may contact me by telephone or text message number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Urology Specialists, P.C. if I have given up ownership or control of any such telephone number.

SIGNED:______________________________

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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 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.

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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.

4704 Whitesburg Drive Huntsville, AL 35802 (256) 882.3605 Fax (256) 880-1272 2020

Initial Patient Visit -**History and Physic**

Urology Specialists, P.C.

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

Please fill out items 1-13

1. Name ______________________ **Age** _____ **Date of Birth** ___/___/___ **Today's Date** ___/___/___

2. History of Present Illness: (location, quality, severity, duration timing). State the reason(s) you are seeing a urologist. How long has this problem(s) been going on?

____

HPI: For Physician Use Only (Backslash = negative)

___ Freq ______
___ Urg ______
___ Noct ___ x ______
___ Dysuria ______
___ Incontinence ___ pads/day ______
___ Obst sx's: straining dribbling intermittency split stream

3. Genitourinary History / ROS: Check if you now have or have had any of the following:

- ☐ Blood in your urine
- ☐ Leaking urine
- ☐ Painful Urination
- ☐ Pain over your bladder
- ☐ Passage of kidney stones: number ___
- ☐ Catheter placed b/c of inability to urinate
- ☐ Sexual Dysfunction

4. 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**
- ☐ **High blood pressure**
- ☐ **HIV/ AIDS**
- ☐ **Anemia**
- ☐ **Cancer (list what type below)**
- ☐ **Other (Please explain below)**
- ☐ **Kidney disease**
- ☐ **Kidney stones**
- ☐ **Kidney failure**
- ☐ **Emphysema**
- ☐ **Bronchitis**
- ☐ **Lung disease other**______
- ☐ **Heart disease**
- ☐ **Heart attack**
- ☐ **Congestive heart failure**
- ☐ **Stroke or other vascular disease**
- ☐ **Poor circulation**
- ☐ **Blood clots**
- ☐ **Sexually transmitted disease**
- ☐ **Herpes**
- ☐ **Gonorrhea**
- ☐ **Condyloma**
- ☐ **Liver disease**
- ☐ **Cirrhosis**
- ☐ **Hepatitis**

______________________ (If unchecked then PMHx is normal)

5. Pregnancy History: ___ No. of pregnancies: ___ No. of vaginal deliveries ___ No. of Caeserean sections

6. Are you ALLERGIC to any medications?

____

☐ I have no known medication allergies

7. List your MEDICATIONS & dosages. (including over the counter, such as aspirin):

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______

☐ Coumadin ☐ Plavix

8. Past Surgical History: Check all the operations you have had:

- ☐ Cystoscopy by urologist
- ☐ Hysterectomy - ovaries remain
- ☐ Hysterectomy - ovaries removed
- ☐ Heart valve replaced
- ☐ Heart bypass
- ☐ Kidney stone removal
- ☐ Any blood transfusions?
- ☐ Hernia Repair
- ☐ Colon removal
- ☐ Appendectomy
- ☐ Joint replacement
- ☐ Other cancer surgery (list below)
- ☐ Other surgery (please explain) ______

9. Social History:

Occupation: ______
Do you smoke? ☐No; ☐Yes, ___ packs/day for ___ years; ☐ Quit
How much alcohol do you drink? ☐None; ___ drinks/week;
How much caffeine do you drink a day? ___ coffee; ___ soda; ___ tea

10. Family History: Does anyone in your family have:

☐ Heart disease; ☐ Diabetes; ☐ Kidney stones; ☐ Kidney disease
☐ Prostate cancer; ☐ other cancer, please explain: ______

11. Review of Systems - Check if you now have or have had any problems related to the following systems: (if unchecked then normal)

Constitutional Symptoms	Psychologic	Musculoskeletal	Neurological	Eyes	
☐ Weight loss ☐ Weight gain ☐ Fever	☐ Depression ☐ Anxiousness	☐ Joint pain	☐ Stroke	☐Glaucoma ☐Cataract	
Gastrointestinal ☐ Abdominal pain ☐ Nausea/vomiting	**Cardiovascular** ☐ Chest pain ☐ Irregular heartbeat	**Respiratory** ☐ Shortness of breath ☐ Asthma	**Hematologic** ☐ Blood clotting problems		☐ ROS reviewed with pt --no significant findings

Urology Specialists, P.C. **H&P page II** Patient Name________________ Chart # ________

Pert

12. AUA symptom score

Circle the number that best describes your voiding symptoms over the past month:	Not at All	<1 in 5	Less than 1/2 the time	1/2 the time	More than 1/2 the time	Almost always	
1. How often have you had a sensation of not emptying your bladder completely?	0	1	2	3	4	5	Inad empt
2. How often have you had a weak urinary stream?	0	1	2	3	4	5	Weak str
3. How often have you had to push or strain to begin urination?	0	1	2	3	4	5	Straining
4. How often have you had to stop and start again when you urinate?	0	1	2	3	4	5	Intermit.
5. How often have you had to urinate less than 2 hours after you finish urinating?	0	1	2	3	4	5	Freq.
6. How often have you found it difficult to postpone urination?	0	1	2	3	4	5	Urg.
7. How many times do you typically get up to urinate at night?	0	1	2	3	4	5	Noct.
					SUM ____		

13. Who referred you to Urology Specialists? ________________

☐ Check if self referred

**** For Physician use only below this line****

T______ Wt______lbs.
P______ BP______/______

pH	Glu	Pro	Nit	Bld	L.E.
SG	Ket	Epi	Bact	RBC	WBC

PE (check if normal or no abnormality; circle if abnormal and describe)

Constitutional ☐ Gen appear- normal ☐ Vital signs reviewed
Skin ☐ Inspection/palpation — Neck ☐ Normal
Neurologic ☐ Orientation — Lymphatic ☐ No abnorm. in neck and groin
Respiratory ☐ Effort normal ☐ Ausc - no abn.
CV ☐ Reg rate and rhythm ☐ Ausc - no abn.

GI ☐ Abd soft and nontender ☐ Liv/Kid/Spln nonpalpable
☐ No hernia ☐ Stool specimen not indicated

GU Male
- ☐ Urethral meatus
- ☐ Penis ____circ ____ uncirc
- ☐ Testes/ Scrotum
- ☐ Epididymis; ☐ cyst
- ☐ Anus/perin
- ☐ Sphincter tone
- ☐ Sem. Ves.
- ☐ Prostate ( )
- Smooth, no nodules
- 1+ 2+ 3+

GU Female
- ☐ Ext genitalia
- ☐ Urethral Meatus
- ☐ Urethra
- ☐ Vagina
- ☐ Cervix ☐ absent
- ☐ Uterus ☐ absent
- ☐ Bladder
- ☐ Anus/perin
- ☐ Rectal

Notes / Abnormalities:

☐ Bl Scan: ______ cc (PVR)
☐ KUB: ________
☐ No Ca++ or abnorm. noted

IMPRESSION:
1.
2.
3.
4.

PLAN:
1.
2.
3.

Rx: ________ Samples given: ________

Labs
- ☐ Urine Cx
- ☐ Cytol
- ☐ PSA
- ☐ PSA II
- ☐ BUN / cr
- ☐ Testost

Imaging
- ☐ IVP
- ☐ CT UTS
- ☐ Renal US

Procedures Planned
- ☐ Cysto
- ☐ Prostate biopsy

☐ New Pt ☐ Consult | I II III IV V | Time: ____ min | ☐ Chapman ☐ Brown ☐ Flatt ☐ Jiminez

☐ Dictated Note ☐ Dictated Letter to Dr.____________ Physician Signature ________________

Urology Specialists, PC
4704 Whitesburg Drive, Suite 100
Huntsville AL 35802
Phone (256) 882-3605 **Fax (256) 880-1272**
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____
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

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