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

Urology Specialists, P.C. **Annual Urochart Update**

V. Keith Jiminez, M.D., F.A.C.S., M. Tyler Wood, M.D., Daniel Osula, M.D., Kyle H. Gennaro, M.D., Dustin Whitaker, M.D., Christine Wood, CRNP, Carmen Herring, CRNP

Name _____ **Date of Birth** _____/_____/_____ **Today's Date** _____/_____/_____

Address _____ **City** _____ **ST** _____ **Zip** _____

Home Phone _____ **Cell** _____

Email _____ **Gender** ☐ Male ☐ Female

Emergency Contact _____ **Phone** _____

Emergency Contact's Relationship to You _____

Primary Insurance _____

Holder's Name _____

Holder's DOB _____/_____/_____

Secondary Insurance _____

Holder's Name _____

Holder's DOB _____/_____/_____

FAMILY DOCTOR _____ **Referring Doctor** _____

PHARMACY _____ **Location** _____

List any Medication Allergies: _____

_____

_____

Are you allergic to Iodine / Contrast Dye?

☐ Yes ☐ No

List your MEDICATIONS & dosages (include anything over the counter): _____

_____

_____

_____

_____

_____

_____

_____

_____

Are you currently taking any blood thinners?

☐ Aspirin ☐ Coumadin (Warfarin) ☐ Eliquis (Apixaban) ☐ Plavix (Clopidogrel) ☐ Other: _____

Name _____ **Date of Birth** _____/_____/_____ **Today's Date** _____/_____/_____

Check all operations you have had:

☐ Cystoscopy by urologist ☐ Heart valve replaced ☐ Appendectomy

☐ Kidney stone removal ☐ Hernia repair ☐ Hysterectomy – ovaries removed? ☐ Yes ☐ No

☐ Pacemaker ☐ Joint replacement ☐ received colonoscopy within last 9 years

☐ Heart bypass ☐ Colon removal ☐ received pneumonia vaccine

☐ Cancer surgery (list): _____

☐ Other surgery: _____

_____

Check all conditions you have been diagnosed with and/or treated for:

☐ Kidney disease, stones, failure ☐ Anemia

☐ Liver disease (cirrhosis, hepatitis, etc.) ☐ Type 1 Diabetes

☐ Lung disease (emphysema, bronchitis, etc.) ☐ Type 2 Diabetes

☐ Heart disease, heart attack, congestive heart failure, etc. ☐ High blood pressure

☐ Stroke or other vascular diseases, poor circulation, blood clots, etc. ☐ HIV / AIDS

☐ Sexually transmitted disease (herpes, gonorrhea, condyloma, etc.) ☐ Sleep Apnea

☐ Cancer (type): _____

☐ Other (please explain): _____

_____

☐ I have no serious medical conditions

Does anyone in your family have or previously had:

☐ Heart disease ☐ Diabetes ☐ Kidney stones ☐ Kidney disease ☐ Prostate cancer

☐ Other cancer: _____

Marital Status:	**Do you smoke?**	**Smokeless Tobacco?**
☐ Married ☐ Single ☐ Divorced ☐ Widowed	☐ Yes, _____ packs/day for _____ years ☐ Quit, _____ packs/day for _____ years ☐ No	☐ Yes ☐ No

How much caffeine do you drink a day?	**Do you drink alcohol?**	**Any blood transfusions?**
_____ coffee _____ soda _____ tea	☐ Yes, _____ drinks/week ☐ No	☐ Yes ☐ No

Race:	**Ethnicity:**	**Language:**
☐ White	☐ Hispanic/Latino	☐ English
☐ Black/African American	☐ Other: _____	☐ Spanish
☐ Other: _____		☐ Other: _____

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 / Guardian Date

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UROLOGY SPECIALISTS, P.C.

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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: *(please check all that apply)*

☐ Appointment Reminders	☐ Insurance/Payment Issues	☐ Test Results
☐ Medical Information	☐ Prescription Refills	☐ Mail

I further authorize and give consent to Urology Specialists to communicate any of my PHI to the following person(s):

Name	Relationship to you
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

→ _____ _____
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. 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. 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.

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. 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 acknowledge and agree that Urology Specialists, P.C. and any affiliates or vendor 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.

→ _____ _____

Signature of Patient/Guardian Date

A "no show" is someone who misses an appointment without canceling it 24 hours prior to their scheduled appointment time. "No shows" inconvenience those individuals who need access to medical care in a timely manner. I acknowledge and agree that a failure to appear at the time of a scheduled appointment will be recorded in my medical chart as a "no show." An administrative fee of $25.00* will be billed to my account for a routine follow up. A $50.00* administrative fee will apply to procedural visits, such as a biopsy, cystoscopy, vasectomy or any in office surgical visit. I acknowledge and agree that "no show" charges are my responsibility and will not be billed to my insurance company.

→ _____ _____

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 Agreement

The Patient Portal is a way to view and maintain your health information online in a secure environment shared between you and your urologist.

With the Patient Portal, you can:

- Update your address, insurance, and choose a preferred pharmacy to receive your prescriptions
- Update your allergy, medication, and personal history information
- View documentation sent by your urologist such as education material and lab results
- Communicate with your urologist online about future appointments or questions you may have (Messages are only monitored during normal business hours)

Usage of the Patient Portal is voluntary. To participate, please fill out your information below:

Full Name:
_____

Date of Birth:
_____

Email Address:
_____

We will send you an email with further instructions to complete this system. The temporary password provided in this email will expire after 72 hours; please contact our office if you need the password reset.

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