UROLOGY SPECIALISTS, P.C.

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

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

LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

REFERRING PHYSICIAN _____ FAMILY PHYSICIAN _____

HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ GENDER _____ MARITAL STATUS _____ SPOUSE'S NAME _____

RACE _____ ETHNICITY _____ LANGUAGE _____ SS# _____

E-MAIL ADDRESS _____ EMPLOYER _____

Name of nearest relative, outside 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 # _____

Please list any blood thinners you are currently taking, such as Aspirin, Coumadin (Warfarin), Eliquis (Apixaban), or Plavix (Clopidogrel): _____

PHARMACY _____ LOCATION _____

***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: *(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, P.C.
4704 Whitesburg Drive, Suite 100
Huntsville AL 35801
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 years? ☐ Yes ☐ No

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

Have you ever had a pneumonia shot? ☐ Yes ☐ 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, P.C. Initial Patent Visit – History and Physical, page II

Patient Name _____ Date _____/_____/_____ Chart # _____

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	
How often have you had a sensation of not emptying your bladder completely?	0	1	2	3	4	5	Inad empt
How often have you had a weak urinary stream?	0	1	2	3	4	5	Weak Str
How often have you had to push or strain to begin urination?	0	1	2	3	4	5	Straining
How often have you had to stop and start again when you urinate?	0	1	2	3	4	5	Intermit.
How often have you had to urinate less than two hours after you finish urinating?	0	1	2	3	4	5	Freq.
How often have you found it difficult to post-pone urination?	0	1	2	3	4	5	Urg.
How many times do you typically get up to urinate at night?	0	1	2	3	4	5	Noct.
				SUM: _____			

Primacy Care Physician: _____ **Pharmacy:** _____

**** * FOR PHYSICIAN USE ONLY BELOW THIS LINE * ****

Temperature _____ Height _____ Weight _____ P _____ BP _____ / _____

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:

☐ BI Scan: _____ cc (PVR) ☐ KUB: _____

IMPRESSION:

1. _____
2. _____
3. _____
4. _____
5. _____

Labs

- ☐ Auto UA
- ☐ Urine Cx
- ☐ Cytol
- ☐ PSA
- ☐ Testost
- ☐ BUN/cr
- ☐ H&H
- ☐ LFT

PLAN:

1. _____
2. _____
3. _____
4. _____
5. _____ **E&M Code:** _____

Urology Specialists, P.C. Initial Patent Visit – History and Physical, page I

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

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_____
_____Dysturia_____
_____Incontinence_____pads/day_____
_____Obst sx's: straining dribbling intermittency split stream

List any Medication Allergies: _____

_____
_____

Are you allergic to Iodine / Contrast Dye? ☐ Yes ☐ No

Your MEDICATIONS & dosages (include anything over the counter):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you currently taking any blood thinners?

☐ Aspirin ☐ Coumadin (Warfarin) ☐ Eliquis (Apixaban) ☐ Plavix (Clopidogrel)

☐ Other blood thinner: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you smoke or use tobacco products?
☐ Yes, _____ packs/day for _____ years
☐ Quit, _____ packs/day for _____ years
☐ No

Do you vape?
☐ Yes
☐ No

Do you drink alcohol?
☐ Yes, _____ drinks/week ☐ No

Any blood transfusions?
☐ Yes ☐ No

How much caffeine do you drink a day?
_____ coffee _____ soda _____ tea

Race:
☐ White
☐ Black/African American
☐ Other: _____

Ethnicity:
☐ Hispanic/Latino
☐ Other: _____

Language:
☐ English
☐ Spanish
☐ Other: _____

Check all operations you have had:

- ☐ Cystoscopy by urologist
- ☐ Kidney stone removal
- ☐ Pacemaker
- ☐ Heart bypass
- ☐ Heart valve replaced
- ☐ Hernia repair
- ☐ Joint replacement
- ☐ Cancer surgery (list): _____
- ☐ Colon removal
- ☐ Appendectomy
- ☐ Hysterectomy (ovaries remain)
- ☐ Hysterectomy (ovaries removed)
- ☐ received colonoscopy within the last nine years
- ☐ received pneumonia vaccine
- ☐ Other surgery (please explain): _____

Pregnancy History:

No. of pregnancies:	No. of vaginal deliveries:	No. of c-sections:
_____	_____	_____

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

- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Liver disease
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Lung disease
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Heart disease
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Cancer (type): _____
- ☐ Stroke or other vascular diseases
- ☐ Poor circulation
- ☐ Blood clots
- ☐ Sexually transmitted disease
- ☐ Herpes
- ☐ Gonorrhea
- ☐ Condyloma
- ☐ Anemia
- ☐ Type 1 Diabetes ☐ Type 2 Diabetes
- ☐ High blood pressure
- ☐ HIV / AIDS
- ☐ Sleep Apnea
- ☐ Other (please explain): _____

☐ I have no serious medical conditions

Does anyone in your family have or previously had:

☐ Heart disease ☐ Kidney stones ☐ Prostate cancer
☐ Diabetes ☐ Kidney disease
☐ Other cancer: _____

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

Genitourinary History:
- ☐ 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

Psychologic: ☐ Depression, ☐ Anxiousness
Musculoskeletal: ☐ Joint pain
Neurological: ☐ Stroke
Eyes: ☐ 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