Accurate Urology
1234 S. Power Road, Ste 102
Mesa, AZ 85206
Phone 480-380-7897
Fax 480-380-9509

Date _____

_____

Prefix Last Name First Name Suffix

Gender M F Date of birth _____ SSN _____- _____-_____

Best contact number: _____ Home Mobile Other

Email _____

Address: _____

Street APT/LOT City State Zip

Primary Care Physician _____

Previous Urologist (If applicable) _____

Pharmacy: _____ Address: _____

Phone _____ Mail order Pharmacy: _____

Occupation: _____ Employer: _____

Ethnicity: Non-Hispanic Hispanic Not specified

Preferred language: _____

Race: American Indian or Alaska Native Hispanic or Latino Asian Black or African American Native Hawaiian or other Pacific Islander White

INSURANCE INFORMATION

Primary Insurance: _____

Policy ID _____ Policy Group Number _____

Cardholder name: _____ Relationship: self spouse parent

Copayment for specialists $_____

Secondary Insurance: _____

Policy ID _____ Policy Group Number _____

Cardholder name: _____ Relationship: self spouse parent

Copayment for specialists $_____

IN CASE OF EMERGENCY

_____

Local friend or relative Relationship Home Number Cell Number

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Accurate Urology. I understand that I am financially responsible for my balance. I also authorize Accurate Urology and/or my insurance company to release any information required to process my claims.

Signature _____ Date _____

PATIENT HISTORY

DOB: _____ Today's Date: _____

Last Name: _____ First Name: _____

WHY ARE YOU HERE TO SEE US?

_____

MEDICATIONS: List current medications including over-the-counter, vitamins, herbs

Medication	Dose	Frequency	Medication	Dose	Frequency

ALLERGIES: Please circle/list all that apply

NONE Penicillin Sulfa Codeine Iodine IV dye Morphine Demerol Latex Other _____ _____ _____

MEDICAL HISTORY: (Please circle)

Diabetes High blood pressure Heart disease COPD Stroke Thyroid disease Hepatitis Asthma Fibromyalgia Migraine Endometriosis Depression Anxiety Seizure Disorder Parkinson's Multiple Sclerosis Glaucoma Arthritis Gout Anemia Atrial Fibrillation Diverticulosis

COVID19? If yes, when tested: _____ results: Positive Negative

Cancer? If yes, type: _____ date of diagnosis? __ _____

UTI? If yes, last UTI _____ How many in the past 12 months? _____

Other _____

SURGICAL HISTORY: (Please circle)

Kidney/Bladder Stones Prostate Kidney Hernia Repair Appendectomy Gallbladder Heart Bypass Hysterectomy Ovaries removed? Y N C-Section Tonsillectomy Vasectomy Shoulder Repair Pacemaker Breast Cataracts

Total Joint Replacement: Knee R L Hip R L Arthroscopy R Knee L Knee

Other _____

SOCIAL HISTORY:

Single Married # of Years _____ Divorced Separated Widowed

Children? YES How many? _____ NO

Occupation _____ Retired- Previous occupation? _____

Do you: Exercise Walk Run Weights Go to the gym Other: _____

Do you consume caffeine? NO YES Type_____ Cups _____ Cans _____

Do you consume alcohol? Occasionally 1-2 Drinks per day 3 or more drinks per day None

Do you smoke? NO YES # of packs per day _____ for how long? _____ Cigars Chew

Former smoker, quit since _____

Any previous or current drug use? NO YES **PREVIOUS CURRENT** (Please circle)

Meth Cocaine Marijuana Heroin Prescription Drugs Opioids

Patient Name: _____

FAMILY HISTORY:

Father: alive? YES age _____ NO age at death _____ Mother: alive? YES age _____ NO age at death _____

Does anyone in your family have?

Prostate Issues? If yes, who? _____

Cancer? If yes, Type _____ who? _____

Diabetes? If yes, who? _____

Heart disease? If yes, who? _____

Stroke? If yes, who? _____

High blood pressure? If yes, who? _____

Kidney disease/stones? If yes, who? _____

Other? _____ who? _____

REVIEW OF SYMPTOMS: (Circle only those that apply to you **NOW**)

CONSTITUTIONAL

fever unexplained weight loss

chills night sweats fatigue

Other _____

EYES

blurry vision double vision

glaucoma cataracts

other _____

GASTROINTESTINAL

abdominal pain nausea vomiting

blood in stool indigestion/heartburn

other _____

ALLERGIC/IMMUNOLOGIC

runny nose hives

swollen glands food allergies

other _____

MUSCULOSKELETAL

joint pain neck pain

back pain walker wheelchair

other _____

EAR/NOSE/THROAT

sore throat sinus infection

ear infection hearing loss

ringing in ears

other _____

RESPIRATORY

wheezing cough

shortness of breath

other _____

NEUROLOGICAL

tremors stroke dizzy spells

vertigo headache

other _____

ENDOCRINE

excessive thirst too hot/too cold

tired sluggish

other _____

CARDIOVASCULAR

chest pain palpitations ankle swelling

irregular beats varicose veins

other _____

GENITOURINARY

incontinence # of pads/day _____

blood in urine painful urination frequent infections

other _____

SEXUAL HEALTH

MEN-

erectile dysfunction painful sex

testicle/ scrotal lumps

premature ejaculation blood in semen

WOMEN-

irregular periods heavy bleeding

vaginal odor discharge

yeast infections menopause painful sex

last menstrual period _____ miscarriage

# of pregnancies ____ # of children _____

PSYCHIATRIC

depression anxiety thoughts of suicide

Gender Identity: Male Female Transgender Female-to-Male Transgender Male-to-Female

Other (please specify) _____ Decline to answer

Sexual Orientation: Straight/Heterosexual Lesbian Gay Bisexual Other _____ Decline to answer

Patient Name: _____ Date completed _____

In the past month:	Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started while urinating?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urinating?	0	1	2	3	4	5	
7. Nocturia How many times do you typically get up per night to urinate?	0	1	2	3	4	5	
Total Score							

Score: 1-7: Mild 8-19: Moderate 20-35: Severe

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

ACCURATE UROLOGY

PRACTICE FINANCIAL POLICY

If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policy.

CO-PAYMENTS AND DEDUCTIBLES: These payments must be made either at time of service or at check-in. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients is considered a violation of contract. Please help us uphold our contracts by making your co-payments at each visit and paying deductibles owed at the beginning of the year (Including Medicare deductibles and 20% co-insurance).

CLAIM SUBMISSION: As a courtesy to you, we will process and file your insurance claims for services rendered by our Practice. Your insurance company may need additional information from you to process a claim, and it is your responsibility to comply with this request. If your insurance company has not paid your claim within 60 days, the balance becomes your responsibility. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

NON-COVERED SERVICES: Not all services are covered by insurance; they vary from contract to contract. Some insurance companies arbitrarily select certain services they will not cover or which they may consider not medically necessary. In these instances, you will be responsible for the cost of these services. We will make every effort to ascertain your coverage for our services before treatment and make you aware of findings. However, this does not guarantee payment from your insurance carrier.

For services that are not covered by your insurance, the Practice requires payment of 100% of the total charges at the time of service unless prior arrangements have been made.

COVERAGE CHANGES: If your insurance changes, please notify us as soon as possible so that we can update our records and help you receive the maximum benefits allowed under your coverage. If you are insured by a plan that we accept but you do not have a current insurance card, payment is expected in full at the time of service until we can verify your coverage.

NONPAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full or make payment arrangements with us. Please be aware that if your balance remains unpaid, we reserve the right to refer your account to a collection agency, and your account will become inactive until paid. Account balances turned over to a collection agency will accrue interest at the rate of 16% per annum, or 1.33% per month after 90 days. If your account is turned over to an attorney or pursued legally for collection, you will be responsible for all reasonable attorney's fees, filing fees, and service fees.

All returned checks are subject to a $40.00 fee. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Our Practice is committed to providing quality medical care. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our financial policies. Please let us know if you have any questions or concerns about the above information or any uncertainty regarding your insurance coverage.

We are here to help!

PLEASE READ THE ABOVE FINANCIAL POLICY CAREFULLY BEFORE SIGNING.

I hereby authorize photocopies of this form to be as valid as the original.

SIGNATURE: _____ DATE: _____

ACCURATE UROLOGY

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I consent to the use of my Protected Health Information (PHI) by Accurate Urology (AU) for purposes of Treatment, Payment, and Health Care Operations as described in the Notice. I understand that this consent remains in effect until I rescind it. I have the right to revoke my consent in writing at any time, but any such revocation does not apply to uses or disclosure before the effective date of the revocation. I understand I have the right to request restrictions in how my PHI is used or disclosed to carry out Treatment, Payment, and Health Care Operations, but that AU is not required to agree with or grant those requests.

The Notice of Privacy Practices for Accurate Urology is posted in the office and on the practice website, www.accurateurology.com. If desired, patients may ask for a copy of Privacy Practices.

To assist us in maintaining confidentiality when calling about your test results or similar PHI, please complete this form indicating how we may contact you regarding such information.

HIPPA guidelines prohibit us from leaving a confidential message with your spouse, family member, or friend without your written permission, therefore, you may wish to designate a specific individual (one person only) with whom we may use our discretion to discuss your PHI under limited circumstances. Ideally, that person should be the individual who would assume responsibility for your health care decisions in the event you became incapacitated (i.e. your legal "next of kin" – spouse, parent, eldest child, guardian, etc).

At which phone numbers may we contact you?

_____

Home Work Cell Other (please specify)

I give permission for AU to use its discretion in disclosing my PHI to the following individual (limited to one person):

_____ _____ _____

Your designee's printed name Relationship Telephone

Or,

_____ I do not want my PHI discussed with anyone other than myself.

The AU Notice of Privacy Practices is subject to change and revision from time to time. Any such changes will be posted in our office, or on our web site, as of the effective date.

I hereby acknowledge all of the above:

_____

Printed Name

_____

Signature of patient or personal representative

_____ _____

Relationship of personal representative to patient Date

James Cord, MD
Peter J. Matthews, MD
James Slonaker, ACNP-BC
1234 S. Power Road, Suite 102
Mesa, AZ 85206
Ph # 480-380-7897
Fax # 480-380-9509

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize _____
(Place from which we will obtain records)

To release healthcare information of the patient named above to:

Accurate Urology
1234 S. Power Road, Suite 102
Mesa, AZ 85206
Fax: 480-380-9509

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, conditions, or dates:
  _____
  _____
- ☐ All healthcare information
- ☐ Other:
  _____
  _____

Patient Signature: _____ Date signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.