ACCURATE UROLOGY

10238 E. Hampton Ave. Ste. 402
Mesa, AZ 85209
Ph # 480-380-7897
Fax # 480-380-9509

Date _____

_____ S M D W P
LAST FIRST MIDDLE Sr. / Jr.

Date of Birth _____ Gender M F Age _____ SSN# _____

E-mail Address _____

Phone: Home _____ cell _____ work _____

_____
STREET APT / LOT # CITY STATE ZIP

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Not specified **Preferred language:** _____
Race: ☐ African or African American ☐ Asian or Asian American ☐ Caucasian ☐ Native American or Alaskan
☐ Native Hawaiian or other Pacific Islander ☐ Other Race

Primary Care Physician: _____ Phone: _____

Local pharmacy _____ cross streets _____ Phone: _____

Mail order pharmacy: _____ Phone: _____ fax: _____

Occupation _____ Employer _____

How did you find us: PCP Insurance Hospital Yellow pages other _____

INSURANCE INFORMATION

Name of **Primary** Insurance: _____
Cardholders Name: _____ Relationship to patient: self spouse parent
Policy ID # _____ Group # _____
Co-payment for specialist: $_____
Name of **Secondary** Insurance: _____
Cardholders Name: _____ Relationship to patient: self spouse parent
Policy ID # _____ Group # _____
Co-payment for specialist: $_____

IN CASE OF EMERGENCY

_____
LOCAL FRIEND OR RELATIVE RELATIONSHIP HOME # CELL #

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

Today's Date:_____ Primary Physician:_____
Last Name:_____ First Name:_____
Social Security #:_____
Date of Birth:_____ Age:_____

WHY ARE YOU HERE TO SEE US? _____

HAVE YOU EVER HAD:

Urinary infection? ---------- yes no
Kidney stones? ----------yes no
Prostate disorder? ----------yes no
Surgery on kidneys, bladder, genital organs? yes no
Blood, pus, protein, sugar in urine? ---- yes no
Venereal disease: ----------yes no
Previous x-ray/ultrasound/CT scan of kidneys? yes no

MEDICATIONS:

List current medicines (including over-the-counter, vitamins, herbs)

MEDICINE DOSE FREQUENCY

_____
_____
_____
_____
_____
_____
_____

MEDICATIONS: cont.

MEDICINE DOSE FREQUENCY

_____
_____
_____

ALLERGIES: 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 cancer type_____ asthma fibromyalgia migraine
endometriosis depression anxiety seizure disorder Parkinson's
multiple sclerosis glaucoma arthritis gout anemia
atrial fibrillation diverticulosis
Other _____

SURGICAL HISTORY (please circle) NONE

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 Partnered
Children? NO YES how many? _____
Occupation _____ Retired- prior occupation _____
Do you: exercise walk run weights go to a gym Other _____
Do you drink alcohol? NO occasionally 1 – 2 drinks/day 3 or more/day
Do you smoke? NO YES # packs/day_____ for how long?_____ cigars chew
former smoker, quit since_____
Previous drug or alcohol dependence? NO YES
Meth Cocaine Marijuana Heroin Prescription drugs

FAMILY HISTORY: ***Your Name:*** _____

Does anyone in your family have:

Cancer? Yes type _____ who? _____
Diabetes? Yes who? _____
Heart disease? Yes who? _____
Stroke? Yes who? _____
High blood pressure? Yes who? _____
Kidney disease/stones? Yes who? _____
other? _____ who? _____

Father
alive? YES age____ NO age @ death? _____
cause of death? _____

Mother
alive? YES age_____ NO age @death ____
cause of death _____

REVIEW OF SYSTEMS
(Circle only those that apply to you <u>now</u>)

CONSTITUTIONAL
fever unexplained wt 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 the 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
Urinary frequency urgency
Getting up at night 1 2 3 4 5+
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

Accurate Urology

PRACTICE FINANCIAL POLICY

If you have medical insurance, we are anxious 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 and fraud. Please help us uphold the law 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 compliay with their 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 companied arbitrarily select certain services they will not cover or which they may consider not medically necessary. In these instances, you will be responsible for these services. We will make every effort to ascertain your coverage for our services before treatment and make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

For services that are not covered by insurance, the Practice requires payment of 100% of the total charges at 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 $30.00 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 acknowledge that I have received a copy of the Notice of Privary Practices for Accurate Urology, or have been informed that the Notice is posted in the offices and on the practice web site www.accurateurology.com.

I consent to the use of disclosure 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 occurring 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.

To assist us in maintaining confidentiality when calling about your test results or similar PHI, please complete this form indicating where 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 _____ _____ (Indicate home,

may we contact you: _____ _____ cell, work, etc)

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

_____ 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 posed 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
Michael A. Chasin, MD
Katrina Steinberger, NMD
10238 E. Hampton Ave. Ste. 402
Mesa, AZ 85209
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
10238 E. Hampton Avenue, Suite 402
Mesa, AZ 85209
FAX: 480-380-9509

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.