Urology Group of Princeton

Last Name	**Type of Insurance (circle):** **Medicare HMO/PPO/POS Other**	
First Name, Middle initial	**Person Responsible for bill (circle):** **Self Parent Other**	
Street Address		**Date of Birth**
City, State	**Referring Doctor**	**Family Doctor**
Zip Code	**Patient Occupation**	
Social Security # (Parent or Guardian)	**Name & Address of Employer**	
Home Telephone ( ) **Leave detailed message Yes No**	**Pharmacy, Location & Phone #**	
Cell Telephone ( ) **Leave detailed message Yes No**	**Emergency Contact Name** **Phone # ( )**	
Work Telephone ( )		
E-Mail	**Drivers License #**	
Gender (circle): Male Female **Marital Status (circle): S M D W**	**Spouse's Name .Number of Children**	

Primary Insurance Co.	**Secondary Insurance Co.**	**Tertiary Insurance Co.**
Name of Primary Insured	**Primary Insured Date of Birth**	**E-mail Address**

Do you have a living will? Yes No Do you want information regarding a living will? Yes No

- I hereby extend authorization for myself or the above named patient to be seen, examined and treated by the Urology Group of Princeton physicians and staff as indicated by the standard of Urologic practice.
- I hereby authorize the release of medical information to my referring physician

_____ _____
Signature of Patient or Responsible Party Print Name of Patient

_____ _____
Relationship/Authority of Responsible Date

Patient Medical Information

Explain briefly what brought you to the office to see the doctor today:

What is your approx Height? _____Ft. _____Inches Approx Weight? _____Lbs.

Genito-Urinary History	Not at All	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
Incomplete Emptying - Over the past few months how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Intermittency - Over the past month how often have you found you stopped and started again several times during urinating?	0	1	2	3	4	5
Urgency - Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Frequency — Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Weak Stream — Over the past month, how often have you had a weak urinary stream?	0	I	2	3	4	5
Straining — Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Nocturia — How many times do you typically get up at night to urinate, from the time you go to bed until the time you get up in the morning?	0 times	1 time	2 times	3 times	4 times	5 times

Total Score _____

If you were to spend the rest of your life with your voiding condition just the way it is now, how would you feel about that? (circle):

Delighted Pleased Mostly Satisfied Mixed Most Dissatisfied Unhappy Terrible

Do you have leakage of urine? Yes No

How many pads do you use each day (if applicable) _____

Do you have:

A history of bladder, kidney, or prostate infections? Yes No
A history of blood in the urine? Yes No
A history of kidney stones? Yes No
Difficulty or dissatisfaction with sexual function? Yes No
A history of HIV/Veneral Disease? Yes No

Please review the following and check off any symptoms that have affected your current and prior health. If you have not experienced symptoms in a particular system check "negative".

Constitutional: □ Weight Loss/Gain □ Fatigue □ Fever/Chills, Sweats □ Other □ Negative	**Psychiatric:** □ Depression □ Anxiety □ Other □ Negative
Eyes: □ Blurry Vision/glasses □ Cataracts □ Glaucoma □ Other □ Negative	**Gastrointestinal:** □ Nausea/Vomiting □ Diarrhea/Constipation □ Blood in Stool □ Other □ Negative
Ears/Nose/Mouth/Throat: □ Ringing in Ears/Hearing Loss □ Nasal Discharge/Bleeding □ Sore Throat □ Other □ Negative	**Gynecologic: (Woman only)** □ Menopause/ Abnormal Menses □ Breast Lump □ Vaginal Discharge/Problems □ Other □ Negative
Cardiovascular: □ Irregular Heartbeat □ Chest Pain (Angina)/Heart Attack □ Heart Murmur/Valve Problem □ Elevated Cholesterol □ Hypertension/High Blood Pressure □ Other □ Negative	**Respiratory:** □ Cough □ Shortness of Breath □ Wheezing □ Other □ Negative
Musculoskeletal: □ Joint Pain/Arthritis □ Low Back Pain □ Other □ Negative	**Endocrine:** □ Diabetes □ Thyroid Disease □ Adrenal Disease □ Erectile Dysfunction/Loss of Libido □ Other □ Negative
Skin: □ New Skin Lesion □ Rash/Dry Skin □ Skin Cancer □ Other □ Negative	**Hematological:** □ Easy Bruising/Bleeding □ Swollen Lymph Nodes □ Other □ Negative
Neurologic: □ Numbness of Arms/Legs/Face □ Weakness of Arms/Legs/Face □ Memory Loss □ Other □ Negative	

Social/FamilyHistory

Do you currently smoke? No Yes ___packs per day for the last ___years
Have you been a smoker in the past? No Yes ___years Quit? ___years ago
Do you drink wine, beer or alcoholic beverages? daily socially rarely never
How many cups of caffeinated beverages (coffee, tea, cola) do you consume in a day? ____ cups
Do you have a family history of Cancer? Yes No
Do you exercise regularly? Yes No
Circle if any family history of Genito Urinary Cancer — Prostate, Kidney, Bladder, Uterine, Ovarian, Breast

Medication History

Do you have any allergies? No If Yes, please list _____

Do you have a heart murmur, heart valve or joint replacement that requires antibiotics for dental work?

Yes No

Are you currently taking any medications or vitamins? Yes (please specify below) No

Medication	Dosage	Frequency
Aspirin, Antinflammatories, Coumadin, Vitamin E, Herbs		

History of Medical Illness

List all condition for which you have received evaluation or treatment such as asthma, heart disease, high blood pressure, elevated cholesterol, ulcers, diabetes, strokes, etc.

Date	Type of Medical Illness

History of Surgery

List all surgeries which you have had including appendectomy, hysterectomy, tonsillectomy, hernia repair, etc.

Date	Type of Surgery

GYNHistory (Women Only)

How many pregnancies? _____ __ How Many children? _____
Please list any gynecological problems for which you have been treated:

Urology Group of Princeton

FINANCIAL POLICY

Regarding Insurance: In order to be seen by physicians at Urology Group of Princeton and receive care through your insurance carrier**,** you must provide us with your current insurance card. If you receive a new card, you must provide it to us. If your insurance has lapsed or is not in effect at the time of service, you will be required to pay the entire bill for services provided when the insurance has lapsed or is not in effect.

If we have a contract with your insurance plan:

• If you have an HMO insurance plan with which we have a contract, then before you come for your appointment with us, you must obtain a proper referral from your Primary Care Physician containing a diagnosis, and stating the number of office visits approved, and the date the referral expires. **You** are responsible to keep track of the number of visits allowed and the expiration date. If your referral expires or you use all allowed visits, and then you are seen by one of our providers, you will be responsible for the entire bill for that visit. If your card says that you have a copay, you must pay that copay before you will be seen for your appointment.

• If you have a PPO or POS insurance with which we have a contract, you do not need a referral to see us. POS insurance is your choice whether you choose to have a referral or pay on your deductible. If your card says that you have a copay, you must pay that copay before you will be seen for your appointment. We will bill your insurance the balance. If your insurance company tells us that you have not satisfied your deductible for the year, then we will bill you for the deductible amount that you are required to pay, and you must pay us.

If we <u>DO NOT</u> have a contract with your insurance plan:

• You will be required to pay in full for our services at the time of the visit. Please do not ask our front desk personnel to send you a bill after services have been performed, unless approved in advance by the office manager when the appointment is made.

• We will submit a bill to your insurance company unless you ask us not to do so, with the instruction for your insurance carrier to make payment to you (because you already have paid us). If you do not agree with your plan's payment, that is between you and your plan, because we do not have a contract with your plan.

If you are not sure whether we have a contract with your insurance plan, please discuss this with our staff.

CANCELLATION/NO SHOW POLICY:

• Appointment times are scheduled and reserved just for you. If you know there is a problem with your appointment time, the sooner you contact our office, the more effective we can be in allowing another patient the opportunity to fulfill their treatment needs. We ask that you give us at least 24-hours notice for cancellations to avoid being charged a $50 fee.

• The first time you do not show up to your appointment, you will receive a no-show letter in the mail. If you do not call to cancel within 24-hours of your appointment and no show again in the future, you will be charged a $50 fee.

• If you call after our business hours (9am-5pm) please leave a message with the answering service that you need to cancel or reschedule your appointment.

Medicare Patients:

• You must give us your Medicare card and any card for your supplemental or other insurance (where applicable).

• You will be required to satisfy your annual $183.00 deductible and pay your 20% copayment. If you have given us your Medicare card and other supplemental insurance cards, we do not require that you pay us at the time of service, and we will submit the claim to Medicare and to any secondary or supplemental insurance that you have.

• Approximately thirty to sixty days after the appointment, we will bill you for the balance that you owe to us, which will be the amount allowed for the service by Medicare, minus the amount that Medicare has paid us, and also minus any amount that your supplemental insurance has paid us. You are required to pay this bill.

Medicaid Patients:

We are **not** contracted with any type of Medicaid Plans. Therefore, if you have Medicare as your primary insurance and Medicaid as your secondary insurance you will be required to pay the 20% balance at the time of service. If you have a Medicare deductible you will be responsible for that balance.

Regarding Biopsy/Miscellaneous Lab Charges:

There will be an additional fee charged by an outside lab for the processing of any biopsies/labs taken either in our office or our surgery center. The professional component of reading/interpreting the results will also be billed separately by an outside lab.

About non-covered services:

A service considered by your insurance carrier to be non-medically necessary [cosmetic or otherwise] will not be covered by your insurance policy. You will be required to pay in full for this service in advance. Payment will be expected at the time of service in this circumstance, unless arrangements are made with our office administrator.

Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy (above). I have asked any questions that I had about this Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party | Print Name of Patient

_____ _____

Relationship/Authority of Responsible | Date

The following fees will be charged:

Cancel/ Reschedule Appointment (less than 24hr notice)	**$50**
No show	**$50**
Copying Medical Records	**$1 per page**

Urology Group of Princeton

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Accountability and Portability Act of 1996, HIPAA, requires that we have your consent prior to our healthcare professional discussing your personal health with your family members or significant others that are not directly involved in your care.

Can our physicians discuss your healthcare with any of your family members? Yes No

Please circle those that apply:
Spouse Mother Father Sister Brother Child Other

Provide Name, Relationship, and Telephone # of designated contact:

I hereby give my permission to the Urology Group of Princeton, allowing for the physicians or their representatives to release or discuss authorized medical information and/or billing issues, with the above family members or to leave a voicemail message at the designated phone number where appropriate.

Leave Voicemail (Home/Cell) Yes No

Discuss billing issues with designated person(s) Yes No

Please indicate a specific family member if desired _____

This authorization will be in effect until such time as you request its revision. Release of Patient Personal Health Information covered by this authorization will be disclosed only for the purpose of keeping your designated family members knowledgeable about your healthcare condition.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that as a part of my medical services, Urology Group of Princeton documents and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence for healthcare professionals

I have received a copy of the Urology Group of Princeton's Notice of Privacy Practices, and give my consent for the practice to use and disclose my PHI.

_____ Signature of Patient or Responsible Party

_____ Print Name of Patient

_____ Relationship/Authority of Responsible

_____ Date

Urology Group of Princeton

Notice of Practice Privacy Practices (As required by the Health Insurance Portability and Accountability Act -HIPAA)

Patient Copy

This notice describes how health information about you, a patient in our practice, may be used and disclosed as well as how you can get access to your Protected Health Information (PHI). The Urology Group of Princeton is committed to maintaining the privacy of your Protected Health Information. While conducting the business of providing your healthcare, we create records regarding you and the treatment and services we provide to you. We are required by law to maintain this notice of our legal duties and the privacy practices that we maintain in our practice. By federal and state law, we must follow the terms of the privacy practices that we have in effect at the time.

HIPPA laws can be very complicated and confusing. We will do our best to explain the following important information contained in the law:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligation concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

A. The Urology Group of Princeton may use and disclose your Protected Health Information (PHI) in the following ways:

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests) and we may use the results to help us reach a diagnosis. We may use your PHI in order to write a prescription for you, or we may need to disclose you PHI to a pharmacy when we order a prescription for you. Many of the employees of the Urology Group of Princeton, including but not limited to the physicians and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may disclose your PHI to another healthcare provider for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your UHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Healthcare Operations.** Our practice may use and disclose your PHI to operate our business. For example, we may use or disclose your information for our operations; to evaluate the quality of care you receive from us, or to conduct cost management and business planning activities for our practice. We may disclose your PHI to other healthcare providers and entities to assist in their healthcare operations.

B. Your Rights regarding your PHI

1. **Confidential Communication.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a certain type of confidential communication,

you must make a written request to the practice administrator, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have a right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment of your care, such as family members or friends. WE ARE NOT REQUIRED TO AGREE WITH YOUR REQUEST; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use and disclosure of your PHI, you must make your request in writing to our administrator. Your request must describe, be clear and concise:
   1: the information which you wish restricted
   2: whether you are requesting to limit our practice's use, disclosure or both; and
   3: to whom you want the limits to apply.

3. **Inspection and copies.** You have the right to inspect and obtain copies of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not psychotherapy notes. You must submit your request in writing to our Medical Records Coordinator in order to inspect and /or obtain a copy of your PHI. Our practice will charge a $1 per page fee for the cost of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct the review.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Administrator. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and complete; (b) not part of the PHI kept by our practice; (c) not part of the PHI which you would be permitted to inspect or copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operational purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, if the doctor shares information with the nurse; or the billing department uses your information to file an insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our Administrator. All requests for "accounting disclosures" must state a time period, which may not be longer than 6 years from the date of the disclosure and may not include dates before April 14, 2003.
   The first list you request within a 12- month period is free of charge, but our practice will charge you got additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to File a Complaint.** If you believe that your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. **Right to provide authorizations for other uses and disclosures.** Our practice will obtain a written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reason described in the authorization. Please note we are required to retain record of your care.

If you have any questions about this notice, please contact our office at (609) 924- 6487.