MidLantic UROLOGY

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Dear Patient,

Thank you for selecting Midlantic Urology for your urologic care. In order to expedite your initial visit, please complete the enclosed forms and bring them with you to your appointment. These forms are necessary in order for us to comply with insurance guidelines. Also, please bring your insurance card, as well as any co-pay or referral that may be required. We cannot see you without the required insurance referral and co-pay. Please remember to bring any relevant lab tests, x-rays, reports or any other recent records pertaining to your condition. The telephone numbers to request your x-ray films are as follows:

PMMC File Room: 610-327-7496
Phoenixville Hospital File Room: 610-983-1130
Penn Medicine/Limerick: 610-495-2370
Oaks Radiology: 610-650-0267

We also will need a complete list and dosage of medications, herbal supplements and vitamins you are taking.

Kindly give our office at least 24 hours' notice if you are unable to keep your appointment. We have instituted at $40.00 fee for missed office visits and $75.00 fee for missed procedure visits for those cancelled with less than 24 hours' notice. We maintain a list of patients eager to be seen and a missed appointment helps no one.

Our group NPI#1811351083 for referrals

Thank you for your cooperation.

PLEASE ARRIVE 20 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME TO ALLOW ADEQUATE TIME TO PROCESS YOUR INFORMATION.

Dear Patient,

Effective June 1, 2010, the Federal Trade Commission (FTC) requires medical providers to implement an Identify Theft Prevention and Detection Program in order to prevent Medical Identity Theft. Therefore, any new patients are now required to show photo ID (driver's license, passport, employee ID, student ID, green card, government issued photo ID) at the time of the first office appointment. Please be prepared to show our staff at the front desk your photo ID when you register for your appointment. This is done to verify that you are the person listed on your medical insurance card.

Thank you,
Penny Mest
Practice Administrator

International Prostate Symptom Score (IPSS)

Patient Name: Date of Birth: Today's Date:

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

Total International Prostate Symptom Score = _____

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	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

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)

1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No

NAME _____ *DATE OF BIRTH* _____ *DATE OF APPOINTMENT* _____

How many caffeinated drinks do you have each day? 0 1 2 3 4 +

When was your last colonoscopy? _____ Where _____

When was your last flu shot? _____ Where _____

When was your last pneumovax? _____ Where _____

Do you *CURRENTLY* use tobacco? YES NO *If yes do you use* _____ cigarettes *or* _____ chewing tobacco

In the past year how many times have you consumed more than 5 alcoholic beverages in 1 day? _____

Female patients only – Have you experienced urinary incontinence within the last 12 months? YES NO

REVIEW OF SYSTEMS

Do you currently have any problems related to the following system?

CARDIOVASCULAR

Chest Pain	Y	N
Irregular Pulse	Y	N
Swelling of Ankles	Y	N
Severe Headache	Y	N
Chest Discomfort to Arm	Y	N

GASTROINTESTINAL

Abdominal Pain	Y	N
Black Stools	Y	N
Heartburn/Vomiting	Y	N
Constipation	Y	N

UROLOGIC

Blood in Urine	Y	N
Blood in Ejaculate	Y	N
Burning	Y	N
Wetting with cough/sneeze	Y	N

*Name*_____ *Date of Birth* _____ *Date of Appointment* _____

PLEASE EXPLAIN BRIEFLY WHY YOU ARE HERE

_____

_____

Have you been diagnosed with **MRSA**? Yes No

Have you ever had a **blood transfusion**? Yes No

Do you require antibiotics for dental/medical procedures? Yes No

Allergies (medicine, x-ray dye, iodine, shellfish, LATEX) and your reaction

_____

_____

_____

Current Medications (including vitamins, supplements, aspirin, over the counter) Please note dosages and frequency

_____

_____

_____

Operations (please note approximate date of procedure, hospital and side of the body if relevant)

_____

_____

_____

_____

Medical History

Medical Conditions *Personal*	*Specify Family Member*
_____ Diabetes	_____
_____ High Blood Pressure	_____
_____ Heart Attack	_____
_____ Stroke	_____
_____ Pacemaker	_____
_____ Bleeding Problems	_____
_____ Cancer of	_____
_____ Other	_____
_____ Bladder Stones	_____
_____ Bladder Infections	_____
_____ Incontinence	_____
_____ Genital Issues	_____
_____ Urologic Issues	_____
_____ Urologic Cancer	_____
_____	_____

Diseases of *Personal*	*Specify Family Member*
_____ Heart (coronary artery disease Cardiomyopathy, etc)	_____
_____ Lungs (asthma, emphysema, etc)	_____
_____ Liver	_____
_____ Kidneys	_____
_____ Nervous System (seizures, etc)	_____
_____ Immune System (AIDs, etc)	_____
_____ Other	_____
_____	_____

Social History

Do you currently use tobacco? YES NO

Have you ever used tobacco YES NO

How many cigarettes per day? _____

What year did you *start smoking*? _____

What year did you *quit smoking*? _____

Do you currently drink alcohol? YES NO

Have you ever drunk alcohol? YES NO

How many drinks per month? _____

Circle any of the following you normally consume

Beer Wine Hard Liquor

Does anyone in your family have trouble with anesthesia? YES NO Relationship _____

Employment: Present _____

Past _____

The Patient Health Questionnaire (PHQ-9)

Date of Birth _____

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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HIPAA Patient Consent Form

I, _____, (date of birth:_____, understand that as part of my health care, AU originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication 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, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I further understand that AU reserves the right to change their notice and practices in accordance with Section 164.520 and 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

_____ _____

Signature of Patient (or Patient's Legal Representative) Date

_____ ***(Initial)*** I agree to allow AU physicians and healthcare staff to leave messages that include Protected Healthcare Information of the following: Please initial next to the applicable communication devices:

_____Home # _____ _____cell #_____ _____Work #_____

____***(Initial)*** **No,** I do not agree to allow AU physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

_____ ***(Initial)*** I agree to allow AU physicians and healthcare staff to speak with only the following people regarding my Protected Healthcare Information.

List Name(s), relationship and phone number:

_____

(print name) (relationship) (phone number)

_____

(print name) (relationship) (phone number)

_____ _____ _____

Patient Name (Please Print) Patient Signature Date

☐ Patient Refused to Sign: Staff Name/Date: _____

MidLantic UROLOGY

Financial Policy

Academic Urology of PA, LLC (AU) is dedicated to providing quality patient care and is also aware that financial concerns are important too.

Before your visit, AU is required to verify your member eligibility with your insurance company. In addition, when you arrive for your appointment, for your protection and in accordance with federal regulations, AU is required to verify your identity (valid driver's license or other form of acceptable photo identification). If you are unable to provide an acceptable form of identification, this may cause denial of services. Please inform the front office staff if you have any concerns regarding your insurance benefits or if you do not have insurance coverage (self-pay). If you are self-pay, and are unable to satisfy your financial obligations to AU, you may want to contact your local health department to see if you are eligible for Medical Assistance. Please feel free to contact your Academic Urology doctor's office to discuss your payment options in advance of your scheduled appointment.

We recommend that you contact your insurance carrier for specific questions related to your Explanation of Benefits.

Note: Please be advised that we have a separate policy for self-pay patients with no insurance coverage. Please read the following carefully and sign below.

CO-PAYMENTS: Co-payments are due at the time services are rendered per your contract with your insurance company, if applicable. Payment can be made by check, cash, MasterCard, VISA, or Discover.

REFERRALS: Referral forms must be presented at the time services are rendered, if applicable. If you need a referral form to be faxed to us, our office will have a FAX number available for you to provide to your primary care physician.

FINANCIAL RESPONSIBILITY: You are responsible for all co-payments, deductibles, and charges not covered by health insurance. Without valid health insurance, full payment is expected at the time services are rendered.

ACCOUNT BALANCES: Our office provides you with monthly statements of all account activity including charges, payments and contractual adjustments. Failure to pay outstanding balances that are your responsibility may result in the practice forwarding your account to a collection agency or collection attorney and may result in additional fees to you, including attorney's fees. If your payment is returned due to insufficient funds or stopped payment, you will be charged the return check fee allowed by Pennsylvania Law.

MEDICARE PATIENTS:

THE FOLLOWING PROVISION APPLIES TO ALL PATIENTS WHO ARE COVERED 1) BY MEDICARE AND HAVE SECONDARY COVERAGE, OR 2) IF YOU ARE COVERED BY A MEDICARE ADVANTAGE PLAN.

By my signature below, I hereby authorize and request my insurance company to make payment directly to Academic Urology of PA, LLC for any benefits that may be due for covered services and supplies rendered to me by Academic Urology of PA, LLC.

I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

ALL PATIENTS

I certify that all information given is true. I understand that services rendered to me will be billed to the named Insurance Carrier. If the claim submitted is rejected, I will be responsible to pay the bill.

It is understood that any dispute as to unnecessary medical services, unauthorized, or improperly, negligently or incompetently rendered medical services or medical malpractice will be determined by submission to arbitration as provided by Pennsylvania Law and not by a lawsuit or court process except as Pennsylvania Law provides for judicial review of arbitration proceedings. Montgomery County jurisdiction is agreed and accepted in all filings and proceedings.

I authorize and direct Academic Urology of Pennsylvania, LLC or it's designee to release to insurance carriers, authorized agencies of such insurance carriers or others who are financially liable for services and or medical care, all medical records and other information needed to substantiate payment for such. My signature below indicates that I have read and understood the above.

Print Your Name_____

Sign Your Name_____ **Date of Birth** _____ **Date**_____

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Patient Information

PATIENT					DATE
Name (Last, First, Mi)		Social Security	Birthdate	Sex	Home Phone
Mailing Address	City	State	Zip	Marital Status	
Email Address	Cell Phone	Do you have an Advance Directive? OR Living Wi ____Yes ____No			
Employer	City	State	Zip	Work Phone	
Work Status	Full Time	Part Time	Retired	Student	Occupation

RESPONSIBLE PARTY					
Name (Last, First, Mi)		Social Security	Birthdate	Sex	Home Phone
Mailing Address	City	State	Zip	Marital Status	
Employer	City	State	Zip	Work Phone	

PRIMARY PHYSICIAN	REFERRING PHYSICIAN
Name	Name

PHARMACY	
Name	Phone Number

MAIL ORDER PHARMACY	PHONE NUMBER
Name	Phone Number

INSURANCE INFORMATION				
Primary Insurance Company	Subscriber's Name /DOB	Relationship	Policy Number	Group Number
Second Insurance Company	Subscriber's Name	Relationship	Policy Number	Group Number
Third Insurance Company	Subscriber's Name	Relationship	Policy Number	Group Number

EMERGENCY CONTACT INFORMATION			
Contact Name	Relationship	Primary Phone Number	Secondary Phone Number

DEMOGRAPHIC INFORMATION									
RACE	White	Black/ African American	American Indian/Alaskan Native	Eskimo	Hispanic or Latino	Asian	Unknown	Native Hawaiian or Pacific Islander	
ETHNICITY	Hispanic				Non-Hispanic				
Preferred Language	English	Spanish	French	German	Portuguese	Russian	Chinese	Japanese	Italian	Other