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|  |  | | |  | |  |  | |  |  |  |  |
| Name: |  | | | | | | | | Date of Birth: | |  | |
| Address: |  | | | | | | | | SSN: |  | | |
| City, State/ Zip: | | | | | | | | | Marital Status: | | Married | Single |
| Home Phone: | | | |  | | | | | Widowed | | Divorced | Other |
| Cell Phone: | | | |  | | | | | Preferred method of contact: | | | |
| Email: | | | |  | | | | | Voicemail Email Text | | |  |
| Preferred Language: | | | |  | | | | | Referring Physician: | | |  |
| Ethnicity/Race: | | | |  | | | | |
| Employer: | | | |  | | | | | Employer phone: | |  |  |
|  | |  |  | |
| Guarantor: | | | |  | |  |  | | Same as patient | | Spouse | Parent |  |
|  |  | | | | |  |  | |  |  |  |  |  |  |  |  |
| Primary Insurance: | | | |  | | | | | Insured employee: | |  |  |
| Insured Party's name: | | | |  | | | | | Insured SSN: | |  |  |
| Insured's date of birth: | | | |  | |  |  | | Group Number: | |  |  |
|  |  | | |  | |  |  | |  |  |  |  |
| Secondary Insurance: | | | |  | |  | |
| Insured Party's name: | | | |  | |  |  | | Insured employee: | |  | |
| Insured 's date of birth: | | | |  | |  |  | | Insures SSN: | |  | |
| Insurance Company's name: | | | | | |  |  | | Group Number: | |  | |
|  |  | | |  | |  |  | |  |  |  |  |
|  |  | | |  | |  |  | |  |  |  |  |
| Emergency Contact: | | | |  | | | | | | | | |
| Name: |  | | | | | | | | Relationship: | |  | |
| Phone: |  | | | | | | | | OK to release ROI: | | Yes | No |
| **All patients must complete our patient information form BEFORE seeing the doctor.** | | | | | | | | | | | | |
| I REQUEST THAT PAYMENTS OF AUTHORIZED INSURANGE BENEFITS BE MADE ON MY BEHALF TO TRI-CITIES UROLOGY, LLC. FOR ANY SERVICES FURNISHED BY SAID PHYSICIAN. I HEREBY AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO MY INSURANCE COMPANY AS NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR MY PORTION OF THE CHARGES INQUIRED, INCLUDING. ANY DEDUCTIBLE OR NON-COVERED CHARGES, WITHIN 30 DAYS OF RECEIVING EXPLANATION OF BENEFITS FROM MY INSURANCE COMPANY. (LABORATORY FEES ARE NOT INCLUDED IN THE CHARGES FOR THE VISIT.) | | | | | | | | | | | | |
| Signature: |  | | | | | | | | Date: |  | | |
|  |  | | |  | |  |  | |  |  |  |  |

Thank you for choosing Tri-Cities Urology, LLC as your provider. We are committed to providing you with quality healthcare. Please read the following policies and feel free to ask us any questions that you may have. A copy will be provided to you upon request.

1. ﻿﻿﻿**Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, then payment in full is expected at each visit. If you are insured by a plan, we participate with but do not have an up-to-date insurance card, then payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. **Please provide your Social Security number for insurance purposes.**
2. ﻿﻿﻿**Co-payments and Deductibles**: All co-payments and deductibles must be paid at time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Non-sufficient funds will have a service fee of $50 added to the face value of the check.
3. ﻿﻿﻿**Non-covered services:** Please be aware that some-and perhaps all-of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. Prior Authorizations is not a guarantee of payment, payment is at the discretion of your insurance company.
4. ﻿﻿﻿**Proof of Insurance:** All patients must complete our patient information form **before** seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim. If required, obtaining the proper referral from you Primary Care Physician is your responsibility. Patients presenting to our office without a valid referral will be asked to pay in full. These payments will be held for 48 hours and will become nonrefundable if the proper referral is not obtained.
5. ﻿﻿﻿**Claims submission:** As a courtesy we will submit your claims for all services to your insurance company. Your individual health insurance policy is a contract between you and your insurance. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim, we will not alter your claim, change diagnosis, or report a different service other than what was performed.

Private Practice Policy: The notice provides, in detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice’s legal duties with respect to my information.

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

I have read and understand the above policies and agree to abide by these guidelines.

|  |
| --- |
| **Release of Information/HIPPA**  I Authorize Tri-Cities Urology, LLC to discuss medical treatment, results, and scheduled appointment to the following person/s.  **Name and Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Name and Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|

**Appointment Cancellation/No Show Policy**

Thank you for trusting your medical care to Tri-Cities Urology, LLC. When you schedule an appointment with Tri-Cities Urology, LLC we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible and no later than 24 business hours prior to your appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show policy below:

* Effective February 1, 2022, any established patient who fails to show or cancel/reschedule an appointment and has not contacted our office with at **least 24 business hours** will be considered a no show and charged a **$25 fee.**
* Any established patient who fails to show or cancel/reschedule an appointment within 24-hour business hours for a **second** time will be charged a **$50 fee.**
* If a **third,** no show or cancellation/reschedule without 24-business hours should occur, the patient may be **dismissed** from Tri-Cities Urology, LLC.
* Any new patient who fails to show for their initial visit will be given the next available appointment and if they miss the second new patient appointment will not be rescheduled.
* Vasectomy procedures are allowed one cancellation and reschedule if you cancel a 2nd time, you will not be offered an additional appointment.
* The fee is charged to the patient, not the insurance company and **is due prior to or at the time of the patient's next visit.**
* As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office manager who may be able to waive the no show fee.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Signature: |  | | | Date: | | |  | |
|  |  |  |  |  |  |  | |  | |  |

Personal Medical History  None

|  |  |  |
| --- | --- | --- |
| DISEASE/CONDITION | DISEASE/CONDITION | DISEASE/CONDITION |
| Asthma | Hematuria (blood in urine) | Erectile Dysfunction |
| Cancer *(type:\_\_\_\_\_\_\_\_\_\_\_ )* | Nocturia (urination at night*)* | Pelvic Pressure |
| Depression/Anxiety/Bipolar/Suicidal | Overactive Bladder (OAB) | Renal Cyst |
| Diabetes *(type:\_\_\_\_\_\_\_\_\_\_\_\_****)*** | Dysuria (painful urination) | Benign Prostatic Hyperplasia (BPH) |
| Emphysema *(COPD)* | Chronic Urinary Tract Infection (UTI) | Urinary Retention |
| Heart Disease/High Blood Pressure (hypertension) | Elevated Prostate Specific Antigen (PSA) | Suprapubic Catheter |
| High Cholesterol | Bladder Infection | Self-Catheterization |
| Hypothyroidism/Thyroid Disease | Bladder Cancer | Male Infertility |
| Kidney Stones or Ureter Stones | Kidney Cancer | Overflow Incontinence |
| Prostate Enlargement | Prostate Cancer | Low Testosterone |
| Renal *(kidney)* Disease | Renal *(kidney)* Disease | Testicular Cancer |
| Urinary Incontinence | Stress Urinary Incontinence (SUI) | Priapism |
| Urinary Frequency | Difficulty Urinating | Peyronies |
| Other: | Other: |  |

Surgical History

|  |  |  |
| --- | --- | --- |
| TYPE *(specify left/right)* | DATE | LOCATION/FACILITY |
|  |  |  |
|  |  |  |
|  |  |  |
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None

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Occupation** *(or prior occupation)*: | | | | □ Retired □ Unemployed □ LOA □ Disabled |
| **Employer**: | | | | Years of Education or Highest Degree: |
| If employed, do you work the night shift? | Y | N | N/A |  |
| **Marital Status** *(check one)*: □ Single □ Partner □ Married □ Divorced □ Widowed □ Other: | | | | |
| Living Arrangements:  Home  Apartment  Alone Spouse  Children. Other: | | | | |
| Do you have children? Y N | | | | If yes, how many? |

Social History

Other Health Issues

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Sexual Activity** | | | | | Currently sexually involved Y N ***(If no sexual history, please continue to Exercise)***  *If yes how often?* | | |
| Sexual partner(s) is/are/have been: □ Male □ Female | | | | | | | |
| **Exercise** | | | | Do you exercise regularly? Y N *(If you answered no, please move to Sleep)* | | | |
| What kind of exercise? | | | | | | ***Duration:*** How long (min.): How often: | |
| **SLEEP** | | How many hours, on average, do you sleep at night *(or during the day, if working night shift)*? | | | | | |
| **DIET** | How would you rate your diet? □ Good □ Fair □ Poor | | | | | | Caffeine consumption? Y N How much: |
| **SAFETY** | | | Do you use a bike helmet? Y N | | | Do you use seat belts consistently? Y N | |
| Working smoke detector in home? Y N | | | | | | Is violence at home a concern for you? Y N | |
|  | | | | | | Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Tobacco USE** | Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)* | | | | |
| ***Current:*** Packs/day # of Years | | | ***Past:*** Quit Date: Packs/day # of Years | | |
| Other Tobacco *(check one)*: □ Pipe □ Cigar □ Snuff □ Chew | | | | | |
| **Alcohol/DRUG USE** | | Do you drink alcohol? Y N | | □ Beer □ Wine □ Liquor | # of Drinks/week: |
| Do you use marijuana or recreational drugs? Y N | | | |  | |

Other Providers/Specialist

|  |  |  |
| --- | --- | --- |
| SPECIALIST | NAME | Last Visit |
| Primary Care Provider |  |  |
| Cardiology |  |  |
| Gastroenterologist (GI) |  |  |
| Oncologist |  |  |
| Neurology |  |  |
| Pulmonary |  |  |
| Other: |  |  |
| Other: |  |  |

Family Medical History

No significant Family History is Known

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Check ALL That APPLY** | Alcohol/Drug Abuse | Asthma | *(type:* Cancer *)* | Emphysema (COPD) | Depression/Anxiety | Bipolar/Suicidal | Diabetes | Early Death | Heart Disease | High Cholesterol | High Blood Pressure | Kidney Disease | Stroke | Thyroid Disease | Migraines | Other: | Other: | Other: |
| Mother |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Brother |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sister |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Child |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MGM |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MGF |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PGM |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PGF |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **ALLERGY** | **ALLERGIC REACTION** |
|  |  |
|  |  |
|  |  |
|  |  |

Medication Allergies

None

Medication

None

|  |  |  |
| --- | --- | --- |
| MEDICATIONS  *(Please list ALL)* | DOSE  *(Mg., pill, etc.)* | TIMES PER DAY |
|  |  |  |
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*If you need more room to list medications, please write them on a blank sheet of paper with the required information.*

|  |  |
| --- | --- |
| Preferred Pharmacy: | *Local:* |
| *Mail Order:* |

Review Of Symptoms

Check all that apply.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Constitution | | Cardiovascular | | Skin | | |
|  | Activity change |  | Chest pain |  | Color change | |
|  | Appetite change |  | Leg swelling |  | Pallor | |
|  | Chills |  | Palpitations |  | Rash | |
|  | Diaphoresis | **Gastrointestinal** | |  | Wound | |
|  | Fatigue |  | Abdominal distention | Allergy/Immuno | | |
|  | Fever |  | Abdominal pain |  | Environmental allergies | |
|  | Unexpected weight change |  | Anal bleeding |  | Food allergies | |
| Head, Ear, Nose & Throat | |  | Blood in stool |  | Immunocompromised | |
|  | Congestion |  | Constipation | NEUROLOGICAL | | |
|  | Dental problem |  | Diarrhea |  | Dizziness | |
|  | Drooling |  | Nausea |  | Facial asymmetry | |
|  | Ear discharge |  | Rectal pain |  | Headaches | |
|  | Ear pain |  | Vomiting |  | Light-headedness | |
|  | Facial swelling | **ENDOCRINE** | |  | Numbness | |
|  | Hearing loss |  | Cold intolerance |  | Seizures | |
|  | Mouth sores |  | Heat intolerance |  | Speech difficulty | |
|  | Nosebleeds |  | Polydipsia |  | Syncope | |
|  | Postnasal drip |  | Polyphagia |  | Tremors | |
|  | Rhinorrhea |  | Polyuria |  | Weakness | |
|  | Sinus pressure | **Genitourinary** | | Hematologic | | |
|  | Sneezing |  | Difficulty urinating |  | Adenopathy | |
|  | Sore throat |  | Dysuria |  | Bruises/bleeds easily | |
|  | Tinnitus |  | Enuresis | Psychiatric | | |
|  | Trouble swallowing |  | Flank pain |  | Agitation | |
|  | Voice change |  | Frequency |  | Behavior problem | |
| Eyes | |  | Genital sore |  | Confusion | |
|  | Eye discharge |  | Hematuria |  | Decreased concentration | |
|  | Eye itching |  | Penile discharge |  | Dysphoric mood | |
|  | Eye pain |  | Penile pain |  | Hallucinations | |
|  | Eye redness |  | Penile swelling |  | Hyperactive | |
|  | Photophobia |  | Scrotal swelling |  | Nervous/anxious | |
|  | Visual disturbance |  | Testicular pain |  | Self-injury | |
| Raspatory | |  | Urgency |  | Sleep disturbance | |
|  | Apnea |  | Urine decreased |  | Suicidal ideas | |
|  | Chest tightness | **Muscular** | |  | | |
|  | Choking |  | Arthralgias |  | | |
|  | Cough |  | Back pain |  | | None of these apply. |
|  | Shortness of breath |  | Gait problems |  | | |
|  | Stridor |  | Joint swelling |  | | |
|  | Wheezing |  | Myalgias |  | | |
|  |  |  | Neck pain |  | | |