Any inpatient hospital stays with the last 30 days?  □ Yes  □ No
Have you received a flu shot in the past 12 months?  □ Yes  □ No
If you are 65 years or older, do you have an Advance Directive?  □ Yes  □ No

Check if you are experiencing any of the following symptoms.

**BREAST:**
- □ Breastfeeding
- □ Breast pain
- □ Lumps
- □ Nipple discharge
- □ Skin changes
- □ None

**EYES:**
- □ Blurred vision
- □ Burning
- □ Cataracts
- □ Double vision
- □ Glasses/contacts
- □ Glaucoma
- □ None

**GENITOURINARY:**
- □ Blood in urine
- □ Burning with urination
- □ Difficulty with urination
- □ Discharge
- □ Frequency of urination
- □ Incontinence
- □ Kidney stones
- □ Pain postponing urination
- □ Pelvic pain/pressure
- □ Sexual problems
- □ Sexually transmitted disease
- □ Unable to urinate
- □ Urgency of urination
- □ Urinary tract infection
- □ None

**NEUROLOGIC:**
- □ Dizziness
- □ Fainting
- □ Headache
- □ Numbness
- □ Paralysis
- □ Seizures
- □ Stroke
- □ Tingling
- □ Tremors
- □ Weakness

**SKIN:**
- □ Color change
- □ Hair loss
- □ Moles
- □ New lesion(s)
- □ Rash
- □ None

**CARDIOVASCULAR:**
- □ Chest discomfort
- □ Fainting
- □ Palpitations
- □ Shortness of breath
- □ Tightness
- □ None

**GASTROINTESTINAL:**
- □ Bowel habit change
- □ Change in appetite
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Heartburn
- □ Hemorrhoids
- □ Nausea
- □ Pain
- □ Rectal bleeding
- □ None

**ENDOCRINE:**
- □ Diabetes
- □ Heat/cold intolerance
- □ Increase in appetite
- □ Thirst
- □ Thyroid issues
- □ None

**HEMATOLOGIC:**
- □ Ease of bleeding
- □ Ease of bruising
- □ Hepatitis
- □ Masses/nodules
- □ Wounds won’t heal
- □ None

**OBGYN:**
- □ Abnormal periods
- □ Birth control pill use
- □ Hot flashes
- □ Pregnant
- □ None

**PSYCHIATRIC:**
- □ Anxiety
- □ Depression
- □ Memory loss
- □ Mood swings
- □ None

**RESPIRATORY:**
- □ Cough
- □ Coughing up blood
- □ Oxygen use
- □ Severe snoring
- □ Shortness of breath
- □ Sleep apnea
- □ Sputum
- □ Tuberculosis
- □ Wheezing
- □ None

**ENT:**
- □ Discharge
- □ Dizziness
- □ Earache
- □ Ear ringing
- □ Hay fever
- □ Hearing loss
- □ Nosebleeds
- □ Sinus pain
- □ Sore throat
- □ Voice change
- □ None

**GENERAL:**
- □ Chills
- □ Fatigue
- □ Fever
- □ Weight gain
- □ Weight loss
- □ None

**MUSCULOSKELETAL:**
- □ Joint swelling
- □ Muscle loss
- □ Pain
- □ Stiffness
- □ Trauma
- □ None

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Patient or Guardian Name

Relationship if other than self

Signature

Physician Signature

Date
Urology of Greater Atlanta, LLC

Payment Options

1. Enroll in the e-billing process by placing a payment method on file and authorizing a future charge up to a maximum of $250 per visit for amounts owed by me as determined by my insurance company. amounts owed by me may include (i) copayments, (ii) coinsurance, (iii) deductibles, (iv) non-covered or out-of-network services or (v) fees (if applicable) charged by the practice for forms, medical records, appointment cancellations, NSF fees, credit card charge backs, etc.

   □ I elect to enroll in the e-billing system.

2. Pay your estimated co-insurance and deductible at the time of service. We have an office visit estimation tool that will allow us to estimate your co-insurance and deductible.

   □ I elect to pay my estimated patient responsibility prior to my visit today.

3. Opt out of the e-billing system for a fee of $50 per year (due today) which covers the costs our practice incurs to send monthly statements and process manual payments. I understand that if I opt-out of the e-billing process and fail to pay my financial responsibility in a timely manner I will not be allowed to opt-out for future dates of service. Instead, I will be required to pay estimated charges in full prior to services being rendered.

   □ I elect to opt-out of the e-billing process. I'm prepared to pay $50 today to opt-out of the program for the next 12 months or I already paid to opt-out this year. I understand I'm still responsible for balances determined to be my responsibility by my insurance carrier.

4. Present valid, verifiable insurance information demonstrating 100% coverage for medical services having met all applicable deductibles. These plans are:

   a. Traditional Medicare with Medicaid secondary
   b. Medicaid (Blue Ridge office only)
   c. Traditional Medicare with a Plan F secondary
   d. Traditional Medicare with Tricare secondary
   e. WellCare SNP

   □ I have provided the appropriate insurance information. I understand that if my insurance carrier(s) doesn't pay my entire balance I'm ultimately responsible.

I have had the opportunity to review the financial policy of Urology of Greater Atlanta, LLC. I confirm that I have received a copy of the policy for my records or that I have declined a copy. I understand that I am ultimately responsible for payment of services rendered to me and/or my dependents. I have indicated my preferred method to handle patient responsibility above.

Patient Name ___________________________  Patient Birthdate ___________________________

Patient (Guardian) Signature ___________________________  Date ___________________________
