

PRINCE WILLIAM UROLOGY

8525 Rolling Road, Suite 220

Manassas, VA 20110

Tel: 703-393-0700

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Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral.

I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Printed Patient Name (and Guardian Name if applicable)

Patient or Guardian Signature

Patient Date of Birth _____

Date _____

Our office does not make the rules. They are determined by your specific medical insurance or vision plan.

PRINCE WILLIAM UROLOGY
Andrew K. Chung, MD
Anshu Guleria MD, FACS
Ali Sajadi, MD
Katie Riley, PA-C

LAB SPECIMEN CONSENT

Prince William Urology recommends several lab testings that will require shipment to outside labs. Listed below are some of the lab test that must be done with the purposes of determining appropriate treatment plans.

- **Prostate biopsy**
- **Bladder biopsy**
- **Vasectomy specimen**
- **Urine culture**
- **Urine cytology**
- **Urine FISH**
- **Urine DNA culture**
- **Kidney/Bladder Stone Analysis**
- **Serum lab tests (PSA, testosterone, chem 7, CBC, vitamin D level, AFP, HCG, LH, FSH levels)**

- I acknowledge that Prince William Urology is unable to determine any out of pocket costs associated with these labs.
- I acknowledge that my insurance could make me responsible for in or out of network deductibles, coinsurance and or copay costs associated with these labs.

Feel free to contact our office Manager with any billing questions or concerns.

Patients Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

PRINCE WILLIAM UROLOGY ASSOCIATES, LTD

Ali M Sajadi, MD - Andrew K Chung, MD - Anshu Guleria, MD - Katie Riley, PA-C

New Patient Urologic History Form - Women

Patient's Name: _____
(Last) (First) (MI) (Date)

Age: _____ DOB: _____ Height _____ Weight _____

Referring Dr: _____ Primary Dr: _____

What is the *main reason* for your visit today? Write in your own words on the lines provided:

When did you first notice the problem? _____

Location of the problem? (You may choose more than one location)

- | | | |
|---|---------------------------------|------------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Flank |
| <input type="checkbox"/> Back | <input type="checkbox"/> Penis | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Groin | <input type="checkbox"/> Rectum | <input type="checkbox"/> Genitalia |
| <input type="checkbox"/> Not applicable | | |

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.

1 2 3 4 5 6 7 8 9 10 N/A

How long does the problem last? _____ Is the problem: Constant Variable Seldom

Does anything make the problem worse? _____ If yes, what makes it worse? _____

Does anything make the problem better? _____ If yes, what makes it better? _____

Does the problem interfere with your normal activities? Yes No

What testing have you had to evaluate your urological problem?

- | | | |
|---|---|---|
| <input type="checkbox"/> I have had no tests to evaluate this problem | | |
| <input type="checkbox"/> X-ray | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Urodynamic Testing |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> Nuclear bone scan | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Nuclear renal scan | <input type="checkbox"/> Unsure |
| <input type="checkbox"/> IVP | <input type="checkbox"/> Urine specimen | |
| <input type="checkbox"/> Blood tests | <input type="checkbox"/> Cystoscopy | |

Where was the test performed? _____

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Do you experience any of the following?

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Urinary urgency | <input type="checkbox"/> Weak stream | <input type="checkbox"/> Dribbling |
| <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Straining to urinate | |
| <input type="checkbox"/> Burning with urination | <input type="checkbox"/> Trouble starting stream | |

How many times do you wake up to urinate at night? 0 1 2 3 4 5 6 7 8 9 10

Do you feel like your emptying your bladder completely? Yes No

Do you leak urine? Yes No

Is your leakage associated with the urge to urinate? Yes No

Is your leakage associated with coughing, laughing, jumping, sneezing, or exercising? Yes No

Do you wear protective pads? Yes No

How many Pads/day? _____ Liners/day? _____ Diapers/day? _____ Other: _____

Are they usually: Dry Moist Wet Soaked

Are there any other urologic issues you would like to discuss with Dr. _____ today? Yes No

(Please explain:) _____

Allergies: Are you allergic to:

- | | | |
|--|--|---|
| <input type="checkbox"/> Latex | <input type="checkbox"/> Iodine/Betadine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Dye/IV Contrast | <input type="checkbox"/> Tape/Adhesives | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Shellfish/Shrimp! | <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Cipro/Levaquin |

I have no medication allergies

Medication allergies: (List all)

Medications:

Do you take any medications? Yes No

Are you currently taking the following blood thinners? Aspirin 81 mg or 325 mg

Motrin Aleve Ibuprofen Celebrex Mobic Other: _____

Coumadin Warfarin Plavix Pradaxa Xarelto Eliquis Heparin Lovenox

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Please list all the medications you take with the dosage and frequency:

<u>Medication</u>	<u>Dose</u>	<u>How Often</u>

Please list all Vitamins & Supplements such as Vitamin E, Fish oil, Herbal preparation, Garlic, etc:

Past & Present Medical Problems

- | | | |
|---|--|---|
| <input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Carotid artery disease
<input type="checkbox"/> Congestive heart failure
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Heart attack
<input type="checkbox"/> Peripheral vascular
<input type="checkbox"/> Heart valvular disease
<input type="checkbox"/> Renal artery stenosis
<input type="checkbox"/> Heart disease
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> COPD
<input type="checkbox"/> Cystic fibrosis
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Pulmonary embolism
<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> Heartburn/GERD
<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Kidney failure
<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Polycystic kidney disease
<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Vesicoureteral reflux
<input type="checkbox"/> Kidney infections/UTI
<input type="checkbox"/> Kidney obstruction
<input type="checkbox"/> Enlarged prostate/BPH
<input type="checkbox"/> Prostate infection
<input type="checkbox"/> STD's
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Gout
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Polio
<input type="checkbox"/> Artificial joints
<input type="checkbox"/> Lupus
<input type="checkbox"/> Addison's Disease
<input type="checkbox"/> Cushing's disease
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Myasthenia gravis
<input type="checkbox"/> Parkinson disease
<input type="checkbox"/> Seizures
<input type="checkbox"/> TIA
<input type="checkbox"/> Anemia
<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Blood clots
<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Drug dependency
<input type="checkbox"/> Depression
<input type="checkbox"/> Bladder cancer
<input type="checkbox"/> Breast cancer
<input type="checkbox"/> Cervical cancer
<input type="checkbox"/> Colon cancer
<input type="checkbox"/> Kidney cancer
<input type="checkbox"/> Lung cancer
<input type="checkbox"/> Penile cancer
<input type="checkbox"/> Prostate cancer
<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Testicular cancer
<input type="checkbox"/> Uterine cancer
<input type="checkbox"/> Cancer, Other: |
|---|--|---|

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- | | | |
|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Peptic ulcer disease | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Dementia | _____ |

Female history

Number of pregnancies: _____ Number of Deliveries: _____ Vaginal C-Section
Have you had a hysterectomy? Yes No When? _____ Why? _____
Have you had any prior bladder surgeries/when? _____
Have you had a bladder tack/when? _____
Have you had a sling/when? _____

Surgical History

Date	Surgery	Date	Surgery

Family History (please indicate which family member)

- | | | |
|---|---|--|
| <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney cancer |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bladder cancer | <input type="checkbox"/> Other: _____ |

Tobacco/Alcohol History

Do you currently smoke? Yes No How much? _____
Did you smoke in the past? Yes No How long? _____ When did you quit? _____
Do you drink alcohol? Yes No How many drinks per day? _____
Do you use recreational drugs? Yes No Substances: _____

Thank you for taking the time to complete your urological health questionnaire. Welcome to our practice! Prince William Urology Associates, Ltd.

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REVIEW OF SYSTEMS

Name: _____

Date: _____

Please check only the problems that **currently** apply to you

CONSTITUTIONAL

- Fever
- Chills
- Weight gain
- Weight loss

EYES

- Blurred vision
- Vision loss

EARS/NOSE/THROAT

- Hearing loss
- Sinus problems
- Difficulty swallowing
- Sore throat
- Dental problems
- Nose bleeds

CARDIOVASCULAR

- Chest pain
- Palpitations
- Irregular heartbeat
- Swelling of feet/
Extremities

RESPIRATORY

- Shortness of breath
- Chronic cough
- Coughing up blood

GASTROINTESTINAL

- Poor appetite
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Abdominal pain
- Blood in stool
- Heartburn

GENITOURINARY

- Blood in urine
- Easy bruising
- Leakage of urine
- Weak stream
- Frequency urination
- Urge to void suddenly
- Getting up at night to
Urinate
- Problems with erection
- Pain with intercourse
- Bladder pain
- Pelvic pain
- Burning with urination
- Frequent urine infections

MUSCULOSKELETAL

- Back pain
- Joint pain
- Muscle aches

INTEGUMENTARY/SKIN

- Rash
- Atypical moles
- Itchy skin

NEUROLOGIC

- Numbness
- Weakness
- Dizziness

HEMATOLOGIC/LYMPHATIC

- Bleeding tendency
- Swollen lymph gland

ENDOCRINE

- Excessive thirst
- Hot/cold Intolerance
- Hormone problem
- Fatigue

ALLERGY

- Medication allergy
- Latex allergy
- Seasonal allergy

PSYCHIATRIC

- Depression
- Anxiety

****Healthcare provider only:** The above systems have been reviewed by: _____

Physician's initials