

Patient Demographic Form

Date: _____

Patient Name: _____ **Date of Birth:** _____

Please Circle: Sex: Male / Female **Marital Status:** Single Married Divorced Widow Life Partner

Race:

- | | |
|---|---|
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Hawaiian Native/Pac Island |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Other Race |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> White |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Decline to Specify |

Ethnicity:

- ☐ Latino/Hispanic
☐ Other
☐ Decline to Specify

Home Address: _____

City / State / Zip: _____

Home Phone: _____ Cell Phone: _____

Social Security: _____ Email: _____

In Case of Emergency, Notify: _____ Home Phone: _____

Relationship to Patient: _____ Cell Phone: _____

If Patient is a Minor, Person Responsible for Charges: _____

Date of Birth: _____ Social Security#: _____ Phone Number: _____

Primary Care Physician: _____ Referring Physician: _____

Primary Pharmacy: _____ Phone: _____

Pharmacy Location/Cross Streets: _____

Mail Order Pharmacy: _____ Phone: _____

Primary Insurance: _____ Ins ID #: _____ Grp # _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship of Policy Holder to Patient: _____

Secondary Insurance: _____ Ins ID #: _____ Grp # _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship of Policy Holder to Patient: _____



HIPAA Acknowledgement and Consent Form

Patient Name: _____
(First Name) (M.I) (Last Name) (Date of Birth)

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider and/or employee of Advanced Urology of Sarasota, LLC.

Patient's Contact Information:

1st Phone Preference: _____ ☐ Cell ☐ Home ☐ Work

2nd Phone Preference: _____ ☐ Cell ☐ Home ☐ Work

Do we have permission to leave a detailed message regarding medical & billing information on your voicemail at the phone numbers listed above?

☐ YES ☐ NO

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship to Patient	Contact Number
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____

Please note that if a person is not listed on this form, Advanced Urology of Sarasota, LLC will not share information with him/her.

Do you have an Advanced Directive / Living Will / Health Surrogate? ☐ Yes ☐ No

Signature of Patient or Legal Representative

Date

Relationship to Patient (Self / Parent / Legal Guardian/Representative)

Interoperability Consent and Rx History Consent

Interoperability Consent

Providing us access to your Electronic Health Records from participating Hospital System(s) and other Care Center(s) allows us to better serve you by being able to access important health information; for example, your allergies, and recent lab results etc.

I grant permission for Advanced Urology of Sarasota, LLC to be able to access my Electronic Health Records from participating Hospital Systems and other Care Facilities in information exchange and interoperability of Electronic Health Records.

Rx History Consent

Providing us access to you Medication History from pharmacies allows us to quickly and efficiently document the list of your current medications and assess drug-to-drug/drug-to-allergy interactions.

I grant permission for Advanced Urology of Sarasota, LLC to query and review my Medication History including drug dose, form, strength, prescribing provider, and pharmacy.

Name of Patient

If Applicable, Name of Legal Guardian/Representative

Signature of Patient

If Applicable, Signature of Legal Guardian/Representative

Date



Assignment of Benefits and Acknowledgement of Receipt of Notice of Privacy Practices Consent

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Advanced Urology of Sarasota, LLC for all covered medical services and supplies provided to me during all courses of treatment and care provided by Advanced Urology of Sarasota, LLC. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with Advanced Urology of Sarasota, LLC, which will authorize and allow for direct payment to Advanced Urology of Sarasota, LLC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Advanced Urology of Sarasota, LLC.

Acknowledgment of Receipt Notice of Privacy Practices

I acknowledge that I have received a copy of Advanced Urology of Sarasota, LLC Notice of Privacy Practices, which describes how Advanced Urology of Sarasota, LLC will use and protect my health information. This Notice describes my rights under the Health Insurance Portability and Accountability Act (HIPAA) and Advanced Urology of Sarasota, LLC policies on use and disclosure of my protected health information.

Name of Patient

If Applicable, Name of Legal Guardian/Representative

Signature of Patient

If Applicable, Signature of Legal Guardian/Representative

Date



Patient Administrative and Financial Policy

Patient Name: _____
(First Name) (M.I) (Last Name) (Date of Birth)

Dear Patient,

Thank you for choosing Advanced Urology of Sarasota, LLC as your healthcare provider. We are committed to providing you the highest quality, most affordable healthcare service available. To do so, we have established the following Financial Policy which we request that you read, agree to and sign before services are provided. A copy will be provided to you upon request.

It is the policy of Advanced Urology of Sarasota, LLC to help keep your health care costs as low as possible. To do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- Always bring your current health insurance card to the office.
- Please notify us at time of check-in of any changes to insurance, address, telephone, or family status.
- Please pay your co-pay, balances, or deductible at the time of service.
- You will be expected to pay in full if:
 - You do not have insurance.
 - Advanced Urology of Sarasota, LLC does not participate with your health plan.
 - You are unable to present a valid member identification card from your insurance carrier at your visit.
 - We are unable to verify your insurance coverage.
 - You have a pre-existing condition or other diagnosis that may not be covered by your plan.
 - You have not met the deductible under your health plan contract or
 - Routine services may not be covered by some insurance plans.
- You should receive a bill for any charges that are responsibility within 30 days of service: and/or an explanation of benefits (EOB) from your insurance company. If you have any questions about your bill, please contact our billing office at 941-371-7700.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid within ten (10) days.

Payment Options if you have Insurance: We are required by our insurance contracts to collect all copays and other patient responsible amounts, at the time of service. To assist you, we accept cash, checks or credit cards.

Insurance: It is the responsibility of the patient/guardian to know what their eligibility and coverage is or if a pre-cert and/or authorization is required with their insurance carrier. If this is not known, we suggest that you verify coverage limitations prior to being treated. It is the responsibility of the patient/guardian to ensure pre-certs and/or authorizations are valid for any visits and/or procedures scheduled. Not verifying your benefits or coverage for a pre-cert and/or authorization could result in the patient/guardian being responsible for anything the insurance does not cover.

If your insurance company has not processed your account within 90 days from the date of service, the balance will automatically be sent to you.

Your signature on this form indicates that you authorize Advanced Urology of Sarasota, LLC to bill your insurance company directly for services rendered and for your insurance company to make payment directly to Advanced Urology of Sarasota, LLC.



I understand in some instances the insurance carrier will pay the patient/guardian directly for services provided by Advanced Urology of Sarasota, LLC, it is the patient/guardian's responsibility to sign over that payment with the Explanation of Benefits to Advanced Urology of Sarasota, LLC. Failure to do this will result in the patient/guardian being responsible for payment in full.

Returned Checks: There is a fee for any checks returned by the bank. This fee will be what the bank charges Advanced Urology of Sarasota, LLC for the returned check.

Collections: I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency for collections, the undersigned shall pay all collection agency fees and risk being dismissed from the physician care of Advanced Urology of Sarasota, LLC.

All accounts sent to the collection agency will be reported to the Credit Bureaus.

No-Show Policy: It is very important that you keep your scheduled appointment with us and arrive on time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment.

If you do not cancel or reschedule your appointment and fail to attend your scheduled appointment, we may assess a "no-show" service charge to your account; \$25 for office visit appointments, \$50 for procedure appointments. This "no-show" charge is not reimbursable by your insurance company. You will be billed directly for it. Any "no-show" fees acquired must be paid before we are able to reschedule your appointment.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

Photography Release: I understand that photographs may be taken in connection with the medical services I receive and that such photographs will be retained in my medical records that may be shared with others, including, but not limited to, my insurance carrier. I give permission for these photos and information relative to them and/or relating to my case to be published and republished for the purpose of medical research, education, or science and I specify that such publication of the photographs will not include my name. I understand that this release remains valid unless I revoke myself.

Permission to Treat: I hereby give the physician and those under the supervision of the physician permission to treat me as a patient. I will comply with their recommendations for treatment, tests, and/or referrals to other specialists that may be necessary for my care.

I have read this Patient Administrative and Financial Policy, as outlined, and understand that I am ultimately responsible for the charges incurred by me or by my child/children as their legal parent or guardian.

This is an agreement between Advanced Urology of Sarasota, LLC as creditor, the Patient, Guardian/Guarantor, or Parent as debtor, named on this form.

In this agreement, the words "you", "your" and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Advanced Urology of Sarasota, LLC.

By executing this agreement, you are agreeing to pay for all services that are received.

Name of Patient

If Applicable, Name of Legal Guardian/Representative

Signature of Patient

If Applicable, Signature of Legal Guardian/Representative

Date

Pelvic Examination Informed Consent

I understand by law my healthcare practitioner requires written informed consent to perform a Pelvic Examination on me. If my healthcare practitioner deems it necessary, I will be informed prior to receiving a Pelvic Examination.

Description of the Examination

A "Pelvic Examination" means an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum or external pelvic tissue or organs using any combinations of modalities which may include, but may not be limited to, the healthcare provider's gloved hand or instrumentation.

I have been informed as to the nature and process of the Pelvic Examination. Any and all questions have been answered to my satisfaction.

I hereby GIVE MY INFORMED AND VOLUNTARY CONSENT to receive a Pelvic Examination. I can withdraw my consent at any time by informing my healthcare provider, in writing, that my consent is withdrawn.

Name of Patient (Print)

Date of Birth

Signature of Patient or Legal Representative

Date

Relationship to Patient (Self / Parent / Legal Guardian/Representative)

PATIENT HISTORY FORM

Date: _____

Patient Name: _____ DOB: _____ Age: _____

PCP: _____ Referring Doctor: _____

HISTORY OF PRESENT ILLNESS

Reason for Visit: _____

Date of Onset: _____ List Location (Left or Right): _____

Any Test? What type and location: _____

Please Check Yes Or No:

Blood in urine	<input type="checkbox"/> Y / <input type="checkbox"/> N (visible or microscopic)	Slow or weak stream	<input type="checkbox"/> Y / <input type="checkbox"/> N
Clots in urine	<input type="checkbox"/> Y / <input type="checkbox"/> N	Burning with urination	<input type="checkbox"/> Y / <input type="checkbox"/> N
Frequent urination	<input type="checkbox"/> Y / <input type="checkbox"/> N (How often? Every ____ hrs)	Leakage of urine	<input type="checkbox"/> Y / <input type="checkbox"/> N
Nocturia (urinating at night)	<input type="checkbox"/> Y / <input type="checkbox"/> N (How often? Every ____ hrs)	Problems with erections	<input type="checkbox"/> Y / <input type="checkbox"/> N
Pain or difficulty with intercourse	<input type="checkbox"/> Y / <input type="checkbox"/> N		

PAST MEDICAL / SURGICAL HISTORY

List all serious illnesses & hospitalizations, including surgeries along with approximate admission date(s):

Have you ever been diagnosed with: (Please Check Yes or No)

TB	<input type="checkbox"/> Y / <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y / <input type="checkbox"/> N	Heart Murmur	<input type="checkbox"/> Y / <input type="checkbox"/> N
Heart Attack	<input type="checkbox"/> Y / <input type="checkbox"/> N	Heart Disease	<input type="checkbox"/> Y / <input type="checkbox"/> N	Elevated Cholesterol	<input type="checkbox"/> Y / <input type="checkbox"/> N
Diabetes (Type 1 or 2)	<input type="checkbox"/> Y / <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y / <input type="checkbox"/> N	Atrial Fibrillation (Afib)	<input type="checkbox"/> Y / <input type="checkbox"/> N
Blood Clots	<input type="checkbox"/> Y / <input type="checkbox"/> N	Asthma	<input type="checkbox"/> Y / <input type="checkbox"/> N	Cancer	<input type="checkbox"/> Y / <input type="checkbox"/> N

Type: _____

Other: _____

SOCIAL HISTORY

Marital Status: _____ Children: _____ Occupation: _____

Do you smoke? ☐ Y / ☐ N How long? _____ How much? _____ When did you quit? _____

Do you drink alcohol? ☐ Y / ☐ N How much? _____ Beer: _____ Wine: _____ Liquor: _____

Do you drink caffeine? ☐ Y / ☐ N How much? _____

Exposure to: Dye Industry? ☐ Y / ☐ N Rubber Industry? ☐ Y / ☐ N Paint Industry? ☐ Y / ☐ N

Patient Name: _____

Date of Birth: _____

FAMILY HISTORY

Condition	Relationship to you
Heart Disease:	_____
Diabetes:	_____
Tuberculosis:	_____
Kidney Disease:	_____
Cancer (Type):	_____
Other:	_____

REVIEW OF SYMPTOMS

Are you currently having problems with the following? (Check Yes or No)

Constitution:	<input type="checkbox"/> Y / <input type="checkbox"/> N Fever	Gastrointestinal:	<input type="checkbox"/> Y / <input type="checkbox"/> N Abdominal pain
	<input type="checkbox"/> Y / <input type="checkbox"/> N Chills		<input type="checkbox"/> Y / <input type="checkbox"/> N Nausea/vomiting
	<input type="checkbox"/> Y / <input type="checkbox"/> N Unwanted weight loss		<input type="checkbox"/> Y / <input type="checkbox"/> N Indigestion/heartburn
	<input type="checkbox"/> Y / <input type="checkbox"/> N Loss of appetite		<input type="checkbox"/> Y / <input type="checkbox"/> N Constipation
	<input type="checkbox"/> Y / <input type="checkbox"/> N Night sweats		<input type="checkbox"/> Y / <input type="checkbox"/> N Blood in stool
	<input type="checkbox"/> Y / <input type="checkbox"/> N Headaches		<input type="checkbox"/> Y / <input type="checkbox"/> N Diarrhea
▪ Approx. date of last Influenza vaccine: _____		▪ Date of last colonoscopy: _____	
Eyes:	<input type="checkbox"/> Y / <input type="checkbox"/> N Blurred vision	Integumentary:	<input type="checkbox"/> Y / <input type="checkbox"/> N Skin rash
	<input type="checkbox"/> Y / <input type="checkbox"/> N Double vision		<input type="checkbox"/> Y / <input type="checkbox"/> N Persistent itch
	<input type="checkbox"/> Y / <input type="checkbox"/> N Eye pain		
Neurological:	<input type="checkbox"/> Y / <input type="checkbox"/> N Tremors	ENT:	<input type="checkbox"/> Y / <input type="checkbox"/> N Hearing loss
	<input type="checkbox"/> Y / <input type="checkbox"/> N Seizures		<input type="checkbox"/> Y / <input type="checkbox"/> N Sore throat
	<input type="checkbox"/> Y / <input type="checkbox"/> N Dizziness		<input type="checkbox"/> Y / <input type="checkbox"/> N Sinus problems
	<input type="checkbox"/> Y / <input type="checkbox"/> N Numbness/tingling		<input type="checkbox"/> Y / <input type="checkbox"/> N Changes in swallowing
Endocrine:	<input type="checkbox"/> Y / <input type="checkbox"/> N Excessive thirst	Respiratory:	<input type="checkbox"/> Y / <input type="checkbox"/> N Shortness of breath
	<input type="checkbox"/> Y / <input type="checkbox"/> N Fatigue		<input type="checkbox"/> Y / <input type="checkbox"/> N Wheezing
	<input type="checkbox"/> Y / <input type="checkbox"/> N Hot/Cold feeling		<input type="checkbox"/> Y / <input type="checkbox"/> N Chronic cough
Cardiovascular:	<input type="checkbox"/> Y / <input type="checkbox"/> N Chest pain	Hematologic:	<input type="checkbox"/> Y / <input type="checkbox"/> N Easy bruising
	<input type="checkbox"/> Y / <input type="checkbox"/> N High blood pressure		<input type="checkbox"/> Y / <input type="checkbox"/> N Bleeding problems
	<input type="checkbox"/> Y / <input type="checkbox"/> N Ankle swelling		
Physiologic:	<input type="checkbox"/> Y / <input type="checkbox"/> N Anxiety	Musculoskeletal:	<input type="checkbox"/> Y / <input type="checkbox"/> N Back pain
	<input type="checkbox"/> Y / <input type="checkbox"/> N Depression		<input type="checkbox"/> Y / <input type="checkbox"/> N Joint pain
			<input type="checkbox"/> Y / <input type="checkbox"/> N Neck pain
Gynecological:	<input type="checkbox"/> Y / <input type="checkbox"/> N Currently pregnant		
(Female Patient)	<input type="checkbox"/> Y / <input type="checkbox"/> N Menopause If yes, date: _____		
	Last menstrual date: _____		

Patient Name: _____

Date of Birth: _____

MEDICATION AND ALLERGY LIST

PRESCRIPTIONS

Medication	Dose (mg)	# of pills	Home many times a day (circle the number)				Time of day taken (AM or PM)
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	
			1	2	3	4	

MEDICATION ALLERGIES AND REACTIONS:

DRUG	REACTION

Latex Allergy? ☐Y / ☐N

Do you take an antibiotic prior to dental procedures? ☐Y / ☐N

Are there any medications you have listed above that require you to get permission from a prescribing physician before you discontinue? ☐Y / ☐N

If yes, from whom: _____