

○ Jeffrey M. Frankel, MD ○ David C. Reed, MD ○ Jeffrey L. Evans, MD

Board Certified Adult and Pediatric Urology

Patient Registration

Name: _____, _____ Sex: M F
Last First Middle

Age: _____ Date of Birth: ____/____/____ Marital Status: S M D W SEP D/P

SS# XXX-XX-_____ (Last 4 Only) Email Address: _____

Please Print Clearly – Thank you

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Preferred –Yes No Preferred -- Yes No

Employer: _____ Work Phone: _____

Referred by: _____ Primary Care Physician: _____
First Name Last Name First Name Last Name

Local Pharmacy: _____ Location: _____ Phone: _____

Mail Order Pharmacy: _____ Location: _____

If patient is a minor please complete below:

Parent or guardian Name: _____ Date of Birth: ____/____/____

SS# _____ - _____ - _____ Employer: _____ Work Phone: _____

Financial and Insurance information

Primary:

Name of insurance company: _____ Referral Required? Y N
*****See Financial Policy if referral required

Policy Holder Name: _____ Date of Birth ____/____/____

Policy number: _____ Group Number: _____

Secondary:

Name of insurance company: _____ Referral Required? Y N

Policy Holder Name: _____ Date of Birth: ____/____/____

Policy number: _____ Group Number: _____

Emergency Contact Information

Name: _____ Home Phone: _____

Relation to patient: _____ Alternate Phone: _____

Release of Benefits and Information

I authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for processing insurance claims.

Signed: _____ Relationship: _____ Date: _____
Signature of Patient (or legally authorized representative) Relation to patient

○ Jeffrey M. Frankel, MD ○ David C. Reed, MD ○ Jeffrey L. Evans, MD

Board Certified Adult and Pediatric Urology

16259 Sylvester Rd SW Suite 303 Burien, WA 98166
Ph. 206-244-2822 Fx. 206-243-7807

1412 SW 43rd St #201 Renton, WA 98057
Ph. 206-244-2822 Fx. 206-243-7807

Name: _____, _____
Last First Middle

Date of Birth: ____/____/____ Height _____ Weight _____

Patient History

- What is the reason for your visit today? _____
- When did you first notice the problem _____
- How often do you notice the problem? _____
- Does anything make the problem worse? _____
- Does anything make the problem better? _____
- Does the problem interfere with normal activity? In what way? _____

Please circle if you have the following:

- | | | |
|---|------------------------------|---|
| Blood in urine | Start and stop urination | Problem with sexual function |
| Pain or burning with urination | Kidney stones | Blood in the semen |
| Frequent urination | Bladder stones | Urethral stricture (narrowing) |
| Hard to start urination | Bladder infection(s) | Fever of unknown cause |
| Pain over the bladder region | Kidney infection(s) | Other kidney disease |
| Straining to urinate | Back pain over the kidney(s) | Previous cystoscopy (look into bladder) |
| Going to the bathroom more than once at night | Accidental loss of urine | Previous urology x-rays |
| Slow/small/weak urine stream | Bedwetting | Previous urology surgery |
| Difficulty emptying the bladder | Prostate problem | |
| | Testicular problem | |

- List of previous surgeries with date(s): _____
- List of all medical problems: _____
- List of all prescription medications: _____
- List of all over-the-counter medications: _____
- Please list illnesses of immediate family members with their relationship (parent/sibling/child): _____

- Do you smoke tobacco? If so, how many packs per day, and for how many years? _____
- Did you smoke in the past, when did you quit? _____ Packs per day? How many years? _____
- Do you drink alcohol? _____ How much? _____
- Are you on a special diet? If yes, explain. _____
- Do you drink caffeine? How many drinks per day? _____

Please circle all that apply:

Constitutional symptoms

Poor General Health Lately
Recent weight change
Fever
Fatigue
Headaches
Chills
Other _____

Eyes

Eye disease or injury
Blurred or double vision
Glaucoma
Other _____

Ear/nose/mouth/throat

Hearing loss or ringing
Earaches or drainage
Swollen glands in neck
Sore throat or voice change
Chronic sinus problems or rhinitis
Mouth sores
Bleeding gums
Other _____

Cardiovascular

Heart trouble
Heart attack
Coronary artery disease
Chest pain
Palpitation
Heart murmur
Shortness of breath
Swelling of feet, ankles or hands
High blood pressure
Varicose veins
Other _____

Respiratory

Asthma
Wheezing
Shortness of breath
Spitting up blood
Chronic or frequent coughs
Tuberculosis
Pneumonia
Pneumonia Vaccine Year _____
Other _____

Gastrointestinal

Ulcer (stomach or duodenal)
Abdominal pain or heartburn
Change in bowel movements
Nausea
Vomiting
Frequent diarrhea
Crohn's or ulcerative colitis
Diverticulitis
Pancreatitis
Painful bowel movements or constipation
Rectal bleeding or blood in the stool
Colonoscopy-Year _____
Hepatitis other _____

Musculoskeletal

Joint pain
Joint stiffness or swelling
Weakness of muscles or joints
Muscle pain or cramps
Back pain
Cold extremities
Difficulty with walking
Other _____

Skin/breast

Rash or itching
Change in skin color
Change in hair or nails
Breast pain
Breast lump
Breast discharge
Recurrent boils
Other _____

Neurologic

Frequent or recurrent headaches
Migraines
Lightheaded or dizzy
Tremors
Convulsions or seizures
Head injury
Numbness or tingling sensations
Stroke
Paralysis
Meningitis
Other _____

Psychiatric

Memory loss or confusion
Nervousness
Depression
Insomnia
Other _____

Endocrine

Glandular or hormonal problem
Thyroid disease
Diabetes
Loss of appetite
Excessive thirst
Cold intolerance
Other _____

Hematologic/lymphatic

Nosebleeds
Slowly heal after cuts
Bleeding or bruising tendency
Anemia
Phlebitis
Enlarged lymph glands
Deep venous thrombosis/"blood clots"
Pulmonary embolus
Other _____

Allergies/immunologic

History skin reaction or other adverse reaction to:

Penicillin
Sulfa
Macrobid/Nitrofurantoin
Morphine
Demerol
Codeine
Novocain or other anesthetics
Aspirin or other pain remedies
Shellfish or contrast dyes
Topical iodine or other antiseptics
Food allergies:

Other drug allergies:

○ Jeffrey M. Frankel, MD ○ David C. Reed, MD ○ Jeffrey L. Evans, MD
Board Certified Adult and Pediatric Urology

Financial Policy Statement ~~~~Please read Carefully

Thank you for choosing Dr's Frankel, Reed, and Evans as your healthcare provider. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

If you have insurance coverage, please give your insurance cards and necessary forms to the receptionist. We will be glad to bill your insurance company directly. Please understand that your medical insurance is a contract between you and your insurance company. You are ultimately responsible for any unpaid balance. If you are unable to supply us with **all** of your current insurance information, you will be asked to pay for services **before** you are seen by the doctor. **If your insurance company requires you to have a referral, we need it in our office at the time of service. If you do not have a referral, you will have the option to reschedule or sign the waiver below stating that you are responsible for services rendered. You are responsible for making sure that you have a current referral each visit to our office. (Most referrals expire after 90 days) Our office will not call on referrals.**

REFERRAL WAIVER

I am aware that my insurance company requires a referral from my primary care physician to see a specialist.

I have been informed that I am responsible for all charges incurred for today's visit. It is also up to me to request the referral from my primary care physician.

Signature: _____ Date: _____

If you do not have any insurance coverage or choose to bill your insurance company yourself, payment is due in full, at the time of service. If you are unable to meet these requirements, please ask about alternative payment options before you are seen. We accept cash, checks, Visa, and MasterCard.

CO-PAYMENTS are due at the time of service. There will be an additional billing fee for co-payments if not paid at the time of service.

There is a \$25.00 fee on all returned checks.

Missed Appointments: Patients will be charged \$25 for missed appointments and a \$100 fee for missed procedures. Cancellations with less than 24 hour notice are considered a missed appointment. **This fee is not billable to your insurance and must be paid before you can make your next appointment. Multiple last minute cancels or no shows will require a non-refundable deposit for future appointments.**

Paperwork Charge Policy: Patients will be charged a fee for filling out various patient paperwork requests including, but not limited to, self-insured/supplemental insurance, disability policy paperwork, FMLA forms, anything requiring a letter, or extended medical review. Please see below for fee range.

No Charge for 1 page or just a signature

\$25 for 2+pages

\$35 and up for dictated summaries, letters or extended medical reviews.

All fee's are paid prior to release of paperwork.

I have a contracted insurance carrier and understand I will be responsible for payment of any co-pay or deductible

Signature

Printed Name

_____/_____/_____
Date of Birth

Date Signed _____

○ Jeffrey M. Frankel, MD ○ David C. Reed, MD ○ Jeffrey L. Evans, MD
Board Certified Adult and Pediatric Urology

16259 Sylvester Rd SW Suite 303 Burien, WA 98166
Ph. 206-244-2822 Fx. 206-243-7807

1412 SW 43rd St #201 Renton, WA 98057
Ph. 206-244-2822 Fx. 206-243-7807

Notice of Privacy Practices Acknowledgement

We keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or the law requires us to do so. You may see your record or get more information about it by contacting our office.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature

Date

○ Jeffrey M. Frankel, MD ○ David C. Reed, MD ○ Jeffrey L. Evans, MD
Board Certified Adult and Pediatric Urology

HIPAA Compliance Patient Consent Form

Name: _____, _____
Last First Middle
Date of Birth: ____/____/____

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.

May we phone 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:

Authorized numbers to call:

This consent was signed by: _____ Date: _____
(Print name)

Signature: _____ Date: _____

Relationship to patient (if other than patient) _____ Date: _____

Witness: _____ Date: _____