Midtown Urology Patient Registration Form

Appointment Reason	
How Did You Hear About Us?	

Patient Information

First Name & MI		Last Name	
Date of Birth		E-mail	
Address			
City		State	
Zip Code		Home Phone	
Cell Phone		Work Phone	

Referred by

Primary Physician	
Referring Physician	
Cardiologist	

Insurance Information

Primary Insurance		Secondary Insurance	
Policy #		Policy #	
Group #		Group #	
Subscriber's Name		Subscriber's Name	
Relationship to Subscriber		Relationship to Subscriber	
Subscriber's DOB		Subscriber's DOB	
Subscriber's Gender		Subscriber's Gender	

Pharmacy Information and Emergency Contact Information

Preferred Pharmacy		Emergency Contact	
Address/Intersection		Relationship	
City, State, Zip		Primary Number	
Phone #		Alternate Number	

Midtown Urology Medical History Questionaire

Date: _____

Patient Name: _____

Reason for Visit: _____

When did your problem start: _____

Allergies to medications or food: _____

_____

Medications, supplements, OTC: _____

_____

_____

_____

Blood Thinners: (Ex: aspirin) _____

Most recent Pneumonia Vaccine:_____Last Colonoscopy:_____

Surgical History (please check all that apply and include year)

☐ Cystoscopy	☐ Kidney Removal	☐ Urethral Stricture Surgery	☐ Vasectomy
☐ Lithotripsy/ESWL	☐ Testical Removal	☐ Enlg. Prostate Surgery/TURP	☐ Hysterectomy
☐ Bladder Cancer/TURBT	☐ Prostate Needle Biopsy	☐ Gallbladder Removal	☐ Heart Bypass
☐ Prostatectomy	☐ Pelvic Prolapse/Sling	☐ Vaginal Deliveries #	☐ Appendectomy

☐ Other_____

Medical History (please check all that apply)

☐ Prostate Cancer	☐ Hypogonadism (Low T)	☐ Kidney Stones	☐ Heart Attack
☐ Bladder Cancer	☐ Erectile Dysfunction	☐ Chronic UTI	☐ Hypertension
☐ Kidney Cancer	☐ Elevated PSA	☐ Incontinence	☐ Diabetes
☐ Testicular Cancer	☐ Enlarged Prostate	☐ Menopause	☐ Hepatitis
☐ Breast Cancer	☐ Urinary Retention	☐ Rash/Warts	☐ Last Period:

☐ Other_____

Family History (please check all that apply)

	Father's Side	Mothers' Side	Brother	Sister
Prostate Cancer				
Kidney Cancer				
Kidney Stones				
Heart Disease				
Diabetes				
Other_____				

Social History (please circle all that apply)

Marital Status: Single Married Divorced Widowed

Smoke: Yes Not Anymore Never

Drink Alcohol: Socially Not Anymore Never

Daily Caffeine Intake: 0 1 2 3 4+

Blood Transfustion: Yes No

Weight: _____ Height: _____

Urological Symptoms (please check all that apply)

General:	☐ Fever	☐ Weight Loss	☐ Chills
Eyes:	☐ Blurry Vision	☐ Double Vision	☐ Cataracts
Ears, Nose, Throat:	☐ Hearing Loss	☐ Nasal Stuffiness	☐ Sore Throat
Cardiovascular:	☐ Chest Pains	☐ Swollen Ankles	☐ Irregular Heartbeat
Respiratory:	☐ Shortness of Breath	☐ Wheezing	☐ Chronic Cough
Gastrointestinal:	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels
Genitourinary:	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine
Musculoskeletal:	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles
Integumentary:	☐ Rash	☐ Persistant Itching	☐ Skin Cancer History
Neurologic:	☐ Numbness	☐ Tingling	☐ Dizziness
Hematologic:	☐ Swollen Glands	☐ Abnormal Bleeding	☐ Transfusion History

Medical Records Release Form

From:_____ **Fax:**_____

I hereby authorize and request the release of the copies of the following information:

Complete Medical Records_____ **All PSA Levels**_____

Laboratory Records_____ **X-Rays**_____

Procedure Reports_____ **Pathology Reports**_____

Office Visits_____ **Other**_____

Including current and previous medical records from other practices, practioners, hospitals, and/or clinics which are a part of my medical records.

To: Dr. Michael Trotter **Phone: 512-451-7935** **Fax: 512-451-7965**

911 W. 38th Street Suite 200 Austin, TX 78705

This information has been released to you specifically with the consent of the patient or his/her authorized representative. It is strictly confidential and no further release or use of this information is authorized without the consent of the patient or authorized representative.

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

Patient Social Security #:_____ **Phone #:**_____

Single Disclosure **Continuing disclosure for 90 days**

Expiration Date:_____

I hereby release the facility from any liability, which may arise as a result of the use of the information contained in the records released.

Patient Name: _____ Date of Birth: _____

FINANCIAL POLICY NOTICE

Please read carefully and initial on each line to indicate you understand our policy.

_____ Insurance co- pays are due **at the time of service and before you see the doctor**. **If you are unable to pay your co- pay you will be asked to reschedule your appointment.** Due to the fact that Midtown Urology is a specialty practice, higher co- pays may be indicated (consult your individual insurance policy benefits for clarification).

_____ In- office procedures are typically applied by your insurance company towards your deductible, co- insurance or other out- of- pocket expense. **All fees are due in advance of the procedure or surgery performed** unless an alternate arrangement is made *prior to* your appointment date.

_____ If you have not met your deductible your payment will be due at time of your visit. All other payments of shared costs will be billed to you after your insurance has completed the processing of your claim. Payment of your bill is due upon receipt.

_____ If we do not participate with your insurance company, and your insurance plan does not provide out- of- network benefits, you will be considered a "self- pay" patient. See the Self- Pay Patient policy below. As a courtesy, we shall provide you with the information necessary to bill your insurance company.

_____ Midtown Urology enforces a $25 fee for appointments and a $75 fee for procedures not cancelled prior to your scheduled appointment/procedure. As a courtesy our office calls 4 days prior to an appointment to remind patients of their future appointment. This is a courtesy only and it is ultimately the patient's responsibility to keep track of appointments made.

_____ It is the patient's responsibility to obtain all referral certifications from the primary care or referring physician when required by your insurance plan. Otherwise you may be responsible for the cost of your office visit.

_____ It is the patient's responsibility to know from whom your insurance company requires that you to obtain any labs, x- rays, or any other ancillary services. Please let your doctor's medical assistant or nurse know so that they may schedule these services accordingly.

_____ Many insurance plans cover ancillary services (labs, x- rays, CT scans, etc.) under alternate benefits, such as higher deductible or co- insurance amounts, even additional co- pays. These additional out- of- pocket expenses are not associated with our contract/participation with your insurance company. Instead, it is simply a matter of your plan benefits. Midtown Urology Associates must comply with both contractual obligations and government regulations, **thus we cannot alter your insurance plan benefits and will bill you accordingly**.

_____ I am aware that the providers at Midtown Urology may have financial interests in procedures, facilities, and/or products that are recommended and/or discussed with me.

_____ I am aware that a list of their financial disclosures is available upon request.

SELF- PAY PATIENTS

_____ If you (1) do not have insurance coverage, (2) choose not to use your insurance coverage, or (3) are seeking treatment/services that are not covered by your insurance plan, you are a "self- pay" patient. A 30% discount of our regular fees will be applied toward our office charges, and payment is required at the time of your visit. Alternate payment arrangements are available at the discretion of the site manager (30% discount may be forfeit). Any labs or imaging done at a third party facility does not apply towards your payment to our office. These services will be at an additional cost to you.

Midtown Urology accepts cash, checks, MasterCard, and Visa. $40 fee applies to all returned checks. Additional fees may apply to special financing arrangements and bad debt collections.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept the above financial policy.

Guarantor/Patient Signature: _____ Date: _____

Name of Guarantor (if different from patient) _____

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION
& ASSIGNMENT OF BENEFITS

_____ (initial) I have read and acknowledge Midtown Urology's Notice of Privacy Practices. Midtown Urology complies with all regulatory guidelines with regard to safeguarding your protected health information (PHI). For example, sharing of my PHI may only occur between authorized entities such as my insurance company and my physician, but not with my spouse. These guidelines and our policies are published in this notice. A for my records will be provided at my request.

_____ (initial) I authorize my primary care physician, referring physician and other care providers to furnish any and all information concerning my present illness or injury to Midtown Urology.

Please list any authorized entities with whom we can share your PHI: None_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

ASSIGNMENT OF BENEFITS

I authorize assignment of my insurance plan benefits directly to Midtown Urology for services provided. I understand that I am financially responsible to Midtown Urology for all cost-share expenses (co-pay, co-insurance, and deductible), as well as any services not covered by my insurance plan.

_____ Patient Name

_____ Patient DOB

_____ Patient Signature

_____ Date Signed

_____ Guarantor Signature (if different than patient)

_____ Date Signed