COMMONWEALTH UROLOGY

Patient Registration
Welcome!

Patient Information — Appointment Scheduled with: ☐ Dr. Basile ☐ Dr. Patel

Please Print Clearly

Today's Date:_____ ☐ New Patient ☐ Update Info

Name:_____ Sex: Male Female
First MI Last

Address:_____
City State Zip Code

Email: _____ Home#:_____ Cell#:_____

DOB:_____ Age:_____ SSN:_____ Marital Status: M S D W

Employer:_____ Occupation:_____

Primary Care/Referring Physician:_____ Doctor #:_____

Pharmacy Name:_____ Pharmacy #:_____

Drug Reactions/Allergies:_____

Spouse Information

Name:_____ DOB:_____ SSN:_____
First MI Last

Work #:_____ Cell #:_____ Employer_____

Insurance Information

PRIMARY:_____ Copay/Deductible:_____

Address:_____
City State Zip Code

Policy ID#:_____ Group#:_____

Policy Holder Name:_____ Relationship:_____ DOB:_____

Type of Insurance: PPO HMO POS MC Referral /Authorization Required: Yes No

SECONDARY:_____ Copay/Deductible:_____

Address:_____
City State Zip Code

Policy ID#:_____ Group#:_____

Policy Holder Name:_____ Relationship:_____ DOB:_____

Information Verified:_____ _____ _____

COMMONWEALTH UROLOGY
AGREEMENT

THIS AGREEMENT is made by and between_____("Patient"), and John J. Basile, MD, PC doing business as COMMONWEALTH UROLOGY [3020 Hamaker Court, Suite B-111, Fairfax, Virginia 22031] ("Physicians").

Whereas, Patient is interested in employing Physician for his professional services and expertise; and
Whereas, Physicians agree to handle Patient's medical issues with the skill, expertise and common knowledge of physicians trained in the same medical field and areas of expertise. Now, therefore, the parties do hereby agree as follows:

1. **Purpose:** Patient agrees to employ Physicians for the purpose of medical diagnosis and treatment.
2. **Services:** Patient understands that it is difficult and impossible at this time to specify the exact nature and extent of treatment, procedures, and Physicians' time involved. The Physicians hereby warrant that they shall exert all of their efforts and skills in resolving Patient's complaints. Due to the nature of medical treatment, Physicians cannot and do not guarantee the outcome of any procedure or treatment plan.
3. **Financial Agreement:** As a courtesy, Physicians office shall file Patient's medical claim with Patient's insurance company. Patient agrees that if insurance plan (including of all HMO plans) requires a referral from their primary care physician, then it is **the Patient's responsibility to obtain and bring the referral from your primary care physician prior to each visit** and further that if Patient does not obtain and bring the referral, then the Patient shall make payment in full at the time of the scheduled appointment. Patient further agrees to make all co-payments at the scheduled appointment time. Patients unable to make payment immediately upon request shall make payment arrangements with the Physicians' business office and agree to pay the balance in full within 10 business days. Patient certifies that the information reported with regard to insurance coverage is correct. Patient agrees that if any or all of the information concerning insurance coverage changes, Patient will immediately inform Physician's business office and provide the updated information. Patient agrees to pay for any and all services rendered which are not covered under Patient's insurance plan, or which are not billed correctly due to information not provided or improperly provided to the Physicians' office by the Patient. **All unpaid balances which are overdue thirty (30) or more calendar days shall accrue interest at ten percent (10%) per annum**.
4. **Secondary claims** will be submitted once as a courtesy to the patient. If the secondary insurance company does not respond, the patient will be billed and be held responsible for obtaining reimbursement from their secondary carrier.
5. **Cancellation/ No Show Fee**: **Any appointment** cancelled within **48 business hours** of the scheduled time will be charged a **cancellation fee: $75.00 for office visit and $150.00 for in office Cystoscopy cancellation. Any procedure or surgery cancelled within 5 business days of the scheduled time will be charged a late cancellation fee of $350.00.** This charge is not covered by insurance, IT IS YOUR RESPONSIBILITY. You will receive an invoice for this and payment is expected prior to scheduling your next appointment.
6. **Medication, Lab, or Radiologic Tests:** No prescriptions for medication, lab, or radiologic tests will be provided if the last office visit was more than 12 months ago. There is a $25.00 fee for any lost prescriptions/orders written during 12 month period from the last office visit.
7. **Collection:** In the event Patient's bill becomes delinquent and is sent for collection, Patient agrees to pay all costs of collection, which include, but are not limited to, court costs, filing fees, subpoena fees, deposition costs, long-distance calls, transportation costs, postage fees, reasonable attorney's fees (defined as 33 1/3% of the principal collection amount), as well as any other cost incurred attempting to collect the delinquent amount.
8. **Law and Binding Effects:** This Agreement shall be construed according to Virginia laws and courts, and shall be binding upon each of the parties, their heirs, successors and assigns.
9. **Venue/Jurisdiction**: The parties agree and consent to venue and jurisdiction as being Fairfax County in the Commonwealth of Virginia

IN WITNESS WHEREOF, this _____ day of _____, 20_____.

_____ ___/___/_____ _____

(Print) Patient Name **DOB** **(Signature) Patient or Legal Guardian**

By:_____
Commonwealth Urology

COMMONWEALTH UROLOGY

INSURANCE: REQUIRED PRIOR AUTHORIZATION FOR MEDICATIONS

Dear Patients:

Most insurance companies have made changes to your pharmacy medication plans. As of January 1, 2014 the majority of drugs that are brand name are now considered non formulary. This means that your **insurance company will not pay nor cover the cost for most Brand Drugs** and then we receive letters/forms from your pharmacy denying coverage payments. This is especially true for **ED drugs, BPH and Overactive Bladder drugs and more recently cancer treating medications (e.g. Lupron, Zoladex, BCG, Mutamicin, Eligard).** If you are to get cancer treatments here, it is YOUR responsibility to contact your insurance company and make certain the payment for these medications will be covered – otherwise it will be YOUR responsibility to pay our office for the cost of these medications as well as the cost of the office visit.

If you receive notification of non coverage, the doctor is requesting that you contact your insurance company to get the Prior Authorization Forms. You may then either:

1. Make an appointment with your doctor and bring the forms to be filled out.
2. You may fax us the prior authorization forms to be filed out for a $20.00 fee payable in advance (non refundable fee.) *There is no guarantee that even if the doctor fills out the prior authorization forms that your insurance will pay for your medications.
3. Request your insurance company to fax YOU the list of approved formulary drugs. Then, make an appointment and bring in the list of approved formulary medications and the doctor will discuss with one may best treat your condition and then prescribe the medications for you.

Print Name:_____ Date:_____

Signature:_____

AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to my dependent or me during the period of such care to third party payers and/or healthcare practitioners. I also authorize and request my insurance company to pay directly to the doctor or to John J. Basile, M.D., P.C. (doing business as Commonwealth Urology) benefits otherwise payable to me.

I understand that if my insurance plan requires a **referral from** my primary care physician, **that it is my responsibility** to obtain it; otherwise, I agree that I am responsible for payment at the time of visit. I certify that the information I have reported with regard to my insurance coverage is correct and that if my insurance plan changes, that I will promptly notify the doctor's office of such change. I also agree to pay for services rendered which are not covered under my insurance plan. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

Print Name:_____ Date:_____

Signature:_____
(Patient, Parent or Guardian)

COMMONWEALTH UROLOGY

NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how medical information about you may be used, disclosed and how you can gain access to this information. A Federal Regulation, known as the "Health Insurance Portability & Accountability Act (**HIPAA**)", requires that we provide notice in writing of our privacy practices. These privacy practices are in place to maintain the privacy of your protected health information (**PHI**). Commonwealth Urology may disclose PHI for the purposes of treatment, payment, and to operate the practice. The following are some examples, and do not imply an exclusive list.

Examples of uses and disclosures for treatment: If the doctor refers you to another physician for continuation of treatment, we may provide your name and the reason for your referral to the doctor's office. The doctor or his staff may call you to advise you of treatment alternatives or recommendations.

Examples of uses and disclosures to obtain payment: Our billing office may submit a claim that contains your name, address, social security number, diagnosis, and procedure(s) performed by our physicians to your insurance company.

Examples of uses and disclosures to operate the practice: Our staff may call you or email you with reminders and leave messages about upcoming appointments, our staff may leave messages for you on your telephone and/or ask you to return the call, the physicians may audit (read and comment upon) your chart to track and improve our performance in assuring that we perform screening test on time.

Commonwealth Urology is permitted or required to use or disclose PHI without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements and court orders.

Commonwealth Urology will not make any other disclosure of your PHI, other than for the aforementioned purposes of treatment, payment, or practice operation, without the individual's written authorization. Such authorization may be revoked by you at any time. Revocation must be in writing.

You have the following rights regarding your PHI, and the practice must act on your request within 60 days: You may request restrictions on certain uses and disclosures of PHI, but we are not required to agree to a requested restriction, you may request to inspect and copy your own PHI, you may request that your information be amended, you may request a paper copy of this notice.

If you would like to authorize us to release your medical information to someone other than yourself, please complete the following: I authorize Commonwealth Urology to release confidential medical information pertaining to my care to the following people. I understand that it is my responsibility to notify Commonwealth Urology in writing, if this authorization information changes.

This HIPPA Form will allow confidential medical information to be obtained by my: (list names)

Spouse: _____ Parent(s):_____
Son/Daughter: _____Other:_____
If No one (Put a check here):_____

_____ _____ _____
Patient/Guardian Signature Printed Name Date

PATIENT HISTORY FORM

Patient Name:_____ **Date:**_____

CHIEF COMPLAINT

State, as clearly as possible, the main reason for your visit.

_____

_____

HISTORY OF PRESENT ILLNESS

Elaborate on your chief complaint.

_____

_____

_____

_____

_____

Please Specify if you have had any of the following:

- ☐ Urinary Tract Infections
  Specify:_____
- ☐ Kidney Stones
  Specify:_____
- ☐ Sexually Transmitted Disease
  Specify:_____
- ☐ Cancer of the Urinary Tract (kidney, bladder, prostate, or testicle)
  Specify:_____
- ☐ Prostatitis
  Specify:_____
- ☐ Incontinence
  Specify:_____
- ☐ Erectile Dysfunction
  Specify:_____
- ☐ Infertility
  Specify:_____

PAST MEDICAL HISTORY

List all personal past illnesses with dates of diagnosis.

Illness:	Date:	Illness:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST SURGICAL HISTORY

List all surgical procedures you have undergone with dates.

Surgery:	Date:	Surgery:	Date:

MEDICATIONS

List all medications you are currently taking with doses.

Medication:	Date:	Medication:	Date:

Do you take aspirin, Ibuprofen, or any product that contains them? ☐ Yes ☐ No

If yes, when was the last time you took it? _____

Do you take Coumadin or any other type of blood thinner? ☐ Yes ☐ No

If yes, when was the last time you took it? _____

ALLERGIES

List all drugs to which you are allergic and your specific reaction to them.

Drug:	Reaction:	Drug:	Reaction:

Are you allergic to Iodine? ☐ Yes ☐ No

If yes, how do you react to it? _____

Are you allergic to shellfish? ☐ Yes ☐ No

If yes, how do you react to it? _____

SOCIAL HISTORY

What is your occupation? _____

Do you smoke? ☐ Yes ☐ No

If yes, how much, and for how long? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, what type, how much, and for how long? _____

FAMILY HISTORY

List all serious illnesses in your immediate family, and the family member affected.

Illness:	Family Member:	Illness:	Family Member:

REVIEW OF SYMPTOMS

Please indicate if you have had any problems related to the following systems:

Constitutional Symptoms

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No

Other:_____

Eyes

Blurred Vision	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Pain	☐ Yes	☐ No

Other:_____

Allergic/Immunologic

Hay Fever	☐ Yes	☐ No
Drug Allergies	☐ Yes	☐ No

Other:_____

Neurological

Tremors	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No
Numbness/Tingling	☐ Yes	☐ No

Other:_____

Endocrine

Excessive Thirst	☐ Yes	☐ No
Too hot/cold	☐ Yes	☐ No
Tired/sluggish	☐ Yes	☐ No

Other:_____

Gastrointestinal

Abdominal Pain	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Indigestion/Heartburn	☐ Yes	☐ No

Other:_____

Cardiovascular

Chest Pain	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No

Other:_____

Integumentary

Skin Rash	☐ Yes	☐ No
Boils	☐ Yes	☐ No
Persistent Itch	☐ Yes	☐ No

Other:_____

Musculoskeletal

Joint Pain	☐ Yes	☐ No
Neck Pain	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No

Other:_____

Ear/Nose/Throat/Mouth

Ear Infection	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No

Other:_____

Genitourinary

Urine Retention	☐ Yes	☐ No
Painful Urination	☐ Yes	☐ No
Urinary Frequency	☐ Yes	☐ No

Other:_____

Respiratory

Wheezing	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No

Other:_____

Hematologic/Lymphatic

Swollen Glands	☐ Yes	☐ No
Blood Clotting Prob.	☐ Yes	☐ No

Other:_____

Psychologic

Feel Depressed	☐ Yes	☐ No
Considered Suicide?	☐ Yes	☐ No

Other:_____

If you are a male patient and have difficulty urinating, please complete the questionnaire on the next page.

Patient Name: _____ **DOB:** _____ **Date Completed:** _____

INTERNATIONAL PROSTATE SYMPTOM SCORE (I-PSS) [MALE PATIENTS ONLY]

In the past month:	Not at all	Less than 1 in 5	Less than half the time	Almost half the time	More than half the time	Almost always	Your score
1. Incomplete Emptying Had a sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have had to strain to start urination?	0	1	2	3	4	5	
	None	1 time	2 times	3 times	4 times	5 times or more	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total I-PSS Score							

SEXUAL HEALTH INVENTORY FOR MEN [MALE PATIENTS ONLY]

Over the past 6 months:		Very Low	Low	Moderate	High	Very High	Your score
How do you rate your confidence that you could get and keep an erection?		1	2	3	4	5	
		Almost never or never	Few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always	
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner?	0(no sexual activity)	1	2	3	4	5	
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	0 (Did not attempt intercourse)	1	2	3	4	5	
During sexual intercourse how difficult was it to maintain your erection to completion of intercourse?	0 (Did not attempt intercourse)	1	2	3	4	5	
When you attempted sexual intercourse, how often was it satisfactory to you?	0 (Did not attempt intercourse)	1	2	3	4	5	
Score							