Joseph A. Lanzone Jr., MD
Diplomate American Board of Urology

SOUTHEAST GEORGIA
UROLOGY
Advanced techniques. Compassionate care.

James M. Muse Jr., MD
Diplomate American Board of Urology

BRUNSWICK OFFICE 2500 Starling St. Suite 406, Brunswick, GA 31520 | 912.261.0447
CAMDEN OFFICE 52 Lindsey Lane, Suite B, St. Marys, GA 31558 | 912.576.5600

SoutheastGeorgiaUrology.com | 1.866.734.8272

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Has an Appointment

☐ Joseph Lanzone, MD

☐ James Muse, MD

☐ 2500 Starling Street #406
Brunswick, GA 31520
(912) 261-0447

☐ 52 Lindsey Lane Suite B
St Mary's, GA 31558
(912) 576-5600

At
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If you cannot make this appointment or need to reschedule,
please give us a call at the number above to avoid a $30 no-show charge.

Please arrive 30 minutes prior to your appointment if you have filled in your paperwork using our patient portal. If you cannot access the portal to update your patient information, please deliver your paperwork to our office 2 days before your appointment so the staff will have the opportunity to prepare for your appointment.

PATIENT PORTAL ACCESS:
The email address assigned to you for portal access is: ______________________________.

If you need additional assistance logging in and setting up your portal login, please contact our office to assist you. If you set up your portal already, but have forgotten how to access it, you can find a link to our portal on our website, *www.SoutheastGeorgiaUrology.com*.

Pages 5 and 6 do not need to be completed if you *enter your information into the patient portal.*

BRING WITH YOU TO YOUR APPOINTMENT:

- Insurance Card(s)
- Driver's License
- List of Current Medications and All Pill Bottles If Possible
- Co-pays or Coinsurance Due at Time of Service
- Preferred Pharmacy Name and Phone Number
- Primary Care Physician Name and Phone Number

If you have had x-rays, diagnostic imaging or other medical records forwarded to our office from your physician, please contact us in advance to ensure that we have received them before your visit

PATIENT DEMOGRAPHIC INFORMATION

Last Name: ___________________ First Name: ____________ Middle Initial: _____ Birthday:_____________

Address: ____

Home Phone: ___________________ Cell Phone: _____________________ SSN: _______________________

Employer: ______________________ Work Phone: _____________________

PRESCRIPTION REFILLS and MEDICAL INFORMATION UPDATES: Our patients can access their medical record, request refills on prescriptions, and access lab results on our secure patient portal. It is the fastest and easiest way for our patients to securely access their records and update their medical history. No medical information will ever be shared via email, and we will never share your email address with any other organization.

Email address for patient portal access: ___________________________________

APPOINTMENT REMINDERS: We provide appointment reminders through text message to your cell phone. No confidential information will ever be distributed via text message.

Cell phone to be used for appointment reminders: __________________________.

PHARMACY AND PRIMARY CARE INFORMATION

Preferred Pharmacy: ________________________________ Phone: ________________________

Primary Care Provider: ________________________________ Phone: ________________________

PRIMARY INSURED INFORMATION

Primary Insured Name: ____

Primary Insured Date of Birth: __________________________________

Primary Insured Social Security Number: _________________________

Financial, Insurance, and Privacy Policies

Insurance co-pays and deductibles are due at time of service. As a courtesy, our office will bill most insurance policies, but those bills that are outstanding after 60 days are the responsibility of the patient. Overdue accounts will be turned over to a collection agency, and a 35% charge of the balance will be added to the account. There is a $30 charge for no shows for your appointment unless canceled with 24 hours notice.

Lab Services/Insurance Coverage

Urine and blood specimens are frequently taken during office visits in our facilities, and these specimens are frequently forwarded to an outside, certified lab for analysis. Each insurance company sets different standards for which lab tests they will pay for, and some insurance companies' policies list particular laboratories that they require specimens be sent to receive full coverage (Medicare has no such requirement). If your insurance policy has such a requirement, it is your responsibility to notify the nurse and/or office staff in writing before your appointment. A photocopy of this document is as valid as the original.

Insurance Authorization

I hereby authorize Southeast Georgia Urology Associates, its physicians and staff, to release any information to any insurance company processing my claim, including the diagnosis and records in the course of my examination or treatment. I hereby authorize payment directly to Southeast Georgia Urology Associates and/or its physicians of the medical and/or surgical benefits otherwise payable to me but not to exceed the charges made for such treatment. A photocopy of this document is as valid as the original.

HIPPA Authorization

Our HIPPA Policies are listed in detail on our website, and available in our office. By signing this document, I acknowledge that I have been given the opportunity to review the above named office's Notice of Privacy Practices, and informed I may keep a copy for reference or obtain a copy upon request.

Form Fees and Prior Authorization Fees

Form Fees & Prior Authorization Fees must be paid before the staff can provide that service. These fees are not covered by insurance and are the responsibility of the patient.

- Prior authorization for each medication …………………. $25
  (Note that we will not attempt prior authorizations for viagra, visalus, or cialias)
- Typed Letters (any reason) …………………. $25
- Forms (insurance/assisted living / etc.) …………………. $25
- Medical Records (depending on the size) …………………. $15 - $25
- Missed Appointments without 24 hour notice …………………. $30

By signing below, I acknowledge that all I have read and agree to the financial, insurance and privacy policies outlined in this document. Additionally, I certify that all information I have provided is correct to the best of my knowledge, and I understand that this information may be relayed to my insurance company(s) for processing.

____

Patient Name Signature (legal guardian if patient is a minor) Date

Authorization to Release Health Information

I _______________________ authorize the following individuals to receive information regarding my treatment at Southeast Georgia Urology Associates by Dr. Joseph Lanzone and/or Dr. James Muse. The individuals listed below have my permission to obtain information regarding my diagnosis, treatments, doctor recommendations, prescriptions and test results. Additionally, I understand that it is my responsibility to inform the office in writing if I choose to add or remove anyone from the list above.

Name: ______________________________________

Name: ______________________________________

Name: ______________________________________

Name: ______________________________________

Name: ______________________________________

____

Patient Name Signature (legal guardian signature if patient is a minor) Date

PATIENT MEDICAL INFORMATION

Complete this page ONLY if you cannot access our secure patient portal to update your information online.

Height:_______ **Weight:_______** **Sex:** Male Female **Year Last Colonoscopy _______** **Year Last Flu Vaccine:_______**

ALLERGIES: Circle all that apply or write NONE

Aspirin	Compazine	Iodine	Macrobid	Sulfa Drugs
Bactrim	Demerol	IVP Dye	Morphine	Talwin
Cipro	Erythromycin	Keflex	Penicillin	Tetracycline
Codeine	Fish	Levaquin	Seafood	Vasotec
Codine	Floxin			

Other:

MAJOR INJURIES If none please, please write NONE

MAJOR SURGERIES: If none please, please write NONE

MAJOR ILLNESSES: Circle all that apply or write NONE

Arthritis	COPD	Hyperlipidemia	Peripheral Neuropathy
Asthma	Coronary Artery Disease	Hypertension	Prostate Cancer
Bladder Cancer	Diabetes	Hypothyroid	Renal Insufficiency
Cholecystectomy	Heart Trouble	Liver transplant	Severe Arthritis
Chronic Fatigue	HIV Positive	Myocardial Infarction	Sleep Apnea
Chronic Obstructive Pulmonary Disease	HX of Renal Cell Carcinoma	Parkinsons Disease	

OTHER:
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Current Medications

Please bring a list of all current medicines and all medicine bottles to your appointment, or write in all medicines here.

Medical and Social History

Marital Status (circle one)	**Smoking Status (answer all that apply)**	**Alcohol Use (circle one)**
Married	Non smoker	None
Single	Currently smoke _____ packs a day	Light
Divorced	Have been smoker for ____ years	Moderate
Separated	Quit smoking ____ years ago	Heavy
Widow/Widower		Recovering Alcoholic

Significant Family Medical History ____
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____
Patient Name Signature (legal guardian signature if patient is a minor) Date

PATIENT REVIEW OF SYMPTOMS

Complete this page ONLY if you cannot access our secure patient portal to update your information online.

Constitutional	Yes	No
Fever		
Chills		
Headache		
Other		

Gastrointestinal	Yes	No
Abdominal pain		
Heartburn		
Indigestion		
Nausea/vomiting		
Other		

Genitourinary	Yes	No
Urine retention		
Painful urination		
Urinary frequency		
Other		

Eyes	Yes	No
Blurred vision		
Double vision		
Pain		
Other		

Cardiovascular	Yes	No
Chest pain		
High blood pressure		
Varicose veins		
Other		

Respiratory	Yes	No
Wheezing		
Frequent cough		
Shortness of breath		
Other		

Allergic Immunologic	Yes	No
Hay fever		
Drug allergies		
Other		

Integumentary	Yes	No
Rash		
Boils		
Persistent itch		
Other		

Hematologic/lymphatic	Yes	No
Swollen glands		
Blood clotting problems		
Other		

Neurological	Yes	No
Tremors		
Dizzy spells		
Numbness/tingling		
Other		

Ear,nose, throat, and mouth	Yes	No
Mouth		
Ear pain		
Sinus infections		
Sinus problems		
Other		

Psychological	Yes	No
Generally satisfied with life		
Feel severely depressed		
Considered suicide		
Other		

Endocrine	Yes	No
Excessive thirst		
Too hot/too cold		
Tired/sluggish		
Other		

Musculoskeletal	Yes	No
Back pain		
Neck pain		
Other		

Anything else we should know about your health that has not been covered?

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Patient Name Signature (legal guardian signature if patient is a minor) Date