UROLOGY ASSOCIATES
595 SHREWSBURY AVE
SHREWSBURY, NJ 07702
PH: 732-741-5923
FX: 732-741-2759

Welcome to our practice! We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner. In order to do so, we appreciate your cooperation in **filling out these forms completely and accurately** to capture your full health record.

The forms in this packet include:

Patient Registration Form
New Patient Interview Form
Medication List/ Pharmacy Info/ Referring Physician info Privacy Practices Acknowledgement
Medical Records Release Authorization

Please bring these completed forms to our office on the day of your appointment. If you wish, you may mail or drop off your completed packet prior to your appointment. However, either way please plan to arrive at least 15 minutes prior to your appointment time, so that we may get all your paperwork together and set up your health record to be ready for your appointment.

You will need to bring your insurance card and a photo ID with you for each appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled.

Along with these forms, insurance card(s), REFERRAL (if required by your insurance plan) and photo ID, please obtain and bring any and all records relating to your current condition/ reason for your appointment. Having all of this necessary information at the time of your appointment will make the best use of your time with us and help the physician in providing the highest quality of professional care!

Some of these needed medical records include:

Any **relevant medical records** from your doctors and/or previous Urologist
X-ray films and reports (Ultrasound, CT Scan, MRI Scan, etc…) from the radiologist center (where you had the test done) or physician's office
Laboratory reports relevant to your condition- ex: blood work, urine testing, semen analysis, PSA results, etc…

All co-pays dictated by your insurance company are collected in full at time of service. Or if you do not have insurance, please be prepared to pay in full at the time services are rendered.
We accept CASH, CHECK, or CREDIT CARD (Visa, MC, Discover, Amer Express)

Please note* If you cannot make your schedule appointment, we do require a minimum of a 24-hour notice otherwise a missed appointment fee will be assessed to your account payable by you.

Again, we welcome you to our practice and thank you for choosing Urology Associates, PA for your health care needs.

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REGISTRATION INFORMATION

Please fill out ALL fields, date & sign

PATIENT NAME:

Last_____ First_____ Middle Int ____ Birthdate _____Age_____

☐Male ☐Female Email_____ SS#_____ Marital Status_____

YOU MUST PROVIDE at least one phone number strictly for Appointment Confirmation calls and reminders. No detailed medical information will be discussed. Authorization will remain in effect until our office receives written notification.

Primary Phone_____ Home/Cell/Other: _____ OK to leave message on phone/with person? ☐

Second Phone_____ Home/Cell/Other: _____ OK to leave message on phone/with person? ☐

STREET ADDRESS_____ City_____State_____ZIP_____

PATIENT'S EMPLOYER_____ Work Phone: _____

Work Address _____

PRIMARY INSURANCE_____Policy/ID#_____Group#_____

Claim Address_____Effective Date_____

Subscriber's Name (policy holder)_____ Birthdate_____ Relationship_____

Employer_____ Address_____Phone_____

SECONDARY INSURANCE_____Policy/ID#_____Group#_____

Claim Address_____ Effective Date_____

Subscriber's Name (policy holder)_____ Birthdate_____Relationship_____

How did you hear about our practice? _____

REFERRING PHYSICIAN:

Name/Address_____ Phone_____

PRIMARY CARE PHYSICIAN

Name/Address_____Phone_____

1. I authorize the release of my medical information necessary to process my insurance claim(s) to: Urology Associates, PA and/or billing agency
on behalf of Urology Associates, PA.
2. I authorize the request payment of medical benefits to my physician(s) at Urology Associates, PA 595 Shrewsbury Ave, Ste 103, Shrewsbury, NJ 07702.
3. I authorize Urology Associates, PA to release and/or request any medical or incidental information that may be necessary for either medical care or in the processing of applications for financial benefit.
4. I agree that a photocopy of this form may be used in lieu of the original.
5. I agree to pay all charges not covered by my insurance carrier(s). These charges include, but are not limited to, deductibles, co-payments, co-insurance and non-covered services.

Patient's Signature: _____ Date: _____

(or Patient's legal representative)/Relationship: _____

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PATIENT INTERVIEW FORM

Patient Information:

First Name: _____ Last Name: _____ Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Email: _____
(Please provide a personal email address)

Consent to share data:
I consent to having my medical and demographic information shared with other health care entities. ☐ YES ☐ NO

Preventative Care Reminders:

I would like to receive preventive care and follow up care reminders.

☐ YES ☐ NO

Contact Preference:

☐ Patient Portal ☐ Mail ☐ Phone ☐ ALL

Please list ALL current Physician(s):

Primary Care Physician (PCP):

Name: _____ Address/Phone#: _____

Cardiologist:

Name: _____ Address/Phone#: _____

OB/GYN:

Name: _____ Address/Phone#: _____

Other:

Name: _____ Address/Phone#: _____

Name: _____ Address/Phone#: _____

Patient Signature: _____ **Date:** _____

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Chief Complaint (reason for your visit today):

_____

History of Present Problem:

_____

System Review: *(Please check all conditions that you currently are experiencing.*

Constitutional:
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss

Other:

Eyes:
- ☐ Blurry
- ☐ Double Vision
- ☐ Cataracts

Other:

Ears, Nose, Mouth, Throat:
- ☐ Hearing Loss
- ☐ Nasal Stuffiness
- ☐ Sore Throat

Other:

Cardiovascular:
- ☐ Chest Pains
- ☐ Swollen Ankles
- ☐ Irregular Heartbeat Other:

Other:

Respiratory:
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chronic Cough

Other:

Gastrointestinal: Abdominal
- ☐ Pain
- ☐ Nausea/Vomiting
- ☐ Change in Bowels

Other:

Genitourinary:
- ☐ Incontinence
- ☐ Painful Urination
- ☐ Blood in Urine

Other:

Musculoskeletal:
- ☐ Chronic Back Pain
- ☐ Chronic Neck Pain
- ☐ Sore Muscles

Other:

Integumentary/Skin:
- ☐ Rash
- ☐ Persistent Itching
- ☐ Skin Cancer History

Other:

Neurological:
- ☐ Numbness
- ☐ Tingling
- ☐ Dizziness

Other:

Hematologic/Lymphatic:
- ☐ Swollen Glands
- ☐ Abnormal Bleeding
- ☐ Transfusion History Other:

Other:

Initials: _____

Social History ***(please circle all that apply for each category)*:**

Occupation: ☐ Employed ☐ Unemployed ☐ Retired ☐ Homemaker

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Life Partner ☐ Unknown

Any Children?: ☐ YES ☐ NO How many? _____ Ages: _____

Smoking Status:

☐ Current every day smoker ☐ Current Social Smoker ☐ Former Smoker/Year Quit? _____ ☐ Never Smoked

How many years: _____ Packs per day: _____

Do you use Recreational Drugs? ☐ YES ☐ NO

Alcohol/Beverage Use:

Do you drink alcohol? ☐ YES ☐ Not Anymore ☐ Never drank

Beer ☐ Wine ☐ Liquor ☐ Other _____

How many caffeinated drinks do you have each day?

Coffee ☐ Tea ☐ Soda ☐ Other: _____

Race:

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Unknown ☐ Patient declines to specify Other: _____

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

Preferred Language:

☐ English ☐ Spanish ☐ Patient declines to specify Other: _____

Family History:

☐ No knowledge of family history

Family History of:

Kidney Stones? ☐ NO ☐ YES Who: _____

Kidney Disease? ☐ NO ☐ YES Condition? _____ Who: _____

Cardiovascular Disease ☐ NO ☐ YES Who: _____

Prostate Cancer? ☐ NO ☐ YES Who: _____

Bladder Cancer? ☐ NO ☐ YES Who: _____

Other Cancer? ☐ NO ☐ YES What Type? _____ Who: _____

Other Family History: What? _____ Who? _____

Initials: _____

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Diagnostic Studies/Testing: *(Check all that apply)*

☐ Cystoscopy ☐ CT Abdomen/Pelvis ☐ Ultrasound (Renal, Bladder, Testicular/Scrotal) ☐ MRI Abd/Pelvis

☐ IVP/KUB ☐ CMG (Urodynamic Testing) Other:

Labwork:

☐ PSA ☐ Testosterone Levels ☐ Urine Analysis ☐ Infertility (Semen Analysis) ☐ Genetic Testing (Male)

☐ Creatinine ☐ Other:

Past Medical History:

☐ Diabetes ☐ Hepatitis ☐ High Blood Pressure ☐ Cardiac ☐ AIDS/HIV ☐ Renal Failure

☐ Multiple Sclerosis (MS) ☐ LUPUS ☐ Blood Disorder (Clot disorders)

Other: _____

Past Surgical History: *(include ALL surgeries from Childhood to present)*

☐ Prostate ☐ Bladder ☐ Colon ☐ Gallbladder ☐ Hernia Appendix Artificial ☐ Cardiac

☐ Pacemaker ☐ Vascular ☐ Testicular ☐ Hysterectomy ☐ Joints/Bones

Other: _____ When: _____

Initials: _____

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MEDICATION – ALLERGIES - PHARMACY FORM

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Local Pharmacy: _____ Address: _____

Pharmacy Phone #: _____

Mail Order Pharmacy Info:
Name of Company: _____ Account#: _____

Pharmacy Phone #: _____ Fax #: _____

Do you have any ALLERGIES? If yes, please list **ALL** allergies here:

I consent to obtaining a history of my medications purchased at pharmacies. **YES☐ NO☐**

MEDICATION:	DOSAGE:	What do you take this for?	FREQUENCY:

Patient Initials: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

PATIENT NAME: _____ **Date Of Birth**: _____

I hereby authorize UROLOGY ASSOCIATES, PA to use and disclose my health information, which specifically identifies me or that can reasonably be used to identify me to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, UROLOGY ASSOCIATES, PA can refuse to treat me.

I have been informed that UROLOGY ASSOCIATES, PA has presented a notice ("Notice") that more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and healthcare operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying UROLOGY ASSOCIATES, PA in writing, but if I revoke my consent, such revocation will not affect any actions that UROLOGY ASSOCIATES, PA took before receiving my revocation.

I understand that UROLOGY ASSOCIATES, PA has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that UROLOGY ASSOCIATES, PA restricts how my individual identifiable health information is used and/or disclosed to carry out treatment, payment, or health care operations. I understand that UROLOGY ASSOCIATES, PA does not have to agree to such restrictions, but that once such restrictions are agreed to, UROLOGY ASSOCIATES, PA must adhere to such restrictions.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient

IMPORTANT ***---→Permission given to call with test results, messages from doctor, billing, etc. to:***

Person(s) _____ *Relationship*_____*Phone #*_____ *Ok to leave message?* ☐

Person(s) _____ *Relationship*_____*Phone #*_____ *Ok to leave message?* ☐

Do not give any information to anyone else but myself ☐ *Phone#*_____ *Ok to leave message?* ☐

APPOINTMENT CANCELLATION/NO-SHOW POLICY

UROLOGY ASSOCIATES, PA requires notice of a cancelled appointment. We understand unexpected occurrences may happen and cause the need to cancel/reschedule your appointment so we ask that you let us know as soon as possible (at least a 24-hour notice) in order to run our office as efficiently as possible and need to utilize canceled appointments for other patients. There will be a $25 charge for missed office visits, $50 charge for missed or canceled less than 24-hour notice for procedure visits and $100 for missed or canceled less than 24-hour notice for schedule surgical procedures. Continuous, unexcused no-show or cancelled appointments may result in discharge from the practice.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient

RECORDS RELEASE AUTHORIZATION REQUEST FORM

(Leave top portion blank until records are needed from another doctor or facility)

To: _____
Doctor or Hospital

_____
Address

_____
Phone/Fax #

I hereby authorize and request you to release my complete records in your possession, concerning my illness and/or treatment to:

Urology Associates, P.A.
595 Shrewsbury Ave., Ste 103
Shrewsbury, NJ 07702
Phone: 732-741-5923
Fax: 732-741-2759

Patient's Name: _____
(Please Print)

Date of Birth: _____

Address: _____

Patient's Signature: _____

Date: _____

Witness: _____

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URINARY SYMPTOM SCREENER (AUA SYMPTOM SCORE)

Patient Name: _____ Date: _____

Circle the number that best describes your experience.	NOT AT ALL	LESS THAN 1 TIMES IN 5	LESS THAN ½ THE TIME	ABOUT ½ THE TIME	MORE THAN ½ THE TIME	ALMOST ALWAYS
1. INCOMPLETE EMPTYING Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2. FREQUENCY Over the past month or so, how often have you had to urinate again less than 2 hours after you finished urinating?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3. INTERMITTENCY Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4. URGENCY Over the past month or so, how often have you found it difficult to postpone urination?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5. WEAK STREAM Over the past month or so, how often have you had a weak urinary stream?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6. STRAINING Over the past month or so, how often have you had to push or strain to begin urination?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7. NOCTURIA Over the past month or so, how many times did you typically get up to urinate from the time you went to bed until the time you got up in the morning?	None 0 ☐	1 Time 1 ☐	2 Times 2 ☐	3 Times 3 ☐	4 Times 4 ☐	5 Times 5 ☐

Add the score for each question above, and write the total in the space to the right.

SYMPTOM SCORE = 1-7 Mild **8-19 Moderate** **20-35 Severe** **TOTAL** _____

QUALITY OF LIFE: How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?

Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
0	**1**	**2**	**3**	**4**	**5**	**6**
☐	☐	☐	☐	☐	☐	☐

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SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: _____ **TODAY'S DATE:** _____

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity	Almost Never or Never	A 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
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse	Almost Never or Never	A 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
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse	Almost Never or Never	A 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
	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Add the numbers corresponding to questions 1-5. **TOTAL:** 0

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED **8-11 Moderate ED** **12-16 Mild to Moderate ED** **17-21 Mild ED**

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FINANCIAL POLICY

Urology Associates believes that communicating our financial policy is good healthcare practice. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. We will file your primary and secondary insurances as a courtesy. Please realize that having secondary insurance does not necessarily mean that your services are covered 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur. You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your copay at the time of service per your insurance company. We accept cash, debit card, check, (except starter checks & not from new patients), MasterCard & Visa. Statements are sent out monthly, and we ask that balances due be paid when you receive your statement or at your next appointment, whichever is sooner. Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances they are applied to the current date of service. Payment will then need to be made by cash, money order or credit card for the balance due. When you receive healthcare services from us and we bill your insurance, it is the same as though we are extending you credit. You receive the service and we await payment from you and/or your insurance. Due to the high cost of rendering care and the lowering reimbursements by many insurers, including Medicare, we simply cannot afford to carry large balances. Balances not paid within 60 days will be turned over to an outside collection agency, unless prior payment arrangements have been made and of course a service fee will be generated. Accounts referred to an outside collection agency or attorney will be subjected to a collection fee of 25% - 35%, which will be added to total balance due. Some patients may accrue large balances for services provided. We will work with these patients to set up a mutually feasible payment plan. In some cases, if the minimum payment due cannot be paid; we will need proof of financial hardship. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. This is a violation of our contracts with the insurance plans. Please be advised that any necessary prior authorizations for medications on behalf of the patient may result in a $10 fee being applied to the patient's account. No prior authorizations will be initiated without the patient's knowledge and explicit consent. A fee of $25 will be applied to the patients account for failure to attend a scheduled appointment or for cancellations made less than 24 hours prior to appointment. Additionally, a $50 fee will be charged to the patients account for failure to attend a scheduled procedure. Please see our Full Financial Policy we have displayed in the waiting room and a copy can be provided if requested.

I understand and agree to Urology Associates Financial Policy.

Print Name_____ Date _____

Signature_____

Notice of Privacy Practices

We maintain protocols to ensure the security and confidentiality of your personal information. Within our practice, access to your information is limited to those who need it to perform their jobs.

At the office of Urology Associates, P.A., we are committed to treating and using protected information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information.

We will use your health information for regular health operations.

We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal and quality improvement activities that are necessary to run our practice and support the core functions.

For example:
Members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce healthcare costs.

Appointment Reminders

We may disclose medical information to provide appointment reminders (e.g. contacting you at the phone number you have provided to us and leaving a message as an appointment reminder).

Decedents

Consistent with applicable law, we may disclose health information to a coroner, medical examiner, or funeral director.

As Required By Law

We may disclose health information as required by law. This may include reporting a crime, responding to a court order, grand jury subpoena, warrant, discovery request, or other legal process, or complying with health oversight activities, such as audits, investigations, and inspections, necessary to ensure compliance with government regulation and civil rights laws.

Business Associates

There are some services provided in our organization through contacts with business associates. Some examples are billing or transcription services we may use. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.

Continued on inside

Our Responsibilities

Our practice is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate your health information.
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

Examples Of Disclosures For Treatment, Payment, And Health Operations

We will use your health information for treatment.
We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care.

For example:
Information obtained by a nurse, physician, or other member on your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your medical information will be shared among health care professionals involved in your care.

We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment.
We may disclose your information so that we can collect or make payment for the health care services you receive.

For example:
If you participate in a health insurance plan, we will disclose necessary information to that plan to obtain payment for your care.

For More Information Or To Report a Problem

If you have questions and would like additional information, you may contact our practice's Privacy Officer:

Arthur Christiano, M.D., at (732) 741-5923.

If you believe your privacy rights have been violated, you can either file a complaint with Arthur Christiano, M.D., or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for New Jersey is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javitz Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278

If you have any questions regarding the Patient Financial Policy, please discuss them with our Practice Manager at (732) 741-5923 x123.

UROLOGY ASSOCIATES

Notice of Privacy Practices and Patient Financial Policy

We are thrilled to have you as our patient and are dedicated to providing the best possible care and service to you.

Please review the enclosed information carefully.