John Boon, M.D. Urology

Board Certified Urologist

16651 SW Freeway, MOB 1, Suite 310 Sugar Land, TX 77479 Phone: (281)565-1250 Fax: (281)565-1255

New Patient Checklist

- ☐ Please fill out the New Patient Demographic and Patient History forms.

(If possible, please fax the completed packet to (281) 565-1255 before your appointment)

- ☐ Please bring your Picture ID or Drivers License.
- ☐ Please bring all of your insurance cards and referral forms required by your insurance company.
- ☐ Please bring a list of ALL the medications you are currently taking.
- ☐ Please bring medical records for the reason of your visit. This includes films from recent X-Rays, imaging studies, and recent lab work done.
- ☐ Please be ready to produce a urine specimen in the office.

Location

We are located in Medical Office Building 1 of the Methodist Sugar Land Hospital. This is at the corner of Highway 59 and Sweetwater Blvd. Our address is 16651 SW Freeway, Suite 310 Sugar Land, Texas 77479. Our phone number is (281) 565-1250.

Payment

Payment is due at the time of service. This includes any copay, coinsurance, or deductibles. **For payment we accept most major credit cards, cash, or check. We do not accept American Express.**

There is a $50 fee for "No Shows" to appointments. Please contact us ahead of time if you can't make it to the appointment.

If you would like to know what your responsibility would be for your visit, please call the office and ask for assistance.

We look forward to seeing you in the office!

Please fill out the New Patient Packet information before your appointment:

Name: (First)_____(MI)____ (Last)_____

DOB:_____Sex: ☐ M ☐ F Marital Status: ☐S ☐M ☐D ☐W SS#: _____

Address: (Street) _____City: _____State:_____Zip_:_____

Home Tel #: _____Work #: _____Cell #: _____

Email Address: _____

How may we contact you regarding appointments or results? ☐Home ☐Work ☐ Cell/Text ☐ Email

Race: ☐White ☐Black/African American ☐ American Indian/Alaska Native ☐ Pacific Islander
☐Asian ☐Indian Subcontinent ☐Hispanic or Latino ☐Middle Eastern ☐ Other

Emergency Contact: _____ Relationship: _____

Home Tel# _____ Work #_____Cell #: _____

Employer : _____Who referred you to our office? ☐ Doctor _____ ☐ Other _____

Pharmacy Name: _____ Pharmacy Phone: (_____) _____

PRIMARY INSURANCE: _____ Phone #_____

Policy Holder _____ ID#_____ Group #_____

Relation to Patient: _____ Date of Birth:_____

SECONDARY INSURANCE: _____ Phone #_____

Policy Holder: _____ ID: _____ Group #: _____

Relation to Patient: _____ Date of Birth: _____

Method of Payment: ☐Credit Card (Circle: Master Card, Visa, Discover) ☐Check ☐Cash

Release of Information: Health information John Boon, M.D. collects or receives about you may be disclosed to the following:

Name: _____ Relationship: _____
Name: Relationship: _____

I have reviewed the Notice of Privacy Policies and Practices. I authorize the person(s) listed above to receive all health information about appointments, treatments and/or other information pertinent to my healthcare provided by John Boon, M.D. I authorize the release of any medical information needed to determine my medical reimbursement benefits under my insurance policy. This includes authorization to obtain medical information from the insurance carrier and pharmacy. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. The insurance may deny coverage for infertility, sexual dysfunction, and pre-existing medical condition. The office has no way of knowing all the terms of the policy.

Patient's Signature: _____ **Date:**_____

Important

We ask that you kindly give 24-hour notice to cancel or reschedule an appointment. _____**Initials**

Our office may be able to pull your prescription, lab and claim history from your insurance carrier. I authorize this office to review my prescription, lab, and medical history if available electronically. _____ **Initials**

Dr. John Boon is pleased to offer you the opportunity to communicate with him via e-mail. There is no guarantee that e-mail messages will be secure once they are sent. This practice will not release confidential information about you without your written consent. ☐ **I CONSENT** ☐ **I REFUSE** I understand that e-mail messages I send will not be answered. _____ **Initials**

Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance we are committed to help you receive the maximum allowable benefits. **In order to achieve these goals we need your assistance and your understanding of our payment policy.**

Payment for all office services and supplies is due at the time service is rendered. This includes any copay, deductible or co-insurance determined by your insurance company.

We accept all major credit cards, checks, and cash. Returned checks are subject to an additional fee of $50.00 and will terminate your privilege to pay by check.

We are happy to process your insurance form for reimbursement, but must be provided with appropriate proof of insurance and identification. This is a courtesy we extend to you, but ultimately payment for all charges for care provided is your responsibility.

Please inform us of any changes in your insurance policy. If such information is not provided, you will be responsible for the charges associated with your visit.

Surgical procedures may require a deposit, including deductible and or co-pay. Remaining balances are to be paid within one month of settlement with your insurance company. We pre-approve the surgical procedure with individual insurance carriers to determine benefits, but it is ultimately the patient's responsibility to pre-approve all surgical procedures and to be aware of conditions of approval, such as obtaining 2nd opinion, etc.

Important- Some insurance plans require patients to obtain referrals and/or preauthorization for services provided with a Specialist (i.e. Urologist). Ultimately it is the patient's responsibility to obtain the necessary referral or preauthorization from their Primary Care Physician (PCP). If we are not notified and subsequently unable to obtain preauthorization, you will be responsible for the bill.

We emphasize that as a medical care provider, our relationship is with you and not your insurance company. We cannot be responsible for any loss of benefits. It is your responsibility to know your policy. If you have any questions concerning the above information, please do not hesitate to ask us. We are here to help you.
By signing below I acknowledge that I have read and agree with the policy listed above.

_____

Signature of Patient or Guarantor **Date**

Last Name:_____ First:_____Date of Birth:_____

Reason for your visit today: _____

MEDICATIONS LIST INCLUDING DOSE AND HOW OFTEN YOU TAKE IT.: ☐ None

_____

_____

_____

_____

ALLERGIES: ☐ No known drug allergies

☐ IV contrast ☐ Levaquin ☐ Ciprofloxacin ☐ Aspirin ☐ Codeine ☐ Penicillin

☐ Iodine ☐ Sulfa Drugs ☐ Demerol ☐ Morphine ☐ Latex ☐ Other_____

TYPE OF REACTION:_____

FOR FEMALES: Are you currently pregnant? : ☐ YES ☐ NO Date last menstrual period began: _____

FOR MALES: Are you currently taking ☐ Viagra ☐ Levitra ☐ Cialis ☐ Staxyn ☐ None of these

PAST UROLOGICAL HISTORY: ☐ None ☐ Difficulty starting urination ☐ Difficulty stopping urination

☐ Bed wetting ☐ Blood in urine ☐ Frequent urination ☐ Kidney stones ☐ Pain in testis

☐ Prostate trouble ☐ Urgent urination ☐ Bladder Infection ☐ Burning urina. ☐ Kidney infections

☐ Leaking urine ☐ Painful urination ☐ Swelling of testicles ☐ Urinating at night ☐ Venereal disease

☐ Bladder Cancer ☐ Kidney Cancer ☐ Prostate Cancer ☐ Urine infections ☐ Incontinence

☐ Problems with sexual function

PAST MEDICAL HISTORY: ☐ None ☐ Diabetes ☐ High blood pressure ☐ High Cholesterol

☐ Asthma ☐ Lung Disorder ☐ Heart attack ☐ Hemorrhoids ☐ Stroke ☐ Bleeding Disorder

☐ Glaucoma ☐ Gout ☐ Hepatitis ☐ Depression ☐ Seizures ☐ Thyroid Disorder

☐ Liver disease ☐ Other: _____

FAMILY HISTORY: ☐ Cancer (Type: _____) ☐ Diabetes ☐ Heart disease ☐ Kidney disease

PREVIOUS SURGERIES

_____

SOCIAL HISTORY:

Are you a smoker? ☐ Yes ☐ No ☐ Secondary smoking exposure

If you are a smoker, please check off: ☐ /4 pack/day ☐ /3 pack/day ☐ /2 pack/day ☐ 3/4 pack/day

☐ 1 pack/day ☐ 1.25 pack/day ☐ 1.5 pack/da y ☐ less than ¼ pack/day ☐ occasionally ☐ Former smoker

☐ Social smoker Smoking onset date: _____ ☐ Quit date _____

☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If you drink, please check off: ☐ Rare ☐ Socially ☐ Occasionally

☐ Former drinker ☐ Alcohol dependency ☐ Recovering alcoholic

Exercise History: ☐ Walking ☐ Running ☐ Cardio ☐ Weights ☐ Aerobic ☐ Cycling ☐ Swimming

☐ Hiking ☐ Yoga ☐ Active lifestyle, but no organized exercise ☐ No exercise

How many hours per week do you exercise?_____

Nutrition History: ☐ Poor diet ☐ Average diet ☐ Good diet ☐ Excellent diet ☐ Vegetarian

Occupation:_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record #_____

Date of Birth _____ Social Security #_____

I authorize the following individual / organization to disclose the above named individual's health information:

Name:_____ Address:_____

This information may be disclosed TO and used by the following individual or organization:

John Boon, M.D. Phone: (281) 565-1250 Fax: (281) 565-1255

16651 S.W. Freeway, Suite 310 Sugar Land, Texas 77479

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐ **Yes, I consent to the release of this information.** ☐ **No, I do not consent to the release of this information.**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold John Boon, M.D. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____

Signature of Patient or Legal Representative (Sign at the office) Date

_____ _____

Relationship to Patient (If Legal Representative) Witness

FOR OFFICE USE ONLY: Please release the following:

_____ Progress Notes _____ Complete Record from _____ to _____

_____X-Ray Films _____Laboratory Results-from _____to _____

_____History/Physical Exam _____X-Ray/Imaging Reports-from _____to _____

_____Medication List ____EKG Report Other _____