PATIENT DATA FORM

UROLOGY GROUP, PA

DATE:__________________ SOCIAL SECURITY #________________________INSURANCE____________________

PATIENT NAME________________________________AGE _____BIRTHDATE:___________DOCTOR:__________

ADDRESS:____OCCUPATION___________________

CITY:____STATE:__________ZIP:_________________

TELEPHONE: HOME______________________ CELL______________________ WORK_________________________

MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐

SPOUSE'S NAME:____________________________________NUMBER OF CHILDREN:__________

DO YOU SMOKE? YES ☐ NO ☐ IF YES, HOW MUCH? ___________________________

DO YOU DRINK ALCOHOL? YES ☐ NO ☐ IF YES, HOW MUCH? __________________________

LIST ALLERGIES: ____

REASON FOR VISIT____

REFERRED BY _______________________________ PHARMACY (INCLUDE PHONE) ______________________________

PRIOR ILLNESSES AND INJURIES (PLEASE LIST): WHEN? PHYSICIAN? WHERE TREATED?

____

____

____

PREVIOUS SURGERIES (PLEASE LIST): WHEN? PHYSICIAN? WHERE TREATED?

____

____

____

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

CANCER ☐ DIABETES ☐ HEART DISEASE ☐ KIDNEY ☐ OTHER UNRINARY PROBLEMS ☐

INDICATE HEALTH STATUS FOR THE FOLLOWING. **IF DECEASED, GIVE AGE AND CAUSE OF DEATH**

MOTHER EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐____

FATHER EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐____

BROTHERS EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐____

SISTERS EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

PLEASE CHECK ANY CONDITIONS WHICH APPLY TO YOU:

HEAD	☐ NORMAL ☐ VERTIGO ☐ SINUS ☐ NOSE BLEED ☐ DIZZINESS ☐ OTHER
RESP	☐ NORMAL ☐ SHORTNESS OF BREATH ☐ BRONCHITIS ☐ EMPHYSEMA ☐ ASTHMA ☐ OTHER
C VASC	☐ NORMAL ☐ HIGH BLOOD PRESSURE ☐ HEART DISEASE ☐ HEART MURMUR ☐ ARRHYTHMIA ☐ HEART VALVE DISEASE ☐ OTHER
GI	☐ NORMAL ☐ ESOPHAGEAL DISEASE ☐ ULCERS ☐ HEPATITIS ☐ CROHNS DISEASE ☐ COLITIS ☐ OTHER
PVASC	☐ NORMAL ☐ PAIN WHEN WALKING ☐ VARICOSE VEINS ☐ PHLEBITIS ☐ OTHER
ONC/HEM	☐ NORMAL ☐ CANCER ☐ ANEMIA ☐ EASY BLEEDING ☐ SICKLE CELL ☐ BLOOD TRANSFUSION ☐ OTHER
ENDO	☐ NORMAL ☐ DIABETES ☐ THYROID DISORDER ☐ OTHER
NEURO	☐ NORMAL ☐ STROKE ☐ MIGRAINE ☐ SEIZURES ☐ PARKINSONS ☐ OTHER
ARTH	☐ NORMAL ☐ PAIN IN JOINTS ☐ GOUT ☐ OSTEOPOROSIS ☐ BONE FRACTURE ☐ OTHER
DERM	☐ NORMAL ☐ RASHES ☐ HIVES ☐ ECZEMA ☐ PSORIASIS ☐ HERPES ☐ OTHER
MENTAL HEALTH	☐ NORMAL ☐ DEPRESSION ☐ SLEEP DISORDERS ☐ OTHER
INFECT	☐ NORMAL ☐ RHEUMATIC FEVER ☐ MUMPS ☐ MONO ☐ TUBERCULOSIS ☐ H.I.V. ☐ OTHER
FEMALES	☐ NORMAL ☐ # OF PREGNANCIES______ ☐ LAST MENSTRUAL PERIOD ___________ ☐ BIRTH CONTROL ☐ MENOPAUSE ☐ OTHER

AUTHORIZATION AND CONSENT

I HEREBY AUTHORIZE THAT PAYMENT FROM MY MEDICAL INSURANCE CARRIER OR MY Medicare benefits be made directly to the Urology Group, P.A. on any unpaid bills for services provided on or any time after today. In addition, I authorize any holder of medical or other information about me to release to the Health Care Finance Administration, its intermediaries, insurance companies or agents, any information needed to determine benefits payable for services. I also permit a copy of this consent and authorization to be used in place of the original.

I understand that I am financially responsible for any balance not covered by my insurance carrier or managed care company.

____

PATIENT NAME (PLEASE PRINT)

____

PATIENT SIGNATURE

UROLOGY GROUP, P.A.
FOUR GODWIN AVENUE
MIDLAND PARK, NEW JERSEY 07432
201-444-7070
FAX: 201-444-7228

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Urology Group, P.A.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). **(Urology Group, P.A.'s** Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Urology** Group, **P.A.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Urology Group, P.A. Privacy Officer at 4 Godwin Avenue, Midland Park, NJ 07432.

With this consent, **Urology Group, P.A.** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **Urology Group, P.A.** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked *Personal and Confidential.*

With this consent **Urology Group, P.A.** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Urology Group, P.A.** restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Urology Group, P**.A.'s** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent If I do not sign this consent, or later revoke it, Urology Group, **P.A.,** may decline to provide treatment to me.

____
Patient's Name

______________________________ ____________________
Signature of Patient or Legal Guardian Date

____
Print Name of Patient or Legal Guardian

Urology Group, P.A.

NOTICE TO PATIENTS REGARDING NETWORK STATUS

To Our Valued Patients:

There has been a change in the State of New Jersey with regard to out-of-network insurance coverage. We are required to inform you of this change and how it may affect your coverage with us. Urology Group values our patients and we hope to continue our relationship with our long standing patients as well as build relationships with our new patients.

This notice is to inform you of our health care facility affiliations, health insurance network status and billing policies. Please read this notice carefully and acknowledge your agreement by signing in the space indicated below.

We are affiliated with the following health care facilities:

- The Valley Hospital, Ridgewood, New Jersey
  223 N. Van Dien Ave., Ridgewood, NJ 07450 – (201) 447-8000
- HUMC Pascack Valley Medical Center, Pascack Valley, New Jersey
  250 Old Hook Rd., Westwood, NJ 07675 – (201) 383-1035
- Patient Care Associates, Englewood, New Jersey
  500 Grand Ave., Suite #3, Englewood, NJ 07631 – (201) 567-8090
- The Stone Center, Newark, New Jersey
  150 Bergen St., Newark, NJ 07103 – (862) 235-1983

Note: Not all physicians have privileges at all facilities

We are in-network with the following health benefits plans:

- Medicare
- The Valley Hospital/Valley Medical Group Employee Cigna Plan
- AmeriHealth

We are out-of-network with all other health benefits plans.

If your plan is not one of the in-network plans listed above, we are out of network with your plan and the following is applicable to you:

- The amount or estimated amount we charge for a medical service is available upon request.
- Upon receipt of a request from you for a medical service, we will disclose to you in writing the amount or estimated amount that we will bill you for the service and the Current Procedural Terminology (CPT) codes associated with that service, absent unforeseen medical services that may arise when the service is provided.
- You will have a financial responsibility for health care services provided by an out-of-network professional, in excess of your copayment, deductible, or coinsurance, and you may be responsible for any costs in excess of those allowed by your health benefits plan.
- We advise you to contact your health insurance carrier for further consultation on these costs.
- Please be advised that you may incur additional out-of-network charges for services performed in our offices, including, but not limited to, laboratory, pathology and imaging services.

SIGN NEXT PAGE

ACKNOWLEDGEMENT AND AGREEMENT

I, ______________________, hereby acknowledge and agree that I have reviewed this disclosure notice and understand its terms. I acknowledge and agree that I will be responsible for all payments for services provided by the Urology Group, P.A. as further specified in this notice.

______________________________ ______________

Patient Signature **Date**

____

Patient Name (Please Print)

UROLOGY GROUP, P.A.

FOUR GODWIN AVENUE
MIDLAND PARK, NJ 07432
201-444-7070
FAX: 201-444-7228

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize **Urology Group, PA** to use/and or disclose certain protected health information (PHI) about me to or for the party or parties listed below:

____
(Name of person or Entity to receive information

This authorization permits **Urology Group, PA** to use or disclose the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)

____

____

____

The information will be used or disclosed for the following purpose:

____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that **Urology Group, PA** has acted in reliance upon this authorization. My written revocation must be submitted to Urology Group, PA at 4 Godwin Avenue, Midland Park, NJ 07432

____________________________ Signature of Patient or Legal Guardian	__________________________ Relationship to Patient
____________________________ Patient's Name	__________________________ Patient's Date of Birth
____________________________ Print Name of Patient or Legal Guardian	__________________________ Date

MEDICATION LIST

UROLOGY GROUP,PA

PATIENT NAME ______________________________ DATE__________________________

PLEASE LIST ALL PRESCRIPTION MEDICATIONS (AS WELL AS OVER THE COUNTER MEDICATIONS, HERBAL SUPPLEMENTS AND VITAMINS)

	MEDICATION	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

PLEASE LIST ALL MEDICATION ALLERGIES

1 ____

2 ____

3 ____

4 ____

SIGNATURE _____________________________________ DATE OF BIRTH:____________________________