

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

Prostate Test

FOR YOUR URINARY ACTIVITIES

Name _____

Date _____

Circle your numerical score for each question below

	None	1 time	2 times	3 times	4 times	5 or more times	
1	Over the last month or so, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5
2	Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	Not At all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always
3	Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
4	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
5	Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
6	Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
7	Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5

From the American Urological Association (AUA) Symptom Index for BPH

Total your score here:
Total Symptoms Score = Sum of Questions 1 to 7 =

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

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.

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)

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: _____