Urology Clinics of North Texas

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level. It is important that we have a good understanding with our patients regarding financial responsibility. We hope this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through _____.

- If you have out-of-network benefits we will be happy to give you a receipt so you may file.
- You **must pay** any co payment and applicable deductible amounts **at the time of service** unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 60 days, we may expect payment from you.
- If by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:

1) This is a pre-existing illness that is not covered by your plan
2) You have not met your full calendar deductible
3) The type of medical services required is not covered by your plan
4) The health plan was not in effect at the time of service
5) You have other insurance which must be filed first

Although benefits may be verified at the time of service it is not a guarantee of payment on what was quoted. Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in you plan. If your health plan denies this claim for any of the above reasons, you will then become responsible for this bill. **It is your responsibility as the patient to pay the denied amounts in full.**

Our primary mission is to provide you with quality, cost effective medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our priority is to provide you with the best possible care. We are pleased to welcome you to our practice.

Sincerely

Urology Clinics of North Texas

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier.

_____ _____

Patient Signature Date

_____ _____

Patient name-printed Account Number

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by Urology Clinics of North Texas, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

I also acknowledge that I have been afforded the opportunity to read the *Notice of Privacy Practices* and ask questions.

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date:_____

☐ **I give Urology Clinics of North Texas permission to send appointment reminders via text messaging. Please send message to the following number:** _____

☐ **At this time, I do not want Urology Clinics of North Texas to send appointment reminders via text messaging**

4. PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand UROLOGY CLINICS OF NORTH TEXAS is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize UROLOGY CLINICS OF NORTH TEXAS or UROLOGY CLINICS OF NORTH TEXAS designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

1. Description of the information to be used or disclosed (check as appropriate):

☐ **a. My entire record:**

I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic information, patient histories, medication lists, tests, and diagnoses. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to **(check all that apply)**:

- ☐ Alcohol and Drug Abuse Treatment*
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment
- ☐ Genetic Information (including, but not limited to, Genetic Test Results).

(NOTE: If you checked "my entire record," please skip to number 2. Otherwise, please continue with b. and c. below.)

☐ **b. My demographic information (check "All" or those that apply):**

☐ All ☐ Age ☐ Gender ☐ Race ☐ Other_____
☐ Name ☐ Address ☐ State/Zip Code Only ☐ Telephone

☐ **c. Medical Data/Information as related to (check all that apply):**

- ☐ Specific condition(s):_____
- ☐ Specific professional service(s):_____
- ☐ Specific medication(s):_____
- ☐ Alcohol and Drug Abuse Treatment:*
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment:_____
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS):_____
- ☐ Genetic Information including, but not limited to, Genetic Test Results:
- ☐ Other: _____

2. Please disclose the above information to:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

3. I ☐ do ☐ do not authorize this information to be disclosed electronically.

4. Purpose(s) for disclosure of the information:

_____

_____

(NOTE: If the patient is requesting disclosure, the purpose may simply state: "Patient is requesting disclosure.")

5. **Right to revocation**. I have a right to revoke this authorization in writing (or orally in the case of Part 2 alcohol and drug abuse services), except to the extent that action has been taken in reliance on this authorization. UROLOGY CLINICS OF NORTH TEXAS must receive the revocation in writing (except for Part 2 alcohol and drug abuse services) and the written revocation must include:

a. My name and address,
b. The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
c. My desire to revoke this authorization, and
d. The date of the revocation, and my signature.

UROLOGY CLINICS OF NORTH TEXAS will accept written revocations of this authorization via:

☐ Certified U.S. mail
☒ Facsimile at this number: **214-889-9625**

ALL written revocations must be sent to Cassandra Rodriguez, and are not effective until received by her.

6. **This authorization shall expire upon patient revocation or revision.** After this date/event, UROLOGY CLINICS OF NORTH TEXAS can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

7. I fully understand and accept the terms of this authorization.

_____	_____
Signature of Patient or Patient's Representative	**Date**
_____	
Name of Patient	
_____	_____
Name of Representative (if applicable)	**Description of Representative's authority to act for patient**

***CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS**

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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UROLOGY CLINICS OF NORTH TEXAS

ADULT HEALTH HISTORY FORM

PATIENT NAME: _____ **DATE:** ____/____/_____ **MED REC #:**_____

DATE OF BIRTH: _____/____/_____ **AGE:** _____ **HEIGHT:** _____**FT** _____**IN** **WEIGHT:** _____**LBS**

Reason for your visit today: _____

Name of Referring Physician: _____ Referring Physician's Phone #:_____

Referring Physician's Address: _____

Primary Care Physician (if Different)_____ Phone #:_____

Race: ❒White ❒Black ❒Hispanic/Latino ❒Asian ❒Other: _____ Sex: ❒Female ❒Male

Ethnicity: ❒ **Hispanic/Latino** ❒ **Non Hispanic/Latino**

Pharmacy Name: _____ **Address:** _____ **City:**_____ **Zip:**_____

Pharmacy Phone #:_____ **Pharmacy Fax #:** _____

Drug Allergies: _____

Other Allergies:_____

CURRENT MEDICATIONS: Please list any prescription medications, over-the-counter medications and vitamin supplements you take routinely:

Name of Drug or Supplement:	Strength (mg):	How often (# of times per day)

REVIEW OF SYSTEMS: Please mark all yes or no

Constitutional--❒Neg

No Yes
❍ ❍ chills
❍ ❍ fever

Respiratory--❒Neg

No Yes
❍ ❍ dyspnea (shortness of breath)

Gastrointestinal-❒Neg

No Yes
❍ ❍ diarrhea

Metabolic/Endocrine---❒Neg

No Yes
❍ ❍ Excessive Thirst

Musculoskeletal-❒Neg

No Yes
❍ ❍ back pain

Heent---❒Neg

No Yes
❍ ❍ double vision

Cardiovascular--❒Neg

No Yes
❍ ❍ chest pain

Integumentary--❒Neg

No Yes
❍ ❍ rash

Psychiatric--❒Neg

No Yes
❍ ❍ anxiety

Neurological--❒Neg

No Yes
❍ ❍ seizures

Hema/Lymphatic-❒Neg

No Yes
❍ ❍ easy bleeding
❍ ❍ petechiae/easy bruising

❒ All Negative

MEDICAL HISTORY: Please check any of the following conditions which YOU have had or presently have:

❒Anemia
❒Chest Pain
❒Arthritis
❒Asthma
❒BPH
❒Cancer-Type:_____
_____
_____
❒CVA (Stroke)
❒Chronic UTIs
❒Congestive Heart Failure
❒COPD
❒Coronary Artery Disease
❒Depression
❒Diabetes
❒Diverticular disease
❒GERD
❒Gout
❒Hepatitis C
❒Hyperlipidemia
❒High Blood Pressure
❒Inflammatory bowel
❒Liver disease
❒Migraine Headaches
❒Heart Attack
❒Osteoporosis
❒Parkinson's Disease
❒Peptic Ulcer disease
❒Peripheral Vascular Disease
❒Renal/Kidney disease
❒Seizure disorder
❒Thyroid disease
❒Kidney stones
❒Valvular Heart Disease

♀ **FEMALES ONLY: Date of last Menstrual Period:** _____/_____/_____ **Date of last PAP Smear:** _____/_____/_____ ♀

Patient Name:_____ **Med Rec-#:**_____

SURGICAL HISTORY: Please check any of the following procedures you have had performed and the date of the procedure

	Yr		Yr		Yr	♀ **Females Only**		♂ **Males Only**	
❒Adrenalectmy		❒Cystoscopy		❒Kidney removed			Yr		Yr
❒Appendectmy		❒ESWL		❒Pacemaker		❒Bladdr suspnsn		❒Brachytherapy	
❒Back Surgery		❒Gastic bypass		❒Perc stone removal		❒Abd Hyst		❒Circumcision	
❒Bladder Augumentn		❒Hernia repair		❒Kidney stone removal		❒Vaginal Sling		❒Hernia Repair	
❒CABG		Type:		❒Ureteral Stents Plcd		❒TAH / BSO		❒Hydrocelectomy	
❒Gall Bladder						❒Vaginal Hyst		❒Laser of Prostate	
❒Bladder removal		❒Laparoscopy		**Other:**				❒Orchiectomy	
		❒Lithotripsy		❒				❒Penile Prosthesis	
				❒				❒Prostate Biopsy	
				❒				❒Prostatectomy	
								❒Spermatocelectomy	
								❒TURP	
								❒Varicocele ligation	
								❒Vasectomy	

CHRONIC PROBLEMS LIST: Please list any **chronic** health problems you have

Problem:_____ Date of onset:_____ Treatment:_____
Problem:_____ Date of onset:_____ Treatment:_____
Problem:_____ Date of onset:_____ Treatment:_____
Problem:_____ Date of onset:_____ Treatment:_____

FAMILY HISTORY: Please check any of the following conditions that apply to your family members and list their relation to you:

Diagnosis:	**Yes**	**No**	**Relationship:**		**Diagnosis:**	**Yes**	**No**	**Relationship**
Blood disease					High Cholesterol			
BPH					High Blood Pressure			
Cancer					Inflammatory bowel disease			
Type:					Migraines			
CVA / Stroke					Renal Disease			
Coronary artery disease					Renal failure			
Cardiovascular Disease					Seizure disorder			
Diabetes					Thyroid disorder			
Eczema					Urinary tract infections			
Gout					Kidney stones			
Hearing Impairment					**Other:**			
Other:								

Alive & Well: ❒Father ❒Mother ❒Brother ❒Sister

TOBACCO:

Uses tobacco? ❒Current ❒Former ❒Never ❒Unknown
Tobacco type: _____ Units per day: _____ Years used: _____ Pack Years: _____
Year quit:_____ Longest tobacco free:_____ Relapse reason:_____
◯ Current every day smoker ◯ Smoker, current status unknown ◯ Former smoker
◯ Current some day smoker ◯ Never smoker ◯ Unknown if ever smoked

ALCOHOL: ❒Yes ❒No ❒formerly Year quit: _____ **CAFFEINE:** ❒Yes ❒No

Type: _____ Frequency: _____ Type: _____, _____
Amount: _____ per _____ Last drink: _____ Amount daily: _____

Marital/Family Status:

Current Status: ❒Single ❒Married ❒Divorced ❒Widowed Previously widowed? ❒Yes ❒No Previous divorce?❒Yes ❒No
Do you have children? ❒Yes ❒No If so, number: _____

LIFESTYLE:

Occupation: _____
Exercise? ❒Yes ❒No If yes, Type:_____ Frequency:_____ per _____ Hours per week: _____

Patient Name _____ Date _____ Acct #_____

AUA SYMPTOM INDEX

Circle ONE number in each column that best answers the following questions:	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
1. 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. 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. Over the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. 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. Over the past 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?	None 0	1 time 1	2 times 2	3 times 3	4 times 4	5 or more 5

SEXUAL HEALTH INVENTORY FOR MEN

_____

Select the number that best describes your situation. Enter that number in the blank to the left of the question. Please be sure that you select only one response to each question.

Over the past 6 months:

___ A) How do you rate your confidence that you could get and keep an erection.
1) Very low 2) Low 3) Moderate 4) High 5) Very high

___ B) When you had erections with sexual stimulation, how often were erections hard enough for penetration (entering your partner)?
0) No sexual activity 1) Almost never or never 2) A few times-less than 1/2
3) Sometimes-1/2 the time 4) Most times-more than 1/2 5) Almost always

___ C) During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?
0) Did not attempt intercourse 1) Almost never or never 2) A few times-less than 1/2
3) Sometimes-1/2 the time 4) Most times-more than 1/2 5) Almost always

___ D) During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?
0) Did not attempt intercourse 1) Extremely difficult 2) Very difficult
3) Difficult 4) Slightly difficult 5) Not difficult

___ E) When you attempted sexual intercourse, how often was it satisfactory for you?
0) Did not attempt intercourse 1) Almost never or never 2) A few times-less than 1/2
3) Sometimes-1/2 the time 4) Most times-more than 1/2 5) Almost always

_____