New Patient Information

Which Physician will you be seeing today?_____
How did you hear about our practice? _____

Local Pharmacy Name:_____Pharmacy Phone #:_____
Pharmacy Location/Address:_____

Name _____Preferred_____ Age:_____
(Last) (First) (MI)
Date of Birth:_____Sex:_____ Social Security #:_____Marital Status:_____

Race: Check one: ___ White ___Black/African American ___Asian ___American Indian/Alaska Native ___Native Hawaiian/Pacific Islander ___Other

Ethnicity: __Hispanic or Latino __Not Hispanic or Latino Primary Language: _____

Address:_____ Home#_____
City State Zip Code
Work #:_____Cell #:_____ Preferred Communication: (Check One) ___Home ___Cell ___Work ___Email

Email Address:_____EmployerName:_____

Referring Physician:_____ Phone:_____
Primary Care Physician:_____ Phone:_____
Emergency Contact:_____ Phone:_____

Name of Spouse (or Parent if Minor):_____Spouse/ParentAddress:_____
Spouse/Parent Phone #:_____ Work:_____ Cell:_____

Spouse/Parent Date of Birth:_____Spouse/Parent Social Security#:_____
Spouse/Parent Employer:_____

Primary Insurance Company:_____ Phone:_____
Insured's SS#_____Policy Holder's Date of Birth:_____

Secondary Insurance Company:_____ Phone:_____
Insured's SS#_____Policy Holder's Date of Birth:_____

Initial Each Line and Sign Below:

_____ I authorize Lowcountry Urology Clinics, PA to release medical records to other physicians relating to my treatment and care.

_____ INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize Lowcountry Urology Clinics, PA to furnish information to insurance carriers concerning my illness and treatment(s) and hereby assign to the physician all payment(s) for medical services rendered to myself or my dependents. I further understand that I am responsible for any balance not covered by insurance.

_____ I understand it is my responsibility to obtain insurance referrals from my primary care physician if required by my insurance.

_____ _____
Signature of Patient or Authorized Person Date

Today's Date_____ Date of Birth:_____Patient Name:_____

Reason for Visit:_____

Preferred Pharmacy Name:_____Pharmacy Phone #:_____

Pharmacy Location/Address:_____

Past Medical History (PMHx) Please Check All that Apply

____Anxiety
____Arthritis- **Please Circle**
- Osteoarthritis
- Psoriatic
- Rheumatoid

____Cancer - type:_____
____Coronary Artery Disease (CAD)
____Degenerative Disc Disease
____Depression
____Diabetes (High Blood Sugar)
____Heart Disease
____High Cholesterol
____High Blood Pressure
____Irritable Bowel Syndrome
____ Low Thyroid
____ High Thyroid
____Chronic Obstructive Pulmonary Disease (COPD)
____Seizure
____HIV/Aids

Urologic History:

___Abdominal Pain
___Back Pain
____Bladder Displacement
____Blood in Urine
____Burning
____BPH
____Overactive Bladder
____Prostate Cancer
____Prostatitis
____Renal Failure
____Urinary Frequency
____Urinary Tract Infection (UTI)

____Difficult Voiding
____Elevated PSA
____Erectile Dysfunction
____Incontinence
____Kidney Disease
____Kidney Stones
____Waking to Urinate @ night/times ___
____Urinary Retention
____Urinary Urgency
____Vaginal Discharge

List Any Other Below:_____
_____
_____

Past Surgical History (PSHx) Please List Below

Surgery/Date of Surgery:_____
_____
_____
_____
_____
_____
_____
_____

Please be sure to list dates of each surgery if there is more than one.

Medication List (Meds) Please List All Below

Drug	Dosage	Frequency	Reason for Medication

Allergies Please List All Known

Allergies to Medications: Yes___ No ____ If yes please explain:_____

_____

Food Allergies: Yes____ No____ If yes please explain:_____

Allergic to Latex? Yes___ No_____

Any other Known Allergies? Please explain

_____

Review of Systems

Do you now or have you had any problems relating to these systems?

Please circle "Y' for Yes and "N" for No

Constitutional Symptoms			**Integumentary**		
Fever	Y	N	Skin Rash	Y	N
Chills	Y	N	Boils	Y	N
Headaches	Y	N	Persistent Itch	Y	N
Other	_____		Other	_____	
Eyes	Y	N	**Neurological**		
Blurred Vision	Y	N	Tremors	Y	N
Double Vision	Y	N	Dizzy Spells	Y	N
Pain	Y	N	Numbness/Tingling	Y	N
Other	_____		Other	_____	
Ear/Nose/Throat/Mouth			**Musculoskeletal**		
Ear Infection	Y	N	Joint Pain	Y	N
Sore Throat	Y	N	Neck Pain	Y	N
Sinus Problems	Y	N	Back Pain	Y	N
Other	_____		Other	_____	
Cardiovascular			**Endocrine**		
Chest Pain	Y	N	Excessive Thirst	Y	N
Varicose Veins	Y	N	Too hot/cold	Y	N
High Blood Pressure	Y	N	Tired/Sluggish	Y	N
Other	_____		Other	_____	
Respiratory			**Psychologic**		
Wheezing	Y	N	Are you satisfied with your life?		
Frequent Cough	Y	N		Y	N
Shortness of Breath	Y	N	Do you feel severely depressed?		
Other	_____			Y	N
			Have you ever considered suicide?		
Gastrointestinal				Y	N
Abdomen Pain	Y	N	**Hematological/Lymphatic**		
Nausea/Vomiting	Y	N	Swollen Glands	Y	N
Indigestion/Heartburn	Y	N	Blood Clotting	Y	N
Other	_____		Other	_____	
Genitourinary			**Allergic/Immunologic**		
Urine Retention	Y	N	Hay Fever	Y	N
Painful Urination	Y	N	Drug Allergies	Y	N
Urinary Frequency	Y	N	Other	_____	
Other	_____				

Physician Use Only:

Physician:_____ Date:_____

Family Medical History (FMHx) List relative with history of illness

Diabetes_____
Heart Disease_____
High Blood Pressure_____
Kidney Disease_____
Vascular Disease_____
Prostate Cancer_____
Stroke_____
Other_____

Social History (SHx)

Alcohol Use: ____ Never ____Current ____Former ____# of Drinks per day
Age Started:_____ Age Stopped:_____

Tobacco Use: ____Never ____Current ____Former ____# packs per day
Age started_____ Age Stopped:_____

Drug Use: Do you use recreational drugs? ____Yes ____No ____If yes, explain___
_____

Occupation:_____

# of Children:_____

Physician Notes:

_____
_____
_____
_____
_____
_____
_____

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Receipt of Notice of Privacy Practices
Written Acknowledgement/Authorization

HIPAA Notice of Privacy Practices Acknowledgement

I have received, read, and understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment and normal healthcare operations of the Practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____Initials

Authorization to Release and/or Obtain Medical Records

I hereby authorize all physicians participating in my health care, and Lowcountry Urology Clinics, PAs' physicians, the release, use, and disclosure of my entire medical record by mail, phone, fax, and to carry out my treatment, payment, and healthcare operations.

_____Signature Required

Authorized Methods of Communication (check all that apply)

1. Okay to leave call back phone number only:

   __Home __Cell __Work

2. Okay to leave detailed message on answering machine/voice mail:

   __Home __Cell __Work

3. Okay to discuss my healthcare treatment with:

   ___Spouse

   ___Family Member_____

   __Friend_____

   __Other_____

I understand that the authorization for release of information will be valid for one year from the date of this signature and can only be revoked upon written notice. By signing below, I acknowledge that this form has been read in full and explained as necessary.

_____ _____
Date Patient Name (Please Print)

_____ _____
Date of Birth Signature of Patient or Personal Representative

Lowcounty Urology Clinics, PA / CT Questionnaire / Patient History

Last Name: _____ First Name: _____

SS# _____ DOB ____/_____/_____ Age: _____ Gender: _____

Study Performed: _____

Number of Images _____ Patient's Home Phone Number: _____ Patient ID #_____

Technical: With IV Contrast Only / Without IV Contrast / Without followed by with IV Contrast
With Oral Contrast Only / Without Oral Contrast / PE Protocol / Kidney Stone Protocol

Ordering MD: _____ CC: _____

Reason for test: _____

When did symptoms begin? _____

Surgical History: _____

Asthma:	Yes	No	Pheochromocytoma	Yes	No
Heart Disease	Yes	No	Diabetes:	Yes	No
HTN:	Yes	No	Glucophage, Metformin, Advandamet or Glucovance	Yes	No
Cancer:	Yes	No	Kidney Disease:	Yes	No
Type: _____			BUN_____Creatine _____ Draw Date _____		
Chemotherapy	Yes	No	Instructions given for Glucophage and IV Contrast?	Yes	No
Radiation	Yes	No	Sickle Cell Anemia	Yes	No

***Pertinent Comparison Exams:** _____

Allergies: NKA or _____

***Previous CT Scan** Yes No If yes, where _____

***Previous PET Scan** Yes No If yes, where _____

***Note: If previous exams noted, are the reports being faxed? Yes No**
Are previous films/or CD being sent to compare? Yes No

Ever had IV Contrast Yes No If yes, did you have a reaction, if so, describe: _____

Contrast used for this exam: Omnipaque 300/ _____cc's /Placed 20g/22g/24b INT / Today's Date _____

LR/RT antecubital _____hand _____wrist _____other Technologist: _____

Complications: None Yes and Describe: _____

STAT CALL Report: Yes No / Physician's Contact Number _____
FOR FEMALE PATIENTS: Is there any possibility that you may be pregnant? Yes No
Date of last menstrual period? _____ Have you had a hysterectomy? Yes No

Patient's Signature: _____ Date: _____

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Lowcountry Urology Clinics, PA is committed to providing you with the best possible medical care. Our practice participates with a variety of insurance plans. As a courtesy to our patients we submit all charges to the appropriate insurance companies. If you have any questions about insurance, we will do our best to help you. Specific coverage issues, however, should be directed to your insurance company Customer Service Department (the number is on your insurance card). It is your responsibility to:

- **Bring your current insurance card at every visit.** We consider an insurance card similar to a credit card because you are asking us to bill another party for charges for the services you have been provided. If you do not bring your insurance card, you should be prepared to pay for your services in full on that date.
- **Be prepared to pay your co-pay at each visit.** We are required by your insurance plan to collect co-pays on the date of service. Payment can be made by cash, check, credit card or Care Credit cards. If you do not bring proper payment to your visit, you may be required to reschedule your appointment, except in the case of a medical emergency.
- **Payment in advance for surgical procedures.** If your physician recommends a surgical procedure you will be required to pay your share of the fee in advance of the procedure. We will communicate with your insurance company to obtain authorization and benefit information.
- **For medical care <u>not covered</u> by your insurance, ie. deductible and coinsurance limits that have not been satisfied, or for patients that have no insurance*, payment in full is due at the time of the visit.** We participate in the Care Credit Plan, a GE Money plan designed to assist you in paying for large balances. Specific plans offer you an interest free payment plan. Please ask for a brochure.
- **For your convenience we accept cash, checks, and many credit cards.**

***<u>UNINSURED PATIENTS</u>**

In an effort to assist patients that do not have any health plan whatsoever, the physicians of Lowcountry Urology Clinics, PA will offer a self-pay discount to lower medical fees, provided the entire charge is paid for by the date of service. Please ask us about the Care Credit Plan which may be able to assist you.

<u>Medicare Lifetime Signature on File (for Medicare patients)</u>
I request that payment of authorized Medicare benefits be made on my behalf directly to this practice for any services furnished me by the physician. I authorize the release of any medical or other information necessary for processing claims to the Center for Medicare and Medicaid Services. _____Initials

<u>Private Insurance Authorization for Assignment of Benefits/Information Release</u>
I authorize the payment of medical benefits be made on my behalf directly to the Practice for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I authorize the release to my insurance company information concerning health care, advice, or treatment provided to me necessary for processing insurance claims. _____Initials

<u>Agreement of Financial Responsibility for Routine, Preventive, and Non-Covered Services</u>
Routine and Preventive services are not covered by most insurance plans. Your insurance plan may not cover your visit today if you do not have a medical complaint or significant problem/abnormality. In the event that services provided are denied as routine, preventive, pre-existing, or non-covered, you will be responsible for the balance.
_____Initials

By signing below, I acknowledge that this Practice Financial Policy form has been read in full and explained as necessary.

_____ _____
Date Patient Name (Please Print)

_____ _____
Date of Birth Signature of Patient or Personal Representative