UROLOGY
SAN ANTONIO

P. (210) 614-4544 F. (210) 679-3725
www.urologysanantonio.com

PATIENT REGISTRATION / ENCOUNTER FORM

REV. 11/12/2015

Appointment Date/Time		Medical Provider	
Appointment Reason/Memo		Co-Pay	OFFICE USE

Patient Information

Patient		Address	
Account #	OFFICE USE		
Date of Birth		City	
Age		State	
Gender		Zip	
Doctor		Marital Status	
Social Security #		Home Phone	
Preferred Language		Work Phone	
Race		Cell Phone	
Ethnicity		Email	
Referred By		Highest Education	

Primary Physician

Primary Physician		Address	
Office Phone			
Fax			

Insurance Information (including Medicare and/or Medicaid)

Primary Insurance		Secondary Insurance	
Policy #		Policy #	
Group #		Group #	
Insured's Name		Insured's Name	
Insured's D.O.B		Insured's D.O.B	
Insured's Gender		Insured's Gender	

Pharmacy Information and Emergency Contact Information

Preferred Pharmacy		Emergency Contact	
Address/Intersection		Relationship	
City, State, Zip		Primary Number	
Phone #		Secondary Number	

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Patient's Name: _____

DOB: _____ App't Date: _____

MEDICAL HISTORY

REV. 9/4/2015

Current Medications List all medications you currently take including vitamins, herbal supplements and over-the-counter medications. If needed, attach an additional sheet.

Medication	Indication	Dosage	Frequency You Take It	Start Date

Allergies List any medical or environmental allergies you have.

_____ ☐ None

Labs & Imaging List any recent laboratory or imaging studies completed outside of our of office and where we can request the results, if needed.

_____ ☐ None

Medical History Note any diseases or conditions you now have or have had in the past.

Cardiovascular: ☐ Atrial Fibrillation ☐ Heart Attack ☐ Stroke ☐ Deep Vein Thrombosis
☐ High Blood Pressure ☐ Congestive Heart Disease ☐ Transient Ischemic Attack (TIA)

Endocrine: ☐ Diabetes ☐ Gout ☐ Hyperthyroid ☐ Hypothyroid

General: ☐ Hepatitis ☐ Elevated Cholesterol ☐ HIV

Gastrointestinal: ☐ Crohn's Disease ☐ Diverticulitis ☐ Pancreatitis ☐ Inflam. Bowel Disease ☐ Ulcerative Colitis

Genitourinary: ☐ Bladder Cancer ☐ Enlarged Prostate ☐ Kidney Failure ☐ Hematuria (Blood in Urine)
☐ Bladder Leakage ☐ Kidney Cancer ☐ Kidney Stones ☐ Urinary Retention
☐ Elevated PSA ☐ Erectile Dysfunction ☐ Testicular Cancer ☐ Urinary Tract Infections
☐ Interstitial Cystitis ☐ Prostate Cancer ☐ Low Testosterone

Eyes, Ears: ☐ Blindness ☐ Cataracts ☐ Glaucoma ☐ Deafness

Rheumatology: ☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Sjogren's Syndrom ☐ Lupus ☐ Immunosuppression

Neurological: ☐ Alzheimer's ☐ Bi-polor Disorder ☐ Depression ☐ Migraines ☐ Multiple Sclerosis
☐ Seizures ☐ Parkinson's

Respiratory: ☐ Asthma ☐ COPD ☐ Emphysema ☐ Tuberculosis ☐ Pulmonary Embolism

Cancer: ☐ Breast ☐ Colon ☐ Leukemia ☐ Lung ☐ Lymphoma
☐ Rectal ☐ Other _____

Cancer Treatment: ☐ Surgery ☐ Chemotherapy ☐ Radiation ☐ Other _____

List any other medical problems not noted above. _____

Surgical History Note any surgeries you have undergone.

Cardiovascular: ☐ Angioplasty ☐ Carotid Artery ☐ Heart Stents ☐ Coronary Artery Bypass
☐ Pacemaker ☐ Heart Valve Replacement

General/GI: ☐ Hernia Repair ☐ Appendectomy ☐ Colon Surgery ☐ Gallbladder Removal

Genitourinary: ☐ Urethral Stricture ☐ Prostate Biopsy ☐ Bladder Suspension ☐ Sound wave treatment of kidney stone (ESWL)
☐ Vasectomy ☐ Removal of Testis ☐ Surgery for Enlarged Prostate (TURP)
☐ Surgery on Kidney ☐ Surgery to Remove Kidney Date of procedure(s) _____

Orthopedic: ☐ Hip Replacement ☐ Knee Replacement ☐ Back Surgery ☐ Knee Scope ☐ Shoulder Surgery

Gynecological: ☐ Uterus Removed ☐ Ovaries Removed ☐ Tubal Ligation
— No. Pregnancies — No. Births — No. Vaginal Delivery — No. C-Sections — Menopause Age

List any other surgeries and their dates. _____

Social History Mark the answer that best describes you.

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated/Divorced ☐ Significant Other

Highest Education: ☐ High School ☐ Vocational/Trade ☐ College ☐ Graduate Degree

Job Status: ☐ Full Time ☐ Part-Time ☐ Student ☐ Retired ☐ Other _____

Alcohol Use: ☐ None ☐ Yes: Drinks Per Day _____ Week _____ Month _____

Smoking/Tobacco Use: ☐ None ☐ Ex-Tobacco User: Date Quit _____ ☐ Tobacco User: Packs/Units Per Day _____

Family History Note the diseases and illnesses your biological family members have had.

Cancer:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Heart Disease:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
High Blood Pressure:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Stroke:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Diabetes:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Kidney Stones:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Grandparent
Enlarged Prostate:		☐ Father	☐ Brother		☐ Grandparent
Prostate Cancer:		☐ Father	☐ Brother		☐ Grandparent

Other family history not noted above: _____

Medical Symptoms Mark any of the symptoms you are currently experiencing.

General:	☐ None	☐ Chills	☐ Fever	☐ Weight Loss	☐ Weight Gain
Eyes:	☐ None	☐ Blurred Vision	☐ Double Vision		
Experiencing Allergies:	☐ None	☐ To Medications	☐ To Food	☐ Seasonal	
Neurological:	☐ None	☐ Dizzy	☐ Headache		
Gastrointestinal:	☐ None	☐ Constipation	☐ Diarrhea	☐ Heartburn	
Muscles and Joints:	☐ None	☐ Arthritis	☐ Cramps	☐ Joint Pain	
Respiratory:	☐ None	☐ Shortness of Breath	☐ Wheezing	☐ Productive Cough	
Hematological	☐ None	☐ Anemia	☐ Bleeding	☐ Swollen Gland	

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URINARY SYMPTOM SCREENER (AUA SYMPTOM SCORE)

Patient Name: _____ Date: _____

Circle the number that best describes your experience.	NOT AT ALL	LESS THAN 1 TIMES IN 5	LESS THAN ½ THE TIME	ABOUT ½ THE TIME	MORE THAN ½ THE TIME	ALMOST ALWAYS
1. INCOMPLETE EMPTYING 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. FREQUENCY 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. INTERMITTENCY 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
4. URGENCY Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. WEAK STREAM Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING 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. NOCTURIA Over the past month or so, how many times did you typically get up to urinate from the time you went to bed until the time you got up in the morning?	**None** 0	**1 Time** 1	**2 Times** 2	**3 Times** 3	**4 Times** 4	**5 Times** 5

Add the score for each question above, and write the total in the space to the right.

SYMPTOM SCORE = 1-7 Mild **8-19 Moderate** **20-35 Severe** **TOTAL** _____

QUALITY OF LIFE: How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?

Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
0	**1**	**2**	**3**	**4**	**5**	**6**

Medical Information Release Form (HIPAA Release)

UROLOGY SAN ANTONIO

_____ _____

Patient Name (Printed) **Date of Birth**

I authorize Urology San Antonio to discuss and/or release my protected health information, including labs and test results, diagnosis, and treatments discussed to the following persons:

_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number

☐ Do not release my information to anyone.

Phone Calls & Messages

May we contact you at home? ☐ No ☐ Yes, the number is_____

May we contact you at work? ☐ No ☐ Yes, the number is_____

May we contact you on your cell phone? ☐ No ☐ Yes, the number is_____

If unable to reach you, Urology San Antonio may:

☐ Leave a detailed message ☐ Leave a message to return call ☐ Not leave a message

I acknowledge that Urology San Antonio has made available to me a copy of the Notice of Privacy practices (HIPAA). This notice describes how this office may use and disclose my protected health information. I understand that I can obtain a complete copy upon my request.

This release of information will remain in effect until terminated by the patient in writing.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

For Internal Use Only:

Patient Act #_____

Patient PQRS Questions

As part of the Affordable Care Act, the government requires that we ask the questions below, many of which have nothing to do with your urologic care. If you have concerns with any of the conditions below, we encourage you to seek treatment through your Primary Care Physician.

Last name		First name	
Urologist Name		Date of Birth	
Today's Date	____/____/____		

1. Have you had a Pneumonia Vaccination?

   Yes or No If yes, what was the date of the vaccination? _____/____/____

2. Do you suffer from lower back pain? (Circle one)

   Yes or No If yes please indicate: Mild Moderate or Severe

3. Do you have any cardiac issues? Do you take aspirin every day?

   Yes or No Yes or No

4. Have you had a Colonoscopy within the last nine years?

   Yes or No If yes, what date was the procedure? ___/___/___ (approx.)

5. Do you currently use tobacco? Have you ever used tobacco?

   Yes or No Yes or No

   This includes smokeless tobacco as well as cigars and cigarettes. If you are a previous tobacco user, when did you quit? _____

6. Do you have Diabetes? Insulin, Diet or medically controlled? (Circle all that apply)

   Yes or No

7. Do you have high blood pressure?

   Yes or No

The following pages are for your information only. Please take your time reading them and be prepared to sign any corresponding consent statements when you arrive for your appointment.

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PATIENT CONSENT STATEMENTS

REV. 1/11/2016

Treatment Consent

I request and authorize medical and/or surgical treatment, as may be deemed necessary and appropriate by the physician and his or her designees participating in my care. The possible risks and benefits of any procedures shall be disclosed to me. This care may include diagnostic; radiology and laboratory procedures; therapeutic procedures, including minor procedures like cystoscopies (using a scope to examine the bladder); administration of drugs; hospital care and medically-appropriate referral for medical supplies including to companies in which my provider may be an investor.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by health care providers.

I also understand that Urology San Antonio uses non-physician providers including advance practice nurses and physician assistants to assist in the delivery of urologic care. A non-physician provider has received advanced education and training in the provision of health care. A non-physician provider can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. I understand that at any time, I can refuse consent to the services of a non-physician provider and request to see a physician.

I realize that I have the right to informed participation in all decisions involving my health care. I acknowledge that no guarantees may be made in regard to the effectiveness of any particular treatment.

Financial Policy Consent

Please be advised that the eligibility and benefit information supplied by your insurance is only an estimate and not a guarantee of payment. Actual benefits are subject to all plan terms, definitions, limitations and exclusions in effect on the date of service. Urology San Antonio will submit your bill to your insurance for services performed by our medical providers at our medical facilities; however, it is ultimately the patient's responsibility to pay for any and all services provided. Please verify participation with your insurer prior to scheduling diagnostic, ancillary or specialty care conducted outside Urology San Antonio. Urology San Antonio is not responsible for verifying benefits for hospitals, anesthesia or any other outside ancillary services or facilities.

Confidential Communications Consent

I hereby authorize Urology San Antonio to furnish information to insurance carriers concerning my illness and treatment and hereby assign to the medical provider all payments for medical service rendered to myself or my dependents. I understand that Urology San Antonio may use electronic or facsimile communication devices to share information about me with other health care providers, third party payers or other facilities involved in my care. Urology San Antonio may leave voice mail identifying me as a patient of Urology San Antonio. (If you do not wish us to leave voice mail, please notify us.) Please understand that the use of communication technology may expedite your care. Urology San Antonio will not use or disclose your health care information without your authorization except as described in the Notice of Privacy Practices.

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NOTICE OF PRIVACY PRACTICES

REV. 11/12/2015

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Urology San Antonio uses health information about you for treatment to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Urology San Antonio.

Our Responsibilities: Urology San Antonio is required by law to maintain the privacy of your health information, provide you a description of our privacy practices and notify you following a breach of unsecured protected health information. Urology San Antonio will abide by the terms of this notice.

How Urology San Antonio May Use or Disclose Your Health Information: The following categories describe examples of the way we use and disclose health information.

For Treatment: Urology San Antonio may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. Urology San Antonio may use your health information when referring you to other health care professionals and facilities.

For Payment: Urology San Antonio may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment. Urology San Antonio may use your information to contact you about account balances.

For Health Care Operations: Urology San Antonio may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel and others to

- Evaluate the performance of our staff
- Assess the quality of care and outcomes in your cases and similar cases
- Learn how to improve our facilities and services
- Determine how to improve the quality of and effectiveness of the health care we provide

Appointment Reminders and Treatment Calls: Urology San Antonio may contact you to provide appointment reminders or information about treatment plans, medication or tests results other health-related benefits and services that may be of interest to you. When leaving a voicemail, Urology San Antonio will provide the physician name, person calling and telephone number/extension.

Notification: Urology San Antonio may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, of our location and your general condition.

For Communication with Family: Urology San Antonio's health professionals, exercising their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to you care.

Business Associates: In some cases, Urology San Antonio contracts with business associates to provide services on its behalf. An example includes arrangements with business associates Urology San Antonio has to provide collection services. Urology San Antonio may disclose your health information to such a business associate so that they can perform their respective job functions. To protect your health information, however, Urology San Antonio requires the business associate to safeguard your information.

As Required by Law: Urology San Antonio may use and disclose information about you as required by law. For example, Urology San Antonio may disclose information for the following purposes.

- For judicial and administrative proceedings pursuant to legal authority
- To report information related to victims of abuse, neglect or domestic violence
- To assist law enforcement officials in their law enforcement duties

As Permitted by Law: Urology San Antonio may also disclose health information to the following types of entities, including but not limited to

- Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury or disability
- Correctional institutions
- Workers compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies

- Funeral directors and coroners
- National security and intelligence agencies
- Protective services for the president and others
- A person or persons able to prevent or lessen a serious threat to health or safety

Research: Urology San Antonio may use your health information to assist in developing new knowledge and improve medical care. Urology San Antonio may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). Urology San Antonio may use information to make contact with you to determine your interest in the research study/clinical trials.

Physician Board Certification: Urology San Antonio may use your health information to submit to the professional certification board for purposes required for physicians' qualification to complete their specialty board examination.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Fundraising: Urology San Antonio may contact you to raise funds for the facility; however, you have the right to elect not to receive such communications.

For Marketing: Urology San Antonio may contact you to ask your permission to have your medical outcome published and/or filmed to develop new knowledge, improve medical care and inform patients. An authorization will be completed by the patient prior to any health information being released.

Affiliated Covered Entity: Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

Health Information Exchange/Regional Health Information Organization: Federal and state laws may permit Urology San Antonio to participate in organizations with other health care providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but are not be limited to improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

Your Health Information Rights
You have the right to
- Request a restriction on certain uses and disclosures of your information
- Request disclosure of encounter information to an insurer if it is paid fully out of pocket by the individual
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record, including but not limited to requesting electronic copies of information held electronically
- Request that your health record be amended
- Request communications of your health information by alternative means or at alternative locations
- Receive an accounting of disclosures made of your health information

Obligations of Urology San Antonio
Urology San Antonio is required to
- Maintain the privacy of protected health information
- Provide you with this notice of its legal duties and privacy practices with respect to your health information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations

Complaints
You may complain to Urology San Antonio and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Changes to This Policy
Urology San Antonio reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you on our website at www.urologysanantonio.com or given to you upon your request at your next visit to our practice.

Contact Information
If you have questions or complaints, please contact
Alan Winkler, Executive Director
Urology San Antonio
7909 Fredericksburg Rd., Suite 110
San Antonio, TX 78229
(210) 731-2050

Effective: September 23, 2013