New Patient Form - Female

UROPARTNERS

Date of Visit_____

Name:_____ What do you like to be called?_____ Date of birth?_____
last *first*

Referring physician:_____ Primary care physician:_____

Other physicians you see and why you see them:_____

Special needs (wheelchair, etc.):_____ Height:_____ Weight:_____

Current Problem

What is the main reason for your visit?_____ When did this start?_____

Describe the location of the problem:_____ How severe is the problem (using a scale of 1-10 with 10 being the worst)?_____

Is the problem present all the time?_____ If not, please explain and describe anything that makes the problem better or worse

_____

Have you had any treatment for this condition? _____ If so, please explain: _____

_____

Have you had any blood tests, X-rays or imaging for this problem? If so, what, where and when?

_____

PLEASE BRING ALL RECORDS/X-RAYS CD/FILMS TO YOUR APPOINTMENT

Please share anything else you think may be important about your problem._____

Have you ever seen a urologist before? If so, who, when and what for?_____

Do you currently have any of the following symptoms? If yes, please explain below.

Fever or chills?	Y	N	Are you awakened at night to urinate? How many times? _____	Y	N
Pain in the side or back?	Y	N	Excessive urge to urinate?	Y	N
Blood in the urine?	Y	N	Leaking of urine when coughing, laughing or movement?	Y	N
Pain during urination?	Y	N	Leaking of urine with urgency?	Y	N
Weak urinary stream?	Y	N	Wear pads due to leaking? How many in 24 hours? _____	Y	N
Difficulty emptying bladder?	Y	N	Problems with sexual function?	Y	N
Excessive frequency of urination	Y	N	Pelvic pain?	Y	N
How many times in 24 hours? _____					

_____

_____

Have you ever had any of the following? If yes, please explain below.

Bladder infections?	Y	N	Surgery of the urinary tract?	Y	N	Kidney Stones?	Y	N
Kidney infections?	Y	N	Cancer of the urinary tract?	Y	N	Other urologic problems?	Y	N

_____

_____

Number of pregnancies_____ Vaginal births_____ C-Sections_____ Date of last menstrual period_____

Menopause/Hysterectomy_____ Endometriosis YES NO Other_____

Medications (*please include over the counter medications and supplements, include seperate sheet of paper if more space is needed*)

Medication	*Dosage*	*Freq.*	*Medication*	*Dosage*	*Freq.*

Do you take any blood thinners? (aspirin, Coumadin, Plavix, etc.) Y N Type _____

ALLERGIES_____

MEDICAL CONDITIONS AND PAST MEDICAL HISTORY, **If yes to any, please explain below.**

Diabetes	Y N	Emphysema	Y N		
High blood pressure	Y N	Asthma	Y N		
High cholesterol	Y N	Major trauma	Y N		
Heart valve problem	Y N	Parkinson's disease	Y N		
Heart attack	Y N	Stroke/TIA	Y N		
Hepatitis	Y N	HIV	Y N		
Bleeding tendency	Y N	Depression	Y N		
Blood clots	Y N	Psychiatric disorders	Y N		
Pacemaker/difib implant	Y N	Glaucoma	Y N		

Have you ever had cancer? _____type? _____status? _____

OTHER MEDICAL PROBLEMS

_____

_____

_____

PRIOR SURGERIES (please include date)

_____ _____

_____ _____

_____ _____

HABITS Smoking N Y QUIT If quit, what year?_____Packs per day?_____How many years did (have) you smoke(d)?_____

Alcohol N Y Drinks per week?_____Recreational drugs?_____

Occupation_____Marital Status_____No. of Children_____

Have you ever been exposed to radiation or environmental toxins NO YES _____

FAMILY MEDICAL HISTORY

Has anyone in YOUR FAMILY (other than yourself) ever had the following?

Kidney Stones_____Cancer of the kidney or bladder_____Cancer of the breast, uterus, cervix, or ovaries_____

Mother: age____if deceased, age_____cause_____Father: age_____if deceased, age_____cause_____

Do you currently have any of the following symptoms? If so, please explain below:

Problems with general health	Y	N	Abdominal pain	Y	N	Seizures	Y	N
Recent weight change	Y	N	Diarrhea	Y	N	Tremors	Y	N
Fatigue	Y	N	Constipation	Y	N	Numbness/tingling	Y	N
Sore throat	Y	N	Poor appetite	Y	N	Depression	Y	N
Recent cold	Y	N	Heat/cold intolerance	Y	N	Insomnia	Y	N
Irregular heart beat	Y	N	Joint pain/stiffness	Y	N	Thyroid disease	Y	N
Chest pain	Y	N	Back pain	Y	N	Excessive thirst	Y	N
Shortness of breath	Y	N	Rash	Y	N	Anemia	Y	N
Chronic cough	Y	N	Itching	Y	N	Past blood transfusion	Y	N
Nausea/Vomiting	Y	N	Frequent headaches	Y	N	Easy bleeding/bruising	Y	N

_____

_____

_____

_____

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Date: _____ Patients SSN: _____

Patients Name: _____
Last name First name

Street Address: _____

City: _____ State: _____ Zip code: _____

Date of Birth: _____ Sex: M ___ F___ Single_____ Married_____

Patients Home phone: _____Patients Cell Phone: _____

Name of Primary Insurance Co: _____

Policy holders name: _____ Policy holders DOB: _____

Policy Holders SSN: _____Policy ID: _____

Name of Secondary Insurance Co: _____

Policy holders name: _____ Policy holders DOB: _____

Policy Holders SSN: _____Policy ID: _____

Referring Physician: _____ Primary Care Physician: _____

Pharmacy name: _____ Pharmacy Phone number: _____

Do you have any of the following (please Circle):
POA: Y / N
Living Will: Y / N
DNR: Y / N

In Case of Emergency, who should be notified? _____Phone: _____

4 Bypass Rd, Ste 103 Salem NJ 08079 215 Sunset Rd, Ste 300 Willingboro NJ 08046

Phone: 856 339 4466 Fax: 856 339 6580

CENTER FOR ADVANCED UROLOGY, LLC
AUTHORIZATION AND CONSENT

MEDICARE

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Center for Advanced Urology, LLC for any services furnished me by Center for Advanced Urology, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable to related services. I permit a copy of this authorization be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

MEDIGAP

I request that payment of authorized Medigap benefits be made on my behalf to Center for Advanced Urology, LLC for any services furnished me by South Jersey Family Care Centers, Inc.. I authorize any holder of medical information about me to release to: _____, any information needed to determine these benefits payable for related services.

MEDICAID

AUTHORIZATION to release information and payment request. I certify that the service(s) covered by this claim has been received and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or it's authorized agents any information needed for this or a related claim.

COMMERCIAL

ASSIGNMENT OF INSURANCE BENEFITS: I irrevocably assign all payments to Center for Advanced Urology, LLC for medical insurance benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to Center for Advanced Urology, LLC for services performed during this period of treatment. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

RELEASE OF INFORMATION: Center for Advanced Urology, LLC (hereinafter referred to as CAU) may disclose any or all parts of the clinical record to me (our) insurance company(s) or employer(s) for purposes of satisfying charges billed by CAU. I further understand that it may be necessary for CAU to contact my (our) past or present employer(s) in regards to this claim.
This authorization does not cover 3rd party liability claims.

GUARANTEE OF ACCOUNT: CAU
For and in consideration of services rendered by CAU to the below named patient, the undersigned (jointly and severally, if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills. There will also be added 35% collection and reasonable attorney fee if your account goes to a collection agency.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

_____ _____
Patient's Signature Registration Date

_____ _____
Patient's Agent Representative & Guarantor Signature Registration Date

Name of Patient _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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www.centerforadvanceurology.com

STUART M. DIAMOND, MD, FACS
Diplomate of the American Board of Urology

CANCELLATION & NO-SHOW POLICY

If you do not show up for your appointment AND if you had not cancelled your appointment at least 48 hours (two full days) In advance, Center for Advanced Urology will charge you a "no-show fee". The amount of the no-show fee will result in a $30 no show fee and missed procedures and test will result in a no-show fee of $50. A no-show fee is a separate charge that will not be covered by your insurance plan.

BEFORE CHARGING YOU A NO-SHOW FEE, CENTER FOR ADVANCED UROLOGY MAY CONSIDER EXTENUATING CIRCUMSTANCE ON A CASE-BY-CASE BASIS.

You will need to pay the no-show fee in full before you schedule any future appointments.

WHY WE CHARGE A NO-SHOW FEE: A patient who does not show up for their appointment and who had not cancelled their appointment with at least 48 hours advance notice affects the care we provide our other patients and the cost of care. First, each no-show represents a missed opportunity for another Center for Advanced Urology patient to see the doctor. Second, certain supplies and medications that we have ordered for you may be wasted if you do not show up. Every no show is inconsiderate and cost Center for Advanced Urology time and money.

I understand the Center for Advanced urology no-show policy and agree to pay the no-show fees above if I am a no-show and had not called the office at least 48 hours in advanced of my appointment to cancel.

Patient's Name (PRINT)	Patient Signature	Date:
_____	_____	_____
Responsible Person's names (PRINT)	Responsible Persons Signature	Date:
_____	_____	_____

phone: 856-339-4466 • fax 856-339-6580
4 Bypass Rd Suite 103, Salem, NJ 08079
215 Sunset Rd Suite 300, Willingboro, NJ 08044

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JOEL L. MARMAR, MD, FACS
Diplomate of the American Board of Urology

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I, _____(print last name),_____ (print first name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Signature_____ Date _____

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Laboratory Services Consent Form

ALL LABS SENT ARE IMPORTANT! At The Center for Advanced Urology, we use laboratory testing not only for diagnosis but also for patient optimization. This ensures that all patients receive the most precise, personalized, and effective care possible.

The laboratory we use for most urines, and any pathology is Accupath Laboratories. We send urines out for most new patients and send pathology out for any procedures such as vasectomies, prostate biopsies, and other surgical interventions.

You may receive a bill from Accupath depending on your insurance network status and if you have a deductible and/or co-insurance.

By signing below, you acknowledge that you have read, understand, and consent to the use of Accupath Laboratories for your diagnostic and patient optimization needs.

_____ Date: _____