Associated Urologists of NC, PA

Adult Registration

MRN: _____

Patient Information

Patient First Name	Patient Last Name	MI	DOB

Mailing Address	City	State	Zip

Street Address	City	State	Zip

Place an ☒ for preferred number for electronically generated calls ❑ Home Phone ❑ Work Phone ❑ Cell Phone

Patient Email Address | Patient Gender ❑ Male ❑ Female | Patient Social Security # _____- _____- _____

Spouse Name | Spouse DOB | Spouse Social Security # _____ - _____ - _____ | Preferred Language | Do you need an interpreter? ❑ Yes ❑ No

Preferred Contact		Ethinicity	Race	
❑ Cell Phone	❑ Email	❑ Hispanic/Latino	❑ Native Indian or Alaskan Native	❑ Native Hawaiian or Pacific Islander
❑ Home Phone	❑ Patient Portal	❑ Non-Hispanic	❑ Asian	❑ White
❑ Work Phone			❑ Black or African American	❑ Other:

Marital Status: ❑ M ❑ S ❑ W ❑ D Homebound: ❑ No ❑ Yes How did you hear about us?

Emergency Contact

First Name	Last Name	Relationship to Patient
Contact Phone	Mobile Phone	
Next of Kin Name	Next of Kin Relation	Next of Kin Phone

I give permission to share medical information with: ❑ No One ❑ Guardian ❑ Next of Kin ❑ Emergency Contact ❑ Guarantor ❑ Other

I give permission to share financial information with: ❑ No One ❑ Guardian ❑ Next of Kin ❑ Emergency Contact ❑ Guarantor ❑ Other

Permission to leave message on answering machines / voice mail? ❑ Yes ❑ No

Patient Employer Name **Address** **Phone**

Primary Medical Insurance	**Secondary Medical Insurance**
Insurance Company Name	Insurance Company Name
Policy Holder Name DOB	Policy Holder Name DOB
Policy Number	Policy Number
Group Number (if applicable)	Group Number (if applicable)
Relationship to Patient ❑ Self ❑ Spouse ❑ Other	Relationship to Patient ❑ Self ❑ Spouse ❑ Other
Primary Care Provider	**Referring Healthcare Provider**
Name:	Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone:	Phone:
Fax:	Fax:
Treating Healthcare Specialist (e.g., Cariologist, Gastroenterologist, Oncologist)	**Primary Pharmacy**
Name:	Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone:	Phone:
Fax:	Fax:

Printed Name: _____ **Signature:** _____ **Date:** _____

PATIENT HISTORY FORM

Associated Urologists of North Carolina, PA
Friendly, affordable urology care...when you need it.

Full Patient Name: _____ MRN: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Primary Care Provider: _____ Referring Provider: _____ Cardiologist _____

Main Reason for Visit: _____

Current tobacco user? ☐Y☐N; #per day? _____ Drink alcohol? ☐Y☐N; How much/often? _____

Former user? ☐Y☐N; When did you quit? _____ Consume caffeine? ☐Y☐N; How much per day? _____

Allergies/Reactions (Please include all drug and/or food allergies/reactions):
☐None ☐Latex ☐IV Contrast/Iodine ☐Tape ☐See attached list

- _____
- _____
- _____
- _____
- _____
- _____

Medications: ☐ None ☐ See attached list **Pharmacy:** _____

Do you take blood thinners? *(examples: Aspirin, Coumadin, Plavix, Xarelto, Aggrenox, Eliquis, Vitamin E, Fish Oil, etc.)* ☐Y☐N

Please list **ALL** prescribed and over-the-counter medications, dosage, frequency and reason below:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Surgical History (*Please include date of each surgery)*:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Colonoscopy within last 10 years: ☐Y☐N Date: _____ Pneumococcal Vaccine: ☐Y☐N Date: _____

General Medical History (*examples: diabetes, high blood pressure, heart attack, stroke, glaucoma*): ☐ **NONE**

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

PATIENT NAME: _____ **MRN:** _____

Urologic Medical History:

Do you see blood in your urine? ☐Y ☐N

Have you ever had a kidney stone? ☐Y ☐N

Do you get urinary tract infections? ☐Y ☐N
If yes, how many in the past year? _____

Do you urinate frequently during the day? ☐Y ☐N
If yes, how often? _____

Do you get up during the night to urinate? ☐Y ☐N
If yes, how many times per night? _____

Do you have urinary leakage? ☐Y ☐N
with coughing, sneezing, or physical activity? ☐Y ☐N
with urgency to urinate? ☐Y ☐N

Have trouble starting your urine stream? ☐Y ☐N
Slow urine stream? ☐Y ☐N
Does your urine stream start or stop? ☐Y ☐N

Do you have urgency to urinate? ☐Y ☐N

Do you have trouble emptying your bladder? ☐Y ☐N

For Men Only:

Are you able to obtain an erection? ☐Y ☐N
Are you able to maintain an erection? ☐Y ☐N

Have you had a previous PSA? ☐Y ☐N
If yes, when/where was the test done? _____

Family History (*Please specify which family member*): ☐ **NONE** ☐ **UNKNOWN**

- Parents: _____
- Grandparents: _____
- Siblings: _____
- Other: _____

Review of Systems (*Please check any new symptoms you have experienced in the last MONTH*)**:**

Constitutional/General
☐ Fever
☐ Chills
☐ Weight Loss
☐ Other: _____

Eyes
☐ Blurry Vision
☐ Double Vision
☐ Cataracts
☐ Other: _____

Ears, Nose, Throat
☐ Hearing Loss
☐ Nasal Stuffiness
☐ Sore Throat
☐ Other: _____

Cardiovascular
☐ Swollen Ankles
☐ Chest Pain
☐ Irregular Heartbeat
☐ Other: _____

Respiratory
☐ Wheezing
☐ Shortness of Breath
☐ Chronic Cough
☐ Other: _____

Gastrointestinal
☐ Change in Bowels
☐ Abdominal Pain
☐ Nausea/Vomiting
☐ Other: _____

Musculoskeletal
☐ Chronic Back Pain
☐ Chronic Neck Pain
☐ Sore Muscles
☐ Other: _____

Skin
☐ Persistent Itching
☐ Rash
☐ Skin Cancer History
☐ Other: _____

Neurological
☐ Numbness
☐ Tingling
☐ Dizziness
☐ Other: _____

Hematologic/Lymphatic
☐ Swollen Glands
☐ Abnormal Bleeding
☐ Transfusion History
☐ Other: _____

Patient Signature: _____ *Date:* _____

Associated Urologists of North Carolina, PA

Friendly, affordable urology care...when you need it.

Financial Policy

Welcome to Associated Urologists of North Carolina. Please take a moment to review our financial policy. We are committed to providing excellent medical care at a fair and reasonable price.

We require patients to provide a copy of their insurance card(s) and driver's license at check-in for every visit.

An adult or legal guardian must accompany all minors to their office visit. The adult or legal guardian accompanying the minor assumes all financial responsibility for the cost of the minor's visit (including situations involving divorce or separation, regardless of a court order. We will provide a receipt for proof of services).

Insurance: Insurance coverage is between a member and their insurance company. Insurance policies vary. It is the members responsibility to fully understand the details of their insurance policies. Furthermore, patients are responsible for notifying our staff of any changes in their insurance coverage at appointment check-in; failure to do so may result in charges that they will be responsible for paying. All payments, co-payments, co-insurances, and deductible amounts (when applicable) are required at the time of check-in.

Prior to your visit, our staff will verify your insurance benefits. We will need your insurance information prior to your visit in order to do this. *If we are unable to verify your insurance information, you will be asked to pay in full for your visit or you may choose to reschedule your visit until we can verify insurance benefits.*

As a courtesy, we will file your primary insurance claim for you. If the insurance company has not processed and paid your claim within 90 days, the payment will become your responsibility. Delinquent accounts will be forwarded to Credit Data and/or Collection agency. You will also be responsible for all fees including, but not limited to, collection fees.

Secondary Insurance: we will file your secondary insurance unless your secondary insurance pays you directly, if so please notify our billing department. Once your primary insurance has paid their portion of the claim, you will be responsible for paying the outstanding balance.

Network Providers: if you are a member of a managed care organization, it is your responsibility to determine whether your AUNC provider is 'in network'. You are also responsible for obtaining an authorization/referral from the primary care physician listed on your insurance card *prior to your visit*. Failure to do so will significantly delay your visit or may require rescheduling your appointment. Insurance companies usually refuse to issue retroactive authorizations for office visits, you will not be seen *unless* you are willing to pay in full on the day of your appointment.

Surgery: When a patient requires surgery, we will verify insurance benefits and provide you or your guardian with a pre-surgery estimate of the physician charges. This estimate will not include surgical facility and/or anesthesia charges. This estimate will be *due one week prior* to surgery unless other arrangements have been made with the billing department in advance. If the actual surgical procedure differs from the planned procedure, you will receive a statement if additional monies are due, or a refund if there is a credit balance.

Payment: AUNC accepts checks, cash, all major credit cards and Care Credit © (if approved). A $25.00 service fee will be assessed for any returned checks. In addition, returned checks must be redeemed with cash or a certified form of payment.

Self-Pay: AUNC has established discounted fees for self-pay patients. Self-pay patients will be required to pay a $100.00 deposit at check-in prior to being seen. The deposit will be credited toward the cost of the visit. If the cost of the visit exceeds $100.00, the balance must be paid at check-out or a payment plan must be arranged.

Payment Plan: The first payment must be paid when the payment plan is set up. The remainder of the balance will be made in equal installments according to the terms of the payment plan. All payment plans are interest free. Depending upon the situation, you may qualify for Care Credit © payment plan. Care Credit © is secured with a signed payment agreement with Synchrony Bank.

Refunds: Patient refunds are processed and paid by paper check bi-monthly.

Outside Lab or Radiology Services: For labs not performed by AUNC, we may utilize an outside lab company. Radiology services performed by AUNC require a radiologist read by an outside facility. Charges are not controlled by AUNC. Patients are responsible for any bill associated with an outside lab or radiology service.

Collection Policy: Unless payment arrangements have been made, our policy requires that all "patient-due" accounts (once the insurance company has paid their portion of the claim or time of service for self-pay patient) over 90 days will be referred to a debt collection agency. In addition to being liable for your outstanding balance, any additional court cost and attorney fees required to collect the unpaid balance will be charged to you. **Patients with unpaid balances over 90 days greater than $50.00 may be discharged from the practice for financial non-compliance. AUNC has the right to refuse services until the past due balance has been collected or a payment arrangement has been made with the billing department.**

Medical Records: Upon receipt of your written request, a copy of your medical records will be provided to a designated health care provider at no charge. If you request a copy of your medical records for personal use, a fee per page will be assessed.

Charges for Forms: Insurance companies may request AUNC providers or staff to complete detailed medical request or lengthy paperwork such as disability or life insurance. AUNC reserves the right to charge a $25.00 fee for completing any lengthy medical documents.

Cancellation Policy: If you need to cancel or reschedule your appointment, please contact the appropriate AUNC office at least 24 hours prior. Failure to do so, or failure to show up for your appointment, may result in a $25.00 charge. Reminder calls for office appointments are made as a courtesy. Failure to receive a reminder call does not void our cancellation policy. If you need to reschedule a hospital surgical procedure or office procedure, we request 48 hours' notice; failure to do so may result in a $100.00 charge. Payment of the cancellation fee may be required before to another appointment or surgical procedure can be scheduled.

Permission to Release Information: This document authorizes AUNC to release personal health information to my insurance company(s), and other health care professionals for treatment, payment, and healthcare operations.

Assignment of Insurance Benefits: If we have a contract with your insurance company and accept assignment, or if Medicare or Medicaid provides your insurance, your signature below assigns insurance benefits to AUNC for services rendered.

Attestation: Your signature (or the signature of your guardian) and that of the responsible party acknowledges that you understand and accept the above information.

I have read the above financial policy and I agree to abide with the terms of this agreement.

_____ _____ Date: _____

Patient's Printed Name Patients Signature

_____ _____

Responsible Person's Name Responsible Person's Signature

Associated Urologists of North Carolina

MRN:

Associated Urologists of North Carolina

NOTICE OF PRIVACY PRACTICES - *Effective April 1, 2011*

THIS NOTICE DESCRIBE(S) HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY!

Uses and Disclosure of your protected health information (PHI):

- **FOR TREATMENT:** used by us or another health care provider for treatment of a medical condition. Your health information will be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all professionals who may provide treatment or who may be consulted by your physicians.
- **FOR PAYMENT:** used by us, or affiliated businesses, in order to receive reimbursement for health care treatment provided to you. Your health information will be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer. For example your health care insurance may request and receive information on dates of services, the services provided, and the medical condition being treated.
- **FOR HEALTH CARE OPERATIONS:** used by us to ensure quality care is provided to you.
- **APPOINTMENT REMINDERS:** used in order to contact you regarding upcoming appointment (s) or treatment.
- **TREATMENT ALTERNATIVES:** used in order to inform you of alternative treatment options.
- **HEALTH-RELATED BENEFITS AND SERVICES:** used to inform you of health-related benefits that may be available to you.
- **EMERGENCIES:** used to ensure appropriate health care is provided to you in an emergency.
- **INDIVIDUALS INVOLVED IN YOUR HEALTH CARE OR PAYMENT FOR YOUR HEALTH CARE:** used to inform friends or family members of your treatment or health care needs.
- **JUDICIAL AND ADMINISTRATIVE PROCEEDINGS:** used as required by court or administrative order.
- **LAW ENFORCEMENT:** used as required by a law enforcement official for law purposes. For example we are required by law to report certain communicable diseases to the state's public health department.
- **CORONER, MEDICAL EXAMINERS AND FUNERAL DIRECTORS:** used to help identify deceased or determine cause of death.
- **MILITARY AND VETERANS:** used as required by appropriate military command authorities.
- **INMATES:** used if you are an inmate as required by law.
- **WORK COMPENSATION:** used as required to support benefits for work related injury or illness.
- **OTHER USES AND DISCLOSURES:** used only if you provide written authorization. If you change your mind after authorizing a use or disclosure of your information you must submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights:

- **RIGHT TO REQUEST RESTRICTIONS:** You have the right to request restrictions of limitation on use or disclosure of your PHI.
- **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS:** You may request that we communicate with you in a particular way or at a particular place. Your request must be in writing. We will accommodate all reasonable requests.
- **RIGHT TO INSPECT AND COPY:** You have the right to inspect and copy your PHI. This does not include psychotherapy notes, information compiled in anticipation or preparation of legal action, medical notes that were provided to us from another provider/facility in order to treat you or PHI to which access is denied by law.
- **RIGHT TO AMEND:** You have the right to request an amendment if your PHI is incorrect or incomplete. Request must come in writing. Your request may be denied if the PHI was not created by us or if the information is found to be accurate.
- **RIGHT TO AN ACCOUNTING OF DISCLOSURE:** You have the right to request a list of disclosures of your PHI provided by us. Request must be in writing; only one accounting may be requested per 12-months period without a charge.
- **RIGHT TO RECEIVE A PRINT COPY OF THIS NOTICE:** a copy will be available for you to read upon your first visit, a printed copy will only be provided at your request.

We reserve the right to revise our Privacy Practices:

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit. The revised policies and practices will be applied to all protected health information that we maintain.

COMPLAINTS: If you believe that your rights have been violated, you may file a complaint with Associated Urologists of North Carolina's management team. You will not be penalized or otherwise retaliated against for filing a complaint.

Print: _____ Sign: _____ Date: _____