UROLOGY CENTER
OF COLUMBUS, L.L.C.

Patient Name: _____ **Date:** _____

Name Prefer to be Called: _____

Address: _____ **City:** _____ **State** _____ **Zip:** _____

Phone-Cell: _____ **Phone-Home:** _____ **Phone-Work:** _____

Email Address: _____ **Preferred Method of Contact:** ☐ Cell ☐ Home ☐ Email

Date of Birth: _____ **Social Security #:** _____ **Sex:** ☐ Male ☐ Female

Language Preferred: _____ **Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Other

Employer: _____

Employer Address: _____

Primary Care Physician: _____

How were you referred to Urology Center of Columbus?

☐ Family/Friend ☐ Website ☐My insurance requires me to
☐ Returning Patient ☐ Internet Search ☐Yellow Pages: ☐ Book ☐ Online
☐ Hospital/ER ☐ Health Fair/Screening ☐ Newspaper: _____
☐ Radio ☐ Pharmacy ☐ Magazine/Phamplet
☐ Seminar ☐ Social Media *Which one?* ☐ Facebook ☐ Twitter ☐ Google+
☐ Television ☐ Billboard
☐ Physician Referral: *Who?* _____ *Did you request us?* ☐ Yes ☐ No

Emergency Contacts:

Please list who we should contact in case of an emergency?

_____	_____	_____
Name	Relationship	Phone

(Optional) Additional Contacts:
Urology Center of Columbus recognizes that you may have a spouse, physician, family members, etc., that may be a part of your healthcare. If you would like for Urology Center of Columbus to speak with anyone assisting you with you care please list them below.

_____	_____	_____
Name	Relationship	Limitations
_____	_____	_____
Name	Relationship	Limitations

I hereby authorize Urology Center of Columbus to discuss and/or release a copy of my health information to the person/organization specified above.

_____ _____
Patient Signature Date

Revised 5/2015

FINANCIAL POLICY

Urology Center of Columbus, LLC welcomes you to our practice. We work hard to provide the highest quality care to you. Your clear understanding of our Financial Policy is important to our professional relationship. Please remember that our contract for service is with you, and it is our policy that you are responsible for our fees regardless of insurance coverage.

FEES DUE AT TIME OF SERVICE:

- **Co-Pay, Co-Insurance, Deductible and Non-Covered Services**
- **Self Pay**
- **Medical Records, Special Forms and Letters** *(that fall outside of the normal course of insurance claims)***:** Urology Center of Columbus' Notice of Privacy Practice describes how medical information about you may be used and disclosed and how you may access this information. Medical records will not be released without a written authorization. For continuity of care, your records may be released to another physician's office or healthcare facility or in the event of an emergency. To request and receive a copy of your medical records, Urology Center of Columbus will charge to cover the photocopying and administrative costs. A schedule of fees is available upon request.

OTHER FEES:

- **Late Fee:** A late fee of $30.00 is applied to any account for nonpayment of the balance due.
- **Returned Checks or Declined Post dated credit card transactions:** There is a fee of $35.00 for any checks returned by the bank or declined post dated credit card transaction.
- **"No Show" Appointment Fee:** We reserve the right to charge a missed appointment fee to patients who do not show for a scheduled surgery or office appointment. We require this fee to be paid before your next appointment.
- **Finance Charge:** A finance charge of one and a half percent (1 ½%) will be imposed on each item of your account which is overdue and has not been paid within thirty (30) days.

Insurance Plans: It is ultimately your responsibility to know the details of coverage and network status of providers for your particular insurance plan. However, as a courtesy, we will file all "In or Out of Network" insurance claims to the appropriate carrier. If your insurance company requires a referral, you are responsible for obtaining it.

Contracted Insurance: (In Network): If we are contracted with your insurance company, we will submit claims for services provided. In order for us to file your claim you must furnish us with all pertinent information along with your insurance card(s). It is the insurance company that makes the final determination. If we are unable to verify your insurance information you will be responsible for the charges at the time of service.

Non-Contracted Insurance: (Out of Network): Patients who have insurance plans that do not have an existing contract with Urology Center of Columbus, LLC are expected to pay in full at time of service.

Workers' Compensation: We require written approval / authorization by your employer and / or workers' compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Account Statements: Statements are mailed out monthly to patients who have a balance due on their accounts. Payment of this balance is expected on receipt of the statement. Any payment plans must be arranged with our billing department. Accounts overdue by more than 90 days may be referred to a collection agency. We also have the right to report your account status to any credit reporting agency such as a credit bureau. By signing this Financial Policy you give us permission to check your credit, employment history and answer questions about your credit experience with us.

Authorized Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for all services.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Relationship Party (to the patient): _____

Prescribing Consent

Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be includes in an ePrescribing program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the benefit plan.
- **Medication status transaction** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent form you are agreeing that Urology Center of Columbus, LLC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.
Understanding all of the above, I hereby provide informed consent to Urology Center of Columbus, LLC to enroll me in the ePrescribe Program.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Date

Relationship if not signed by patient_____

For Office Use Only

If written consent is not obtained, please check reason:

☐ Patient unable to sign
☐ Patient declined to sign

UROLOGY CENTER
OF COLUMBUS, L.L.C.

Pediatric Patient History Form (Below 17 yrs old)

Patient Name: _____ DOB: _____ Acct #: _____

Name Prefer to be Called _____

Original Presenting Problem

This is a confidential document. Please answer all sections appropriate to age and problem.

Please describe the main reason for your visit today. _____

_____

1. Where is the problem located? ☐ Front ☐ Back ☐ Side ☐ Left ☐ Right ☐ Other _____

2. How long has the problem existed? ☐ __ Days ☐ ___Week(s) ☐ ___ Month(s) ☐ More than 1 Yr

3. Does anything help the problem? ☐ Sitting/Standing ☐ Lying Down ☐ Pressure ☐ Heat/Cold
☐ Other _____

4. How often does the problem occur? ☐ Daily (# of times___) ☐ Off & On ☐ Constant ☐ Infrequently

5. Are there other symptoms associated with this problem? ☐ Fever/Chills ☐ Nausea/Vomiting ☐ Headache ☐ Difficult Urinating
☐ Other _____

6. Does this problem affect your daily life? ☐ No ☐ Yes; please describe: _____

_____

Circle the number that best describes your problem: Severe ← 10 9 8 7 6 5 4 3 2 1 → Tolerable

7. Have you been treated for this condition in the past? ☐ No ☐ Yes; please explain_____

_____

Pediatric Questions

Does your child have a history of UTI's? ☐ Yes ☐ No

If yes, are they associated with a fever? ☐ Yes ☐ No

Does your child ever complain of lower abdominal pressure while voiding? ☐ Yes ☐ No

How many times per week does the patient have a bowel movement? _____ per week

Is the patient ever constipated? ☐ Yes ☐ No

Does the patient have fecal soiling in their underwear, more than just poor wiping? ☐ Yes ☐ No

Does the patient have excessively large bowel movements? ☐ Yes ☐ No

Does the patient have excessively hard bowel movements? ☐ Yes ☐ No

Does the patient have frequent stomach aches? ☐ Yes ☐ No If yes, how often? _____

Does the patient have uncontrolled loss of urine? ☐ Yes ☐ No

At what age was potty training first attempted? _____

Is the patient potty trained? ☐ Yes ☐ No If yes, at what age? _____

If yes, was potty training ☐ Easy ☐ Normal ☐ Difficult

Does the patient wet their pants during the day? ☐ Yes ☐ No If yes, how often? _____

Does the patient wet the bed? ☐ Yes ☐ No If yes, how often? _____

Have you tried to treat the wetting problem? ☐ Yes ☐ No If yes, how? _____

What has been the patient's longest dry period? (e.g. 1 month, 6 months, never) _____

How many times a day does the patient urinate in a typical day? _____

Female Patients

Has the patient gone through puberty? ☐ Yes ☐ No If no, please skip the next three questions.

Does the patient have menstrual periods? ☐ Yes ☐ No Are they regular? ☐ Yes ☐ No

Does the patient use birth control? ☐ Yes ☐ No Method _____

Is there a chance the patient may be pregnant? ☐ Yes ☐ No

Social Questions

Smoking History:

☐ Current every day smoker ☐Former Smoker
☐Never Smoked ☐ Unknown if ever smoked
☐Has never smoked or chewed tobacco ☐Currently uses smokeless tobacco

Does the patient drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____. For how long? _____

Past Medical History

The patient has a history of... (Please check all that apply)

- ☐ Bladder Cancer
- ☐ Hormone Imbalance
- ☐ Interstitial Cystitis
- ☐ Kidney Cancer
- ☐ Kidney Stone
- ☐ Low testosterone
- ☐ Overactive Bladder
- ☐ Testicular Cancer
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Diverticulosis/diverticulitis
- ☐ Endometriosis
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ High cholesterol/triglycerides
- ☐ HIV/Aids
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Neurologic disorder
- ☐ Obesity
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Other Cancer What type?_____
- ☐ Psychological disorders
- ☐ Sleep apnea
- ☐ Spine, pelvic, or hip fracture
- ☐ Stomach ulcers/reflux/GERD
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ No significant past medical history

Family History

The patient has a family has a history of... (Please check all that apply)

- ☐ Bladder Cancer If so, which relative: _____
- ☐ Kidney Cancer If so, which relative: _____
- ☐ Kidney Stones If so, which relative: _____
- ☐ Prostate Cancer If so, which relative: _____
- ☐ Testicular Cancer If so, which relative: _____
- ☐ Diabetes If so, which relative: _____
- ☐ Kidney Disease If so, which relative: _____
- ☐ Anemia If so, which relative: _____
- ☐ Bleeding Disorders If so, which relative: _____
- ☐ Other Cancer If so, what type? _____ which relative: _____
- ☐ Heart Disease If so, which relative: _____
- ☐ No significant family history

Review of Systems

Has the patient recently had problems with any of the following?….(Please check all that apply)

Genitourinary

☐ Blood in urine
☐ Cloudy urine
☐ Frequent urination
☐ Strong urgency to urinate
☐ Burning/pain with urination
☐ Slow/weak stream
☐ Waking up to urinate
☐ Uncontrolled loss of urine
☐ Pelvic Pain
☐ Pain or difficulty with intercourse

Constitutional Symptoms

☐ Fatigue
☐ Weight gain/ Obesity

Eyes

☐ Dry eyes
☐ Wear glasses or contacts

Ear/Nose/Throat/Mouth

☐ Dry mouth

☐ Wears dentures

Cardiovascular

☐ Palpitations
☐ Swelling in legs
☐ Pain in legs with walking

Gastrointestinal

☐ Nausea/vomiting
☐ Constipation
☐ Difficulty swallowing
☐ Diarrhea
☐ Accidental leakage of stool

Musculoskeletal

☐ Back pain

Neurological

☐ Depression
☐ Anxiety
☐ Trouble sleeping

Endocrine

☐ Flushing/hot flashes

Hematologic/Lymphatic

☐ Easy bleeding or bruising
☐ EVER told you can't donate blood

Allergic
-have you EVER had a reaction to:

☐ Latex
☐ Sutures
☐ Anesthesia
☐ Tape
☐ Iodine
☐ Contrast dye
If so what was the reaction?
_____

☐ **I have not experienced any of the above.**

Patient or Guardian Signature _____ **Date** _____/_____/_____

Reviewed By _____ **Date** _____/ _____/_____

Physician Signature _____ **Date** _____/_____/_____