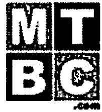
8.2-MTBC-F-07



A Unique Healthcare IT Company®

CONFIDENTIAL

UROLOGY ASSOCIATES OF WEST BROWARD, LLP

REGISTRATION INFORMATION

PLEASE PRINT

◯ New Patient
◯ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

DATE ___/___/______ **EMAIL ADDRESS** ____________________ **HOME PHONE:** (____) _____-______

CELL PHONE: (____) _____-______

PATIENT'S NAME: ____________________ , ____________________ ______
LAST *FIRST* *MI*

STREET ADDRESS: ______________________________

CITY: ______________ **STATE:** ________ **ZIP:** ____________

SSN: _____-_____-______ **SEX:** ◯ ***M*** ◯ ***F*** **BIRTH-DATE:** ____/____/______ ◯ ***SINGLE*** ◯ ***MARRIED*** ◯ ***DIVORCED*** ◯ ***SEPARATED*** ◯ ***WIDOWED***

Referring Physician : ______________________________

Patient Employed By : ______________________________

Business Address: ______________________________

Occupation: ____________________ **Business Phone:** (____) _____-______

Name of Spouse/Responsible Party (If Patient is minor): ____________ , ____________ ______
LAST *FIRST* *MI*

Spouse/Responsible Party Employed by: ______________________________

Business Address: ______________________________

Occupation: ____________________ **Business Phone:** (____) _____-______

RESPONSIBLE PARTY/SPOUSE SSN : _____-_____-______

DO YOU HAVE MEDICAL INSURANCE ? ◯ NO ◯ YES **If Yes:**

NAME OF PRI. INS. : ____________________ **ID #:** ____________ **GRP #:** ____________

***SUBSCRIBER'S NAME:** ____________________ ***BIRTH DATE:** _____/_____/______

ADDRESS OF PRI. INS. : ______________________________

NAME OF SEC. INS. : ____________________ **ID #:** ____________ ***GRP #:*** ____________

***SUBSCRIBER'S NAME:** ____________________ ***BIRTH DATE:** _____/_____/______

ADDRESS OF SEC. INS. : ______________________________

***Required by HIPAA**

Payment is due at the time of service.

In case of emergency, who should be notified? ____________________ Relationship ____________

Person authorized to receive PIH ____________________ Relationship ____________

PHONE: (____) _____-______

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, ____________________ hereby authorize ____________________
(NAME OF INSURED) (NAME OF INSURANCE COMPANY)

to pay and hereby assign directly to ____________________ all benefits, if any, otherwise payable to
(PROVIDER'S NAME)

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to ____________________
(PROVIDER'S NAME)

will be credited to my account, in accordance with the above said assignment.

____________________ ____________
(AUTHORIZED SIGNATURE OF SUBSCRIBER) (DATE)

UROLOGY ASSOCIATES OF WEST BROWARD
UROLOGY CONSULTANTS OF SOUTH PALM

RONALD L. COHEN, M.D., F.A.C.S.
MARSHALL M. KAPLAN, M.D., F.A.C.S.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE
We accept: CASH, CHECKS AND VISA/MASTERCARD

Regarding Insurance:

We will need copies of your insurance cards. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to you. Please be aware some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If a patient has no insurance they are responsible for full payment at time of service.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

____ Date______________

Signature of patient or responsible party

UROLOGY ASSOCIATES OF WEST BROWARD
UROLOGY CONSULTANTS OF SOUTH PALM
MARSHALL M. KAPLAN, M.D., F.A.C.S.
RONALD L. COHEN, M.D., F.A.C.S.

Consent For Use and Disclosure of Health Information

Section A: Patient Giving Consent________________________________Social Security______________________

Section B: To the Patient: Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sheila K. Gilberry
Address: 7710 NW 71 Court, #303, Tamarac, FL 33321 Phone: 954-726-6868 Fax: 954-726-8818
13590 S. Jog Road, #2, Delray Beach, FL 33446 Phone: 561-381-7773 Fax: 561-381-7774

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I,______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Confidential Communications Request

I hereby request that Urology Associates of West Broward/Urology Consultants of South Palm may also communicate my protected healthcare information to my spouse or designated family member. I understand that this request for confidential communications will apply to all future communications, unless I request a change in writing.

Date of Request_________________________Patient:____

Alternate Address (Northern)____Phone:__________________________

____

Can personal health information be left on your home answering machine: YES NO

Alternate Person or Spouse:____Phone:__________________________

Designated Family Member's Name______________________________________Phone:__________________________

Can personal health information be faxed to your number: YES NO Fax Number:_____________________________

Can we E-Mail: YES NO E-Mail Address____

Signature____**Date**____

Patient History Form

Today's date ____________________ Date of birth ____________________ Age __________

Name Last, First & Middle ____ Sex __________

Referred by Doctor ____________________________ Referred by Friend ____________________

Family doctor and address ____

CHIEF COMPLAINT:
What is the main reason for your visit? ____
____

When did you notice the problem? ____

How long does the problem last? ____

Where is the problem located? ____

What makes it better or worse? ____

How severe is the problem on a 0 to 10 scale? (Lease severe) 0 1 2 3 4 5 6 7 8 9 10 (Most severe)

Does it interfere with normal function? ____

Past Medical History and Social History: Please circle answers

Marital Status:	Single	Married	Divorced	Widow
Race:	Caucasian	African-American	Asian	Other __________
Education:	High School/GED	College	Graduate Degree	__________
Occupation:	____________________		Full-time	Part-time Retired
Use of tobacco:	YES NO Former	If yes, how many packs per day/week __________		
Use of alcohol:	YES NO Former	If yes, how many drinks per day/week __________		

Are you taking any blood thinners? e.g. aspirin, coumadin, plavix. YES NO
If yes, please list: ____

Do you need any special antibiotics for dental work or procedures? YES NO
If yes, why? Metal Heart Murmur Other ____________________

List any surgeries, past illnesses, radiation or chemotherapy and dates: e.g. heart attack, diabetes, appendectomy.....

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Family History:

Father: Alive Deceased at age ______ Medical problems ____________________
Mother: Alive Deceased at age ______ Medical problems ____________________
Siblings/ Children Medical problems ____
____

Review of Systems

Do you now or have you had problems related to the following? Please circle

General: Fever Chills Weight loss Other______________________________

Eyes: Vision difficulties Glaucoma Other______________________________

Allergies: Hay fever Other______________________________

Neurological: Dizzy spells Strokes (CVA) Tremors Parkinson's Decreased memory Other__________

Endocrine: Diabetes Thyroid disease Excess thirst Cold intolerance Heat intolerance Other__________

Gastrointestinal: Nausea/vomiting Ulcers Heartburn Hepatitis Other______________________________

Cardiovascular: Chest pain/angina Heart attack High blood pressure Heart murmur Pacemaker/defibrillator Other______________________________

Integumentary: Skin rash Persistent itch Other______________________________

Musculosketetal: Arthritis High back pain Low back pain Other______________________________

Ear/Nose/Throat/Mouth: Dry mouth Sinus problem Decreased hearing Other______________

Respiratory: Emphysema (COPD) Shortness of breath Asthma (wheezing) Other______________

Hematological/Lymphatic: Immune disorder Blood clotting problem Bleeding problem Other__________

Sexual dysfunction: Male Erection difficulty premature ejaculation Other______________
Female Pelvic pain Painful relations Other______________

Urological/Renal: Urinary retention Incomplete emptying Painful urination Urinary frequency Urinary urgency Wetting/leakage Kidney disease/or failure Kidney stones Nighttime voiding Other______________________________

Psychological: Depression Anxiety Other______________________________

Drug allergies? If yes, please list:______________________________

____

CURRENT MEDICATIONS – PRESCRIPTIONS & NON-PRESCRIPTION

Name:	Dose:	Frequency:

UROLOGY ASSOCIATES OF WEST BROWARD

UROLOGY CONSULTANTS OF SOUTH PALM

We will be filling your prescriptions electronically and will need the following information.

Date:________________________ Patient Phone #________________________________

Patient:____ DOB:____________________

Allergies:____

Local pharmacy

Name:____

Address:____

Phone number:____

Publix pharmacy

Address:____

Phone number:____

Mail away drug plan

Name of drug plan:____

Address of drug plan:____

Phone number of drug plan:____

ID#:____

Subscriber:____

(Over for copy of drug plan card)