Welcome to Advanced Urology, PC

Reviewed By:

PATIENT INFORMATION

Please confirm all information is correct:

Name: **Date:** **ACCT#:**

Date of Birth: Sex: Female SSN: *Please check your preferred contact phone#:

Address: ☐ Home Phone#:

City: State: Zip: ☐ Cell Phone#:

☐ Work Phone#:

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other

Spouse / Significant Other Name:

Emergency Contact: (preferably someone not living with you)

Name: Phone#: Relationship:

INSURANCE INFORMATION

Please complete thoroughly. We also need a copy of your insurance card.

Primary Insurance:

Insurance Policy #: Group #:

Secondary Insurance:

Insurance Policy #: Group #:

Please read and sign below:

I understand that I am responsible for all charges or co-payments incurred by me regardless of insurance coverage.

I authorize payment of medical benefits to physician or supplier for these services and future claims. I also authorize the physician to release any information acquired during the course of my treatment which is necessary to process insurance claims.

X

Patient Signature Date

RELEASE OF INFORMATION

Please complete and sign at each "X" below:

I give permission to Advanced Urology, P.C. to relay my medical information to:

(Check all that apply)

☐ Leave a message on my answering machine: ☐ Home ☐ Cell

☐ My spouse/significant other – Name:

☐ Family member – Name(s): Relationship:

☐ I elect to have all information relayed directly to myself and no one else.

X

Patient Signature Date

I authorization Advanced Urology, P.C. to send medical records at my request or the request of a physician:

X

Patient Signature Date

The Physicians at Advanced Urology currently have ownership in the Rocky Mountain Kidney Stone Center.

The Medical Center of Aurora 1411 S Potomac St, #210 / Aurora, CO 80012
Lincoln Medical Center 11960 Lioness Way, #210 / Lone Tree/Parker, CO 80134

(ph) 303-695-6106 (f) 303-695-1211 **AdvancedUrologyPC.com**

ACCT #: _____

Doctor: _____

Patient Portal Authorization Form

Patient Name: _____

DOB: _____

E-mail Address: _____

Cell Phone #: _____

Advanced Urology will provide notices via your personal e-mail that information can be found in your Patient Portal. None of your personal health information available through the portal is transmitted via or into your personal e-mail. The following types of information may be used, disclosed, and retained by health care providers of Advanced Urology as a result of the communications:

1. My personal health information
2. Laboratory test results
3. Pathology reports
4. Other medical records

You will receive an invitation to join our portal via e-mail. Please take the time to accept this invitation so that we can communicate with you via the Patient Portal. For your initial Patient Portal log-in, your security code will be the last four digits of your cell phone number. You will then be prompted to change the code for security purposes.

We want your records to be complete and accurate. Please let us know if there is any problem with your records. Sometimes we may use medical jargon or make mistakes and it can lead to confusion. If something doesn't make sense, please let us know.

You can access the portal day or night, but we don't have 24 hour presence, therefore the portal should not be used for pressing issues. The portal is not intended for "web visits" or new problems. Keep in mind that if a message takes a long time to write, it's probably something better done in person at an office visit.

By signing this form, I authorize Advanced Urology to communicate with me via personal and secured access Patient Portal for all of my medical care and treatment:

X _____

Patient Signature Date

Once you have signed up, you can access the Patient Portal site at: www.followmyhealth.com

ADVANCED UROLOGY, PC MEDICAL HISTORY FORM

REVIEW OF SYMPTOMS

ACCT#:

TODAY'S VISIT

Reason for your visit today: _____

How did you hear about us?

☐ Website / Internet ☐ Family / Friend ☐ Physician Referral: _____
Name Phone #

DEMOGRAPHIC INFORMATION

Race: _____

Ethnicity: _____

Primary Language: _____

PHARMACY INFORMATION

Local Pharmacy

Name: _____ Ph#: _____

Address: _____
(cross-street)

Mail Order Pharmacy

Name: _____ Ph#: _____

Fax#: _____

SYMPTOMS

Please check all symptoms that have been present over the past one month:

General:	☐ None	☐ Chills	☐ Fever	
Skin:	☐ None	☐ Rash		
Neck:	☐ None	☐ Neck Pain		
Respiratory:	☐ None	☐ Difficulty Breathing		
Cardiovascular:	☐ None	☐ Chest Pain		
Gastrointestinal:	☐ None	☐ Abdominal Pain	☐ Nausea	☐ Vomiting
Urological:	☐ None	☐ Blood in Urine	☐ Flank Pain	☐ Male- Difficulty with erection
		☐ Urinary Urgency	☐ Urine Leak	☐ Leaking with Physical Activity
Musculoskeletal:	☐ None	☐ Physical Disability		
Neurological:	☐ None	☐ Decreased Memory		
Psychiatric:	☐ None	☐ Anxiety		
Hematology:	☐ None	☐ Blood Clots	☐ Abnormal Bleeding	

_____

Patient Name Date

Reviewed By: Date:

ACCT#:

PAST MEDICAL HISTORY

Please circle all that apply and provide details/date if applicable:

- ☐ **None:** _____
- ☐ Asthma: _____
- ☐ Blood Clots: _____
- ☐ Benign Prostatic Hypertrophy: _____
- ☐ Congestive Heart Failure: _____
- ☐ Diabetes: _____
- ☐ Heart Attack: _____
- ☐ Heart Disease: _____
- ☐ High Blood Pressure: _____
- ☐ Kidney Stones: _____
- ☐ Lung Disease / COPD: _____
- ☐ Neurological Disorder: _____
- ☐ Stroke: _____
- ☐ Thyroid Disorder: _____
- ☐ Cancer: (please circle)

  Bladder, Brain, Breast, Cervical, Colon, Kidney, Lung, Ovarian, Prostate, Skin, Testicular, Uterine, Other: _____
- ☐ **Other:** _____

PAST SURGICAL HISTORY

Please circle all that apply and provide details/date if applicable:

- ☐ **None:** _____
- ☐ Appendectomy: _____
- ☐ Arthroscopic Surgery: _____
- ☐ Back Surgery: _____
- ☐ Bladder Surgery: _____
- ☐ Gallbladder Surgery : _____
- ☐ Heart Stent: _____
- ☐ Heart Surgery: _____
- ☐ Hernia Repair: _____
- ☐ Hysterectomy: _____
- ☐ Joint Replacement: _____
- ☐ Kidney Stone Surgery : _____
- ☐ Prostate Radiation (type): _____
- ☐ Prostate Removal: _____
- ☐ Transurethral Resection of Prostate (TURP): _____
- ☐ **Other:** _____

ARE YOU ALLERGIC TO ANY MEDICATIONS

☐ No ☐ Yes *Please list below:

CURRENT MEDICATIONS (including over the counter)

Name:	Dose:

Please use the back of this page if more room is needed

FAMILY HISTORY

Please check all that apply and provide family member's relationship to you:

- ☐ **None** ☐ **Unknown**
- ☐ Kidney Stones: _____
- ☐ Bladder Cancer: _____
- ☐ Prostate Cancer: _____
- ☐ Kidney Cancer: _____
- ☐ **Other:** _____

SOCIAL HISTORY

Do you now, or have you ever used the following products?

Tobacco:

☐ Never ☐ Former, yrs:_____ ☐ Present, yrs:_____

Alcohol: _____ Amount / Frequency _____ Years

Street Drugs: _____ Amount / Frequency _____ Years

Patient Name Date

Reviewed By: Date:

ADVANCED UROLOGY, P.C. FINANCIAL POLICY

ACCT#:

INSURANCE BILLING: It is your responsibility to provide us with current and accurate personal and insurance information. As a courtesy, we will bill your insurance company; however, you are ultimately responsible for all charges incurred. Your insurance policy is a contract between you and your insurance company. It is essential that you are aware of the details of your policy. If a referral is required, you are ultimately responsible for making sure this is attained by your insurance company from your Primary Care Provider. We will accept assignment from your insurance company based on our contract with them.

CO-PAYMENTS, CO-INSURANCE, AND DEDUCTIBLES assessed by your insurance company are required at the time of service if specified. If you are unable to pay this at the time of a non-emergent visit, a $15 fee may be assessed, or your appointment may be rescheduled at the discretion of the physician. Co-insurance and deductibles are applied (based upon your specific plan provisions) at the time your claim is processed by your insurance company. We will estimate the amount due prior to surgery, and ask that you arrange payment for these amounts up front.

LABS: During the course of your care, you may need to have your blood drawn or other specimens collected and sent to an outside lab for processing. We bill for the collection and handling of these specimens, the lab will bill for the testing they perform. You will receive a separate statement from the lab for these services. You are responsible for letting us know if your insurance has a specific lab that must be used.

RETURN CHECK POLICY: We will assess a $25 fee for all returned checks. Your financial institution may assess additional fees as well. After repeated returned checks, we may refuse checks as a form of payment and require cash or credit card only. Collection of returned check will be pursued according to state statutes.

COLLECTION POLICY: Any charges incurred and not covered by insurance will be the patient's responsibility, including, but not limited to co-pays, co-insurance, and deductible amounts. As a courtesy, we send statements for balances due. Payment is due upon receipt of a statement. Payment plans are available by speaking to our Billing Department. Unpaid balances will be assessed a fee and may be referred to an outside collection agency.

CANCELLATION POLICY: We require at least 24 hours' notice to cancel a scheduled appointment. Not showing up for appointments, or not canceling within 24 hours prior to the scheduled date will be assessed a $45 fee for office visits, or a $75 fee for office-based procedures. A reminder call before your scheduled appointment is provided as a courtesy. However, there are no guarantees that you will receive a reminder call.

PHARMACY PRIOR AUTHORIZATION FEE: Due to the additional requirements from the insurance company and the administrative burden it has had on our staff, unfortunately a $15.00 fee is required in order to process pharmacy prior authorizations.

MEDICAID: Please be advised that Advanced Urology, P.C. and all the physicians that comprise this practice are not contracted providers with Colorado Medicaid. If you have Medicaid, or you become retroactively covered by Medicaid, you will be expected to pay in full for the services rendered by our physicians.

HIPPA: By signing below you hereby acknowledge that you have received and reviewed Advanced Urology's Notice of Privacy Practices. Please note that our current version of Protected Health Information and Patient's Right to Access health Information is posted in the waiting room. Our Privacy Officer is the practice administrator and can be reached at (303) 695-6106. Also, with this notice you are being notified that our physicians at Advanced Urology as part of research may review your medical records. You may be contacted to see if you would be interested in participating in a research study.

By signing below I acknowledge that I have read and understand the Advanced Urology, PC Financial Policy:

_____

Printed Name

X _____

Patient Signature Date