Patient Registration Form (eCW)

PATIENT INFORMATION

(Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION

(information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

Advanced Urology at Rose

Dr. Ali Sarram, MD

PHYSICIAN CARE

Review of Systems

Name: _____ Date: _____

Reason for your visit with us today: _____

Referring Physician: _____ NONE

REVIEW OF SYSTEMS: (Please circle all symptoms that have been present over the past month)

General:
- Chills
- Fever
- None

Skin:
- Rash
- None

Neck:
- Neck pain
- None

Respiratory:
- Difficulty breathing
- None

Cardiovascular:
- Chest pain
- None

Gastrointestinal:
- Abdominal pain
- Nausea
- Vomiting
- None

Urological:
- Blood in urine
- Flank pain
- Leaking with physical activity
- Male- Difficulty with erection
- Urine leak
- Urine urgency
- None

Musculoskeletal:
- Physical disability
- None

Psychiatric:
- Anxiety
- None

Neurological:
- Decreased memory
- None

Hematology:
- Blood clots
- Abnormal bleeding
- None

Reviewed by: _____ Date: _____

Advanced Urology at Rose

Dr. Ali Sarram, MD

PHYSICIAN CARE

PAST MEDICAL HISTORY (Please provide details/dates)	PAST SURGICAL HISTORY (Please provide details/dates)
None	None
Blood Clots:	Appendectomy:
Benign Prostatic Hypertrophy:	Arthroscopic Surgery:
Congestive Heart Failure:	Back Surgery:
Diabetes:	Bladder Surgery:
Heart Attack:	Gallbladder Surgery:
Heart Disease:	Heart Stent:
High Blood Pressure:	Heart Surgery:
Kidney Stones:	Hernia Repair:
Lung Disease/COPD:	Hysterectomy:
Neurological Disorder:	Joint Replacement:
Stroke:	Kidney Stone Surgery:
Thyroid Disease:	Prostate Radiation (type):
Cancer: Bladder, Brain, Breast, Cervical, Colon, Kidney, Lung, Ovarian, Prostate, Skin, Testicular, Uterine	Prostate Removal:
	Transuretheral Resection of Prostate (TURP):

ALLERGIES TO MEDICATIONS:	FAMILY HISTORY:
	None, Unknown, Kidney Stones, Bladder Cancer, Prostate Cancer, Kidney Cancer

LIST OF MEDICATIONS:
(please include over the counter medications)

NAME	DOSE/FREQUENCY	ROUTE (oral, dermal, etc.)

SOCIAL HISTORY	Marital Status:	Occupation:
Do you now, or have you ever used:	Amount/Years	
Tobacco		
Alcohol		
Street Drugs		

Reviewed by: _____ Date: _____

HCA
Physician Services

Advanced Urology at Rose

Dr. Ali Sarram, MD

Health ONE PHYSICIAN CARE

GENERAL CONSENT TO TREAT FORM

I, the undersigned, hereby consent to the following:

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Advanced Urology at Rose may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize Advanced Urology at Rose practice to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Advanced Urology at Rose.

I acknowledge that I have been given Advanced Urology at Rose's Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initial _____

I, the undersigned, authorize Advanced Urology at Rose to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or responsible party) Signature Date

Advanced
Urology
At Rose

Financial Agreement

Financial acknowledgement for Private Pay Patients or Patients without Insurance
Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

_____ _____
Signature of Patient or Personal Representative **Date**

Assignment and Authorization of Benefits for Patients with Insurance
I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to the practice. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

_____ _____
Signature of Patient or Personal Representative **Date**

Medicare Lifetime Authorization
I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Advanced Urology at Rose. Patient Initial: _____
I request this authorization also apply to all other insurance. Patient Initial: _____

Dr. Ali Sarram
4700 Hale Parkway, Suite 310 | Denver, CO 80220-3925 | 303.316.2450

ADVANCED UROLOGY AT ROSE - PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____

Date of Birth: _____

_____ (Patient/Representative initials) **Notice of Privacy Practices.**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **Release of Information.**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient/Representative Initials) ***I consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient/Representative Initials) ***I do not consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients.

Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

OR

_____ (Patient/ Representative Initials) I decline to receive communication via text.

_____ (Patient/ Representative Initials) I decline to receive communication via email.

If you have previously consented to receive communication via text/email and wish to remove the consent Opt Out/Revocation of communications via email and/or text. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.*

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (Patient/Representative Initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient/ Representative Initials) I ***do not want*** to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____

Advanced
Urology
At Rose

To the patients of Advanced Urology at Rose,

Please be advised that Advanced Urology at Rose, Advanced Urology, P.C. and all the physicians that comprise this practice are not contracted providers with Colorado Medicaid. If you have secondary coverage for Medicare through Medicaid, you will be expected to pay the 20% coinsurance that Medicare does not cover, as well as, the deductible. For the calendar year 2015 the Medicare deductible is $147, which will be expected at the time of service up to the total allowable amount of the services you receive today.

If you have Medicaid or you become retroactively covered by Medicaid, you will be expected to pay in full the services rendered by our physicians. A 35% self-pay discount will be applied to your account when billed.

_____

Patient Printed Name

_____

Patient Signature

_____

Date

Dr. Ali Sarram
4700 Hale Parkway Suite 310
Denver, CO 80220
Ph: 303-316-2450

Advanced Urology at Rose

Dr. Ali Sarram, MD

HealthONE PHYSICIAN CARE

Section A: This section must be completed for all Authorizations			
Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN** (optional)**:**
Provider's Name: Ali Sarram (Advanced Urology at Rose) Ali Sarram (Advanced Urology)	**Recipient's Name:** Advanced Urology; Advanced Urology at Rose; Rose Medical Center; HealthOne Clinic Services		
Provider's Address: 4700 Hale Parkway Suite 310 Denver, CO 80220-4051	**Address 1:** Location(s) as appropriate		
	Address 2:	**Recipient's Phone:**	
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☒ **Paper Copy** ☒ **Electronic Media, if available** (*e.g.*, **USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly): N/A

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **Event:** Discontinuation of Care

Purpose of disclosure: Continuation of Care

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☒ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm Strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☒ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☒ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☒ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**