



Neill Borland, MD  
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### Demographic Information

Name: \_\_\_\_\_ | DOB: \_\_\_\_\_ Sex: **M** **F**

Primary Address: \_\_\_\_\_  
(Street and Apt #) (City) (State) (Zip)

Secondary Address: \_\_\_\_\_  
(Street and Apt #) (City) (State) (Zip)

Home Number: ( ) ( ) None Cell Number: ( )

Email Address: \_\_\_\_\_ (used only for patient portal)

Patient Guardian (if applicable): \_\_\_\_\_ DOB: \_\_\_\_\_

*If you are the legal guardian for this patient, please provide the supporting documentation to the Front Office.*

Emergency Contact: \_\_\_\_\_ Phone Number: ( )

Relationship to Patient: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Cardholder Name and DOB (if different from the patient): \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Cardholder Name and DOB (if different from the patient): \_\_\_\_\_

PCP: \_\_\_\_\_ Referred by: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

I certify that all the above information is accurate. I hereby authorize the release of any information necessary to process my claims. I hereby authorize the release of my medical information to my referring healthcare provider as well as to those I may be referred to for consultation and/or treatment. Payment of any government benefits may be made either to me or to the party who claims assessment.

I authorize the payment of medical benefits directly to my physician. I am financially responsible for any unpaid balance due. I agree to pay any deductible, co-insurance and copays. I understand that I am financially responsible for any charges not covered by my insurance, and if I fail to give updated, current information and the claim is denied, I will be responsible for the entire balance.

In the event your check is returned for any reason, your account will be charged \$35.00. If we determine your account should be placed with an outside collection agency, or an attorney, you will be assessed with an additional 50% of the balance due.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

History and Intake Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary and/or Referring Physician: \_\_\_\_\_

Pharmacy Location and Contact: \_\_\_\_\_

Main Reason for your visit: \_\_\_\_\_

**Social History:**

Do you smoke? YES NO If "YES", how many packs per day? \_\_\_\_\_

Have you previously smoked? YES NO How many packs per day did you smoke? \_\_\_\_\_  
 When did you stop? \_\_\_\_\_ In years, how long did you smoke? \_\_\_\_\_

Do you drink alcoholic beverages? YES NO Occasionally  
 If "YES", how many on a daily basis? \_\_\_\_\_

**Past Medical History: (Please check "YES" for all that apply)**

	YES	NO		YES	NO		YES	NO
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	End Stage Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Bone Marrow Transplant	<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>	<input type="checkbox"/>	Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>
BPH	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>
			HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

**Please list all surgeries you have had and when they occurred:**  No Surgeries

Bladder Surgery: \_\_\_\_\_

Kidney Surgery: \_\_\_\_\_

Joint Replacement: \_\_\_\_\_

Cardiovascular: \_\_\_\_\_

Prostate Surgery/Biopsy: \_\_\_\_\_

Scrotal Surgery: \_\_\_\_\_

Please list all other surgeries, if not listed previously:

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**Urologic Disease History: (Please check “YES” for all that apply)**

	YES	NO		YES	NO		YES	NO
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Hydronephrosis	<input type="checkbox"/>	<input type="checkbox"/>	Renal Tubular Acidosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Bladder)	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Kidney)	<input type="checkbox"/>	<input type="checkbox"/>	Stones (Urolithiasis)	<input type="checkbox"/>	<input type="checkbox"/>	STD/STI	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Penile)	<input type="checkbox"/>	<input type="checkbox"/>	Neurogenic Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Undescended Testis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Prostate)	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination (Dysuria)	<input type="checkbox"/>	<input type="checkbox"/>	Urethral Stricture	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Testicular)	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Elevated PSA	<input type="checkbox"/>	<input type="checkbox"/>	Priapism	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary Trauma	<input type="checkbox"/>	<input type="checkbox"/>	Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>
			Renal Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	Vesicoureteral Reflux	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

**Family History: (Please check “YES” for all that apply and indicate Family Member)**

	YES	NO	
Kidney Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Bladder Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Genital Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____

**Please list any allergies and type of reaction:**

No Known Drug Allergies

Allergies	Reaction

**Review of Systems: (Please check all POSITIVE complaints.)**

No Positive Complaints

**Constitutional:**  Chills  Fever  Weight loss

**Cardio:**  Chest Pains  Swollen ankles  High Blood Pressure

**Eyes:**  Blurred Vision  Eye Pain  Worsening Eyes

**Skin:**  Rash  Lesions  Psoriasis

**Allergies:**  Drug  Food  Seasonal

**Musculoskeletal:**  Arthritis  Cramps  Gout

**Neurological:**  Dizzy  Headache  Seizures

**ENT:**  Sore Throat  Ear Infections  Sinus Problems

**Endocrine:**  Thirst  Tired  Hot/Cold

**Respiratory:**  Asthma  Shortness of Breath  Cough

**GI:**  Heartburn  Diarrhea  Constipation

**Hematologic:**  Anemia  Easy Bleeding  Swollen Glands

**Kidney Disease:**  Renal Failure  Transplant

**Psychologic:**  Anxiety  Depression  Suicidal Thoughts

**Other Conditions:** \_\_\_\_\_

**Please select the most appropriate answer to the following questions.**

	Never	Rarely	Sometimes	Half the Time	Often	Always
How often do you have difficulty in postponing urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you leak urine during activities like coughing, sneezing, lifting or exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have a strong need to empty your bladder before you start to leak urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you lose (leak) urine while you are sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you lose (leak) urine when you do not want to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many times do you urinate during the day?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5+
How many times do you get up at night to urinate?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5+
Have you received treatment for urinary incontinence (leakage) in the past?	<input type="checkbox"/> YES <input type="checkbox"/> NO					
Do you wear a form of protection for your leakage?	<input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", how many pads per day? _____					
Do you see blood in your urine?	<input type="checkbox"/> YES <input type="checkbox"/> NO					
How would you feel if you had to live with your urinary condition the way it is now, no better and no worse, for the rest of your life?	<input type="checkbox"/> Delighted <input type="checkbox"/> Pleased <input type="checkbox"/> Mostly Satisfied <input type="checkbox"/> Mixed <input type="checkbox"/> Unhappy <input type="checkbox"/> Terrible					

**Please, turn this page over to continue.**

**Please list any medications and complete the following table to the best of your abilities:**  
 (If you need more space, we will gladly provide you with another sheet of paper.)

No Medications

Medication Name	Dose	Frequency	Route (i.e., Oral, topical, injection, etc.)

I hereby attest that the information provided on this form is accurate and truthful.

\_\_\_\_\_  
 Patient/Guardian Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Patient/Guardian Printed Name

UROLOGIC PHYSICIANS AND SURGEONS, P.A.  
A Division of Urology Group of Florida, L.L.C.  
MURRAY G. GOLDBERG, M.D.  
R.NEILL BORLAND, M.D.

1411 N. Flagler Dr Suite 5300  
West Palm Beach, FL 33401  
(561)833-5594

2055 Military Trail Suite 210  
Jupiter, FL 33458  
(561)748-9104

**Dear Patient:**

As part of our EHR (Electronic Health Record) Program, we are testing the ability to provide our patients with a clinical summary of your last visit with your Physician.

If you wish to receive a clinical summary, please contact the office where you were seen. The office will print a copy and you can pick it up from that office within 3 business days following your appointment.

Please review the clinical summary. We believe the summary will provide you with relevant information from your visit. If you notice any major discrepancies, you may send a written request for changes to the office in which you were seen. If you prefer, you may bring the changes to your next visit.

**Confirmation of receipt of notification:**

\_\_\_\_\_  
Patient Name (PRINT)

\_\_\_\_\_  
Patient Name (SIGNATURE)

Date \_\_\_\_\_

Thank you,  
Urologic Physicians and Surgeons, P.A.

# Urologic Physicians & Surgeons, P.A.

A Division of Urology Group of Florida, L.L.C.  
Murray G. Goldberg, M.D. R. Neill Borland, M.D.

## Care Provision Policies

Welcome to our practice! It is our mission to provide you with excellent, compassionate care in a safe environment. We pledge to treat you with respect and dignity in a professional and caring manner and to be transparent in our billing process. We rely on you to be an active participant in your care as you are ultimately responsible for settling your account regardless of your medical insurance coverage. We participate in a variety of insurance programs which aid in the payment of your medical cost. If you have concerns about our policies, your treatment, or your account, please notify our practice administrator.

In order to make our relationship with you the best it can possibly be, you need to be familiar with and agree to the following policies:

- ⇒ To be as accurate as possible, we update personal demographics, insurance information, medical history and medications **at each visit.**
- ⇒ If you have tests as part of your appointment, we promise to get the results to you as quickly as possible. Some tests / labs are performed by outside parties, in such cases **they will bill you separately.**
- ⇒ If you do not have insurance, choose not to file with your insurance, or if we are out of network with your insurance, a **minimum DEPOSIT of \$250.00** is due at the time of service for our **new patients.** For our **established patients** with the same designation, a **minimum DEPOSIT of \$150.00** is due at the time of the service. Any additional charges (over the amount of the deposit) will be collected after your visit. Any overpayments will be refunded to you.
- ⇒ If you have insurance, please bring your insurance card to every appointment; without it we cannot bill your carrier. We are required to collect co-payments and co-insurance and reserve the right to reschedule or cancel appointments to comply with insurance company agreements. If you have a deductible that has not been met, we will be collecting the amount of the visit and or procedures, **PRIOR** to being seen.
- ⇒ Your health insurance policy is an agreement between you and your insurance carrier. You are responsible for understanding your own coverage. Your insurance company makes the determination of your eligibility. You authorize your insurance benefits to be transferred directly to the rendering provider and acknowledge you are financially responsible for paying any co-pay, co-insurance or deductible amounts. You agree to pay for services rendered within the limits of this care provisions policy.
- ⇒ Missing your appointment or failure to give us 24 hours notice of cancelling an appointment, creates an undue burden and increases the cost of care to other patients. Should you miss your appointment, you will be billed a **\$50.00 missed appointment fee.** If you miss 3 appointments, you will be dismissed from this practice.
- ⇒ We accept cash, check or credit card. We send two statements, after which delinquent accounts are turned over to a collection agency. You understand and agree that if we are forced to send your account to collections, a **fee of 50% of the unpaid balance will be added.** This amount shall be in addition to any other cost incurred directly or indirectly to collect amounts owed under this agreement.

Your signature below signifies that you have read each item, understand your responsibilities as a patient and agree to the terms of service provided herein:

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Sign)

**UROLOGIC PHYSICIANS  
AND SURGEONS, P.A.**

*a division of UGF*

*Diplomates, American Board of Urology*

Murray G. Goldberg, M.D.

R. Neill Borland, M.D.

To our patients,

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

**I understand that this information serves as:**

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

**I understand that I have the right:**

- To object to the use of my health information for directory purposes.
- To request restrictions as to how health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to an address other than your home address.

The physicians and staff of Urologic Physicians and Surgeons, P.A. respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preferences for the areas noted below.

I wish to be contacted in the following manner (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Home Telephone _____   | <input type="checkbox"/> Mobile Phone: _____   |
| <input type="checkbox"/> O.K. to leave message with detailed information                    | <input type="checkbox"/> O.K. to leave message with detailed information, including auto appointment confirmation calls. |
| <input type="checkbox"/> Leave message with call-back number only.                          | <input type="checkbox"/> I do not wish to receive auto confirmation calls on my cell phone.                              |
| <input type="checkbox"/> Work Telephone _____   |  |
| <input type="checkbox"/> O.K. to leave message with detailed information                    |  |
| <input type="checkbox"/> Leave message with call-back number only.                          |  |
| <input type="checkbox"/> Written Communication  |  |
| <input type="checkbox"/> O.K. to mail to my home address                                    |  |
| <input type="checkbox"/> O.K. to mail to my work/office address                             |  |
| <input type="checkbox"/> O.K. to fax to this number: _____                                  |  |
| <input type="checkbox"/> Other individuals (family, friends, etc.) you may speak with about |  |
| <input type="checkbox"/> My care of treatment   | <input type="checkbox"/> My bill   |

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
Print Patient Name	Date of Birth
_____	_____
Patient Signature	Date
_____	_____