UROLOGIC PHYSICIANS AND SURGEONS, PA

Patient Name: _____ Date of Birth: _____

Main Reason for your visit: _____

MEDICATIONS: LIST ALL MEDICATION YOU ARE PRESENTLY TAKING INCLUDING STRENGTH AND DOSAGE	

Any New Allergies? □ NO □ YES _____

Any New Medical Problems? □ NO □ YES _____

Any New Surgeries? □ NO □ YES _____

Any Change in Family History? □ NO □ YES _____

Any Change in Marital Status? □ NO □ YES _____

Do you Currently Smoke? □ NO □ YES _____

REVIEW OF SYSTEMS (Please Check Positive Complaints.)

Constitutional: □ Chills □ Fever □ Weight loss
Eyes: □ Blurred Vision □ Eye Pain □ Worsening Eyes
Allergies: □ Drug □ Food □ Seasonal
Neurological: □ Dizzy □ Headache □ Seizures
Endocrine: □ Thirst □ Tired □ Hot/Cold
GI: □ Heartburn □ Diarrhea □ Constipation
Kidney Disease: □ Renal Failure □ Transplant
Cardio: □ Chest Pains □ Swollen ankles □ High Blood Pressure
Skin: □ Rash □ Lesions □ Psoriasis
Musculoskeletal: □ Arthritis □ Cramps □ Gout
ENT: □ Sore Throat □ Ear Infections □ Sinus Problems
Respiratory: □Asthma □ Shortness of Breath □ Cough
Hematologic: □Anemia □ Easy Bleeding □ Swollen Glands
Psychologic: □ Anxiety □ Depression □ Suicidal Thoughts

	Never	Rarely	Sometimes	Half the Time	Often	Always
How often do you have the temptation of not emptying your bladder completely?	☐	☐	☐	☐	☐	☐
How often do you have to urinate again within 2 hours of urinating?	☐	☐	☐	☐	☐	☐
How often have you stopped and started several times during urination?	☐	☐	☐	☐	☐	☐
How often have you had difficulty in postponing urination?	☐	☐	☐	☐	☐	☐
How often is the urinary stream weak?	☐	☐	☐	☐	☐	☐
How often do you strain to begin to urinate?	☐	☐	☐	☐	☐	☐
How many times do you get up at night to urinate?	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5+

Do you have burning pain upon urination? ☐ YES ☐ NO

Do you have leakage of urine? ☐ YES ☐ NO

Do you see blood in your urine? ☐ YES ☐ 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?

□ Delighted □Pleased □Mostly Satisfied □Mixed □Unhappy □Terrible

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UROLOGIC PHYSICIANS AND SURGEONS, P.A.
a division of UGF Diplomates, American Board of Urology

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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 transparent in our billing process. We rely on you to be an active participant in your care as you are ultimately responsible for setting 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 $300.00** is due at the time of service for our **new patients**. For our **established patients** with the same designation, a minimum **DEPOSIT of $175.00** is due at the time of 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. We 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 appointments, 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 collection, **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 services provided herein.

_____ _____

Patient Name (PRINT) Date

_____

Patient Signature