UROLOGIC PHYSICIANS AND SURGEONS, P.A.

a division of UGF and Diplomates, American Board of Urology
Murray G. Goldberg, M.D., R. Neill Borland, M.D., Patrick O. Tenbrink, M.D., and Stephanie Cindric, APRN

3399 PGA Boulevard, Suite 230, Palm Beach Gardens, FL 33410

DATE:

NAME	SEX AT BIRTH M ☐ F ☐	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

FLORIDA ADDRESS	CITY AND STATE	ZIP CODE	TIME SPENT AT ADDRESS

NORTHERN ADDRESS	CITY AND STATE	TIME SPENT AT ADDRESS

HOME PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS

SPOUSE'S/PARTNERS NAME	NUMBER OF CHILDREN AND AGES	MARITAL STATUS S	M	DP	W	D

EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE NUMBER	BUSINESS PHONE NO.

PRIMARY CARE PROVIDER	PHONE NUMBER	FAX NUMBER

PHARMACY ADDRESS AND PHONE NUMBER	REFERRED BY

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE	POLICY HOLDER

GOVERNMENT MANDATED QUESTIONS:

RACE ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander Other _____
PRIMARY LANGUAGE ☐ English ☐ Spanish ☐ Other _____ ☐ Declined

ETHNICITY (CHECK APPROPRTATE)
☐ NO, Not Hispanic, Latino, or Spanish Origin ☐ YES, Mexican, Mexican-American or Chicano Origin
☐ YES, Puerto Rican Origin ☐ YES, another Hispanic, Latino or Spanish Origin ☐ Declined

I certify that all 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 health care 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 assignment.

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 deductibles, co-insurance and co-pays. 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.

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 the practice.

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.

We accept cash, check or credit card. We send 3 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 unpaid balance will be added. This amount shall be in addition to any other cost incurred directly or indirect to collect amounts owed under this agreement.

Signed _____ Date _____

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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	☐	☐	Depression	☐	☐	Hyperthyroidism	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐	Hypothyroidism	☐	☐
Asthma	☐	☐	End Stage Renal Disease	☐	☐	Leukemia	☐	☐
Atrial Fibrillation	☐	☐	GERD	☐	☐	Lung Cancer	☐	☐
Bone Marrow Transplant	☐	☐	Hearing Loss	☐	☐	Lymphoma	☐	☐
Breast Cancer	☐	☐	Heart Attack	☐	☐	Radiation Treatment	☐	☐
Colon Cancer	☐	☐	Hepatitis	☐	☐	Seizures	☐	☐
COPD	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Coronary Artery Disease	☐	☐	High Cholesterol	☐	☐	HIV/AIDS	☐	☐

Other: _____

OB/GYN History:

When was your last menstrual period? _____

Have you ever been pregnant? YES NO
If "YES", please answer the following questions.

- □ How many times have you been pregnant (Para)? _____
- □ How many children have you given birth to (Gravida)? _____
- □ Any Cesarean Sections? How many? _____

Surgical History: **(Please list all surgeries you have had and when they occurred)** □ No Surgeries

☐ Bladder Surgery: _____

☐ Kidney Surgery: _____

☐ Joint Replacement: _____

☐ Cardiovascular: _____

☐ Reproductive: _____

Please list all other surgeries, if not listed above:

_____

_____

_____

_____

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

	YES	NO		YES	NO		YES	NO
Blood in Urine	☐	☐	Stones (Urolithiasis)	☐	☐	STD/STI	☐	☐
Cancer (Bladder)	☐	☐	Neurogenic Bladder	☐	☐	Urethral Stricture	☐	☐
Cancer (Kidney)	☐	☐	Painful Urination (Dysuria)	☐	☐	Urinary Incontinence	☐	☐
Genitourinary Trauma	☐	☐	Polycystic Kidney Disease	☐	☐	Urinary Retention	☐	☐
Hydronephrosis	☐	☐	Renal Insufficiency	☐	☐	Urinary Tract Infection	☐	☐
			Renal Tubular Acidosis	☐	☐	Vesicoureteral Reflux	☐	☐

Other: _____

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

	YES	NO	
Kidney Cancer	☐	☐	Who: _____
Bladder Cancer	☐	☐	Who: _____
Prostate Cancer	☐	☐	Who: _____
Genital Cancer	☐	☐	Who: _____
Kidney Stones	☐	☐	Who: _____
Kidney Disorders	☐	☐	Who: _____
Bleeding Disorders	☐	☐	Who: _____
Heart Disease	☐	☐	Who: _____

Allergies: **(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 lose (leak) urine when you do not want to?	☐	☐	☐	☐	☐	☐
How often do you leak urine during activities like coughing, sneezing, lifting or exercise?	☐	☐	☐	☐	☐	☐
How often do you have difficulty in postponing urination?	☐	☐	☐	☐	☐	☐
How often do you have a strong need to empty your bladder before you start to leak urine?	☐	☐	☐	☐	☐	☐
How often do you lose (leak) urine while you are sleeping?	☐	☐	☐	☐	☐	☐
How many times do you urinate during the daytime?	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5+
How many times do you get up at night to urinate?	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5+
Have you received treatment for urinary incontinence (leakage) in the past? □ NO □ YES						
Do you wear a form of protection for your leakage? □ NO □ YES If "YES", how many pads per day? _____						
Do you see blood in your urine? □ NO □ YES						
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						

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

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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 up from the 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.

_____
Patient Name (PRINT)

_____
Patient Signature

_____
Date

Thank you,
Urologic Physicians and Surgeons, P.A

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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

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To our patient,

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

I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health 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
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of
- healthcare professionals.

I understand that I have the right to:

- To object 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 give individuals right to request a restriction on uses or disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that 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 preference for the areas noted below.

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

- ☐ Home Telephone _____
  - ☐ Ok to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Work Phone _____
  - ☐ Ok to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Other Individuals (family, friends, etc) you may speak with about
  - ☐ My care of treatment
  - ☐ My Bill

- ☐ Mobile Phone_____
  - ☐ Ok to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Written Communication
  - ☐ Ok to mail my home address
  - ☐ Ok to mail my work/office address
  - ☐ Ok to fax: _____

Name	Relationship
_____	_____
_____	_____
_____	_____
	_____

_____ _____
Patient Name (PRINT) Date of Birth

_____ _____
Patient Signature Date