UROLOGY SPECIALISTS
OF THE LEHIGH VALLEY

PATIENT REGISTRATION

Date__________________________ SS#_________ /______ /_________ DOB__________________________ Sex: ❑ Male ❑ Female

First Name___________________________ Middle Initial________ Last Name ____ Suffix______

Street Address ____ City___________________________ State____ Zip___________

Email____ Home Phone ____

Work Phone ____ Cell Phone ____

Spouse's Name ____ DOB ________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated Ethnicity ____

Employment Status: ❑ Employed ❑ Self Employed ❑ Unemployed ❑ Disabled ❑ Student ❑ Retired

Employer ____

Employer's Address ____

Referring Provider ____ Primary Care Physician ____

How did you hear about us? ❑ Referred by Physician ❑ Family/Friend ❑ Website ❑ Yellow Pages ❑ Newspaper Advertisement ❑ Billboard

❑ Other (Specify) ____

Primary Insurance ____ID # _____________________Grp # ______________________

Policy Holder: ❑ Self ❑ Spouse ❑ Guardian ❑ Other____

If different than patient: Policy Holder's Name ____

DOB_____________________ SS#________ /_____ /________ Sex: ❑ Male ❑ Female

Policy Holder's Address____

Policy Holder's Employment Status: ❑ Employed ❑ Self Employed ❑ Unemployed ❑ Disabled ❑ Student ❑ Retired

Policy Holder's Employer____

Employer's Address ____

Secondary Insurance ____ID # _____________________Grp # ______________________

Policy Holder: ❑ Self ❑ Spouse ❑ Guardian ❑ Other____

If different than patient: Policy Holder's Name ____

DOB_____________________ SS#________ /_____ /________ Sex: ❑ Male ❑ Female

Policy Holder's Address____

Policy Holder's Employment Status: ❑ Employed ❑ Self Employed ❑ Unemployed ❑ Disabled ❑ Student ❑ Retired

Policy Holder's Employer____

Employer's Address ____

Please bring all insurance cards and a photo ID to the office on day of appointment.

Urology Specialists
OF THE LEHIGH VALLEY

PATIENT MEDICAL HISTORY

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Name ______________________ SS# ____________ DOB __________ Age ______

Family Dr.______________________ Dr. Phone # ____________ Referred By __________

CHIEF COMPLAINT – What is the reason for your visit?

ALLERGIES – Please list allergies and type of reaction ❑ NO ALLERGIES

MEDICATION / FOOD / X-RAY DYE / LATEX	REACTION

CURRENT MEDICATIONS – Presciption Medications / Blood Thinners / Supplements / Vitamins

NAME	DOSAGE	HOW OFTEN

Preferred Pharmacy/Address ______________________ Phone # ____________

MEDICAL HISTORY

SURGICAL PROCEDURES (Type and Year) ❑ None

1. ____________ / ______ 2. ____________ / ______ 3. ____________ / ______

4. ____________ / ______ 5. ____________ / ______ 6. ____________ / ______

MEDICAL PROBLEMS (ex. High Blood Pressure, Diabetes, Cancer, Heart Disease, Kidney Stones, etc) ❑ None

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

Do you have a pacemaker? ❑ Yes ❑ No

Do you have a defibrillator? ❑ Yes ❑ No

(over)

FAMILY HISTORY

Father: ❑ Living – Age _____ ❑ Deceased – Age at death _____

Cause of death ______________________________

Mother: ❑ Living – Age _____ ❑ Deceased – Age at death _____

Cause of death ______________________________

Siblings: # Living ______ # Deceased _______

Cause of death ______________________________

____

List other urology-related illnesses in your family (Hypertension, Kidney Stones, Prostate Cancer, Renal Failure, Testicular Cancer)

Relation	Illness

SOCIAL HISTORY

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Have you ever smoked? ❑ Yes ❑ No

If yes - # packs/day ________ # of years ________

When did you stop smoking? ______________________

Do you drink alcohol? ❑ Yes ❑ No

If yes - # drinks/day ________ # of years ________

When did you stop drinking? ______________________

How many caffeinated drinks do you have each day? _______

What is your primary Language? ______________________

Race ____________________ Ethnicity __________________

Do you use smokeless tobacco? ❑ Yes ❑ No

Do you use recreational drugs? ❑ Yes ❑ No

Have you ever had a blood transfusion? ❑ Yes ❑ No

What is or was your occupation? ______________________

REVIEW OF SYSTEMS – Do you now or have you had any problems related to the following systems?

General:	❑ Fever ❑ Chills ❑ Weight Loss ❑ Diabetes
Eyes:	❑ Blurry Vision ❑ Double Vision ❑ Cataracts ❑ Glaucoma
Ear, Nose, Mouth, Throat:	❑ Hearing Loss ❑ Nasal Stuffiness ❑ Sore Throat
Cardiovascular:	❑ Chest Pain ❑ Irregular Heartbeat ❑ Swelling in Ankles
Respiratory:	❑ Shortness of Breath ❑ Wheezing ❑ Chronic Cough ❑ Asthma
Gastrointestinal:	❑ Abdominal Pain ❑ Nausea/Vomiting ❑ Change in Bowels (Diarrhea, Constipation)
Genitourinary:	❑ Incontinence ❑ Painful Urination ❑ Blood in Urine ❑ Urgency ❑ Frequent Infections
Musculoskeletal:	❑ Chronic Back Pain ❑ Chronic Neck Pain ❑ Sore Muscles ❑ Gout
Skin:	❑ Rash ❑ Persistent Itching ❑ Skin Cancer History
Neurological:	❑ Numbness ❑ Tingling ❑ Dizziness ❑ Stroke
Hematologic/Lymphatic:	❑ Swollen Glands ❑ Abnormal Bleeding ❑ Transfusion History
Psychological:	❑ Dissatisfied with life ❑ Feel severly depressed ❑ Considered suicide

Date Completed ______________________ **Patient Signature** ______________________________

Urology Specialists
of the Lehigh Valley

NOTICE OF PRIVACY PRACTICES

PLEASE KEEP THIS DOCUMENT FOR YOUR RECORDS

This notice describes how medical information about you may be used and disclosed (shared) and how you can get access to this information. PLEASE REVIEW IT CAREFULLY

WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). PHI includes information that can be used to identify you. We collect or receive this information about your past, present, or future health condition, to provide health care to you, or to receive payment for this health care. We must provide you with this notice that explains how, when and why we use and share your PHI.

WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION for many different reasons. Below, we describe the different categories of when we use and share your PHI. All of the ways we are permitted to use and share information will fall within one of the categories.

- **For treatment.** We may share your PHI with physicians, nurses, medical students, and other health care personnel and agencies that provide or are involved in your health care.
- **To obtain payment for treatment.** We may share your PHI in order to bill and collect payment for the services provided to you. It is important that you provide us with up-to-date and correct PHI. We may share your PHI with our billing service and your health insurance to get paid for the health care services we provided to you.
- **To run our health care business.** There are some services that we contract with as business associates. We may share your information with them. However, we require our business associates to protect your PHI through contracted agreements.
- **When government or law enforcement agencies request your PHI.** We share your PHI when a law or law enforcement agency requires that we report information about victims of abuse, neglect, domestic violence or in response to a court order, subpoena, warrant, summons, or similar request.
- **For public health activities.** We are required to report information about births, deaths, and various diseases to government officials and agencies such as the CDC and FDA.
- **For Health Oversight Activities.** We share your PHI with health oversight agencies as authorized by the law.
- **For Military and Veterans, National and Intelligence Activities, Protective Services for the President and others.** We may share your information as required by military command authorities, authorized federal officials for lawful intelligence, counterintelligence, and national security activities, or other authorized persons as required by law.
- **For Research.** We may share your PHI with researchers only when an Institutional Review Board (IRB) has approved the research. We will ask for specific permission to be included in any such research.
- **For Worker's Compensation purposes.** We are required to share your PHI to comply with worker's compensation laws.
- **For appointment reminders and health-related benefits and services.** We may use your name, address and phone number to contact you as a reminder that you have an appointment.

Your prior written consent is required in other situations. In situations not described above, we will ask for your specific consent before using or sharing any of your PHI. If you choose to sign a specific consent to share your PHI, you can cancel that consent later in writing.

YOUR RIGHTS REGARDING YOUR PHI

A. **You have the right to require limits on how we use and share your PHI.** If we accept your request, we will put your limits in writing and follow them except in an emergency situation. You may not limit PHI that we are legally required or allowed to share.

B. **You have the right to choose how we communicate PHI to you.** All of our communications to you are considered confidential. You have the right to ask and we will send information to you at another address (for example, work instead of home) or by other means such as e-mail instead of regular mail. You will be billed for any additional cost.

C. **You have the right to see and get copies of your PHI.** You must request to see your PHI in writing. We will respond to you within 30 days after receiving your written request. If you request copies of your PHI, we will quote and charge you the current rate for each page.

D. **You have the right to get a list of when and to whom we have shared your PHI.** This list will not include uses to which you have already consented. We will respond within 60 days of receiving your request.

E. **Please forward all requests for information in writing to:**

Thomas Tranbaugh
Chief Financial Officer
Urology Specialists of the Lehigh Valley, PC
5018 Medical Center Circle
Suite 220
Allentown, PA 18106

CHANGES TO THIS NOTICE. We may change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the PHI that we already have. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby. You may request a copy of this notice from the Privacy Officer at any time.

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES. If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may send a written complaint to the person listed at the end of this notice. You may also send a written complaint to the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES:

Thomas Tranbaugh
Chief Financial Officer
Urology Specialists of the Lehigh Valley, PC
5018 Medical Center Circle
Suite 220
Allentown, PA 18106

COMMUNICATION CONSENT

PATIENT NAME ____________________________________ DOB__________________

I understand that as part of my health care, **Urology Specialists of the Lehigh Valley, P.C.** will need to contact me, or others involved in my care, from time to time for the purposes of communicating medical or billing information. Examples of medical information might include making or confirming appointments, notifications of test results and treatment plans, or follow-up after a procedure.

I hereby <u>authorize</u> Urology Specialists of the Lehigh Valley, P.C. to contact me in the following ways (Please check all that apply)

- ❑ primary address
- ❑ home telephone phone # ______________________________
- ❑ home voice mail
- ❑ cell phone phone # ______________________________
- ❑ work phone phone # ______________________________
- ❑ work voice mail
- ❑ email email address _________________________

Without specific permission, Urology Specialists of the Lehigh Valley, P.C. will not release my medical information to any other person. I hereby <u>authorize</u> Urology Specialists of the Lehigh Valley, P.C. to release information to the following individuals:

Name:_____________________________ Relation: ________________ Contact #: __________

Name:_____________________________ Relation: ________________ Contact #: __________

Name:_____________________________ Relation: ________________ Contact #: __________

Signature of Patient
Or Legal Representative: ____ Date: __________

Legal Representative
Relationship to Patient: __________________________________ Effective Date: __________

Urology Specialists
— of the Lehigh Valley —

PRIVACY AND CONFIDENTIALITY NOTICE ACKNOWLEDGEMENT

I understand that protected health information may be used and disclosed to perform treatment, payment and/or healthcare operations. I acknowledge I've been given the opportunity to read and review a complete copy of the **Urology Specialists of the Lehigh Valley, PC Privacy Notice** with a complete description of such uses and understand I had a right to review the privacy notice before signing below. I understand I have a right to request this office restrict how my information is used, but this office may not agree with the requested restrictions. I have a right to revoke this authorization and consent, in writing, at any time.

This office reserves the right to amend the privacy policy, whether required by law or otherwise, and a revised notice will be published and made available.

My signature below indicates that I have been provided with or given the opportunity to read and review a complete copy of the **Urology Specialists of the Lehigh Valley, PC Privacy Notice**.

Patient Name: ____ **DOB:** ____________________

Signature of Patient
or Legal Representative: ________________________________ **Date:**____________________

If signed by legal representative,
relationship to patient: ________________________________ **Effective Date:** ____________

Urology Specialists
of the Lehigh Valley

FINANCIAL POLICY & ACKNOWLEDGEMENT

(Effective November 1, 2008)

Urology Specialists of the Lehigh Valley PC is committed to providing every patient with the best possible care and we are pleased to discuss our professional fees at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask, if you have any questions about our fees, our financial policy, or your financial responsibility.

Please understand that Health Insurance is a contract between you and your insurance company. As Guarantor, you are financially responsible for services provided by any provider within Urology Specialists of the Lehigh Valley. While our physicians participate with many of the health plans in the Lehigh Valley, we do not determine your personal financial responsibility or obligations including referrals. This is set by your insurance contract. We will submit claims to most insurance companies as a courtesy to you. To ensure that you experience the best possible insurance coverage, please contact our office for an up-to-date list of the insurance plans with which we participate. We will use the information that you provide to us in filing all claims, but we will not get involved in disputes between you and your insurance company regarding deductibles, copays, referrals, covered services or secondary insurance coverage other than to supply factual information as necessary. Please help us to keep our records current by contacting our office with any changes to your insurance coverage.

The following information is a summary of Urology Specialists of the Lehigh Valley PC Financial Policy. Upon your request, we will provide a copy of our entire Financial Policy.

Copayment: It is the patient's responsibility to satisfy their insurance copayment requirements at the time of service. There will be a $5 processing fee for anyone unable to make payment at the time of service. You may also be asked to reschedule your appointment.

Photo Identification: Some sort of photo identification, usually a valid driver's license, is now required upon registration at the front window. This measure has been implemented for safety and identification purposes. Your cooperation and understanding is greatly appreciated.

Managed Care Referrals: It is the patient's responsibility to obtain proper referrals from their Primary Care Physicians for all services provided by any Urology Specialists of the Lehigh Valley PC provider. Patients are encouraged to contact us, within 48 hours of their scheduled appointment, to confirm that a referral has been issued and received. Your appointment may be rescheduled without the proper referral from your PCP. If the appointment is an emergency, you will be asked to sign a Financial Waiver indicating that you accept financial responsibility, if referral is not received for that service.

Missed/Cancelled Appointments: Patients who cancel an appointment less than 24 hours (one business day) in advance, or fail to show for an appointment may be charged a fee. The following fees apply: New Patients $100; Established Patients $50; Cystoscopy, Ultrasound or any 1/2 hr procedure $100; Vasectomy, Urodynamic Studies or any 1-hr procedure $200. Any outstanding fees must be satisfied, prior to the patient being seen in any USLV office. If you cancel or fail to show for more than one consecutive appointment, the office may choose to dismiss you from their practice.

Additional Fees/Charges: Please note that if your patient account balance remains unpaid for a period greater than 30 days, your account may be placed with a third party collection agent. You will be responsible for interest of 1.5% per month (18% APR) and for reasonable collection and/or attorney fees. You will be given advance notice by our billing department.

UROLOGY SPECIALISTS
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Self-Pay Patients: Patients will be responsible for payment in full at the time of service.

Medicare Advantage: We do not participate with every Medicare Advantage plan and not every Medicare Advantage plan allows and pays for its members to be seen out of network. Please contact our office for a list of participating plans. You will be responsible for contacting your insurance plan for benefits and coverage information. If your plan has the ability to go out of network and we do not participate with your plan, you may be subject to higher out of pocket expenses including higher coinsurances.

Miscellaneous: You will be responsible for knowing your insurance programs requirements regarding preauthorization, referrals, and coverage of certain services and/or administration of in office injectables. You must notify the office in advance of any non-covered services.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER

By my signature below, I agree to the following: I understand that I am financially responsible for services provided by any provider within Urology Specialists of the Lehigh Valley PC. This may include copayments, deductibles, coinsurances, and other amounts up to the full fee charged for services provided. In the event that an invoice becomes 30 days or more past due, it may be placed with a collection agent. I/we agree to pay a service charge of 1.5% per month (18% APR), and any and all collection and reasonable attorney fees. I will be informed in advance of the above. I understand that this is a binding agreement and that I can request a copy of all applicable policies. (Failure to sign this contract may result in appointment cancellation.)

Patient Name ____ DOB ______________

Patient's Signature ____ Date ______________

UROLOGY SPECIALISTS
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INSURANCE AUTHORIZATION

Patient Name: ____ DOB: ____________

MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to **Urology Specialists of the Lehigh Valley, PC** for any services furnished me by that physician group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I permit a copy of this to be used in place of the original.

Signed (insured or authorized person):__________________________________ Date:____________

MEDIGAP

Name of Medigap Insurer:______________________________ Medigap Policy #: ______________

Medigap Insurer's Address: ____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to **Urology Specialists of the Lehigh Valley, PC** for any services furnished me by that physician group. I authorize any holder of medical information about me to release to ______________________________ any information needed to determine benefits payable for related services.

I permit a copy of this to be used in place of the original.

Signed (insured or authorized person):__________________________________ Date:____________

INSURANCE AUTHORIZATION

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to **Urology Specialists of the Lehigh Valley, PC**.

I hereby authorize USLV to appeal my insurance plan's determinations on my behalf and act as my Designated Representative in all aspects of the appeal.

I understand I am financially responsible for any balance not covered by my insurance carrier.

I permit a copy of this to be used in place of the original.

Signed (insured or authorized person):__________________________________ Date:____________