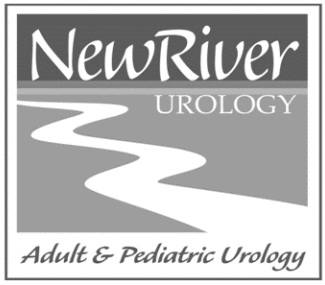

Billing and Registration Form

LASTNAME _____ FIRST NAME_____

DATE OF BIRTH ___/___/_____ SOCIAL SECURITY #_____-_____-_____ SEX (M / F)MARITAL STATUS_____

MAILING ADDRESS_____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # _____ CELL PHONE #_____ PRIMARY CARE PHYSICIAN_____

EMERGENCY CONTACT & PHONE _____

EMPLOYER INFORMATION:

COMPANY NAME _____ WORK PHONE _____ EXT _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

BILLING INFORMATION:

NAME OF RESPONSIBLE PARTY (if other than self) _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

RELATIONSHIP _____ DATE OF BIRTH ____/___/_____ PHONE NUMBER _____

INSURANCE INFORMATION/WORKERS COMP INFO:

Please give your card to the receptionist to copy

IS CONDITION RELATED TO EMPLOYMENT?_____ AUTO ACCIDENT?_____ OTHER ACCIDENT?_____

DATE OF INJURY _____ TIME OF INJURY _____

INSURANCE 1 _____ **COPAY AMOUNT** _____

SUBSCRIBER NAME _____ RELATIONSHIP_____

CERTIFICATE # _____ GROUP # _____

INSURANCE 2 _____ **COPAY AMOUNT** _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

CERTIFICATE # _____ GROUP # _____

SUBSCRIBER DATE OF BIRTH (IF DIFFERENT THAN SELF) ___/___/_____ SOCIAL SECURITY # _____-____-_____

I authorize the release of any medical information necessary to process this claim. (REQUIRED) **Signature_____Date _____**	**I authorize payment of medical benefits to my physician for services provided. (REQUIRED)** **Signature_____Date _____**

PAYMENT POLICY FOR SERVICES RENDERED

- **If You Have Health Insurance:** Please **Initial** the Line Next Your Insurance in **Section 1, 2 Or 3**.
- **If You Do Not Have Health Insurance**: Please Read **Section 4**.
- **Everyone: Read and Sign Section 5** and give your card (if applicable) to the Receptionist so we may make a copy for your file.

1. **IF YOU HAVE INSURANCE WITH ONE OF THE FOLLOWING INSURANCE COMPANIES,** please initial the appropriate line. We will bill these companies directly and will follow up on outstanding balances. You will be responsible for payment of your designated co-pay at each visit to the office BEFORE you see the doctor. You are responsible to present updated referral authorizations from your insurance carrier when required.

____ Medicare
____SC Medicaid
____ AETNA
____ BCBS
____Total Health PPO
____ CIGNA
____ United Healthcare
____ Humana Tricare
____Coventry

2. **IF YOU HAVE BEEN INJURED ON THE JOB AND YOUR EMPLOYER HAS WORKERS COMPENSATION COVERAGE,** we must have information approving the claim from your employer and an accurate billing address to send the claim to for processing. Without this, we will consider payment for this visit to be your responsibility. New River Urology follows the South Carolina State Workers Compensation fee schedule and is not a member of any Worker's Comp PPO's.

Name of Insurance Company: _____ Contact Person: _____

Address: _____ Phone: _____

3. **IF YOU HAVE COVERAGE WITH INSURANCE COMPANY, NOT LISTED ABOVE.** If you provide us with a copy of your card, we will submit a claim directly to your insurance company for reimbursement as a courtesy. Please review the following procedure and sign.

"I understand that my services are being billed directly to my insurance carrier for me. The insurance company should send payment directly to me (the patient). If the payment is received at our office the payment will be forwarded to the patient. I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility."

Insurance Co Name: _____Signed: _____ Date: _____

4. **IF YOU DO NOT HAVE HEALTH INSURANCE,** you are responsible for payment of your bill at the time of your visit. We accept personal checks, credit cards, and cash. A payment of $65.00 is due before your visit. The balance will be due when your visit is complete. If your bill exceeds $200.00, a payment plan can be worked out at the time of the visit. Please ask for our payment agreement form.

5. **"I understand and agree that regardless of my insurance coverage, I am responsible for the balance of this account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and The New River Urology incurs any collection charges, they will be my responsibility."**

If the patient is a minor: **"By consenting to care at New River Urology, I am agreeing that I will take responsibility for the payment of the medical bills. I will provide the office with all information necessary and will communicate with the office regarding any changes in responsibility.**

Patient or Guardian Signature_____ **Date**_____

Consent to Use or Disclose Protected Health Information
For Treatment, Payment and Health Care Operations

I consent to allow *New River Urology* to use or disclose my protected health information for treatment, payment and health care operations.

- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.

- Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.

- Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of *New River Urology* .

I consent to allow *New River Urology* to disclose my protected health information for treatment activities of another health care provider.

I consent to allow *New River Urology* to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow *New River Urology* to disclose protected health information to another covered entity for health care operations activities, provided that *New River Urology* and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations or for the purpose of health care fraud and abuse detection or compliance.

Name of patient_____Date_____
(Please Print)

_____

Signature of Person Authorizing Consent

_____

Relationship to patient

Notice of Health Information Practices Summary

Your Medical Record Each time you visit a hospital or physician, a record is made of your visit. This information, commonly known as a medical record, contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care. The confidentiality of your medical record is protected under the State-specific and Federal law.

Your Health Information Rights Your medical record is the physical property of the physician or healthcare facility that compiled it, but the information belongs to you. Therefore, you have rights regarding the use and disclosure of your health information.

Our Responsibilities *New River Urology* is required by the Federal Privacy Rule to maintain the privacy of your medical record and to provide you with a notice of our legal duties and privacy practices.

Uses and Disclosures for Treatment, Payment, and Health Care Operations *New River Urology* will use your health information in order to treat you. We will provide other providers or hospitals with copies of your medical record to assist them in treating you, should that become necessary. We will also use and disclose health information about you to make appointments with you.
New River Urology will use your health information for payment. The information on a bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.
New River Urology will use your health information for regular health operations to assess the quality of your care.
New River Urology will disclose your health information to business associates, such as a medical transcription or billing service; so that they can perform the job we have asked them to do.

Uses and Disclosures that We May Make Unless You Object You have the right to object to certain situations in which *New River Urology* may disclose information from you medical record.

Disclosures Permitted without Consent *New River Urology* is required by state and Federal law to disclose health information from your medical record under specific circumstances.

Uses and Disclosures Specifically Authorized by You *New River Urology* expects to make other uses and disclosures of your protected health information only on the basis of specific written authorization forms signed by you.

To Report a Problem You have the right, under Federal law, to report a problem or file a complaint about how your personal health information is being handled. You can do this directly with *New River Urology* or to the Secretary of Health and Human Services in Washington, D.C.

Medical History

Patient's Name: _____ Age:_____

Why are you here to see the doctor? _____

_____

_____

Past Medical History:

High Blood Pressure: ___ Yes ___ No

Heart Disease: ___ Yes ___ No

Diabetes: ___ Yes ___ No

Other: _____

Have you had any bleeding problems or blood disorders? ___ Yes ___ No Other: _____

Have you been tested for HIV (AIDS) virus? ___ Yes ___ No

Past Surgical History:

Please list your prior surgeries:

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Family History:

Men: Is there any history of Prostate Cancer in your family? ___ Yes ___ No

Has any blood relative ever had any of the conditions listed below, and who?

Cancer ___ Yes ___ No Family Member(s)_____

Tuberculosis ___ Yes ___ No Family Member(s): _____

Diabetes ___ Yes ___ No Family Member(s): _____

Heart Disease ___ Yes ___ No Family Member(s): _____

Hypertension ___ Yes ___ No Family Member(s): _____

Stroke ___ Yes ___ No Family Member(s): _____

Convulsions ___ Yes ___ No Family Member(s): _____

Suicide ___ Yes ___ No Family Member(s): _____

Mental Illness ___ Yes ___ No Family Member(s): _____

Bleeding Tendency ___ Yes ___ No Family Member(s): _____

Gout or Other Arthritis ___ Yes ___ No Family Member(s): _____

Hereditary Defects ___ Yes ___ No Family Member(s): _____

Medical History

Social History:

Do you smoke?	___ Yes	___ No
Do you drink alcohol?	___ Yes	___ No
Do you use illicit drugs?	___ Yes	___ No
Are you working?	___ Yes	___ No
Retired?	___ Yes	___ No

Allergies:

Please List Medication Allergies: _____

_____

Please List Any Other Allergies: _____

_____

Medications:

Please List Current Medications: _____

_____

_____

_____

_____

_____

_____

Immunizations:

Have you had the flu shot recently?	___ Yes	___ No
Have you had the pneumonia vaccine?	___ Yes	___ No

Systemic Review

Do you have any of the following?

Constitutional:

Fever	___ Yes	___ No
Chills	___ Yes	___ No
Feeling Poorly	___ Yes	___ No
Feeling Tired	___ Yes	___ No
Recent Weight Gain	___ Yes	___ No
Recent Weight Loss	___ Yes	___ No

Eyes:

Eye Pain	___ Yes	___ No
Red Eyes	___ Yes	___ No
Eyesight Problems	___ Yes	___ No
Discharge From Eyes	___ Yes	___ No
Dry Eyes	___ Yes	___ No
Eyes Itch	___ Yes	___ No

ENT:

Earache	___ Yes	___ No
Loss of Hearing	___ Yes	___ No
Nosebleeds	___ Yes	___ No
Nasal Discharge	___ Yes	___ No
Sore Throat	___ Yes	___ No
Hoarseness	___ Yes	___ No

Cardiovascular:

Chest Pain	___ Yes	___ No
Palpatations	___ Yes	___ No
Heart Rate Fast	___ Yes	___ No
Heart Rate Slow	___ Yes	___ No
Leg Claudication	___ Yes	___ No
Leg Swelling	___ Yes	___ No

Respiratory:

Shortness of Breath	___ Yes	___ No
Wheezing	___ Yes	___ No
Cough	___ Yes	___ No

Gastrointestinal:

Abdominal Pain	___ Yes	___ No
Vomiting	___ Yes	___ No
Constipation	___ Yes	___ No
Diarrhea	___ Yes	___ No
Heartburn	___ Yes	___ No
Dark Stools	___Yes	___ No

Genitourinary:

Burning with Urination	___ Yes	___ No
Incontinence	___ Yes	___ No
Hesitancy	___ Yes	___ No
Nocturia	___ Yes	___ No
Genital Lesions	___ Yes	___ No
Testicular Pain	___ Yes	___ No
Pelvic Pain	___ Yes	___ No
Menstrual Pain	___ Yes	___ No
Vaginal Dryness	___ Yes	___ No
Vaginal Discharge	___ Yes	___ No
Abn Vaginal Bleeding	___ Yes	___ No
Decreased Sex Drive	___ Yes	___ No

Musculoskeletal:

Joint Pain	___ Yes	___ No
Joint Swelling	___ Yes	___ No
Joint Stiffness	___ Yes	___ No
Limb Pain	___ Yes	___ No
Limb Swelling	___ Yes	___ No

Skin:

Skin Lesions	___ Yes	___ No
Skin Wound	___ Yes	___ No
Itching	___ Yes	___ No
Change in Mole	___ Yes	___ No
Dry Skin	___ Yes	___ No
An Unusual Growth	___ Yes	___ No

Neurological:

Confused	___ Yes	___ No
Dizziness	___ Yes	___ No
Fainting	___ Yes	___ No
Limb Weakness	___ Yes	___ No
Difficulty Walking	___ Yes	___ No

Endocrine:

Hot Flashes	___ Yes	___ No
Muscle Weakness	___ Yes	___ No
Erectile Dysfunction	___ Yes	___ No
Deepening of the Voice	___ Yes	___ No
Feeling of Weakness	___ Yes	___ No

Psychiatric:

Suicidal	___ Yes	___ No
Sleep Disturbances	___ Yes	___ No
Anxiety	___ Yes	___ No
Depression	___ Yes	___ No
Change in Personality	___ Yes	___ No
Emotional Problems	___ Yes	___ No

Heme/Lymph:

Easy Bleeding	___ Yes	___ No
Easy Bruising	___ Yes	___ No
Swollen Glands	___ Yes	___ No
Swollen Neck Glands	___ Yes	___ No

Erectile Function;

Erectile Dysfunction	___ Yes	___ No
Inability to Initiate Erection	___ Yes	___ No
Incomplete Erection	___ Yes	___ No
Inability to Perform Intercourse	___ Yes	___ No
Excessive Penile Curvature	___ Yes	___ No
Lack of Morning Erections	___ Yes	___ No
Lack of Nocturnal Erections	___ Yes	___ No
Premature Ejaculations	___ Yes	___ No
Decrease Libido	___ Yes	___ No
Claudication	___ Yes	___ No
Back Pain	___ Yes	___ No
Fatigue	___ Yes	___ No
Weight Loss	___ Yes	___ No
Depression	___ yes	___ No
Vision Problems	___ Yes	___ No
Urinary Impairment	___ Yes	___ No

International Prostate Symptom Score (IPSS)

Name:_____ **Date:** _____

	Not at all	Less than 1 time in 5	Less than half the	About half the time	More than half the	Almost always	**Your score**
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	

	None	1 time	2 times	3 times	4 times	5 times or more	**Your score**
Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	

Total IPSS score	

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed – about equally satisfied	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6