

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 # _____

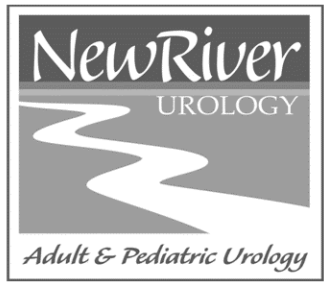
INSURANCE 2 _____ COPAY AMOUNT _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

CERTIFICATE # _____ GROUP # _____

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

<p>I authorize the release of any medical information necessary to process this claim. (REQUIRED)</p> <p>Signature _____ Date _____</p>	<p>I authorize payment of medical benefits to my physician for services provided. (REQUIRED)</p> <p>Signature _____ Date _____</p>
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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.

- | | |
|---|--|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> CIGNA |
| <input type="checkbox"/> SC Medicaid | <input type="checkbox"/> United Healthcare |
| <input type="checkbox"/> AETNA | <input type="checkbox"/> Humana Tricare |
| <input type="checkbox"/> BCBS | <input type="checkbox"/> Coventry |
| <input type="checkbox"/> Total Health PPO | |

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."

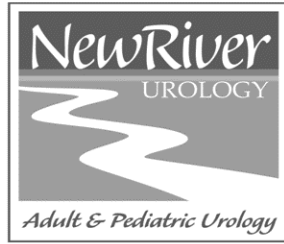
Insurance Co Name: _____ Signed: _____ Date: _____

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.

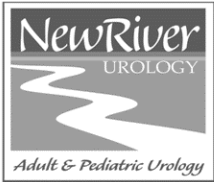
New River Urology will disclose your health information to business associates, such as a medical transcription or billing service; so that they can perform the job we have asked them to do.

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 your 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:

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): _____

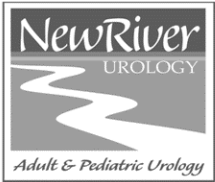
Suicide ___ Yes ___ No Family Member(s): _____

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: _____

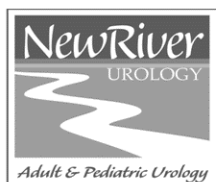
Please List Any Other Allergies: _____

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
Palpitations 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

Psychiatric:

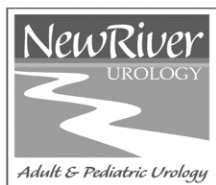
Suicidal ___ Yes ___ No
Sleep Disturbances ___ Yes ___ No
Anxiety ___ Yes ___ No
Depression ___ Yes ___ No
Change in Personality ___ Yes ___ No
Emotional Problems ___ Yes ___ No

Endocrine:

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

Heme/Lymph:

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



Overactive Bladder Symptom Quiz

Name: _____ Date: _____

	Not at all	A little bit	Some-what	Quite a bit	A great deal	A very great deal	Your score
How bothered have you been...							
Frequent urination during the daytime hours?	0	1	2	3	4	5	
An uncomfortable urge to urinate?	0	1	2	3	4	5	
A sudden urge to urinate with little or no warning?	0	1	2	3	4	5	
Accidental loss of small amounts of urine?	0	1	2	3	4	5	
Night time urination?	0	1	2	3	4	5	
Waking up at night because you had to urinate?	0	1	2	3	4	5	
An uncontrollable urge to urinate?	0	1	2	3	4	5	
Urine loss associated with a strong desire to urinate?	0	1	2	3	4	5	

Total Score	
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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