UROLOGY CENTER
OF SOUTH FLORIDA,P.A.

MAIN OFFICE
10151 Enterprise Center Blvd., Suite 201
Boynton Beach, Florida 33437
Phone (561) 737-9191 • Fax (561) 737-2413

Robert G. Gold, M.D. • *William K. Skinner, M.D.* • *Joseph N. Biase, M.D.* • *Stuart M. Popowitz, M.D.*

NEW PATIENT MEDICAL QUESTIONNAIRE

Print Name_____

Today's Date_____ Date of Birth_____

Why did you choose the Urology Center of South Florida? _____

If referred, by whom?_____

HAVE YOU **EVER** HAD ANY OF THE FOLLOWING CONDITIONS?

YES	NO	NOT SURE		YES	NO	NOT SURE	
☐	☐	☐	Diabetes Mellitus (sugar)	☐	☐	☐	Glaucoma
☐	☐	☐	High blood pressure (hypertension)	☐	☐	☐	Other eye disease
☐	☐	☐	High cholesterol	☐	☐	☐	Sinus problems
☐	☐	☐	Heart disease	☐	☐	☐	Hay fever
☐	☐	☐	Heart attack	☐	☐	☐	Skin disease
☐	☐	☐	Atrial fibrillation	☐	☐	☐	SLE or connective disease
☐	☐	☐	Cardiac arrhythmia (irregular heartbeat)	☐	☐	☐	Gout
☐	☐	☐	Heart murmur	☐	☐	☐	Rheumatoid arthritis
☐	☐	☐	Congestive heart failure	☐	☐	☐	Osteoarthritis
☐	☐	☐	Cancer (any type)	☐	☐	☐	Osteoporosis
☐	☐	☐	Emphysema	☐	☐	☐	Disease of the spine
☐	☐	☐	Chronic bronchitis	☐	☐	☐	Sciatica
☐	☐	☐	COPD (lung disease)	☐	☐	☐	Other musculoskeletal disorder
☐	☐	☐	Asthma	☐	☐	☐	Anemia
☐	☐	☐	Other respiratory problem	☐	☐	☐	Disorders of blood or lymph
☐	☐	☐	Thyroid disorder	☐	☐	☐	Stroke
☐	☐	☐	Other endocrine disorder	☐	☐	☐	Ministroke/TIA
☐	☐	☐	Poor circulation	☐	☐	☐	Cerebral aneurysm
☐	☐	☐	Peripheral vascular disease	☐	☐	☐	Parkinson's disease
☐	☐	☐	Aneurysm of aorta	☐	☐	☐	Alzheimer's disease
☐	☐	☐	Gastritis	☐	☐	☐	Tremors
☐	☐	☐	Peptic ulcer	☐	☐	☐	Peripheral neuropathy
☐	☐	☐	Diverticulosis	☐	☐	☐	Shingles/Herpes Zoster
☐	☐	☐	Diverticulitis	☐	☐	☐	Kidney disease
☐	☐	☐	Other gastrointestinal disorder	☐	☐	☐	Kidney stones
☐	☐	☐	Liver disease or hepatitis	☐	☐	☐	Aids or HIV positivity

OTHER_____

_____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS?

YES	NO		YES	NO	
☐	☐	Weakness/fatigue	☐	☐	Poor eyesight
☐	☐	Unexplained weight loss	☐	☐	Other eye problems
☐	☐	Frequent headaches	☐	☐	Poor hearing
☐	☐	Excessive thirst	☐	☐	Throat pain/hoarseness
☐	☐	Intolerance to heat or cold	☐	☐	Trouble swallowing
☐	☐	Any abnormal lumps or masses	☐	☐	Frequent earaches
☐	☐	Poor appetite/eating disorder			
☐	☐	Chest pain/angina	☐	☐	Heartburn/indigestion
☐	☐	Palpitations	☐	☐	Flatulence/gas pain
☐	☐	Frequent shortness of breath	☐	☐	Abdominal/belly pain
☐	☐	Difficulty breathing while lying flat	☐	☐	Nausea or vomiting
☐	☐	Wheezing	☐	☐	Constipation
☐	☐	Frequent cough	☐	☐	Diarrhea
☐	☐	Fainting or dizzy spells	☐	☐	Blood in stool
☐	☐	Swelling of legs/ankles	☐	☐	Black or tarry stools
☐	☐	Pain in legs with walking			
☐	☐	Non-healing sores on legs, feet, or toes			
☐	☐	Varicose veins			
☐	☐	Insomnia	☐	☐	Swelling, pain, or deformity of joints
☐	☐	Poor memory	☐	☐	Lower back pain
☐	☐	Tremors	☐	☐	Upper back pain
☐	☐	Paralysis	☐	☐	Head/shoulder pain
☐	☐	Anxiety, nervousness	☐	☐	Pain of arms/legs
☐	☐	Depression	☐	☐	Muscle weakness
			☐	☐	Muscle cramps

Please list all surgeries or procedures you have had and date: _____

_____

_____

Please list all of your current medications: _____

_____

_____

List any medication allergies or any medications you cannot tolerate: _____

_____

_____

Please list you other physicians and their specialty: _____

_____

_____

_____

Patient Signature

UROLOGY CENTER OF SOUTH FLORIDA,P.A.

MM#: _____ APPT. DATE: _____

TODAY'S DATE: _____

DOCTOR: G S B P

Robert G. Gold, M.D. • *William K. Skinner, M.D.* • *Joseph N. Biase, M.D.* • *Stuart M. Popowitz, M.D.*

Patient Information

NAME: _____ SEX: _____ REFERRED BY: _____

SOCIAL SEC. #: _____ BIRTH DATE: _____ MARITAL STATUS (SMWD): _____

HOME PHONE #: _____ CELL PHONE #: _____ AGE: _____

LOCAL STREET ADDRESS: _____ APT. #: _____

CITY: _____ ST: _____ ZIP: _____

EMAIL ADDRESS: _____

OUT OF STATE STREET ADDRESS: _____ APT. #: _____

CITY: _____ ST: _____ ZIP: _____

DRIVERS LICENSE #: _____ DRIVERS LICENSE STATE: _____

EMPLOYER/SCHOOL: _____ TITLE: _____ PHONE: _____

STREET ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

SPOUSE: _____ AGE: _____ BIRTH DATE: _____

SPOUSE EMPLOYER: _____ TITLE: _____ PHONE: _____

STREET ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PRIMARY CARE PHYSICIAN: _____ DO YOU HAVE A LIVING WILL? ❑ YES ❑ NO

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

NAME: _____ PHONE: _____ RELATIONSHIP: _____

STREET ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING

FATHER'S NAME: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

FATHER'S SS#: _____ DATE OF BIRTH _____

EMPLOYED BY: _____

PHONE: _____

MOTHER'S NAME: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

MOTHER'S SS#: _____ DATE OF BIRTH _____

EMPLOYED BY: _____

PHONE: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE #: _____

I.D. #: _____

GROUP NAME OR #: _____

INSURED'S LAST NAME: _____

FIRST NAME: _____

IS THIS AN EMPLOYER PLAN: _____

INSURED'S S.S #: _____

INSURED'S DOB: _____

RELATIONSHIP TO INSURED: _____
(SELF-HUSBAND-WIFE-CHILD-OTHER)

SECONDARY INSURANCE INFORMATION

INSURANCE CO: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE #: _____

I.D. #: _____

GROUP NAME OR #: _____

INSURED'S LAST NAME: _____

FIRST NAME: _____

IS THIS AN EMPLOYER PLAN: _____

INSURED'S S.S #: _____

INSURED'S DOB: _____

RELATIONSHIP TO INSURED: _____
(SELF-HUSBAND-WIFE-CHILD-OTHER)

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to make payments directly to my doctor and further permit a copy of this authorization to be used in place of the original. This authorization applies to all claims submitted by my doctor. i hereby authorize my doctor to release any information required in the course of examination and treatment.

To avoid misunderstanding regarding medical insurance we wish our patients to know all professional services rendered are charged directly to the patient and the patient is personally responsible for payment of fees. As a courtesy, we will prepare necessary forms to help you obtain your benefits from your insurance company. We do not render our services on the basis that insurance companies will pay our fee, except in the instances such as with specific PPO/HMO groups. If the insurance company does not cover our fee in full, the balance is due and payable by you.

Signed _____ Date _____

MEDICARE

Name of Beneficiary_____ Medicare #_____

I request that payment of authorized medicare benefits be made to my treating physician for any services rendered. 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 benefits payable for related services.

Signed _____ Date _____

MEDIGAP

Name of Beneficiary_____ Medicare #_____

I request that payment of authorized Medigap benefits be made to my treating physician for any services rendered. I authorize any holder of medical information about me to release to the above mentioned insurance carrier any information needed to determine these benefits or benefits payable for related services.

Signed _____ Date _____

I understand that any account balance that is not paid may be sent to a collection agency. Should my delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

Signed _____ Date _____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME:_____ DOB:_____

I hereby authorize the following individual or organization to release my health information to the Urology Center of South Florida:

_____

_____

_____

PLEASE SUBMIT THE FOLLOWING INFORMATION (FAX 561-737-2413):

☐ Demographic information
☐ Medication list
☐ All PSAs
☐ Path report:_____

☐ Other:_____

_____

I understand that the health information authorized for disclosure may include information relating to sexually transmitted disease, AIDS, HIV, as well as behavorial, mental health services or treatment for alcohol or drug abuse.

I understand that I can revoke this authorization at any time, and I must do so in writing. The revocation will not apply to information that has already been released and will not apply to my insurance company. Unless otherwise revoked, this authorization will expire twelve months from this date. I understand that this authorization is voluntary and that I need not sign this form to assure treatment. I understand that I can inspect or copy the information to be used or disclosed, and that any disclosure of information carries with it the potential for unauthorized re-disclosure. If I have any questions about disclosure of health information, I can contact the Medical Record Department at 561-737-9191.

_____ _____
Signature of Patient or Representative Date

_____ _____
If Legal Representative, Relationship to Patient Witness

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UROLOGY CENTER OF SOUTH FLORIDA, PA
Electronic Prescription Information

This form must be completed in order for us to fill ANY prescription we issue. Please be sure you provide accurate information to us to avoid a delay in your prescription processing time.

Patient name: _____

Date of birth: _____

Social Security number: _____

Phone number: (_____)_____

Pharmacy name: _____

Pharmacy phone number: (_____)_____

Pharmacy location:_____

I understand that it is my responsibility to provide accurate pharmacy information and to keep the office updated on any pharmacy changes.

Patient Signature: _____

Today's Date:_____

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PQRI Incontinence Questionnaire

Patient Name:_____

Date of Birth:_____ Date of Service_____

1. During the last 3 months, have you leaked urine (even a small amount)?

   Yes_____

   No _____ (If you answered NO, please stop here).

2. During the last 3 months, when you leak urine: (Please check all that apply)

   A) _____ when you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?

   B) _____ When you had the urge or feeling that you needed to empty your bladder, but could not get to the toilet fast enough?

   C) _____ Without physical activity and without a sense of urgency?

   D) How frequently did you leak urine?

      Times per day: _____

      At what times: Daytime: _____ Nighttime only _____

   E) How bothersome was this?

      Somewhat _____ Very bothersome _____

SIGNED BY (PHYSICIAN/STAFF): _____

DATE: _____

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CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions –** Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification –** Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions –** Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Urology Center of South Florida as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form, you are agreeing that your provider at Urology Center of South Florida may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Urology Center of South Florida to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____Print Patient Name _____Patient DOB

_____Signature of Patient or Guardian _____Today's Date

_____Relationship to Patient

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CONSENT TO TREATMENT – FINANCIAL RESPONSIBILITY

CONSENT TO TREATMENT

The undersigned patient/responsible party consents to the medical/surgical procedure(s) and treatment(s), including but not limited to anesthesia, laboratory procedures, x-rays, and examinations to be rendered pursuant to the general and special instructions of my physician., This extends to the anesthesiologists, emergency physicians, pathologists, and radiologists, all of whom are independent contractors and not employees of Urology Center of South Florida, PA.

FINANCIAL RESPONSIBILITY

By accepting any medical services or treatment, including but not limited to consultations, examinations, x-rays, and surgery, the undersigned patient/responsible party agrees to pay Urology Center of South Florida, PA all charges for such service or treatment.

Fees and interest charges may be added onto the account if payment for services is delinquent and an outside collections agency is required. The amount of the fees and interest charges will vary and is dependent on what Urology Center of South Florida, PA deems necessary to collect funds.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I am aware that as a courtesy, my primary insurance will be billed. It is my responsibility to follow up on any delinquent claims.

I hereby authorize Urology Center of South Florida, PA to furnish information to insurance carriers concerning myself or my dependents' illness or treatments. I assign the insurance benefits to Urology Center of South Florida, PA and authorize and direct my insurance carrier to pay those benefits directly to Urology Center of South Florida, PA. I authorize Urology Center of South Florida, PA to release medical information to other physicians when deemed necessary for my medical treatment. I understand that if my medical insurance does not pay for any reason, it will be my responsibility to pay the bill in full, unless prohibited by law.

If Tricare, Medicare, or similar government programs should determine that I am *not* eligible for coverage, or that the service or treatment is *not* covered, I will be responsible for payment unless prohibited by law.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned patient/responsible party authorizes Urology Center of South Florida, PA to disclose financial and medical information and records to: my employer and third-party payers who are, or may be responsible for payment of all or a portion of the charge; to other health care and/or to the referring physician to ensure continuity of medical care; and for purposes of accreditations, audits, certification, and peer or utilization reviews.

NOT RESPONSIBLE FOR PERSONAL PROPERTY

Patients should not bring valuables to this facility. Urology Center of South Florida, PA is not responsible for any personal property brought into or left in the facility.

BY SIGNING THE PATIENT INFORMATION FORM, PATIENT/RESPONSIBLE PARTY ACKNOWLEDGES THAT THEY HAVE HAD THE OPPORTUNITY TO READ THIS FORM, AND AGREES TO THE TERMS SET FORTH IN THIS FORM

Patient _____ Date _____

Witness _____ Date _____

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Patient Name: _____ DOB: _____

Please provide the names of your physicians and the office phone numbers:

Primary care/Family Medicine/Internist: _____

Phone Number: _____

Nephrologist: _____

Phone Number: _____

Cardiologist: _____

Phone Number: _____

Oncologist: _____

Phone Number: _____

Out of State Urologist: _____

Phone Number: _____

Please handwrite any other physician or specialist and the office number treating you:

_____

_____

_____

_____

Must provide valid email address: _____ @ _____

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CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, _____, whose signature appears below, authorize the Urology Center of South Florida and its Affiliated Providers to view my external prescription history via the RxHub service.

I understand that prescriptions history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS

_____

Patient Date

_____

Witness Date

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MEANINGFUL USE PATIENT REGISTRATION FORM

In compliance with the HITECH Act (EHR) to attain Meaningful Use we are required to capture demographic data including your preferred language, race and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process. Please complete the information below.

Patient Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

Email: _____

Race:
__ African-American
__ Arabic
__ Asian
__ Caucasian
__ Filipino
__ Hispanic
__ Other

Ethnicity:
__ Hispanic
__ Non-Hispanic

Primary Language:
__ Arabic
__ Chinese
__ English
__ French
__ Korean
__ Spanish
__ Other _____

Please provide information about previous tests, immunization (including date or year of the last).
Flu Shot _____ Pneumococcal Vaccine _____

Male:
Colonoscopy _____

Female:
Colonoscopy _____
Mammogram _____

Tobacco Use:
Never: _____
Current Every Day Smoker: _____
Current Smoker - Does Not Smoke Every Day: _____
Former Smoker: _____

_____

Patient Signature Date

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PATIENT CONSENT FORM
OBSERVATION BY MEDICAL STUDENTS

Please read, complete, and sign the bottom of this consent form

I hereby acknowledge and understand that as part of its medical team, The Urology Center of South Florida trains, educates and utilizes medical students who are not yet licensed physicians and who may participate in my care under the supervision of a licensed physician. I hereby consent and give my express permission to the Urology Center of South Florida and its employees, agents, and supervised medical students to educate, interview, examine and to observe treatments and procedures as necessary. I also understand that I may revoke this consent in writing at any time, except to the extent that the Urology Center of South Florida has taken action relying on this consent.

Patient Signature: _____ **Today's Date:** _____

Print Patient Name: _____ **Date of Birth:** _____

If patient is a minor:

Patient Representative Signature: _____ Today's Date: _____

Description of Legal Guardianship: _____

Print Name: _____ Phone No.: _____

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AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

UCSF will use and disclose your health information only for purposes of treatment, payment, and healthcare operations, unless you authorize us to use or disclose your health information for other purposes.

*You hereby authorize your physicians, hospitals, and healthcare facilities to disclose all or any part of your medical record to UCSF in connection with treatment, payment, and healthcare operations for treatment and services provided to you by UCSF.

*This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may affect or limit the insurance coverage for treatment, services, or supplies provided by UCSF.

*** Please list the names of family members or caregivers we may speak with regarding your health information. We will not give any information out to anyone not listed on this form***

1. _____ **Relationship** _____

2. _____ **Relationship** _____

3. _____ **Relationship** _____

OR

_____ Do not leave me a message or release information to anyone. Speak directly with me before releasing medical information.

_____ **Date:** _____

Signature of Patient or Guardian/Representative

_____

Print Name

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ , have received a copy of this office's Notice of Privacy Practices.
(Patient's Name)

Signature of Patient (Responsible Party):_____

Witness:_____

Date:_____

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could to be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining the Acknowledgment

_____ Other _____