UROLOGY CENTER
OF SOUTH FLORIDA, P.A.

William K. Skinner, M.D.
Joseph N. Biase, M.D.
Stuart M. Popowitz, M.D.

PATIENT INFORMATION

Date: _____ Account #: _____ ☐ New Patient ☐ Follow Up

Patient: _____ (Last) _____ (First) _____ (MI) _____ (Preferred) _____ (Title)

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient Date of Birth: _____ Patient SSN: _____

Address: _____ Home: _____

Cell: _____

_____ _____ _____ Other: _____

City State ZIP

Out of State Address: _____ Fax: _____

Primary Doctor: _____

_____ _____ _____

City State ZIP

Email: _____ Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ _____ _____

Name Relationship Phone

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Work: _____

Address: _____ Direct: _____

Other: _____

_____ _____ _____

City State ZIP

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Secondary Insurance Carrier: _____

Policy Number: _____ Policy Number: _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber Employer: _____ Subscriber Employer: _____

Subscriber SSN: _____ DOB: _____ Subscriber SSN: _____ DOB: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical or medial benefits. I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in course of my treatment necessary to process insurance claims.

_____ _____

Patient Signature Date:

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PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ _____ _____ Date: _____
City State ZIP

PAST MEDICAL HISTORY

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY) ☐ NONE

- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ BARRETT'S ESOPHAGUS
- ☐ BLEEDING DISORDER
- ☐ BLOOD TRANSFUSION
- ☐ CANCER
- ☐ CHRONIC ANXIETY
- ☐ CHRONIC SINUSITIS
- ☐ CIRRHOSIS
- ☐ COLON CANCER
- ☐ COLON POLYPS
- ☐ CONGESTIVE HEART FAILURE
- ☐ CONSTIPATION
- ☐ COPD
- ☐ CORONARY ARTERY DISEASE
- ☐ CROHN'S DISEASE
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIVERTICULITIS
- ☐ FATTY LIVER
- ☐ GALLBLADDER DISEASE
- ☐ GASTRITIS
- ☐ GERD (REFLUX)
- ☐ GI BLEEDING
- ☐ HEART ATTACK
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIATAL HERNIA
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROLS
- ☐ HIV OR AIDS
- ☐ IRREGULAR HEART BEAT
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ KIDNEY DISEASE/ FAILURE
- ☐ KIDNEY STONES
- ☐ LIVER DISEASE
- ☐ NEUROLOGIC DISORDERS
- ☐ OSTEOPOROSIS
- ☐ OVARIAN CYST
- ☐ PANCREATITIS
- ☐ PARKINSON'S DISEASE
- ☐ PEPTIC ULCER
- ☐ OTHER - PLEASE LIST: _____
- ☐ PHLEBITIS
- ☐ PNEUMONIA
- ☐ PROSTATE ENLARGEMENT
- ☐ PSORIASIS
- ☐ RHEUMATIC FEVER
- ☐ SCIATICA
- ☐ SEIZURES
- ☐ SLEEP APNEA
- ☐ STROKE
- ☐ TB (TUBERCULOSIS)
- ☐ THYROID DISORDERS
- ☐ ULCERATIVE COLITIS
- ☐ VASCULAR HEART DISEASE

SURGERIES/PROCEDURES

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

- ☐ APPENDECTOMY
- ☐ BARIUM ENEMA
- ☐ BREAST SURGERY
- ☐ CAPSULE ENDOSCOPY
- ☐ CHOLECYSTECTOMY
- ☐ COLON SURGERY
- ☐ COLONOSCOPY
- ☐ COLOSTOMY
- ☐ C-SECTION
- ☐ EGD
- ☐ ERCP
- ☐ GALLBLADDER SURGERY
- ☐ HEART BYPASS
- ☐ HEART VALVE REPLACEMENT
- ☐ HEMORRHOID SURGERY
- ☐ HIATAL HERNIA REPAIR
- ☐ HYSTERECTOMY
- ☐ JOINT REPLACEMENT
- ☐ KIDNEY SURGERY
- ☐ LIVER BIOPSY
- ☐ OBESITY SURGERY
- ☐ OVARIAN SURGERY
- ☐ PACEMAKER PLACEMENT
- ☐ PROSTATE (TURP)
- ☐ RADIATION THERAPY
- ☐ SIGMOLDOSCOPY
- ☐ OTHER - PLEASE LIST: _____
- ☐ SMALL BOWEL RESECTION
- ☐ STOMACH SURGERY
- ☐ THYROID SURGERY
- ☐ TONSILLECTOMY
- ☐ TUBAL LIGATION
- ☐ ULCER SURGERY
- ☐ UPPER GI SERIES X-RAY
- ☐ UTERINE SURGERY

SOCIAL HISTORY

☐ NONE

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

OCCUPATION: _____ ☐ UNEMPLOYED ☐ RETIRED

SMOKING HISTORY: ☐ NEVER ☐ YES _____ PACK A DAY FOR _____ YEARS; QUIT _____ (HOW LONG)

OTHER TOBACCO USE: ☐ NO ☐ YES; DETAILS: _____

ALCOHOL USE: ☐ NO ☐ YES; AMOUNT PER DAY: _____

DRUG USE: ☐ NO ☐ YES; SPECIFY DRUGS & AMOUNTS: _____

EXERCISE HABITS: ☐ NO ☐ YES; HOW MUCH & HOW OFTEN: _____

RECENT TRAVEL OUTSIDE US: ☐ NO ☐ YES; WHERE: _____

CAFFEINE USE: ☐ NO ☐ YES; HOW MUCH & HOW OFTEN: _____

VOLUNTARY TATTOO: ☐ NO ☐ YES; WHEN: _____

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REVIEW OF SYSTEMS

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

☐ NONE

GENERAL
- ☐ CHILLS
- ☐ FEVER
- ☐ LOSS OF APPETITE
- ☐ NIGHT SWEATS
- ☐ WEIGHT GAIN
  AMOUNT? _____
- ☐ WEIGHT LOSS
  AMOUNT? _____
- ☐ FEELING TIRED OR POORLY

EYES
- ☐ WORSENING VISION
- ☐ BLURRED VISION
- ☐ VISION DISTORTION
- ☐ EYE PAIN

OTOLARYRIGEAL SYMPTOMS
- ☐ EARACHE
- ☐ NASAL DISCHARGE
- ☐ MOUTH SORES
- ☐ BLEEDING GUMS
- ☐ HOARSENESS
- ☐ THROAT PAIN
- ☐ FACIAL PAIN
- ☐ SINUS PAIN

CARDIOVASCULAR
- ☐ CHEST PAIN/DISCOMFORT
- ☐ FAST HEART RATE
- ☐ SWELLING OF LEGS
- ☐ VARICOSE VEINS
- ☐ OTHER - PLEASE LIST: _____
- ☐ OTHER - PLEASE LIST: _____

RESPIRATORY
- ☐ CHRONIC COUGH
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH
- ☐ OTHER - PLEASE LIST: _____
- ☐ OTHER - PLEASE LIST: _____

GASTROINTESTINAL
- ☐ ABDOMINAL PAIN
- ☐ BLACK STOOLS
- ☐ RED BLOOD IN BOWEL MOVEMENT
- ☐ CHANGE IN BOWEL MOVEMENT FREQUENCY
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ BLOATING/GAS
- ☐ HEARTBURN
- ☐ HEMORRHOIDS
- ☐ GALLBLADDER DISEASE
- ☐ NAUSEA
- ☐ DECREASE IN APPETITE
- ☐ RECTAL BLEEDING
- ☐ RECTAL PAIN
- ☐ INCONTINENCE OF STOOL

MUSCULOSKELETAL
- ☐ JOINT PAIN
- ☐ JOINT STIFFNESS
- ☐ SWOLLEN JOINTS
- ☐ LOW BACK PAIN
- ☐ MUSCLE PAIN

SKIN SYMPTOMS
- ☐ PRURITIS (ITCHING)
- ☐ SKIN LESIONS
- ☐ RASHES

NEUROLOGIC
- ☐ NUMBNESS OR TINGLING
- ☐ DIZZINESS/LIGHTHEADEDNESS
- ☐ VERTIGO
- ☐ HEADACHES
- ☐ WEAKNESS IN ARMS OR LEGS
- ☐ BLURRED VISION
- ☐ MEMORY LAPSES OR LOSS
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ PANIC ATTACKS
- ☐ LOSS OF SLEEP

ENDOCRINE
- ☐ HEAT OR COLD INTOLERANCE
- ☐ EXCESSIVE THIRST
- ☐ EXCESSIVE URINATION
- ☐ HOT FLASHES

HEMATOLOGIC/ LYMPHATIC
- ☐ EASY BRUISING TENDENCY
- ☐ SWOLLEN GLANDS
- ☐ NOSEBLEEDS

URINARY
- ☐ PAIN OF DIFFICULTY WITH URINATION
- ☐ FREQUENT URINATION
- ☐ BLOOD IN URINE
- ☐ INCONTINENCE OF URINE
- ☐ KIDNEY STONES

GENITOREPRODUCTIVE FEMALE
- ☐ VAGINAL DISCHARGE
- ☐ HEAVY PERIODS
  DATE OF LAST PERIOD _____

GENITOREPRODUCTIVE MALE
- ☐ DISCHARGE FROM PENIS
- ☐ TESTICULAR PAIN
- ☐ TESTICULAR LUMP
- ☐ ERECTILE DYSFUNCTION

Today's Date: _____

Patient Name: _____ Date of Birth: _____

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FAMILY HISTORY

	FATHER	MOTHER	SIBLING	OTHER
☐ COLON POLYPS	☐	☐	☐	
☐ COLON CANCER	☐	☐	☐	
☐ GASTRIC ULCER DISEASE	☐	☐	☐	
☐ LIVER DISEASE	☐	☐	☐	
☐ PANCREAS DISEASE	☐	☐	☐	
☐ CROHN'S DISEASE	☐	☐	☐	
☐ ULCERATIVE COLITIS	☐	☐	☐	
☐ STOMACH CANCER	☐	☐	☐	
☐ DIABETES MELLITUS	☐	☐	☐	
☐ HEART ATTACK	☐	☐	☐	
☐ BREAST CANCER	☐	☐	☐	
☐ OTHER CANCER	☐	☐	☐	
☐ OTHER: _____	☐	☐	☐	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ASPIRIN ☐ CODEINE ☐ LACTOSE INTOLERANCE ☐ SLEEPING PILLS
☐ ANESTHETIC - LOCAL ☐ DAIRY ☐ METAL SENSITIVITY ☐ SULFA DRUGS
☐ BARBITURATES ☐ LATEX ☐ NITROUS OXIDE SEDATION ☐ PENICILLIN/OTHER ANTIBIOTICS
☐ OTHER - PLEASE LIST: _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS ☐ ANTIHISTAMINES/ALLERGY ☐ DAILY ASPIRIN ☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS ☐ CANCER/CHEMO MEDICATIONS ☐ CORTISONE/STEROIDS ☐ HEART MEDICATION/DIGITALIS
☐ INSULIN ☐ NITROGLYCERIN ☐ ORAL CONTRACEPTIVES ☐ OSTEOPOROSIS MEDICATIONS
☐ OTHER DIABETIC MEDICATIONS ☐ RECREATIONAL DRUGS ☐ THYROID MEDICATIONS ☐ TRANQUILIZERS
☐ OTHER (PLEASE LIST)

DRUG NAME	DOSAGE	REASON PRESCRIBED

ETHNICITY / RACE / LANGUAGE

ETHNICITY
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO
☐ ETHNICITY NOT KNOWN BY PATIENT
☐ DECLINED TO SPECIFY ETHNICITY

RACE
☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ ASIAN
☐ BLACK OR AFRICAN AMERICAN
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ WHITE

PREFERRED LANGUAGE
☐ ENGLISH
☐ SPANISH
☐ OTHER _____
☐ ADDITIONAL LANGUAGE
_____

Today's Date: _____

Patient Name: _____ Date of Birth: _____

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RECONCILIATION OF MEDICATIONS

Patient Name _____ Date of Birth _____

Patient Signature _____ Today's Date _____

Allergies: _____ ☐ No known allergies

HOME MEDICATION LIST

1. Include all prescription, over the counter, vitamin and herbal products
2. Draw a line through any item that bas been stopped, with the date in the last column
3. Write in NEW or CHANGED items below the last entry listed

DATE	MEDICATION NAME (Please print)	DOSE (how many milligrams)	ROUTE (orally, etc.)	HOW OFTEN IS THE PRODUCT TAKEN?	DATE LAST TAKEN "UNK" if Unknown	DATE STOPPED OR CHANGED
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		

Date	Reviewer Signature/Emp#	Action Taken	Copy Sent/Given to:	
		☐ No change in therapy ☐ Changes indicated	☐ Patient ☐ Next provider of care	☐ Patient refused to provide information
		☐ No change in therapy ☐ Changes indicated	☐ Patient ☐ Next provider of care	☐ Patient refused to provide information
		☐ No change in therapy ☐ Changes indicated	☐ Patient ☐ Next provider of care	☐ Patient refused to provide information
		☐ No change in therapy ☐ Changes indicated	☐ Patient ☐ Next provider of care	☐ Patient refused to provide information

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AUA BPH SYMPTOM SCORE QUESTIONNAIRE

Date

Patient Name

Date of Birth

Item	Question	None	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1	Over the past month or so, how often have you had to push or strain to begin urination?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2	Over the past month or so, how often have you had a sensation of not emptying your bladder* completely after you finished urinating?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3	Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4	Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5	Over the past month or so, how often have you found it difficult to post-pone urination?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6	Over the past month or so, how often have you had a weak urinary* stream?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7	Over the past month or so, how many times during a single night 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 ☐
	Symptom Score (total of all the numbers you circled): _____						

0-7 Mild
8-19 Moderate
20-35 Severe

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DESIGNATION OF HEALTH CARE SURROGATE

Print Patient Name: _____ Patient Date of Birth _____

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Surrogate Name: _____

Relationship to Patient: _____

Address: _____

Phone Number: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

2nd Surrogate Name: _____

Relationship to Patient: _____

Address: _____

Phone Number: _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Patient Signature _____ Date _____

Witness _____ Witness 2 _____

(At least one witness MUST NOT be a husband or wife or a blood relative of the patient.)

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ _____ _____
Last Initial First

Date of Birth: _____ Address: _____

To: _____

I have been a patient at the Practice or I am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way.

I hereby authorize release of my records to: **Urology Center of South Florida, P.A.**
Fax: 561-737-2413

_____ Hospital/Doctor documents (H&P , op notes , discharge summary, etc)

_____ Lab Results

_____ Radiology Results (x-ray, CT, MRI, etc.)

_____ Medication list

_____ The above information and/or the entire Medical Records which includes HIV-Related information.

_____ The above information and/or the entire Medical Records including mental health, drug or alcohol treatment

_____ Entire Medical Record EXCLUDING HIV-Related, mental health, drug, or alcohol treatment

_____ Other (specify):

From (date): _____ To (date): _____

I understand that this authorization is subject to revocation at any time, except to the extent that Urology Center of South Florida, P.A. has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Privacy Officer. I understand that recipients may re-disclose information which I have authorized them to receive.

_____ _____
Patient Signature (If representative, give relationship and authority to act) Date

_____ _____
Witness (When required by policy or signing by mark) Date

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Today's Date: _____

Print Patient Name: _____ Patient Date of Birth: _____

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 currently treating you and their office phone number:

_____

_____

_____

_____

_____

_____

Must provide valid email address: _____

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ELECTRONIC PRESCRIPTION INFORMATION

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

Patient Name: _____

Date of Birth: _____

Local Pharmacy Name: _____

Local Pharmacy Phone: _____

Local Pharmacy Address: _____

_____ _____ _____
City State Zip Code

Mail in Pharmacy Information

Pharmacy Name: _____

Pharmacy Number: _____

I understand that 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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CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, _____ whose signature appears below, authorize the Urology Center of South Florida, PA 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 Signature Date

_____

Date of Birth

_____ _____

Witness 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, PA 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, PA 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, PA 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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GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perfom reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Print Patient Name	Patient Date of Birth
If applicable: Print Name of Personal Representative	Relationship to Patient
Signature of Patient or Personal Representative	Date
Print Witness Name	Witness Signature

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CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is a way for doctors to send electronically an accurate, error free 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 bas 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, PA 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, PA 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, Thereby provide informed consent to Urology Center of South Florida, PA 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 Date of Birth
Patient or Guardian Signature	Today's Date
Relationship to Patient	

UROLOGY CENTER
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CONSENT TO TREATMENT - FINANCIAL RESPONSIBILITY

CONSENT TO TREATMENT

The undersigned patient/responsible party consents to the medical/surgical procedures and treatments, 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 includes 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, exams, x-rays, 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 may be added onto the account if payment for services is delinquent and an outside collections agency is required. The amount of fees and interest charges will vary and is dependent upon 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-patty 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 (PRINT)	Patient Signature	Date
Patient Date of Birth	Witness	Date

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CONSENT TO TREATMENT - FINANCIAL RESPONSIBILITY

Completion of this document authorizes the disclosure and/or use of health information about you. The purpose is to give permission to leave certain health information on your voice or text messaging service. Failure to provide all information requested may invalidate this authorization.

Print Patient Name _____ Patient Date of Birth _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Urology Center of South Florida, P.A. to call or text the following telephone numbers:

Mobile: _____ Work: _____

Home: _____ Other: _____

and leave detailed voice or text messages with the following information:

- ☐ Details about my next appointment (provider name, date/time, and callback number).
- ☐ Test and other exam results.
- ☐ Account payments, balances, or cost estimates.
- ☐ Only the following types of health information (including any dates): _____
- ☐ I DECLINE. Please do NOT leave any voice or text messages.

PURPOSE

Purpose of requested use or disclosure:

☐ Patient Request ☐ Other

_____

_____

EXPIRATION

This authorization expires:

- ☐ Until I revoke
- ☐ 1 Year
- ☐ 2 Years

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. If the health information is being disclosed or used, I may inspect or obtain a copy of this health information. I may revoke this authorization at any time, but I must do so in writing and submit it to Urology Center of South Florida, P.A. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

Signature of Patient or Personal Representative _____ Date _____

If applicable: Print Name of Personal Representative _____ Relationship to Patient _____

Print Witness Name _____ Witness Signature _____

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Financial Agreement

You agree to be responsible for and pay in full all charges to Urology Center of South Florida, PA (UCSF) for treatment, services, and supplies provided to you. Payment is due upon receipt of our statement for services rendered. As a courtesy to you, UCSF will bill your insurance company ("your health plan"), for the medical services and supplies we provide to you. In billing your health plan, UCSF will rely upon the information you provide, including your current insurance identification card or other evidence of valid coverage. If your health plan changes in any way, or your coverage terminates, please notify UCSF immediately so that we may update our records. It is particularly important to provide us with current and accurate billing information because the unpaid balance on your account will begin to incur an interest charge 30 days after the date of the invoice. Interest will accrue at a rate of 1-1/2% per month.

UCSF's efforts to bill and collect on your behalf from your health plan and UCSF' s acceptance of payment from your health plan will not relieve you of your obligation to make payment to UCSF in full. The amount your health plan pays UCSF may be less than the full charges or the amount you owe to UCSF. UCSF will credit all payments received from your health plan to your account and will bill you for the balance, unless otherwise provided under Florida law or if UCSF contracts with your health plan to accept the amount paid by them as payment in full.

All deductibles and co-payments required by your health plan are your responsibility. UCSF is prohibited by law from waiving deductibles and co-payments.

If payment is not made at any time and UCSF engages an attorney to assist in collection, you will be responsible for all fees and costs UCSF incurs in connection with the collection efforts. Your responsibility for the fees and costs UCSF incurs will be in addition to the charges and interest accrued on your account.

Assignment of Insurance Benefits

You hereby authorize payment to be made directly to UCSF and assign to UCSF all Medicare and other insurance benefits that may be due and payable to you or on your behalf for any services and supplies rendered to you by UCSF. You hereby authorize UCSF and any other holder of medical or other information about you, including any Medigap insurer, to release to the Social Security Administration, the Centers for Medicare and Medicaid Services, and their agents, intermediaries and carriers, any information needed to determine the benefits or benefits payable to you for any claim with respect to UCSF' s provision of health care services and supplies. Where Medicare benefits are applicable, you certify that the info1mation given in applying for payment under Title XVIII or XIX of the Social Security Act is complete and correct. **You authorize UCSF to use this Agreement as evidence of your consent to bill and receive payment for health care services and supplies provided to you by UCSF. You further acknowledge that this assignment of benefits does not in any way relieve you of your liability to make payment to UCSF, and that you will remain financially responsible to UCSF until all charges for which you are legally responsible are paid in full. In the event the insurance carrier mistakenly sends payment for the claim directly to me, I agree that I will remit payment in its entirety to Urology Center of South Florida, PA.**

I have read and understand each of the above paragraphs and I acknowledge and accept these terms and conditions.

Patient or Guardian Signature

Date

Print Name

Patient's Social Security Number

Signature of Designated Representative of Urology Center of South Florida, PA

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Financial Policy

Thank you for choosing Urology Center of South Florida, P.A. as your health care provider. We are committed to providing you the best possible medical care. We would like to keep you informed of our current office and financial policies. We require you to read and sign this agreement. We will place a signed copy in your chart, and you may keep the original for future reference.

Insurance: As a courtesy, our office will bill your insurance for the services you receive. We cannot bill your insurance company unless you give us your correct insurance information. Please understand that your medical insurance is a contract between you and your insurance company. We are not a party to that contract, and your bill is ultimately your responsibility whether your insurance company pays or not. We can often help with providing information to help get your claim paid, but if your insurance company has not paid your account in full within 45 business days, it will then become your responsibility to pay the balance.

Co-payments, deductibles and fees: All co-payments, insurance deductibles and fees for services not covered by your insurance policy are due at the time service is rendered. The co-pay cannot be waived, as it is a requirement placed on you by your insurance company.

No insurance: Payment is due at the time of service.

Payment: We accept cash, personal checks, VISA, Master Card, Discover Card and American Express.

Returned checks: A $30.00 charge will be added to your account for any check returned by your bank for any reason. This will be in addition to any charges applied by your bank.

Missed appointments: If you are unable to keep your scheduled appointment, please call our office at least 24 hours in advance to cancel or to reschedule. This will allow us to provide that time slot to another patient.

New patients who miss an appointment may reschedule, but after two missed appointments, the referring doctor's office must call to reschedule. Established patients who miss an appointment may reschedule, but missing three appointments in a 12 month period may result in dismissal from our practice.

I have read the Urology Center of South Florida, P.A. Financial Policy in full, and I understand and agree to this policy. I acknowledge full financial responsibility for services rendered by Urology Center of South Florida, P.A. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and copayments. I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. I understand that payment of co-payments is expected at the time of service, as well as any prior balance that I owe. I understand the policy regarding missed appointments. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to Urology Center of South Florida, P.A. for any medical services furnished.

Print Patient Name	Patient Date of Birth
Patient Signature	Today's Date

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AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Urology Center of South Florida, PA (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

Name	**Relationship**	**Phone Number**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

OR

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

_____ _____

Patient or Guardian Signature Date

_____

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)

_____ _____
Patient or Guardian Signature Date

_____ _____
Witness Date

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could NOT be obtained because:

_____ 1. Individual refused to sign

_____ 2. Commercial barriers prohibited obtaining the acknowledgment

_____ 3. An emergency situation prevented us from obtaining the acknowledgment

_____ 4. Other