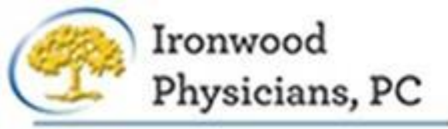


Urologic Consultants

PATIENT INFORMATION/ASSIGNMENT OF BENEFITS FORM

PATIENT INFORMATION

Please fill out completely

Patient Name:

Last *First* *M.I.* *Telephone*

Home Address:

Is Arizona your permanent residence? Yes / No

City *State* *Zip Code*

Date of Birth *Age* *Sex* *Social Security Number* *Marital Status*

Employer:

Name *Telephone*

Are you currently working? Yes / No **Retired?** Yes / No **Disabled?** Yes / No

Responsible Party:

(Other than patient) *Name* *Relationship* *Telephone*

Address *City* *State* *Zip Code*

Email address:

Emergency Contact Name________________________________ **Emergency Contact number**____________________

Who referred you to us?

Referring Physician *Phone* *Primary Care Physician* *Phone*

Pharmacy Name ___________________________Phone number _____________________

INSURANCE INFORMATION

Primary Ins: Telephone:

Insured Name *DOB* *Group #* *Policy #*

Secondary Ins: Telephone:

Insured Name DOB: Group #: Policy #:

Patient Signature / Responsible Party Date

See Reverse

PATIENT HISTORY FORM

(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)

Last Name:______________________________ **First Name**:_________________________ **MI:**_______

age: __________ **date of birth:** ________________ **occupation:** ________________________________

phone # (home):_____________________________ **phone # (mobile):**______________________________

phone# (work):___________________________ **email address:**___________________________________

Marital status: single married separated divorced widowed life partner
Primary Care Physician: ______________________________**Phone Number:**_____________________
Referring Physician: __________________________________**Phone Number:** ____________________
Pharmacy:____________________________________ **Pharmacy Phone Number**:__________________
Race: White African American American Indian Asian Hawaiian Decline
Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline

ALLERGIES:____

____

CURRENT MEDICATIONS - list all medications you are currently taking including over-the-counter medications and supplements. (attach a list or write on back of sheet if necessary)

drug name:	dosage:	directions/how you take it:
______________________________	________	_______________________________________
______________________________	________	_______________________________________
______________________________	________	_______________________________________
______________________________	________	_______________________________________
______________________________	________	_______________________________________
______________________________	________	_______________________________________
______________________________	________	_______________________________________

Alcohol Consumption: ____none ____yes ____occasional/social # of drinks per day______

Tobacco use: _____none ____yes #______packs/day ______cigarettes/day ___smokeless tobacco

If you previously smoked; when did you quit?_________________________

REVIEW of SYSTEMS: please circle any problems that apply or circle "no problems"

Constitutional: no problems
- Fever
- Chills
- weight gain/loss

Cardiovascular: no problems
- chest pain/angina
- heart attack
- heart murmur
- irregular heartbeat
- pacemaker
- heart failure

Respiratory: no problems
- Asthma
- shortness of breath
- frequent cough
- wheezing
- emphysema/bronchitis

Gastrointestinal: no problems
- abdominal cramps/pain
- nausea/vomiting
- change in bowel habits
- constipation
- bloody stools

Musculoskeletal: no problems
- Arthritis
- neck/back pain
- joint pain
- muscle weakness
- osteoporosis

Endocrine: no problem
- Diabetes
- thyroid disease
- tired/sluggish

Hematologic: no problems
- blood clotting problems
- bleeding problem
- AIDS/HIV
- swollen glands

Psychologic: no problems
- anxiety
- depressed

Neurologic: no problems
- tremors
- leg or arm weakness
- headaches
- stroke
- memory loss
- speech problems
- balance problems

GenitoUrinary: no problems
- weak stream
- bedwetting
- blood in urine
- dribbling
- burning on urination
- erection problems
- flank pain
- hesitancy
- kidney infections
- urinary tract infections
- night time voiding
- not emptying
- painful ejaculation
- stones
- suprapubic pain
- urgency
- urinary frequency
- urinary incontinence

MD initials/date

Urologic Consultants

initials: ________________

a division of Ironwood Physicians, PC
Barry E. Gordon, MD

CHIEF COMPLAINT: (What is the main reason for your visit?)

____

____

SURGICAL HISTORY: please CIRCLE if you have had any of the following surgeries and indicate the year of the surgery:

CARDIOVASCULAR YEAR
Angioplasty
aortic aneurysm repair
CABG
carotid artery surgery
cardiac stents
pacemaker implantation
defibrillator implantation

GENERAL SURGERY
Disc surgery
Brain surgery
Parathyroidectomy
hernia repair

GI
Appendectomy
bariatric surgery
bowel resection
cholecystectomy
colon resection
laparoscopy
splenectomy
stomach surgery
umbilical hernia repair

SKIN
melanoma

GU YEAR
bladder surgery
prostate biopsy
brachytherapy
circumcision
cystoscopy
epididymectomy
ESWL (shockwave stones)
hydrocelectomy
Interstim
laser treatment of stone
needle biopsy of prostate
nephrectomy (removal of kidney)
nephrolithotomy (removal of stones)
orchiectomy
orchidopexy
penile implant/prosthesis
penile surgery
pyeloplasty
radical prostatectomy
spermatocelectomy
TURBT (bladder tumor)
TUR prostate
ureteroscopy
varicocelectomy
vasectomy
laser of prostate

GYNECOLOGY YEAR
Hysterectomy
Tubal Ligation
Oophorecotomy (ovaries)
Vulvectomy
Vaginectomy

HEENT
cataract surgery
septoplasty
sinus surgery
thyroid surgery

MUSCULOSKELETAL
amputation
arthroscopic knee surgery
back surgery
cervical spine surgery
disc surgery
hip surgery
knee surgery

RESPIRATORY
lung surgery

OTHER SURGERIES: ____

____

____

Family History: family history of Prostate Cancer: yes no
family history of Kidney Stones: yes no

Please indicate which family member (mother, father, siblings, etc.) has/had any of the following:

Bladder cancer___________________________ Kidney cancer______________________________

Diabetes__________________________________ Kidney disease_____________________________

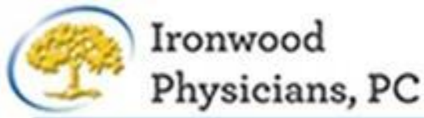
Prostate cancer____

Heart disease____

Other____

____

____



FINANCIAL POLICY FOR PATIENTS

- I understand that I have medical insurance which when billed on my behalf should pay for their portion of my office visits and treatment charges. _______ initials

- I will inform Ironwood Physicians, PC or Ironwood Cancer and Research Centers of a change in my insurance coverage. _______ initials

- I understand the billing process may take 4-6 weeks at which time my insurance company will determine and pay for services per my contract. _______ initials

- I understand that it is my responsibility to pay all co-pay, deductible and estimated co-insurance amounts at the time of service rendered and remaining balance as determined by my insurance company. ______ initials

- I thereby assign all medical benefits directly to Ironwood Physicians, PC and Ironwood Cancer and Research Centers for services rendered at their facilities. ______ initials

- I understand if a CT or PET/CT scan is completed it will be necessary for a licensed Radiologist to interpret or read your scan results. You will be receiving two statements for your CT or PET/CT scan for their professional interpretation of the CT or PET/CT scan separate of Ironwood. ______ initials

- If possible, I consent to receiving statements by email provided. _______ initials

- I have read and received a copy, if desired, of this document. ______ initials

Patient Printed Name: __________________________

Patient Signature: ______________________________ Date: ______________

Ironwood Physicians PC---Urologic Consultants

Consent to Release Health Information

Patient Name: ________________________________ DOB: ____________ Date: _____________

I hereby authorize Ironwood to use and disclose my personal health information to the individuals identified on this form. Initials _________

I approve and understand that the staff at Ironwood may leave detailed messages on my voicemail. Initials _________

EMERGENCY CONTACT		( )
Last First M.I.		*Telephone*
Address:		
City	*State*	*Zip*
☐Spouse ☐Family (Describe) _______________	☐ Friend ☐Other (Describe) ________________	Emergency Contact? ☐ Yes
Contact Name:		( )
Last First M.I.		*Telephone*
Address:		
City	*State*	*Zip*
☐Spouse ☐Family (Describe) _______________	☐ Friend ☐Other (Describe) ________________	Emergency Contact? ☐ Yes
Contact Name:		( )
Last First M.I.		*Telephone*
Address:		
City	*State*	*Zip*
☐Spouse ☐Family (Describe) _______________	☐ Friend ☐Other (Describe) ________________	Emergency Contact? ☐ Yes

I hereby authorize Ironwood Physicians PC to use and disclose my personal health information to the individuals identified on this form.

I understand this may include information relating to communicable diseases, such as HIV/AIDS, STD, behavioral, and/or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist.

I understand that the individuals identified on this form will be treated by Ironwood Physicians PC as individuals involved directly in my care and as such Ironwood Physicians PC will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations.

I understand that I have a right to request and receive a Notice of Privacy Practices from Ironwood Physicians PC.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Ironwood Physicians PC will not be affected if I refuse to sign this authorization.

Patient Signature		Date/Time	AM or PM (*circle on*
Personal Representative Signature Relationship		Date/Time	AM or PM (*circle one*)

Information entered into system

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

- *Treatment.* Your health information may be used by staff members or disclosed to other healthcare professionals for the purposes of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

- *Payment.* Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

- *Healthcare Operations.* Your health information may be disclosed as necessary to support the day-to-day activities and management of **Urologic Consultants.** For example, information on the services you received may be used to support the budgeting and financial reporting, and activities to evaluate and promote quality.

- *Law Enforcement.* Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

- *Public Health Reporting.* Your health information may be disclosed to public health agencies as required by state law. For example, we are required to report certain communicable diseases to the state's public health department.

- *Research.* We conduct clinical research here. Our clinical research staff may look at your health records as part of your current care to determine if you may be eligible for any research studies being done at our facility. All patient research conducted at Urologic Consultants goes through a special process required by law that reviews protections for patients involved in research, including privacy. *We will not use your health information or disclose it outside of Urologic Consultants for research reasons without getting your prior written approval or determining that your privacy is protected.*

- ***Other uses and disclosures require your authorization***. Disclosure of your health information or its uses for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.
Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest.

We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Urologic Consultants

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice of your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer.

Complaints/Contact Person

If you would like to submit a question, comment, or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer/Administrator
Urologic Consultants
2450 E. Guadalupe Road, Suite102
Gilbert, AZ 85234

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.