Clinical Urology Associates, P.C.

John Pirani, M.D.
Manish Shah, M.D.
Merle Wade, M.D.
Dawon Stephens, D.O.
Michael O. Jennings, M.D.
Tami Sparks, CRNP
Tabitha Rush, CRNP
Spencer Wallace, CRNP

Patient Information Sheet

Provider: _____ Date: ___/____/____ Time: ___:____

Have you ever been seen by one of our Provider's? Yes or No When?

_____

Patient Name: _____ **Date of Birth:** ___/___/____ **Age:** ____

Social Security #: ____-____-_____ (Most insurance plans require this as a patient identifier. Your insurance may deny charges without your full social security number.)

Male / Female (circle one) **Marital Status: Single Married Divorced Widow** (circle one) **Race:** _____

Mailing Address: _____

City _____ **State:** _____ **Zip Code:** _____

Phone Number: (____) ____-_____ **Cell Number:** (____) ____-_____ **Work Number:** (____) ____-_____

Email Address: _____ **Patient's Employer:** _____

Patient's Pharmacy: _____ **Pharmacy Phone Number:** (____) ____-_____

Family Physician: _____ **Physician Phone Number:** (____) ____-_____

Spouse Name: _____ **Spouse Birthdate:** ___/___/____

Primary Insurance: _____	**Secondary Insurance:** _____
ID #_____ **Group #**_____	**ID #** _____ **Group #**_____
Subscriber: _____	**Subscriber:** _____
Subscriber Birthdate: ___/___/____	**Subscriber Birthdate:** ___/___/____

** I acknowledge that I have been provided access to Notice of Privacy Practices of Clinical Urology Associates, P.C. and that a copy will be provided to me upon my request. I understand that terms are for services rendered (If these terms create a problem, please see the business office about making other arrangements before you are examined). I will be responsible for all charges incurred by me.*

**I understand that I am giving consent to authorize medical testing by Clinical Urology Associates, P.C. and a copy of the testing results will be provided to me upon request. I understand my consent is for the services rendered. I authorize Clinical Urology Associates (Laboratory Name) to release to Medicare, the insurance carrier of health plan providing my healthcare benefits, and any health plan to which I am a member, any medical information needed for claim or payment purposes. I will be responsible for all charges incurred by me.*

Signed: _____ **Date:** ___/___/___ **Signed:** _____ **Date:** ___/___/___

Patient **Guardian or Responsible Party**

Clinical Urology Associates, P.C.

Patient History Questionnaire Form

Today's Date: ____ /____ / _____ **Date of last physical exam:** ____ / ____ / _____

Last Name: _____ **First Name** _____ **Middle** _____

Date of Birth: / /

What is the main reason for your visit today? _____

Patient's Family History

List all illnesses in your immediate family: (Family Ex: Grandfather, Grandmother, Father, Mother, Brother, Sister, Uncle, Aunt) (Illness Ex: diabetes, tuberculosis, cancer, heart disease, stroke, etc.)

_____

Patient's Medical/Surgical History

List patient's medical history: _____

_____

List patient's past surgeries: _____

_____

List complete and current list of medications: _____

_____

Do you smoke? Yes ____ (Packs/day ____) **No**____ **Quit Smoking** ____ (When? _____)

Do you drink alcohol? Yes ____ (Drinks/day ____) **No** ____ **Quit Drinking Alcohol** ____ (When? _____)

Are you allergic to any medication: (Example: Penicillin, Sulfa, Latex, Iodine, etc.) **Yes** ___ **No** ____ **If yes, list here:**

_____

Do you have any other allergies: Yes ___ **No** ____ **If yes, list here:** _____

_____

Are you on a special diet: Yes ___ **No** ___ **If yes, explain:** _____

Describe your job and activities: _____

For Pediatric Patients only

Child's Name:_____ Date of Birth: ____ / ____ / _____

Are all immunizations current? Yes _____ **No** _____

Has or does your child had or have the following? Please check all that apply and explain:

Asthma ___ Diabetes ___Rheumatic Fever ___ Epilepsy ___ Other Illnesses _____

Explain: _____

_____

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Review of Systems

Constitutional systems

						Explain any yes answer here
Fever	Y	N	Weight loss	Y	N	
Chills	Y	N	Weight gain	Y	N	
Headaches	Y	N	Other			

Eyes

Blurred vision	Y	N	Double Vision	Y	N	
Pain	Y	N	Other			

Ears/Nose/Throat/Mouth

Ear infection	Y	N	Sinus Problems	Y	N	
Sore throat	Y	N	Other			

Respiratory

Wheezing	Y	N	Shortness of breath	Y	N	
Frequent cough	Y	N	Other			

Gastrointestinal

Abdominal Pain	Y	N	Constipation	Y	N	
Nausea/vomiting	Y	N	Diarrhea	Y	N	
Indigestion	Y	N	Other			

Genitourinary

Urine retention	Y	N	Incontinence (leaking), slow stream, waking up at night to urinate, straining to			
Painful urination	Y	N	void or dribbling	Y	N	
Urinary frequency	Y	N	Impotence	Y	N	
Other						

Musculoskeletal

Joint pain	Y	N	Back pain	Y	N	
Neck pain	Y	N	Other			

Integumentary

Skin rash	Y	N	Boils	Y	N	
Persistent itching	Y	N	Other			

Neurological

Tremors	Y	N	Numbness/tingling	Y	N	
Dizzy spells	Y	N	Other			

Endocrine

Excessive thirst	Y	N	Tired/sluggish	Y	N	
Too hot/cold	Y	N	Other			

Cardiovascular

Chest pain	Y	N	Pain in legs/buttocks			
High blood pressure	Y	N	when walking	Y	N	
Varicose veins	Y	N	Other			

Hematologic/lymphatic

Swollen glands	Y	N	Blood Clotting Problems	Y	N	
Bleeding problems	Y	N	Other			

Allergic/Immunologic

Hey fever	Y	N	Other			

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For Men

	Not At all	Less Than 1 time in 5	Less than half the time	About 1/2 the time	More than½ the time	Almost always
1. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder after you finished urinating?	0	1	2	3	4	5
2. Frequency During the last month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Intermittency During the last month, how often have you stopped and Started again several times when you urinated?	0	1	2	3	4	5
4. Urgency During the last month, how often have you found it difficult to postpone urine?	0	1	2	3	4	5
5. Weak Stream During the last month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Straining During the last month, how often have you had to push or strain to begin urinating?	0	1	2	3	4	5
7. Nocturia During the last month, how many times did you typically get up to urinate from the time you went to bed at night until the time you woke in the morning?	0	1	2	3	4	5

Now add up your symptom score (1-7 Mild, 8-19 Moderate, 20-35 Severe) Total Score:

For Women

		0	1	2	3	4
1.	How many times do you go to the bathroom In one day?	3- 6	7-10	11-14	15-19	20+
2.	How many times do you go to the bathroom at night?	0	1	2	3	4+
3.	Do you now or have you ever had pain or or symptoms during or after sexual activity?	Never Bothers	Occasionally	Usually	Always	
4.	Do you have pain associated with your bladder or in your pelvis (vagina, labia, lower abdomen, urethra, perineum)?	Never	Occasionally	Usually	Always	
5.	If you have pain, is it usually		Mild	Moderate	Severe	
6.	Do you still have urgency after you go to the bathroom?	Never	Occasionally	Usually	Always	
7.	If you have urgency, is it usually		Mild	Moderate	Severe	
8.	If you get up at night to go to the bathroom, does it bother you?	Never	Occasionally	Usually	Always	
9.	Has pain or urgency ever made you avoid sexual activity?	Never	Occasionally	Usually	Always	
10.	If you have pain, does your pain bother you?	Never	Occasionally	Usually	Always	
11.	If you have urgency, does it bother you?	Never	Occasionally	Usually	Always	

Are you sexually active? Yes No

Now add up your symptom score (1-7 Mild, 8-19 Moderate, 20-35 Severe) Total Score:

Add all scores and total. Ranges from 1-35. 10-14 = 74% pos. PST, 15-19= 76%; 20+%= 91 % Potassium positive PUF, Pelvic Pain and urgency/frequency: PST, potassium sensitivity

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Patient Name _____ DOB _____

Financial & Privacy Policy

Thank You for Choosing Clinical Urology Associates, P.C. (CUA) as your Healthcare Provider. The Following guidelines have been established to help you understand our expectations for our services.

Assignment of Benefits (by signing this you state that)

I hereby assign and authorize payment directly to Clinical Urology Associates, P.C. all benefits payable under the terms of any insurance policy if insurance is filed by this office. I realize the insurance benefits may not pay the entire bill and agree to pay the difference or the entire bill if necessary. I authorize the release of any medical and medication information necessary to process my insurance claims or to continue my medical care.

Payment in Full

You are responsible for your co-pay, any unmet deductibles, and "co-insurance" that your insurance plan considers your responsibility at the time of your visit. We gladly accept cash, checks, and most credit cards.

Insurance Claims

As a courtesy to our patients, we will file your primary and secondary insurance claims. In order for us to provide this service, we need to copy your most current insurance card and a picture ID. Any payment from your insurance company will come to CUA for our services when we file for you. Please remember that insurance coverage is a contract between the patient and the insurance company, therefore any co-payments or deductibles are due at the time of your appointment. You will be responsible for any non-covered services. If your insurance payment is not received within 60(sixty) days, the balance will automatically be assigned to you for payment and will be due immediately.

Usual & Customary Reimbursement

Our charges (fees) have been set to accurately reflect the complexity of care rendered and the skill and expertise required for your care. We assure you that our fees reflect what is usual and customary. If your insurance company's fee schedule falls below the level of charge, you will be responsible for payment in full (unless we have a written contract with your insurance company).

Self-Pay

You are required to pay in full when services are rendered if you have no insurance. Any payment arrangements must be made prior to seeing the physician.

Collection Policy

If your account becomes delinquent, and sent to an outside agency or attorney for collection you will be responsible for all costs, including agency fees, attorney fees, court costs, and any other related expenses. Your account will be changed to a "cash only" status and prepayment prior to service will be required. You agree and waive all rights to claim personal property exempt under the laws of the state of Alabama.

Missed Appointments

If you miss more than one appointment (without rescheduling in advance) you may be charged a $20 "No Show" fee that must be paid prior to coming in for a new visit. This fee is $50 for in office procedures.

HIPAA

I acknowledge that I have been offered and received a copy of the HIPAA policy.

Laboratory Medical Testing

I understand that I am giving consent to authorize medical testing by Clinical Urology Associates, P.C., and a copy of the testing results will be provided to me upon request. I understand my consent is for the services rendered. I authorize Clinical Urology Associates (Laboratory Name) to release to Medicare, the insurance carrier of health plan providing my healthcare benefits, and any health plan to which I am a member, any medical information needed for claim or payment purposes. I will be responsible for all charges incurred by me.

Initial: _____ Date: _____

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Medicare Patients

We are participating physicians with Medicare. This means that you will be responsible for 20% of the approved Medicare fee, the yearly deductible and full payment of non-covered services. As a courtesy to our patients, CUA will file any secondary claims.

Financial Hardship Policy

Please ask to speak to the billing department to discuss payment plans and options if you have a financial hardship. Please be prepared to present proof of the hardship including previous year's tax statements, outstanding debt, proof of income or proof of no income, and other documents as needed. Failure to establish a written payment policy with CUA can result in your account being sent to an outside collection agency. This can result in additional legal fees and charges. CUA reports to credit agencies.

Prescription Medication

Please remember that your prescription drug coverage is a contract between you and your insurance provider. Because insurance companies rapidly change, we must charge a fee prior to performing the steps required to satisfy your insurance company requests. You must contact your insurance company or your pharmacy if there is a problem with filling your prescription.

Blue Cross

According to Article 4 (IV) of the PMD agreement, each patient must sign notification of responsibility for payment of medical services in writing for services not covered under the PMD benefit agreement plan.
Article 10 (X) states that the patient will be responsible for any and all rendered professional services not covered by Blue Cross & Blue Shield of Alabama.
EXAMPLE: Services for experimental or investigative treatment, cosmetic surgery, pre-existing conditions, and routine check-ups.
The patient is responsible for all charges not covered by his/her insurance plan.

If you have any questions regarding CUA's financial & HIPAA policy, we will be most happy to answer them for you.

Signature: _____ **Date:** _____

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Privacy & Confidentiality Notice Acknowledgement

(Reference Federal Register 45 C.F.R. 5 Part 164.506)

I understand that protected health information may be used and disclosed to perform treatment, payment and/or healthcare operations. I acknowledge I've been given the opportunity to read and review a complete copy of the Clinical Urology Associates Privacy Notice with a complete description of such uses and understand I had a right to review the privacy notice before signing below. I understand I have a right to request this office restrict how my information is used, but this office may not agree with the requested restrictions. I have a right to revoke this authorization and consent, in writing, at any time. This office reserves the right to amend the privacy policy, whether required by law or otherwise, and a revised notice may be obtained by calling our office or physically coming to our office.

Designated Party Authorization for Release of Medical Information (Optional)
Some patients prefer that other individuals, especially family members, be allowed access to their medical information. In order to comply with strict legal standards, a written release is required to allow another person access to your medical records. This release grants permission to individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication and will be in effect unless I notify this office of any changes or revocations.

I authorize this information:

I authorize this office to leave messages on my answering machine or voice mail regarding protected health information. **YES or NO (circle one)**

Emergency Contact: _____ **Tel:**(___)____-_____ **Relation:** _____
Should this person also be able to make inquiries and receive medical information on me? **YES or NO (circle one)**
Should this person also be able to make inquiries about or pay balances on my account? **YES or NO (circle one)**

1. **Designated Party:** _____ **Tel:**(___)____-_____ **Relation:** _____
   Should this person also be able to make inquiries about or pay balances on my account? **YES or NO (circle one)**

2. **Designated Party**: _____ **Tel**:(___)____-_____ **Relation:** _____
   Should this person also be able to make inquiries about or pay balances on my account? **YES or NO (circle one)**

3. Release any medical office and/or laboratory records deemed necessary for my continuation of care as directed by my Clinical Urology Associates, P.C. Provider. **YES or NO (circle one)**

x_____ _____/_____/_____
Signature Date

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FEE SCHEDULE

Medication Prior Authorization	**$25.00**
FMLA	**$25.00**
Disability Forms	**$25.00**
Insurance Forms	**$25.00**
Forms Needing Provider Signature	**$25.00**
Letter of Medical Necessity	**$25.00**
Certificate of Medical Necessity	**$25.00**

Your physician may write a prescription that requires a "prior-authorization" (PA) from your insurance company. The PA is a form your insurance company may require prior to them agreeing to pay for your medicine.

The PA is your insurance company's document so you will have to call and have your insurance company fax us their form in order for us to process your request. Our fax number is (256) 492-4017. It is common for them to state they have faxed the form over but they often do not check to see if the paperwork was received. It may not go through if our fax machine is busy at the time.

We require a $25 payment to process your request. The fee covers the time necessary to get their form processed. We often have to fax it multiple times before they acknowledge receipt. They also require our staff to call and remain on hold for lengthy periods in order to process the request. The entire PA process can take several days.

Paying the $25 does not guarantee they will pay for the medicine. All it means is that we will process the request. The decision to pay for your medicine is between you and your insurance carrier.

Please know- We want you to have this medicine and would not have prescribed it unless we thought it beneficial for your care. Your insurance carrier may not have the same interests. We also realize how inconvenient this process is and wish your insurance company would simplify or eliminate their need for PA forms.

Patient Signature _____ Date: _____