ADVANCED **UROLOGY**

FEMALE
New Patient Demographics

Do you need assistance with these forms? ☐ Y ☐ N

DEMOGRAPHICS

Last Name: First: MI	DOB: (MM/DD/YYYY) Gender: ☐ Male ☐ Female ☐ Other:
Address:	Social Security No.
City: State: Zip:	Phone:
Primary Care Physician: (Name)	(Phone)
Referring Physician: (Name)	(Phone)
Emergency Contact: (Name) (Phone) (Relationship)	
Additional Information	
Email:	
Race: Ethnicity:	Preferred Language: ☐ English ☐ Spanish ☐ Other
Preferred Pharmacy: (Name)	(Phone)
Do you have an Advance Directive (Living Will)? ☐ Y ☐ N	

NOTICE OF PRIVACY PRACTICE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I have been provided a copy of Advanced Urology's Privacy Practices as required by the Health Insurance Portability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I authorize Advanced Urology to release my health information to persons/organizations listed below:

☐ Same as Emergency Contact	Other person/organization Name:_____ Relationship: _____ Phone: _____

By signing this document, I acknowledge the following:

- I have been provided a copy of Advanced Urology's Privacy Practices
- I have reviewed this authorization to release my medical records and confirm it is correct.
- I understand that this authorization will remain in effect for a period of one (1) year, unless revoked.
- I may revoke this authorization at any time by writing to: Advanced Urology, ATTN: Medical Records
- 1561 Janmar Rd., Snellville, GA 30078: The revocation will become effective upon receipt of the notice.

_____ _____
Signature of patient (or guardian) Date

OFFICE

For Office Use Only

Staff Initials:	☐ Patient Photograph	**Scan ALL patient documents**		
		☐ Pt. ID	☐ Insurance Card	
		☐ Pt. Demographics	☐ Pt. History	☐ Pt. Surveys

ADVANCED **UROLOGY**

Annual – Financial Policy & Consents

PAYMENT POLICY

Please *initial and sign* to your acknowledgement and consent for Medical Treatment and Payment Policy.

Thank you for choosing Advanced Urology as your provider. We are committed to providing you with quality and affordable health care. Please be sure to carefully read our payment policy. A copy will be provided upon request.

- ***Insurance.*** We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- ***Co-payments and deductibles***. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your account is turned over to a collection agency, a $100 collections processing fee will be added to any outstanding balance.
- ***Non-covered services***. Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- ***Proof of insurance***. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- ***Claims submission***. We will submit your claims and assist you in any way we can to help get your claims paid. Please be aware that any unpaid balances are your responsibility.
- ***Coverage changes***. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- ***Nonpayment.*** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

_____ **INITIAL HERE**

CONSENT TO MEDICAL TREATMENT

I have reviewed and consent to the following:

- I voluntarily present for treatment and consent to my provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.

- I acknowledge that my treatment is intended to address specific illnesses and is not intended as a substitute for a primary care physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Advanced Urology.

- In the event an employee has a needle stick or otherwise is exposed to my blood or body fluids, I consent to testing for HIV or Hepatitis C & B.

_____ **INITIAL HERE**

SIGNATURES

By signing below, I acknowledge that I have reviewed Advanced Urology's payment policy and consent to medical treatment.

Print name of person signing: _____ Relationship to patient: _____

_____ _____

Signature of patient (or guardian) Date

ADVANCED UROLOGY

Medical Release

Request for Healthcare information
Please forward the healthcare records of the following patient
Fax to 678.666.5201 or mail to 1561 Janmar Rd., Snellville, GA 30078

Authorization to obtain protected healthcare information

Patient Name (LAST) _____ (FIRST) _____ (MI) _____ (Suffix) _____

Date of Birth: _____/_____/_____ Phone: _____

☐ I authorize Advanced Urology to obtain and the named facilities to release to Advanced Urology my healthcare information.

This release applies to:

☐ All my healthcare information

☐ Healthcare information related to the following treatment, condition or dates

_____

☐ Other

_____

For Office Use Only

Facility: (Name) _____

Address:

_____

Phone: _____

(Fax)_____

_____ _____/_____/_____

Signature of patient (or guardian) Date

_____ _____

Print name of person signing Relationship to patient

ADVANCED **UROLOGY**

Female
Patient History

Patient Name:_____ Date of birth:_____

Height: _____ Weight: _____

Reason for today's visit:

CURRENT

List ALL current medications including over the counter, birth control, vitamins, herbals & prescriptions

Medication Name & Dose	**Medication Name & Dose**

MED HISOTRY

List ***ALL*** current or past medical conditions

ALLERGIES

Are you allergic to the following: ☐ Latex ☐ Band-aids/Adhesives ☐ Iodine ☐ Shellfish ☐ IVP Dye

List all medication allergies

Name of medication	**Reaction to medication**

SURG HISTORY

List ***ALL*** surgeries including the year

HOSPITALIZATION

List all hospitalizations, including the year **[Not ER visits]**

ADVANCED **UROLOGY**

Female
Patient History

FAMILY HISTORY

Is there any family history of genitourinary cancer? (kidney, bladder, prostate, testicular) ☐ **Yes** ☐ **No**

Relationship	**Type**

Please answer the following:

Mother	Father
☐ Alive	☐ Alive
☐ Deceased	☐ Deceased
☐ Unknown	☐ Unknown
Cause of death:	Cause of death:

SOCIAL HISTORY

Tobacco Use

- Do you use tobacco products? ☐ Yes ☐ No (How long?) _____ (How much?) Packs/day:_____
- Are you a former smoker? ☐ Yes ☐ No (Quit date?) _____

Alcohol Use

- Do you consume alcohol? ☐ Yes ☐ No (Type?) ☐ Beer ☐ Wine ☐ Liquor

How much? _____ drinks per ☐ Day ☐ Week ☐ Month (Date of last drink?)____/_____/____

Drug Use

Do you routinely use any illegal substances? ☐ Yes ☐ No

If yes, please list substance(s):

GYN

For women of childbearing age:

Are you currently pregnant? ☐ Yes ☐ No ☐ Unknown

Date of last menstrual period:

Patient history completed by:

☐ Patient

☐ Other Name:_____ Relationship to patient:_____

ADVANCED **UROLOGY**

FEMALE - Bladder Survey
UDI-6/IIQ-7

Name:	DOB:	Today's date:

The following questions ask about your bladder and urinary function.
Please review and answer all questions as best as you can.

Do you usually experience any of the following, and if so, how much are you bothered… (Circle all that apply)	If yes, how much does this bother you?			
	Not at all	**Somewhat**	**Moderately**	**Quite a bit**
1. Frequent urination	0	1	2	3
2. Small amounts of urine leakage (drops)	0	1	2	3
3. Leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom	0	1	2	3
4. Urine leakage related to physical activity (coughing, sneezing, or laughing	0	1	2	3
5. Difficulty emptying your bladder	0	1	2	3
6. Pain or discomfort in the lower abdomen or genital region	0	1	2	3
Has urine leakage affected your… (Circle all that apply)	**Not at all**	**Slightly**	**Moderately**	**Greatly**
1. Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

- If you checked "Yes" to any of the above problems, how long have you been experiencing this?

☐ Less than 1 year ☐ About 1 year ☐ About 2 years ☐ 3 to 5 years ☐ Greater than 5 years

- On average, how many times do you urinate during the daytime (Waking hours)? _____
- On average, how many times do you urinate overnight (Sleeping hours)? _____
- If you leak urine, how frequently does this occur?

☐ Every day ☐ A few times per week ☐ A few times per month ☐ Less than once per month ☐ Never

  - If you leak urine, how much do you lose at a given time? ☐ drops ☐ Small splashes ☐ More
  - Has urine leakage caused you to feel frustrated? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly
  - Do you ever leak urine while asleep? ☐ Yes ☐ No
  - Do you ever leak urine without awareness? ☐ Yes ☐ No

- What events trigger urine leakage? **(Check all that apply)**

☐ Cough ☐ Laugh ☐ Sneeze ☐ Exercise ☐ Sex
☐ Positional Changes ☐ Urgency ☐ Other:_____

2020.01.20
Adapted from Uebersax JS, Wyman FF, Shumaker SA, et al. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and urogenital distress inventory. Neurourol Urodyn 1995; 14: 131

ADVANCED UROLOGY

FEMALE - Bladder Survey
UDI-6/IIQ-7

- Have you noticed any of the following with regards to your urine stream? **(Check all that apply)**
  - ☐ Slow to start (hesitancy) ☐ Weak stream ☐ Slow stream ☐ Intermittent stream
  - ☐ Dribbling after stream ends ☐ Double voiding
- Do you need to do any of the following to help your bladder empty? **(Check all that apply)**
  - ☐ Bearing down ☐ Pushing on lower abdomen ☐ Pushing up vaginal bulge
  - ☐ Position changes ☐ Catheter usage
- Have you had a urinary tract infection (UTI) with a positive urine culture in the past year? ☐ Yes ☐ No
  - If yes, about how many have you had in the past year? _____
  - When was your most recent one (date)? _____
  - Do you think you may have one today? ☐ Yes
- Have you noticed any blood in your urine? ☐ Yes
- Do you have any burning or pain with urination? ☐ Yes
- Do you ever have pain associated with a full bladder? ☐ Yes
- Have you ever tried any medications for your bladder? (**Check all that apply**)
  - ☐ Detrol/Tolterodine ☐ Ditropan/Oxybutynin ☐ Vesicare/Solifenacin ☐ Sanctura/Trospium
  - ☐ Toviaz/Fesoterodine ☐ Enablex/Darifenacin ☐ Myrbetriq/Mirabegron ☐ Cardura/Flomax
  - ☐ Elmiron/PPS ☐ Methenamine/Hipprex ☐ D-Mannose ☐ Antibiotics
- Have you had any side effects from the above medications? (**Check all that apply**)
  - ☐ Dry mouth ☐ Dry eyes ☐ Constipation ☐ Urine retention
  - ☐ Impaired emptying ☐ Other
- Do you have any of the following medical problems?
  - ☐ Glaucoma ☐ Gastroparesis/Slow GI transit ☐ Dementia
  - ☐ Hypertension ☐ Myasthenia gravis ☐ QT prolongation
- Have you had any of the following treatments/procedures for your bladder?
  - ☐ Sling/Sphincter ☐ Urethral bulking ☐ Botox in bladder ☐ PTNS ☐ PNE/Interstim ☐ Hydrodistention
  - ☐ Pelvic floor physical therapy ☐ Other_____

2020.01.20
Adapted from Uebersax JS, Wyman FF, Shumaker SA, et al. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and urogenital distress inventory. Neurourol Urodyn 1995; 14: 131

Narcotic and Opioid Patient Prescriber Agreement (PPA)

- Pain and pain treatment are different for each person. Narcotic and opioid medicines are a type of medicine used to reduce moderate to severe pain. Narcotic and opioid medicines can reduce some (but not all) types of pain. It is not known how much improvement in pain, activity and quality of life I may have by using these medicines.

- My prescriber and I may also try alternative or additional treatment options for my condition, including: Non-opioid medicines, Physical therapy, appropriate exercises, Self-management techniques and coping strategies, or surgical or other medical procedures.

- Using narcotic and opioid medicines may cause:
  - *Physical dependence*: If the medicine is suddenly stopped I may experience withdrawal symptoms.
  - *Tolerance*: Over time, I may need more medicine to get the same pain relief.
  - *Addiction*: I may develop an intense craving for the opioid medicine, even if I take it as prescribed. If someone in my family has been addicted to drugs or alcohol, I may be at greater risk for addiction.

- Narcotic and opioid medicines can impair my judgment and responses. I understand that I must be cautious if I drive or operate machinery or do any activity that requires me to be alert until I am sure I can perform such activities safely.

- Taking even small amounts of alcohol or taking medicines such as sleeping pills, antihistamines, and anti-anxiety medicines while taking an opioid or narcotic medicine will increase the chance of side effect such as drowsiness, dangerously slowed breathing, and decreased alertness. If I start to have more pain or other unusual or severe side effects, I will contact my prescriber right away.

- I agree to discuss with my prescriber my and my family's past and present use of any habit-forming substances before we decide to try to treat my condition with an opioid medicine

- I told my prescriber about all the medicines I am taking, including any prescription, over-the-counter and herbal medicines. I will also discuss with my prescriber any new medicine that I take in the future.

- I will tell my prescriber if I am pregnant or planning to become pregnant

- I will not share this opioid medicine with other people.

- I will keep my opioid medicine in a secure place where other people cannot reach it.

- I will remove expired, unwanted, or unused opioid medicine from my home to avoid accidentally harming children, other adults, or myself.

- I understand that my prescriber may be required to check the Georgia Prescription Drug Monitoring Program before issuing a prescription for certain narcotics or opiates.

_____

Patient Signature Date