Southeast Florida UROLOGY

Robert H. Sherman, M.D., F.A.C.S.

PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____ AGE: _____ DATE OF BIRTH: _____

☐ MALE ☐ FEMALE ☐ WIDOWED ☐ DIVORCE ☐ MARRIED ☐ SINGLE

SOC. SEC. NO.: _____ DRIVERS LICENSE NO.: _____

LOCAL ADDRESS: _____ HOME PHONE ( )

PERMANENT ADDRESS: _____ WORK PHONE ( )

PERSON TO PAY BILL: _____ RELATIONSHIP _____ CELL PHONE ( )

ADDRESS: _____ PHONE ( )

NAME OF SPOUSE (OR PARENT, IF PATIENT IS CHILD): _____

PATIENT EMPLOYERS: _____ WORK PHONE ( )

ADDRESS: _____

Email: _____

ADDRESS: _____

TO NOTIFY IN CASE OF EMERGENCY: _____ RELATIONSHIP: _____ PHONE ( )

REFERRED BY: _____ HOW DID YOU HEAR ABOUT THE PRACTICE _____

INSURANCE INFORMATION

MEDICARE NUMBER: _____ NAME OF INSURED: _____

BLUE SHIELD POLICY NO.: _____ GROUP NO.: _____ STATE: _____ NAME OF INSURED: _____

COMMERCIAL INSURANCE NO.: _____ ADDRESS FOR CLAIMS: _____

POLICY NO.: _____ GROUP NO.: _____ NAME OF INSURED: _____

COMMERCIAL INS. CO. (2nd): _____ ADDRESS FOR CLAIMS: _____

POLICY NO.: _____ NAME OF INSURED: _____

PRE CERT: ☐ YES ☐ NO _____ AMOUNT OF COVERAGE: _____

PRE-CERT NO.: _____ OFFICE / HOSPITAL: _____

LABS / DIAGNOSTIC TESTING: _____ DEDUCTIBLE: _____

CO-PAY: _____

I authorize any holder of medical or other information about me to release to my insurance company or, for Medicare/Blue Cross Blue Shield to the Social Security Administration and Health Care Financing Administration or any other intermediaries or carriers or to the billing agent of Blue Cross/Blue Shield of Florida any information needed for this or a related insurance or claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefits, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for those charges not paid by my insurance.

X _____ DATE

_____ OTHER SIGNATURE/REASON IF PATIENT IS UNABLE TO SIGN

IDENTIFICATION * This confidential history will be part of your permanent records.

Last Name _____ First _____ Middle _____ Date of Birth ___/___/___

Age:_____ Social Security # _____ Sex: M F (circle one)

Referring Physician _____ Primary Care Physician _____

History provided by: ☐ Patient ☐ Relative ☐ Surrogate ☐ Caregiver

What medications are you taking now?

MEDICATIONS	DOSAGE	FREQUENCY

PAST MEDICAL HISTORY Check only the ones you have had in the past.

Past general state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Hay Fever	☐ Leukemia	☐ Tuberculosis	☐ Gallstones	☐ Bladder Trouble	☐ Epilepsy	☐ Blood Transfusion
☐ Mumps	☐ Cataracts	☐ Heart Trouble	☐ Liver Trouble	☐ Diabetes	☐ Paralysis	
☐ Measles	☐ Tonsilitis	☐ Varicose Veins	☐ Hepatitis	☐ Syphilis	☐ Alzheimers	
☐ Rheumatic Fever	☐ Sinusitis	☐ Phlebitis	☐ Parasites	☐ Gonorrhea	☐ Mental Illness	
☐ Allergies	☐ Parkinson's	☐ Hypertension	☐ Dysentery	☐ Hernia	☐ Alcoholism	
☐ Angina	☐ Asthma	☐ Stroke	☐ Colitis	☐ Sexual Problems	☐ Depression	
☐ Cancer	☐ Bronchitis	☐ Ulcers	☐ Polyps	☐ Prostate Problems	☐ Nervous Breakdown	
☐ Tumor	☐ Pleurisy	☐ Jaundice	☐ Kidney Infections	☐ Hemorrhoids	☐ Migraines	
☐ Blood Disease	☐ Pneumonia	☐ Skin Trouble	☐ Kidney Stones	☐ Gout	☐ Other: _____	

☐ HIV

ILLNESSES * INJURIES * OPERATIONS	DATE	HOSPITAL	TREATMENT	PHYSICIAN

SOCIAL HISTORY Check the boxes and fill in as appropriate.

Marital Status
☐ Married ☐ Single
☐ Widowed ☐ Divorced

Tobacco
☐ Smoker ☐ Non-Smoker
_____Packs per day

ETOH/Alcohol
Amount_____

Drugs Use
Type_____

Caffeine
Amount_____
Amount_____

Occupation:_____

FAMILY HISTORY Have any of your relatives had any of the following?

Prostate Cancer	☐ Yes ☐ No	If yes, who? _____
Other Cancer	☐ Yes ☐ No	If yes, who? _____ What type of cancer (e.g., breast, lung)_____
High Blood Pressure	☐ Yes ☐ No	If yes, who? _____
Diabetes	☐ Yes ☐ No	If yes, who? _____
Heart disease	☐ Yes ☐ No	If yes, who? _____
Lung disease	☐ Yes ☐ No	If yes, who? _____
Other Conditions (list):		_____

Pharmacy #

Allergies:

Height _____ Weight _____

Systems Review

Patient Name: _____ **Date:** _____

Do you now or have you recently had any of the following problems? Circle Y or N.
Please explain any yes answers in the space provided.

Constitutional Symptoms

Weight change	Y	N
Fever	Y	N
Loss of appetite	Y	N
Fatigue	Y	N
Night sweats	Y	N

Other_____

Skin

Rashes	Y	N
Psoriasis	Y	N
Dandruff	Y	N
Dry skin	Y	N
Itching	Y	N
Hair loss	Y	N
Change in skin color	Y	N
Sun Sensitivity	Y	N

Other_____

Neurologic

Any tremors	Y	N
Weakness/ Numbness	Y	N
Loss of balance	Y	N
Memory loss	Y	N
Burning in extremities	Y	N
Headache	Y	N

Other_____

Cardiovascular

Palpitations	Y	N
Chest pain	Y	N
Edema	Y	N
Dizziness	Y	N
Murmur	Y	N
Pain when walking that is relieved by rest	Y	N

Other_____

Endocrine

Thirsty	Y	N
Weight Change	Y	N
Excessive Body Hair	Y	N
Change in shape of face	Y	N

Other_____

Respiratory

Shortness of Breath	Y	N
Cough	Y	N
Blood in sputum	Y	N
Fatigue	Y	N
Chills	Y	N

Other_____

Eyes

Dry eyes	Y	N
Inflammation or redness	Y	N
Double vision	Y	N
Blurry vision	Y	N
Gritty feeling in the eyes	Y	N
Pain in the eyes	Y	N
Loss of vision	Y	N
Tearing	Y	N

Other_____

ENT

Dry mouth	Y	N
Mouth sores/ulcers	Y	N
Sore throat	Y	N
Bad taste in mouth	Y	N
Ear ache	Y	N

Other_____

Musculoskeletal

Pain when walking	Y	N
Joint pain	Y	N
Joint swelling/stiffness	Y	N
Loss of motion	Y	N
Decreased strength	Y	N
Muscle cramps	Y	N
Fractures due to trauma	Y	N

Other_____

Hematologic/Lymphatic

Easy bruising	Y	N
Anemia	Y	N
Abnormal bleeding	Y	N
Enlarged lymph glands	Y	N
Blood clots	Y	N

Other_____

Genitourinal

Frequency	Y	N
Burning with urination	Y	N
Blood in urine	Y	N
Impotence	Y	N
Discharge	Y	N
Menstrual irregularities	Y	N
Pregnancy/miscarriages	Y	N

Age at menopause _____

Other_____

Gastrointestinal

Rectal bleeding	Y	N
Abdominal pain	Y	N
Change in bowel habits	Y	N
Nausea	Y	N
Vomiting	Y	N
Heartburn	Y	N

Other_____

Psyche

Anxiety	Y	N
Mood changes	Y	N
Sleep patterns	Y	N
Fatigue	Y	N
Memory loss	Y	N
Depression	Y	N
Irritability	Y	N

Other_____

Explain: _____

_____

To the best of my knowledge, the information provided here is accurate and complete.

_____ _____

Patient/Responsible Party Signature Date

Physician Review:_____ Date: ____/____/____

Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Medical Record Number

Address (Street, City, State, ZIP Code)	Telephone Number

I request that my health information or medical billing record be disclosed or restricted, as follows:

I authorize the names listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

Authorized Name	**Relationship to Patient**

***DO NOT** discuss or provide information to the following individuals or entities:

Restricted Name/Entity	**Relationship to Patient**

*I request the use of **ONLY** the following address and/or phone number(s) to contact me regarding my health or billing information:

_____

_____

_____

Patient Rights: Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY

DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:

*Granted _____ Denied _____

*If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s).

Reason(s) for Denial, if Applicable _____

_____

_____

Physician Office Representative: Date:

Southeast Florida
UROLOGY

Robert H. Sherman, M.D., F.A.C.S.
Urology & Urological Surgery
Diplomate, American Board of Urology
Fellow, American College of Surgeons

Cancellation & "No Show" Fee Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide us with 24 hour's notice. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, SOUTHEAST FLORIDA UROLOGY LLC reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. Operative procedure cancellation require a 48 hour notification and are subject to at $100.00 cancellation fee.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only by management approval.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

500 North Hiatus Road, Suite 107 • Pembroke Pines, FL 33026 • (954) 392-6606 • Fax: (954) 392-6169

Southeast Florida
UROLOGY

Robert H. Sherman, M.D., F.A.C.S.
Urology & Urological Surgery
Diplomate, American Board of Urology
Fellow, American College of Surgeons

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I THE UNDERSIGNED, HEREBY AUTHORIZE DR. ROBERT H. SHERMAN TO OBTAIN ALL MEDICAL RECORDS AND X-RAYS AS DEEMED NECESSARY.

DATE:_____ PATIENT'S SIGNATURE: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

AUTHORIZATION OF THIS FORM AND SIGNATURE SHALL BE AS VALID AS ORIGINAL

I HEREBY AUTHORIZE PAYMENT TO SOUTHEAST FLORIDA UROLOGY, FOR MEDICAL BENEFITS, OTHERWISE PAYABLE TO ME FOR SERVICES AS DESCRIBED ON THE ACCOMPANYING STATEMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY AUTHORIZATION. I HEREBY AUTHORIZE THE ABOVE NAMED PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY TREATMENT.

DATE:_____ PATIENT'S SIGNATURE: _____

WITNESS: _____

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMATION. THIS RIGHT APPLIES TO DISCLOSURES FOR PURPOSES OTHER THAN TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS AS DESCRIBED IN THIS NOTICE OF PRIVACY PRACTICES. IT EXCLUDES DISCLOSURES WE MAY HAVE MADE TO YOU, FOR A FACILITY DIRECTORY, TO FAMILY MEMBERS OR FRIENDS INVOLVED IN YOUR CARE, FOR A FACILITY DIRECTORY, TO FAMILY MEMBERS OR FRIENDS INVOLVED IN YOUR CARE, OR FOR NOTIFICATION PURPOSES. YOU HAVE THE RIGHT TO RECEIVE SPECIFIC INFORMATION REGARDING THOSE DISCLOSURES THAT OCCURRED AFTER APRIL 14, 2003. YOU MAY REQUEST A SHORTER TIME FRAME. THE RIGHT TO RECEIVE THIS INFORMATION IS SUBJECT TO CERTAIN EXCEPTIONS, RESTRICTIONS, AND LIMITATIONS. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US, UPON REQUEST, EVEN IF YOU HAVE AGREED TO ACCEPT THIS NOTICE ELECTRONICALLY.

COMPLAINTS:

YOU MAY COMPLAIN TO US OR TO THE SECRETARY OF HEALTH AND HUMAN SERVICES IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED BY US. YOU MAY FILE A COMPLAINT WITH US BY NOTIFYING OUR OFFICE OF YOUR COMPLAINT. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

YOU MAY CONTACT OUR OFFICE FOR FURTHER INFORMATION ABOUT THE COMPLAINT PROCESS. THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE DECEMBER 1, 2002.

Assignment of Benefits/Right to Payment, Patient Responsibility and Release of Information Form

Southeast Florida Urology

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ Date:_____

Signature of Patient/Person Legally Responsible

_____

Print Name of Patient/Person Legally Responsible

_____

Relationship to Patient
(If signed by Person Legally Responsible)