UROLOGY CENTER of WINTER PARK

TopLine MD Alliance

Patient's Name: _____ D.O.B. _____

Referring Physician: _____ Ph. Number _____

Fax. Number _____

Primary Care Physician: _____ Ph. Number _____

Fax. Number _____

Additional Physician: _____ Ph. Number _____

Fax. Number _____

Medication/Chronic Problems Profile

ALLERGIES

Medication	Type of Reaction

PRESCRIPTION MEDICATIONS **CHRONIC MEDICAL PROBLEMS**

Date	Name of Medication	Dosage	Directions for Use	Date	Problem

UCWP-FL02 11/20 R/O MPS 407-657-7414

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PATIENT INFORMATION

Patient Name:_____
Home Address:_____
_____Zip_____
Billing Address: Same as above_____
_____Zip_____
Occupation:_____
Employer:_____
Work Phone:_____Ext_____

Home Phone:_____ Cell:_____
SSN:_____
DOB:_____ Age:_____
Gender: ☐ Male ☐ Female
Ethnicity:_____ Language preferred:_____
Hispanic ☐ Non-Hispanic ☐ Smoker ☐ Non-Smoker ☐
Marital Status: ☐ Single ☐ Married ☐ Other
Driver's Lic. #:_____ E-mail:_____

Primary Care Physician:_____ Phone:_____
Referring Physician: _____ Phone:_____
Pharmacy: _____ Phone:_____

Emergency Contact:_____
Relationship:_____
Phone:_____

Emergency Contact:_____
Relationship:_____
Phone:_____

PRIMARY INSURANCE

☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid
Ins. Company Name:_____
Claims Address:_____
_____Zip_____
Phone Number:_____
ID#:_____ Group#:_____
Name of the Insured Party:_____
Insured's SSN:_____DOB:_____
What is the patient's relationship to the Insured Party?
☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY

☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid
Ins. Company Name:_____
Claims Address:_____
_____Zip_____
Phone Number:_____
ID#:_____ Group#:_____
Name of the Insured Party:_____
Insured's SSN:_____DOB:_____
What is the patient's relationship to the Insured Party?
☐ Self ☐ Spouse ☐ Child ☐ Other

Payment is expected IN FULL at the time services are rendered by the patient or person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide up with complete insurance information at the time of your visit, you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier.

I have read and understand the office policy for payment and agree to the terms as stated.

Patient or Parent/Guardian Signature_____ **Date:**_____

Print Name:_____

Patient Name: _____ DOB: _____

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Patient, Parent, Legal Guardian or Authorized Representative Date

Printed name of patient's representative:_____

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Urology Center of Winter Park. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Signature: _____ Date: _____

FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION - LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act if correct I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services o authorize such physician or organization to submit a claim to Medicare for payment to me.

_____ _____

Patient Name Patient Signature

_____ _____

Medicare B # Date

ADVANCED DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

{ } I HAVE executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

Please provide copies of Advance Directive/Living Will to the receptionist to be included in your medical record.

{ } I HAVE NOT executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

_____ _____

Signature Date

UROLOGY CENTER of WINTER PARK

TopLine MD Alliance

PATIENT AUTHORIZATION

Please Print

Patient's Name:_____ Date of Birth:_____

Address:_____ Telephone #:_____

Today's Date:_____

COMMUNICATION USE AND DISCLOSURE AUTHORIZATION

1. Urology Center of winter Park may leave the following messages on answering machines:
   - ☐ Referral Information
   - ☐ Test results
   - ☐ Prescription refill information
   - ☐ Other:_____
2. Urology Center of winter Park may discuss information regarding my treatment and care with the following family members and/or friends:

   _____
3. Urology Center of winter Park may contact me regarding my treatment and care at the following numbers:

   _____

Signature:_____ Date:_____

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO UROLOGY CENTER OF WINTER PARK

By signing this Authorization, I hereby authorize and permit the use and/or disclosure of my protected health information for the limited purpose(s), and in the manner, described in this form. In addition, I understand that this authorization is completely voluntary and I am signing it under my own free will. All questions/statements on this form mus be completed.

Physician's office(s) providing the information:_____

Specific description of information to be used/disclosed about me: Demographic information and medical diagnosis.

The patient or the patient's representative must read and initial the following statements:

1. I understand that my health care and the payment for my healthcare will not be affected if I do sign this form.
2. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
3. I understand that this authorization will expire one year from the date I signed this authorization.
4. I understand that I may revoke this Authorization at any time by notifying Urology Center of Winter Park.

_____ _____

Signature of patient or patient's representative Date

Printed name of patient's representative:_____

Witnessed by staff member: _____ Date:_____

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FINANCIAL POLICY

Thank you for choosing Urology Center of Winter Park. We are committed to providing you with the highest quality urologic care. We would like to help you receive the maximum covered benefits offered to you. The following points will help us do that:

1. We must have accurate information from you in order to process your claim correctly.

2. Some services may not be covered by your insurance company as there are many different plans available and not all plans cover all services. It is important that you become familiar with your plan and the coverage it offers you.

3. It is important to know, that even within the same insurance company, different rules apply to different plans, and coverage of services.

4. We believe that the choice for medical treatment should be yours. Should you choose to receive treatment at one of our offices for any service or product not covered by your insurance company, you agree to be responsible for the payment of these charges.

5. Your insurance plan is a contract between you and your insurance company. We file claims to your insurance company as a courtesy to you.

6. Patients with insurances that require authorizations and or referrals (ie. HMO, VA) are responsible to obtain their authorizations and or referrals from their PCP or VA or insurance carrier. Failure to do so may result in cancelled appointment, cancellation fee, or payment responsibility of all services received.

7. Deductibles, co-insurance and or co-payments, as stated in your plan are due at time of service.

8. We may need you to assist us in contacting your insurance carrier to resolve any insurance problems that may arise.

9. Should your insurance company determine a service is non-covered, you will be held responsible for all unpaid balances. If that occurs please refer back to your insurance carrier.

10. SELF PAY patients are responsible for full payment of services at time of service.

11. In case the account is not paid in full within the specified amount of time, it will be rendered to collections. Patient will then be responsible for collection expenses and attorney fees. In addition the account may be charged interest at the legal rate.

12. We require a 24 hour call ahead in case of appointment cancellations, otherwise a **NO SHOW fee** may be assessed.

We accept CASH, CHECKS, VISA, MASTER CARD, DISCOVER, AND AMERICAN EXPRESS as form of payment. Return check fee is $35.00.
The fee to copy Medical Records is $1 per photocopied page plus shipping and handling.

I have read the above Financial Policy and agree to all terms and conditions as described in it.

Patient's Name:_____

Patient's Signature:_____ Date:_____

Date: _____

PATIENT HISTORY FORM
INITIAL VISIT

NOTE: This is a confidential record and will be kept in your private medical file. The information contained here will not be released to anyone without authorization to do so.

PLEASE ANSWER ALL QUESTIONS

Last Name:_____ First Name:_____

Date of Birth:_____ Age:_____ Gender: Male_____ Female_____ Married: Y___N___

Why are you here to see the doctor today? _____Children: Yes___ No___Ages:_____

When did this problem begin? _____

How severe is your problem, on a scale of 1 to 10, 10 being most severe? _____

URINARY COMPLAINTS:

Do you experience urinary frequency during the day?	N	Y	If yes, how often?
Do you wake up at night to urinate?	N	Y	If yes, how often?
Have you ever seen blood in your urine?	N	Y	
Have you ever had a urinary tract infection?	N	Y	If yes, how often?
Do you have to push or strain to begin urination?	N	Y	
Does your urinary stream stop and start?	N	Y	
Do you experience incomplete bladder emptying?	N	Y	
Do you have burning or discomfort with urination?	N	Y	
Do you ever have the urge to rush to urinate?	N	Y	If yes, when?
Do you ever lose control or leak urine suddenly?	N	Y	
Do you ever leak urine when you cough, sneeze, or exercise?	N	Y	
Do you wear pads to collect urinary leakage?	N	Y	If yes, how many?
Are you bothered by the way that you urinate?	N	Y	
Do you have pain associated with your bladder or pelvic area (lower abdomen, vagina, penis, urethra, testicles, or scrotum)?	N	Y	If yes, since when?

Do you have difficulty:

Initiating an erection?	N	Y
Maintaining an erection?	N	Y
Reaching ejaculation?	N	Y
Problem with libido or sex drive?	N	Y

Rate the quality of your erection 1 to 10 (10 is strongest): 1 2 3 4 5 6 7 8 9 10 (circle one)

Any additional information you would like to tell the doctor? _____

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PAST MEDICAL AND SOCIAL HISTORY
PLEASE ANSWER ALL QUESTIONS

Patient Name: _____ Date: _____

Please list all of your known medical conditions: _____

Please list all of your past surgeries (including pregnancies): _____

Have you ever had any of the following conditions? Answer *Yes* or *No*

High blood pressure	N	Y	High cholesterol	N	Y
Diabetes	N	Y	Heart disease	N	Y
Heart murmur	N	Y	Stroke	N	Y
Cancer	N	Y	HIV	N	Y
Kidney stones	N	Y	Kidney infection	N	Y

Please list all allergies to foods or medications: _____

Are you allergic to IVP dye, Iodine, or shell fish? _____

Please list all medications (with dosage) you are currently taking: _____

_____

Are you currently taking aspirin or products containing aspirin? N Y

Are you taking (circle): Coumadin Plavix Heparin Lovenox Arixtra Persantine Arthritis meds

Have you ever smoked cigarettes? N Y Packs-per-day? _____ Quit date?_____

Do you drink alcohol? N Y Drinks-per-day? _____ Quit date?_____

Do you drink coffee? N Y Cups-per-day? _____

Are you sexually Active? N Y

Any history of sexually transmitted disease (STD) N Y If so, which? _____

Occupation: _____

FAMILY HISTORY:

List all medical conditions that affect any blood-relatives *(specify condition and which relative is affected)*: _____

Is there a family history of: ____prostate cancer ____bladder cancer ____kidney stones

REVIEW OF SYSTEMS:
PLEASE ANSWER ALL QUESTIONS

Constitutional Symptoms			**Cardiovascular**		
Fever	Y	N	Chest pain	Y	N
Chills	Y	N	Varicose veins	Y	N
Headache	Y	N	High blood pressure	Y	N
Other:_____			Other:_____		
Eyes			**Musculoskeletal**		
Blurred vision	Y	N	Joint pain	Y	N
Double vision	Y	N	Neck pain	Y	N
Pain	Y	N	Back pain	Y	N
Other:_____			Other: _____		
Neurological			**Genitourinary**		
Tremors	Y	N	Urinary retention	Y	N
Dizzy spells	Y	N	Painful urination	Y	N
Numbness/tingling	Y	N	Urinary frequency	Y	N
Other:_____			Other:_____		
Endocrine			**Respiratory**		
Excessive thirst	Y	N	Wheezing	Y	N
Too hot/cold	Y	N	Frequent cough	Y	N
Tired/sluggish	Y	N	Shortness of breath	Y	N
Other:_____			Other:_____		
Gastrointestinal			**Hematologic/Lymphatic**		
Abdominal pain	Y	N	Swollen glands	Y	N
Nausea/vomiting	Y	N	Blood clotting problem	Y	N
Indigestion/heartburn	Y	N	Other:_____		
Other:_____			**Females Only**		
Psychologic			Birth control	Y	N
Satisfied with life?	Y	N	Other (Explain):_____		
Feel depressed?	Y	N			
Considered suicide?	Y	N			
Other:_____					

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International Prostate Symptom Score (I-PSS)

Patient's Name _____ Date of Birth _____ Date Completed _____

	Not at all	Less than 1 Time in 5	Less than Half the Time	About half The Time	More than Half the Time	Almost Always	
1. Incomplete Emptying Over the past month, how often have you had sensation of not emptying your bladder completely after you finiash urinating?	0	1	2	3	4	5	
2. Frequency Over the past 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 Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you to push or strain to begin urination?	0	1	2	3	4	5	
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 Times or more**	
6. Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	
						Total I-PSS Score	
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	Delighted 0	Pleased 1	Mostly Satisfied 2	Mixed 3	Mostly Dissatisfied 4	Unhappy 5	Terrible 6

Patient's Name:_____ Date of Birth:_____ Date Completed:_____

Sexual Health Inventory For Men (SHIM)

Instructions:

Each question has 5 possible responses. Circle the number that best describes your own situation. Select only 1 answer for each question.

Over the past 6 months:

1. How do you rate your confidence that you could keep an erection?

1	2	3	4	5
Very low	Low	Moderate	High	Very high

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

1	2	3	4	5
Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult

5, When you attempted sexual intercourse, how often was it satisfactory for you?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

Scoring Instructions:

Add the numbers corresponding to the answers for questions 1 through 5. If the patient's score is 21 or less, erectile dysfunction (ED) should be addressed. The SHIM score characterizes the severity of the patient's ED in the following manner:

22-25 No ED
17-21 Mild ED
12-16 Mild-to-moderate ED
8-11 Moderate ED
5-7 Severe ED

Score:_____

Low Testosterone Questionnaire

ADAM Questionnaire (Androgen Deficiency in the Aging Male)

Patient's Name:_____ Date of Birth:_____ Date Completed:_____

If you are concerned that your testosterone level is low, this set of ten simple questions is a good place to start.

	Answer YES or NO to each of the following questions:	Yes	No
1.	Do you have a decrease in libido (sex drive)?		
2.	Do you have a lack of energy?		
3.	Do you have a decrease in strength and/or endurance?		
4.	Have you lost height?		
5.	Have you noticed a decreased "enjoyment of life?"		
6.	Are you sad and/or grumpy?		
7.	Are your erections less strong?		
8.	Have you noticed a recent deterioration in your ability to play sports?		
9.	Are you falling asleep after dinner?		
10.	Has there been a recent deterioration in your work performance?		

If you answered YES to questions 1 or 7 or any 3 other questions, you may be experiencing androgen deficiency (low testosterone level).

***Adapted from Morley, et al. Validation of a screening questionnaire for androgen deficiency in aging males. Metabolism 2000;49(9): 1239-1242*