UROLOGY CENTER of WINTER PARK

TopLine MD Alliance

315 North Lakemont Avenue
Winter Park, FL 32792
Phone: 407-622-2030
Fax: 407-622-2033

Daniel D. Cohen, M.D.
Janet Rodriguez, PA-C
Renchu Ann Alex, MSN, ARNP-C

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-FL01 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:____

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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:________________

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:______________

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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

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other:______________________________

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other:______________________________

Neurological

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

Other:______________________________

Endocrine

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

Other:______________________________

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other:______________________________

Psychologic

Satisfied with life?	Y	N
Feel depressed?	Y	N
Considered suicide?	Y	N

Other:______________________________

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other:______________________________

Musculoskeletal

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

Other:______________________________

Genitourinary

Urinary retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other:______________________________

Respiratory

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

Other:______________________________

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other:______________________________

Females Only

Birth control	Y	N

Other (Explain):______________________________

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OVERACTIVE BLADDER SHORT FORM QUESTIONNAIRE

Today's Date:____________________

Last Name:______________________ First Name:______________________Date of Birth:__________Age:____

OVERACTIVE BLADDER PART A	Not At All	A Little Bit	Some-What	Quite A Bit	A Great Deal	A Very Great Deal
1. An uncomfortable **Urge** to urinate?	1	2	3	4	5	6
2. A sudden urge to urinate with **Little or No Warning**?	1	2	3	4	5	6
3. **Accidental Loss** of small amounts of urine?	1	2	3	4	5	6
4. **Nighttime urination**?	1	2	3	4	5	6
5. **Waking up at Night** because you had to urinate?	1	2	3	4	5	6
6. Urine loss associated with a **Strong Desire** to urinate?	1	2	3	4	5	6
TOTAL SCORE, PART A (Lowest = 6, Highest = 36)						

OVERACTIVE BLADDER PART B	Not At All	A Little Bit	Some-What	Quite A Bit	A Great Deal	A Very Great Deal
7. Caused you to **Plan "Escape Routes"** to restrooms in public places?	1	2	3	4	5	6
8. Made you feel like there is **Something Wrong** with you?	1	2	3	4	5	6
9. Interfered with your ability to get a good **Night's Rest**?	1	2	3	4	5	6
10. Made you frustrated or annoyed about the amount of **Time you spend in the Restroom?**	1	2	3	4	5	6
11. Made you **Avoid Activities** away from Restrooms (e.g. sports exercising)	1	2	3	4	5	6
12. **Awakened** you during Sleep?	1	2	3	4	5	6
13. Caused you to **Decrease your Physical Activity**? (e.g. sports, exercising)	1	2	3	4	5	6
14. Caused you to have **Problems with your Partner or Spouse**?	1	2	3	4	5	6
15. Made you uncomfortable with **Traveling** with others because of needing to stop for a restroom?	1	2	3	4	5	6
16. **Affected your Relationships** with family and friends?	1	2	3	4	5	6
17. Interfered with getting **Amount of Sleep** you needed?	1	2	3	4	5	6
18. Caused you **Embarrassment**?	1	2	3	4	5	6
19. Caused you to **Locate the Closest Restroom** as soon as you arrive at a place you have never been?	1	2	3	4	5	6
TOTAL SCORE, PART B (Lowest = 13, Highest = 78)						

URGENT: none

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