TMD MEN'S HEALTH

Division Of Amarillo Urology Associates

PATIENT HISTORY FORM

Last Name: _____ First Name: _____ Age: _____

Address: _____ Home Phone Number: _____ Cell: _____

City: _____ State: _____ Zip: _____ Work Phone Number: _____

DOB: _____ SSN: _____ Marital Status: _____ Male: ☐ Female: ☐

Ethnicity: _____ Preferred Language: _____ Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone Number (other than patient's home phone): _____

Referring Doctor: _____ Primary Care Doctor: _____

Which Doctor are you here to see today? _____ Date of your **LAST** physical exam: _____

****

CHIEF COMPLAINT: *(Main reason for your visit today)* _____

History of Present Illness:

Location of Problem: Abdomen _____ Legs: _____ Back: _____ Front: _____

How long does problem last? 30 minutes ☐ 1 hour ☐ Always there ☐

On a scale of 1-10 (with 10 being most severe), circle number best describing problem: 1 2 3 4 5 6 7 8 9 10

Is anything else occurring at the same time? Yes ☐ No ☐ If yes, explain: _____

When did you first notice problem? 2 days ago ☐ 2 weeks ☐ 1 month ☐ other: _____

Is problem constant or variable? dull then sharp ☐ sharp then gone ☐ always there ☐ other: _____

Does anything help or make problem worse? Moving around ☐ Standing up ☐ Lying on side ☐ other: _____

Does problem interfere with normal functioning? Yes ☐ No ☐ If yes, explain: _____

Doctor / Date: _____

PAST MEDICAL AND SOCIAL HISTORY

List all past **SURGICAL PROCEDURES** and the year they were performed: _____

_____

_____

_____

List your current **MEDICAL ILLNESSES** or problems: Circle any of the following that you have: Asthma Diabetes

Emphysema Heart disease High blood pressure Seizures Stroke Ulcers

Other: _____

_____

_____

Do you have a pacemaker? _____Yes _____No Do you have dentures? _____Yes _____No

Do you have contact lenses? _____Yes _____No Do you smoke? _____Yes _____No

If yes, how many packs per day? _____

Past history of smoking? _____Yes _____No If yes, when did you quit? _____

Smokeless tobacco? _____Yes _____No If yes, chew or dip? _____

Do you drink alcohol? _____Yes _____No If yes, how much? _____

Are you on a special diet? _____Yes _____No If yes, please describe: _____

LADIES, are you pregnant? _____Yes _____No Number of pregnancies _____ vaginal delivery _____ c-section _____

****

DRUG ALLERGIES: _____

Please list all of you current **MEDICATIONS** with dosages and timing: **Circle** any of the following that you are taking:

Nitroglycerin Glucophage Blood thinners Digitalis Dilantin Theophylline

Other: _____

_____

Vitamins / Herbs: _____

(patient sticker)

Doctor / Date: _____

FAMILY HISTORY

List all serious illnesses in your **FAMILY**: Circle any of the following that any family member has: Breast cancer

Diabetes Heart disease Kidney cancer Prostate cancer Tuberculosis

Other: _____

_____

FATHER: Age living _____ Age deceased _____

Medical Illnesses: _____

_____

MOTHER: Age living _____ Age deceased _____

Medical Illnesses: _____

_____

BROTHERS: How many _____ Age living _____ Age deceased _____

Medical Illnesses: _____

_____

SISTERS: How many _____ Age living _____ Age deceased _____

Medical Illnesses: _____

_____

(patient sticker)

Doctor / Date: _____

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems: Circle **YES** or **NO**
Please explain any YES answers in the space provided.

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: _____

Allergic / Immunologic
- Hay fever Y N
- Drug Allergies Y N
- Other: _____

Neurological
- Tremors Y N
- Dizzy spells Y N
- Numbness / tingling Y N
- Other: _____

Endocrine
- Excessive Thirst Y N
- Too hot / Too cold Y N
- Tired / Sluggish Y N
- Other: _____

Gastrointestinal
- Abdominal pain Y N
- Nausea / vomiting Y N
- Indigestion / heartburn Y N
- Other: _____

Cardiovascular
- Chest pain Y N
- Varicose veins Y N
- High blood pressure Y N
- Other: _____

_____

Integumentary
- Skin rash Y N
- Boils Y N
- Persistent itch Y N
- Other: _____

Musculoskeletal
- Joint Pain Y N
- Neck pain Y N
- Back pain Y N
- Other: _____

Ears / Nose / Throat / Mouth
- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Other: _____

Genitourinary
- Urinary retention Y N
- Painful urination Y N
- Urinary frequency Y N
- Other: _____

Respiratory
- Wheezing Y N
- Frequent coughing Y N
- Shortness of breath Y N
- Other: _____

Hematologic / Lymphatic
- Swollen glands Y N
- Blood clotting problem Y N
- Other: _____

Psychologic
- Are you generally satisfied with your life Y N
- Are you severely depressed Y N
- Have you considered suicide Y N
- Other: _____

(patient sticker)

Doctor / Date: _____

AMARILLO UROLOGY ASSOCIATES, L.L.P

PATIENT MEDICATION SHEET

PATIENT NAME _____
DOCTOR _____
DATE _____

DRUG ALLERGIES (include type of reaction)

_____
_____
_____

PHARMACY _____

CURRENT MEDICATIONS (include dose & directions)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, Discover and American Express.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided. Any balance due is your responsibility and is due upon receipt of a statement from our office.

No Insurance – Self Pay Discount

- A patient with no insurance will be required to make a deposit of $300 prior to seeing a doctor and will be billed the remaining amount due or receive a refund check if the $300 represents an overpayment.
- A patient who has no insurance will automatically receive a 25% discount off of billed charges. The 25% uninsured discount is not contingent upon payment time frame.

Lab Work

- For all Lab Work performed at Amarillo Urology Associates, L.L.P., it is the patient's responsibility to notify Amarillo Urology Associates, L.L.P. where your health plan dictates your work be sent

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____

Signature of Patient or Responsible Party of Minor Date

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Amarillo Urology Associates, L.L.P.** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount assigned by your insurance provider as "patient responsibility."

Authorization to Release Information

I hereby authorize **Amarillo Urology Associates, L.L.P.** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **Amarillo Urology Associates, L.L.P.** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

AMARILLO UROLOGY ASSOCIATES

LAB AUTHORIZATION

Amarillo Urology Associates performs the following tests in house: Prostate cancer screening and low testosterone diagnostic screening.

ALL OTHER LAB TESTING WILL BE SENT TO LABCORP, BSA OR NWTH.

This decision was made due to the constantly changing preferences of the hundreds of insurance companies we are contracted with and the confusion it causes our staff as well as you, the patient. Each insurance company may have many different plans and each may prefer a different lab. We are not provided this information from the insurance companies. Each individual lab has its own specific collection requirements as well that are difficult to keep up with. If your insurance requires you to utilize another reference lab please notify the medical assistant, nurse or lab personnel that is assisting you. You will be given a written order form to take to the reference lab you require.

We sincerely apologize for any inconvenience this may cause you.

_____I understand and agree to have my lab tests performed at LabCorp, BSA, or NWTH

_____I DO NOT agree to have my lab sent to LabCorp, BSA, or NWTH. I prefer a written order to take to the following lab: _____

_____ _____

Patient Signature **Date**

PHOTO AUTHORIZATION

I authorize Amarillo Urology Associates to take and use my photo as part of my permanent medical record.

_____ _____

Patient Signature **Date**

NOTICE OF PRIVACY PRACTICES

I have been informed that Amarillo Urology Associates, L.L.P. has a Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that upon request, I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative
(Printed Name)

_____
Personal Representative relationship to Patient
(Printed Name)

I authorize that my medical information can be released as follows:

Information to be released to:

_____
Name / Relationship to Patient
(Printed Name)

_____
Signature of Patient

_____
Date

Information to be released to:

_____
Name / Relationship to Patient
(Printed Name)

_____
Signature of Patient

_____
Date

Amarillo Urology Associates, L.L.P.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:
Full Name: _____
Other Name(s) Used: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (_____) _____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:
Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (_____) _____ Fax: (_____) _____

Information regarding person or entity who can receive and use this information:
Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (_____) _____ Fax: (_____) _____

Specific information to be disclosed:
□ Medical Record from (insert date) _____ to (insert date) _____
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
□ Other: _____

Include: (*Indicate by Initialing*)
_____ Drug, Alcohol or Substance Abuse Records
_____ Mental Health Records (Except Psychotherapy Notes)
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:
(Choose all that Apply)
□ Treatment/Continuing Medical Care
□ Personal Use
□ Billing or Claims
□ Insurance
□ Legal Purposes
□ Disability Determination
□ School
□ Employment
□ Other *(Specify)*: _____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____