UNIVERSITY UROLOGY ASSOCIATES of New Jersey
UUANJ

Welcome!

You are scheduled for an appointment with our office and a new patient packet is enclosed. Once completed, please bring the packet with you to your appointment; this will help you through the check in process and improve your patient experience.

Needed for Appointment:

▣ Arrive on time for your scheduled appointment, early if requested.

▣ Be sure to bring the following:

- Photo ID
- Current insurance card
- Co-Payment
- Referral (if required)

▣ Bring copies of:

- Recent test results
- Medical records
- Labs
- X-Ray(s)
- CT Scans
- MRIs

▣ Bring a list of medications with dosage or prescription bottles (including any over the counter medications, vitamins or supplements).

During the visit, your physician will review your medical history, may perform an exam, inform you of the findings and discuss recommended treatment plan.

We look forward to seeing you!

Thank you for choosing UUANJ.

♀

UNIVERSITY UROLOGY ASSOCIATES of New Jersey
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PATIENT REGISTRATION INFORMATION

Name_____
FIRST MI LAST

Race_____ Ethnicity_____ Preferred language_____

Mailing Address:_____ City_____

State_____ Zip_____ Date of Birth_____ Male_____ Female_____

Home Phone (____)_____ Work Phone(_____)_____

Cell Phone (_____)_____ E-mail_____

Please check appropriate space: Minor___ Single____ Married_____ Widowed_____ Divorced____

Patient's or Parent's Employer_____

Business Address_____

Spouse or Patient's Name_____

Are you parent or spouse currently an active member of the military? Yes_____ No____ if yes please

Indicate name, relationship, branch of service_____

Whom may we "thank" for sending you?_____

Allergies_____
DRUGS-FOODS-SEASONAL

Person to contact in case of emergency_____

Relationship_____ Phone (____)_____

RESPONSIBLE PARTY

Person responsible for this account_____ Relationship_____

Employer_____ Phone(_____)_____

Birthdate_____ SS#_____ Work Phone(_____)_____

INSURANCE INFORMATION

Please give your insurance card to our staff so we make a copy of them.

PRIMARY INSURANCE

Company_____

Insurance company address_____

Name of Insured_____ Relationship to Insured_____

SS# of Insured_____ ID#_____ Group_____

How much is your deductible? _____ Insured date of birth? _____

Primary Physician_____ is this managed care program (HMO)? Yes_____ No_____

Primary Physician Address_____

Primary Physician Phone ( ) _____ Group Name_____

SECONDARY INSURANCE

Company_____

Insurance Company Address_____

Name of Insured_____ Relationship to Insured_____

SS# of Insured_____ ID#_____ Group_____

Name of Employer_____ Phone(___)_____

How much is your deductible? _____ Insured date of birth? _____

Primary Physician_____ Is this a managed care program (HMO)? Yes___No__

Primary Physicians Address_____

Primary Physicians Phone (___)_____ Group Name_____

PHARMACY INFORMATION

Pharmacy Name_____ Phone(_____)_____

Pharmacy Address_____

Our office will attempt to assist you with the completion of your insurance claim. However, each patient, not the insurance company, is responsible for payment to this office. Our office cannot accept responsibility for collecting your insurance claims or for negotiating or settlement on a disputed claim.

Due to the increasing complexity of insurance policies regarding PRE-CERTIFICATION, ASSISTANT SURGEON, SECOND OPINIONS, etc., for hospital stays and operations, **YOU ARE RESPONSIBLE** for notifying your insurance company before being admitted to the hospital. This will avoid unnecessary denials or lowering of payment for failing to follow the OBLIGATIONS of YOUR POLICY.

We cannot be responsible for any loss of benefits. It is YOUR RESPONSIBILITY TO KNOW YOUR POLICY.

AUTHORIZATION & RELEASE

I, the undersigned hereby authorize payment of medical benefits to LAKEWOOD UROLOGY, LLC d/b/a UNIVERSITY UROLOGY ASSOCIATES OF NEW JERSEY for any service furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract.

I authorize release of information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

X_____

Signature of patient (or parent if patient is a minor) Date

MEDICARE LIFETIME SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made on my behalf to LAKEWOOD UROLOGY, LLC d/b/a UNIVERSITY UROLOGY ASSOCIATES OF NEW JERSEY for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

X_____

Signature PHOTO COPY AS VALID AS ORIGINAL Date

ASSURANCE OF PRIVACY FOR OUR PATIENT

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulation regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem or improper disclosure of PHI. As part of this plan, we have implemented a Compliance program that we believe will help us prevent any inappropriate use of PHI.

We realize there is always room for improvement! It is our policy to listen to our employees and our patients. If you feel your privacy has been compromised in any way, please ask to speak with our compliance officer or express your concern to tour physician.

Please read the following "Notice of Privacy." After reading, sign and return this form to the receptionist. If you have any questions, please ask. Thank You.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that the personal health information (PHI) is protected for privacy. The privacy Rule provides standards for health care providers to follow when disclosing patient health information that is needed to carry out proper treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum amount of necessary information to only those we feel are in need of your health care information **We strive to the best health care that is in <u>your</u> best interest.**

We also want you to know that we support your full access to your personal medical records. If you want to request restrictions pertaining to parties, you do not want PHI released to please tell our compliance officer and it will documented in your chart. If there is any party that is not directly connected to your treatment, payment, or health care operations that you would like to have your PHI released to, please fill in their name(s)and relationship in the section below.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our compliance officer. You have the right to review our entire privacy policy manual upon request. Please sing this form to acknowledge that you have patient of privacy.

<u>Persons authorized to receive information (HIPAA)</u>

Name_____ Relationship_____

Name_____ Relationship_____

Patient Name: _____

Signature: _____Date:_____

If minor, signature of parent or guardian: _____

Thank you for being one our highly valued patients.

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UNIVERSITY UROLOGY ASSOCIATES of New Jersey

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FINANCIAL RESPONSIBILITY

I hereby authorize payment of my medical benefits billed to my insurance to Lakewood Urology, LLC d/b/a University Urology Associates of New Jersey ("UUANJ"). I accept responsibility for payment for any service(s) provided to me that is not covered by my insurance.

I agree to provide all current insurance information at the time of service including presenting my insurance card.

I agree to pay my co-payment at the time of service.

I agree to pay my account balance, which may include any deductibles, co-insurances or non-covered charges in accordance with my healthcare coverage. All patients are responsible for their in-network deductible and co-insurance. No verbal agreements or waivers will be honored.

I agree to pay for services, which my insurance company defines as non-covered or not medically necessary. If your claim is denied, you are responsible for the payment of the service.

I agree to have a current and active referral at the time of service (if applicable). If at the time of my appointment I do not have my referral, my appointment will be canceled and rescheduled or I will pay cash for my service. UUANJ is not responsible for obtaining referrals and will not call your primary care physician at the time of service.

I agree that I am responsible for knowing the details of my insurance policy and benefit plan. UUANJ is not responsible for obtaining your benefit information.

I agree to have UUANJ appeal my claims to my insurance company on my behalf if a service is denied or if a payment is deemed unreasonable.

We wish to stress that financial responsibility for services rendered is ultimately the responsibility of the patient or his or her family regardless of the nature or extent of insurance coverage. If your insurance provider does not pay your bill in a timely manner, you will be responsible for payment of the bill.

We are required to ask our patients to prove their identity by showing a photo ID and by answering certain questions that only you or your family members would know when you contact us by phone. We appreciate your cooperation with our efforts to protect your identity and comply with federal regulations.

I HAVE READ THE ABOVE STATEMENTS AND AGREE TO THESE TERMS FULLY

X_____

Print Patient Name **Date**

X _____

Patient Signature

UNIVERSITY UROLOGY ASSOCIATES of New Jersey
UUANJ

FINANCIAL INTEREST DISCLOSURE

Dear Patient –

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, chiropractor, or podiatrist inform patients of any significant financial interest held in a health care service.

Accordingly, we wish to inform you that practitioners in this office do have a financial interest in the following health care service (s) to which patients are referred:

- The Surgery Center at Hamilton
  a surgical facility
- New Jersey Kidney Stone Center, LLC
  a provider of lithotripsy, laser and other urology-related services
- Shore Point Radiation Oncology Center
  a provider of radiation oncology services
- Shore Outpatient Surgicenter
  a surgical facility
- Jackson Surgical Center
  a surgical facility
- United Medical Systems
  a provider of lithotripsy and other urology-related services

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading. Please note that you must consult your insurance carrier or other third party payer to determine whether any services or facility fees associated with your visit will be considered to be, and reimbursed at, an "out of network" level.

Acknowledged,

_____ _____

Signature of Patient Date

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CARE TEAM INFORMATION

Patient Name		
Referring Physician	Date of Birth	Today's Date

Which physician(s) are involved with your care? Please include name & phone number below.

Primary Care Provider: (Internal or Family Medicine)	
General Surgeon	
Oncologist (Cancer Doctor)	
Cardiologist (Heart Doctor)	
Pulmonologist (Lung Doctor)	
OB/GYN	
Other:	

Have you had any scans, x-rays or other tests related to your diagnosis?

	Test	**Which Facility**	**Date**
☐	CT Scan		
☐	MRI Scan		
☐	Bone Scan		
☐	Ultrasound		
☐	PET Scan		
☐	Other		

Have you had cancer? ☐Yes ☐No If yes, list below.

Date Diagnosed	**Type of Cancer**	**Treatment Received**

Have you had radiation before? ☐Yes ☐No If yes, where? _____

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BLADDER SYMPTOM QUESTIONNAIRE

Name: _____ Date: _____

Which symptoms best describe you? Check all that apply.

☐ Frequent urination—day, night, or both
☐ Sudden or strong urge to urinate
☐ Leakage with little or no warning—sometimes unable to make it to the bathroom in time
☐ Unable to completely empty bladder—feels like there is more even after going to the bathroom
☐ Accidental leakage with physical activity—exercising, sneezing, or coughing
☐ Bladder or pelvic pain
☐ Problems with bowel function (if checked, please select symptom below)
  ☐ Accidental loss or leakage of stool ☐ Constipation ☐ Other
☐ No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? _____

Have you tried medications to help your bladder symptoms? ☐ Yes ☐ No

If yes, how many different medications have you tried?_____

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle a number.

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Complete Symptom Relief***

Are you still taking any of these medications? ☐ Yes ☐ No

If no, why have you stopped taking them?

☐ Did not work as well as expected ☐ Side effects ☐ Expense
☐ Interaction with other medications ☐ Other

If Side effects or Other checked, please explain:

_____

Behavior modifications tried? _____
(i.e, reduced fluid intake, caffeine reduction, Kegel exercises, physical therapy, or lifestyle changes)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Circle a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Extremely Frustrated***

Are you interested in learning more about additional treatment alternatives to bladder medications?

☐ Yes ☐ No

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PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date_____/_____/_____ **Date of Last Physical Exam**_____/_____/_____

Last Name_____ **First Name**_____**Middle**_____

Social Security No. _____ **Date of Birth**_____/_____/_____

Chief Complaint

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

_____

History of Present Illness

Please answer the following questions

Location of the problem

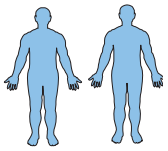
Abdomen Back Leg

Other_____

_____

_____

Front **Back**



On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other_____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other_____

How long does the problem last?

30 minutes 1 hour It is always there

Other_____

Is anything else occurring at the same time?

Yes **No** If yes, please explain.

Nausea Rash Headaches

Other_____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other_____

Does the problem interfere with your normal functions?

Yes **No** If yes, please explain_____

_____

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery **Date**

_____

_____

_____

Do you smoke? **Y** **N**

If yes, how much? _____

Do you drink? **Y** **N**

If yes, how much? _____

Are you on any medications? **Y** **N** **(If yes, list all.)**

_____ _____

_____ _____

Are you on a special diet? **Y** **N** **(If yes, please explain)**

_____

Do you have allergies? **Y** **N** **(If yes, Please explain.)**

_____

_____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5

(OVER)

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Please explain any Yes answers here.

Constitutional Symptoms

Fever	Y	N	Headache	Y	N
Chills	Y	N	Other _____		

Eyes

Blurred Vision	Y	N	Double Vision	Y	N
Pain	Y	N	Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N	Sinus problems	Y	N
Sore throat	Y	N	Other _____		

Respiratory

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

Gastrointestinal

Abdominal Pain	Y	N	Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N	Other _____		

Genitourinary

Urine retention	Y	N	Urinary frequency	Y	N
Painful urination	Y	N	Other _____		

Musculoskeletal

Joint pain	Y	N	Back pain	Y	N
Neck pain	Y	N	Other _____		

Integumentary

Skin rash	Y	N	Boils	Y	N
Persistent itching	Y	N	Other _____		

Neurological

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

Endocrine

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

Cardiovascular

Chest Pains	Y	N	Varicose veins	Y	N
High blood Pressure	Y	N	Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N	Blood clotting problem	Y	N

Other _____

Allergic/Immunologic

Hay Fever	Y	N	Drug allergies	Y	N

Other _____

Psychologic

Are you generally satisfied with you life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other _____

Physician use only: (Comments/Notes)

#Answer Service	Level of
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____ Signature: _____ Date: _____/_____/_____

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Medication List

List all medications that you are currently taking, including over the counter medications (Tylenol, Advil, vitamins, antacids or herbals):

MEDICATION	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

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PATIENT CARE PLEDGE

I _____, _____ acknowledge and understand that
(print last name) (print first name)
even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by the physicians, physician assistants, and nurse practitioners ("Providers") are followed completely in order to increase the likelihood of a positive and healthy treatment outcome. I acknowledge and understand that if any provider in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my Providers.

I understand that if a Provider in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see a specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

_____ _____
Signature Date