



Name \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Preferred language \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Patient/Parent's Employer \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**RESPONSIBLE PARTY & INSURANCE INFORMATION**

**Please give your insurance card(s) to our staff to scan into your chart.**

Person responsible for this account \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

ID Num \_\_\_\_\_

ID Num \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

**PHARMACY INFORMATION (Your care may be delayed if you do not provide your pharmacy information)**

Pharmacy Name \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Pharmacy Address \_\_\_\_\_

Have you recently seen or are you currently seeing another urologist?  No  Yes (list below)

**AUTHORIZATION & RELEASE**

Patient Name: \_\_\_\_\_

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 to 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.

⇒ \_\_\_\_\_  
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 to 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.

⇒ \_\_\_\_\_  
Signature PHOTOCOPY AS VALID AS ORIGINAL Date

**ASSURANCE OF PRIVACY FOR OUR PATIENT**

Our full privacy policy is available in our office and on our website at [www.uuanj.com](http://www.uuanj.com).

**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 provide the best healthcare that is in your best interest.

If you want to request that certain parties not receive your PHI or other records, please let us know, and it will be 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. We may also ask you this question at the window.

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 sign this form to acknowledge that you have been given the opportunity to obtain a copy of the HIPAA privacy rules from us.

**Persons authorized to receive information (HIPAA)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Signature ⇒ \_\_\_\_\_ Date \_\_\_\_\_

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, proof of identity, and social security number (when required).

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.

I agree that financial responsibility for services rendered is ultimately the responsibility of the patient or responsible party regardless of the nature or extent of insurance coverage. If my insurance provider does not pay my bill in a timely manner, I will be responsible for payment of the bill.

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



**Print Patient Name**

**Date**



**Patient Signature**

**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.**



Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

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
- Shore Point Radiation Oncology Center a provider of radiation oncology services
- University Urology Associates of New Jersey – A Surgical Practice located at 1374 Whitehorse Hamilton Sq. Rd. #101, Hamilton, NJ 08690
- New Jersey Kidney Stone Center, LLC a provider of lithotripsy, laser and other urology-related services
- Shore Outpatient Surgicenter a surgical facility
- United Medical Systems a provider of lithotripsy and other urology-related services
- University Lithotripsy Associates of New Jersey 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

Patient Name		
Referring Physician	Date of Birth	Today's Date

Do you have any medication or food allergies?     No     Yes (list below)

Do you currently smoke?  No     Yes    How many packs per day? \_\_\_\_\_ How long? \_\_\_\_\_  
 Have you ever smoked?  No     Yes    How many packs per day? \_\_\_\_\_ How long? \_\_\_\_\_  
 When did you quit smoking? \_\_\_\_\_

Do you currently drink alcohol?  No     Yes    How many drinks per week? \_\_\_\_\_

**What is the reason for your visit today? (Check all that apply)**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Kidney Stones      | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Incontinence   | <input type="checkbox"/> Urinary Problems   | <input type="checkbox"/> Overactive Bladder |  |
| <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Kidney Cancer      |   |  |
- Other \_\_\_\_\_

**Do you have or have had any of the following medical problems?**

- |   |  |   |  |                                 |
|---|--|---|--|---------------------------------|
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD                         | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Depression           | <input type="checkbox"/> Hypothyroidism        | <input type="checkbox"/> Gout   |
| <input type="checkbox"/> Cancer (please specify type) | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Obesity/Weight Issues |                                 |

**Are there any other Medical Problems you are being treated for or have?**

**Please check any of the surgeries listed below you have had with the approximate year**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Hysterectomy _____     | <input type="checkbox"/> Heart Valve Replacement _____ | <input type="checkbox"/> Hip Replacement _____ |
| <input type="checkbox"/> Hernia Repair _____    | <input type="checkbox"/> Appendectomy _____            | <input type="checkbox"/> Cardiac Bypass _____  |
| <input type="checkbox"/> Knee Replacement _____ | <input type="checkbox"/> Colon Resection _____         | <input type="checkbox"/> Cholecystectomy _____ |
| <input type="checkbox"/> Gastric Bypass _____   |  |  |

**Are there any other surgeries you have had? Please list with the year**

**Have you or any relative been diagnosed with:**

Bladder Cancer: **No / Yes** Relationship \_\_\_\_\_  
 Kidney Cancer: **No / Yes** Relationship \_\_\_\_\_  
 Prostate Cancer: **No / Yes** Relationship \_\_\_\_\_  
 Testis Cancer: **No / Yes** Relationship \_\_\_\_\_  
 Kidney Stones: **No / Yes** Relationship \_\_\_\_\_

**WOMEN ONLY:** Number of pregnancies \_\_\_\_\_ No. of deliveries \_\_\_\_\_ Complications? Y / N

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

	Test	Which Facility	Date
<input type="checkbox"/>	CT Scan		
<input type="checkbox"/>	MRI Scan		
<input type="checkbox"/>	Bone Scan		
<input type="checkbox"/>	Ultrasound		
<input type="checkbox"/>	PET Scan		
<input type="checkbox"/>	Other		

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

**For Example: Primary Care, Cardiologist, Nephrologist, etc.**


**List all medications that you are currently taking, including over the counter medications (Tylenol, Advil, vitamins, antacids, or herbals). Please use an additional sheet if required**

MEDICATION	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		

**ELECTRONIC COMMUNICATION CONSENT**

I understand that this practice utilizes electronic communication processes to deliver information to its patients in a timely and cost-effective manner. Cellular telephone calls, text messages, emails, and the online patient portal are utilized to convey information such as appointment reminders, preventive care reminders, patient recalls, patient billing information and statements, practice announcements, and practice newsletters. Information is not sold or distributed outside of our practice. Patients can opt out of the electronic text communication and/or email communication at any time. Patients opting out of electronic communications will not receive appointment reminders and therefore will be subject to a \$25 missed appointment fee.

I wish to Opt-out of electronic messaging



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



## PATIENT CARE PLEDGE

I, \_\_\_\_\_, acknowledge and understand that  
(Print 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 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