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UNIVERSITY UROLOGY ASSOCIATES of New Jersey
UUANJ

PATIENT REGISTRATION INFORMATION

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	Secondary
Insurance_____	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)

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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.

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_____

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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, 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.

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FINANCIAL INTEREST DISCLOSURE

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

☐ Blood in Urine	☐ Elevated PSA	☐ Erectile Dysfunction	☐ Kidney Stones
☐ Incontinence	☐ Urinary Problems	☐ Enlarged Prostate	☐ Infertility
☐ Urinary Tract Infection	☐ Vasectomy Consultation	☐ Overactive Bladder	☐ Testicular Pain
☐ Prostate Cancer	☐ Bladder Cancer	☐ Testicular Cancer	☐ Kidney Cancer

☐ Other_____

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

☐ High Blood Pressure	☐ Diabetes	☐ High Cholesterol	☐ Heart Attack	☐ Stroke
☐ COPD	☐ Asthma	☐ Depression	☐ Hypothyroidism	☐ Gout
☐ Cancer (please specify type)	☐ Bleeding disorder	☐ Radiation Treatments	☐ 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

☐ Heart Valve Replacement_____	☐ Hip Replacement_____	☐ Hernia Repair_____
☐ Appendectomy_____	☐ Cardiac Bypass_____	☐ Cholecystectomy _____
☐ Knee Replacement_____	☐ Colon Resection_____	☐ Gastric Bypass_____

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

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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 R**elationship _____

Kidney Stones: **No / Yes R**elationship _____

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		

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

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Patient Name _____ Date _____ Birthdate _____

IPSS / American Urological Association (AUA) Symptom Index							
1)	**INCOMPLETE EMPTYING** Over the last month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
2)	**FREQUENCY** During the last month, how often have you had to urinate again less than 2 hours after you finished urinating?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
3)	**INTERMITTENCY** During the last month when you urinate, how often have you stopped and started again several times?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
4)	**URGENCY** During the last month, how often have you found it difficult to postpone urination?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
5)	**WEAK STREAM** During the last month, how often have you had a weak urinary stream?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
6)	**STRAINING** During the last month, how often have you had to push or strain to begin urination?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
7)	**NOCTURIA** During the last 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?	Not at all **0**	Times per night **1**	Times per night **2**	Times per night **3**	Times per night **4**	Times per night **5**
	Totals for each column						

Total AUA Symptom Score (Add above column totals together) _____

AUA Symptom Score Scale: 1 – 7 Mild 8 – 19 Moderate 20 – 35 Severe

The Disease Specific Quality of Life Question

The international Prostate Symptom Score uses the same 7 question as the AUA Symptom Index (presented above) with the addition of the following Disease Specific Quality of Life Question (Bother Score) scored on a scale from 0 to 6 points (delighted to terrible)

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 disappointed 4	Unhappy 5	Terrible 6

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SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME:_____ **TODAY'S DATE:**_____

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity	Almost Never or Never	A Few Times (less than half the time)	Sometimes (about half the time)	Most Times (much more than half thetime)	Almost Always orAlways
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (less than half the time)	Sometimes (about half the time)	Most Times (much more than half thetime)	Almost Always orAlways
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (less than half the time)	Sometimes (about half the time)	Most Times (much more than half thetime)	Almost Always orAlways
	0	1	2	3	4	5

_____

Add the numbers corresponding to questions 1-5. **TOTAL:**

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED **8-11 Moderate ED** **12-16 Mild to Moderate ED** **17-21 Mild ED**

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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