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UNIVERSITY UROLOGY ASSOCIATES of New Jersey
UUANJ

PATIENT REGISTRATION INFORMATION

Name_____ Social Security # _____

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

We will make every effort to work with you and your insurance carrier to maximize your health care benefits. It is your responsibility to provide us with accurate and current insurance information at the time of each of your appointments. Please bring your current insurance information with you to each of your services. We regard your complete understanding of your financial obligation an essential element of your care.

APPOINTMENTS: Our office's automated system will call or text ahead of time to remind you of your scheduled appointment. It is the patient's responsibility to remember their appointment and to supply our practice with 24-hour notice if you must cancel your appointment. **Our office will charge a $50.00 missed appointment fee for each missed appointment**.

COPAYS & CO-INSURANCE: All copays & co-insurance are due at the time of service. This is a contractual agreement between you, your insurance, and our practice. If you are not able to meet your financial responsibilities, your appointment will be rescheduled. Please contact your insurance for your benefit allowances. Copays & co-insurance may be higher for specialty services.

DEDUCTIBLES: Deductibles may or may not apply to our services so it is important that you verify your benefits before services are rendered. Based on your insurance benefits, you may be responsible for the cost of the services performed based on the amount of your deductible at the time services are rendered. In these instances, we will request payment or a secured credit card at the time of your appointment. Please contact our office prior to your appointment if you have any questions after you have verified your deductible with your carrier.

PAYMENT PLAN: Patients with a high deductible plan and/or high account balances may qualify for a short-term payment plan. You may be required to have an active credit card on file. Please contact our billing office to discuss.

INSURANCE: Patients must provide all current insurance information at the time of service including presenting their insurance card, proof of identity, and social security number (when required). Patients arriving for their appointment without their insurance cards will be asked to reschedule or remit payment in full. If you are asked to pay in full and insurance information is later obtained and the services are covered, a refund will be issued to you. The patient is responsible for knowing the details of their insurance policy and benefit plan. Any changes to your insurance plan or information should be communicated to our office. UUANJ is not responsible for obtaining your benefit information.

INSURANCE CLAIMS: You will be responsible for any charges that your insurance doesn't cover within 45 days of submission. It is your responsibility to follow up with any unpaid service claims and balances. The patient is responsible for paying for any non-covered services. We can bill primary insurance and a secondary insurance. We do not file third insurance plans.

PAST DUE AND/OR COLLECTIONS: **A service fee of 1.5% per month or 18% per annum will be applied to your balance if the balance is not paid in full within 90 days from the date the first statement is issued**. If your account becomes delinquent or if our attempt to secure the balance or payment fails, the account will be reviewed for placement with a collection agency. If your account is forwarded to an outside collection agency, there will be an added fee of $30.00 added to the account balance. Monthly statements are issued to all patients with an account balance and payment is due upon receipt of the statement. Patients are responsible for all court fees related to balance collections, unless otherwise ordered by a judge.

REFERRALS/AUTHORIZATIONS: Your insurance may require you to obtain a referral or authorization from your primary care physician before you seek services with a specialist. The patient is responsible for contacting the primary care physician to obtain the referral. Our practice is not permitted to see patients without a valid referral per our contractual agreement with carriers. You will be responsible for all denied charges if seen without a valid referral.

PAYMENT METHODS: UUANJ accepts payment by cash, money order, check, or credit/debit card. We accept Visa, Mastercard, and Discover. There will be **a 3% service charge added to all card payments**. **There is a $30.00 service fee for any returned check.** The balance due and the service fee will be required to be paid by the patient in form of a credit/debit card, money order, certified check or cash payment. A personal check for a returned check will not be accepted. We accept payment in-person, over the phone, by mail, or you may use our secure online payment system at http://uuanj.com/pay-bill/.

SELF PAY PATIENTS: Patients who do not have an active or verified insurance plan will be required to pay for services at the time of the service. If you provide us insurance information after the service date, but before the timely filing limitations of that insurance, we will file the claim and reimburse you once your insurance accepts the claim.

MEDICAL RECORDS REQUEST: Our office will provide you or another entity on your behalf a copy of your medical records. You will be required to complete a release of information which can be obtained from our office. **Medical records requested will cost the patient $1.00 per page plus our processing fee of $10.00.**

DISABILITY / FMLA / LIFE INSURANCE FORMS: There will be a one-time processing fee in the amount of $50.00 for the completion of any disability or FMLA paperwork per form. The processing fee will be due the day you present the forms which includes forms sent via online or fax submittal. Any special instructions need to be attached to the form(s).

FINANCIAL ASSISTANCE: Our practice cannot offer financial assistance to patients with active insurance plans. This is due to a contractual agreement we have with your carrier that states patients will be responsible for paying coinsurances, deductibles, and copays as set forth in your policy benefit plans.

I, the undersigned, hereby agree that I have read and understand each of the above financial policies stated. This policy supersedes any verbal agreements or waivers. If I have financial questions or concerns, I will contact the billing office to discuss them. I agree to be financially responsible for any balance due related to services rendered by University Urology Associates of New Jersey or its partners.

⇨ _____ _____

Print Patient Name **Date**

⇨ _____

Patient Signature

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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:

- Bey Lea Ambulatory Surgical 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		
Your Primary Care 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	☐ Glaucoma
☐ 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** Relationship _____

Kidney Stones: ☐ **No** ☐ **Yes** Relationship _____

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

Patient Name _____ Date _____ Birthdate _____

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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

Patient Name _____ Date _____ Birthdate _____

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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 the time)	Almost Always or Always
	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 the time)	Almost Always or Always
	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 halfthe time)	Most Times (much more than half the time)	Almost Always or Always
	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 even with the best
(Print Name)
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