

## NEW PATIENT REGISTRATION



### PATIENT INFORMATION

FIRST NAME	LAST NAME	DATE OF BIRTH	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
SSN	RACE	ETHNICITY	PREFERRED LANGUAGE	
MAILING ADDRESS		CITY	STATE	ZIP
HOME PHONE	CELL PHONE	MARTIAL STATUS		
E-MAIL		PATIENT EMPLOYER		

### CONTACT IN CASE OF EMERGENCY

NAME	RELATIONSHIP	PHONE
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### RESPONSIBLE FOR ACCOUNT (Insurance / Financial Guarantor)

NAME	RELATIONSHIP	PHONE
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### INSURANCE INFORMATION (Please give your insurance card(s) to our staff to scan into your chart.)

PRIMARY INSURANCE	
NAME	
ID NUMBER	
POLICY HOLDER'S NAME	
POLICY HOLDER'S DOB	SS#

SECONDARY INSURANCE	
NAME	
ID NUMBER	
POLICY HOLDER'S NAME	
POLICY HOLDER'S DOB	SS#

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

NAME		PHONE	
ADDRESS	CITY	STATE	ZIP

### HOW DID YOU HEAR ABOUT US?

- ☐ Your physician/PCP
 ☐ Insurance Company
 ☐ Google Search
 ☐ Social Media
 ☐ Family/Friend Referral
 ☐ Other:

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### 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 to me by the provider. 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
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### 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 provider. I authorize any holder of medical information about me to release to *Centers for Medicare and Medicaid Services (CMS)* and its agents any information needed to determine these benefits or benefits payable for related services. This authorization will remain valid for all services provided by this office until revoked by me in writing.

SIGNATURE PHOTOCOPY AS VALID AS ORIGINAL ➡	DATE
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### 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

### PLEASE NOTE

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 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.

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**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 billpay.uuanj.com.

**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.

Patient Signature ➡	DATE
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### FINANCIAL INTEREST DISCLOSURE

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 may have a financial interest in the following health care service(s) to which patients are referred:

- Manchester Surgery Center, 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
- 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.

Signature of Patient ➡	DATE
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Have you recently seen or are you currently seeing another urologist?  <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please list the physician's name(s) and location
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Which physician(s) are involved with your care? Please include name & phone number below.  
For Example: Primary Care, Cardiologist, Nephrologist, etc.

Physician Name	Phone Number
Primary Care Physician:	

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.		

Do you have any medication or food allergies?  <input type="checkbox"/> No <input type="checkbox"/> Yes	List the allergies (if applicable)
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<b>Do you currently smoke?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes How many packs per day? _____ How long? _____	<b>Have you ever smoked?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes How many packs per day? _____ How long? _____	<b>Do you currently drink alcohol?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes How many drinks per week? _____
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What is the reason for your visit today? (Check all that apply)

**Symptoms / Complaints**

- ☐ Blood in Urine
- ☐ Elevated PSA
- ☐ Urinary Problems
- ☐ Incontinence
- ☐ Overactive Bladder
- ☐ Erectile Dysfunction
- ☐ Testicular Pain
- ☐ Other:

**Conditions (Non-Cancer)**

- ☐ Enlarged Prostate
  - ☐ Infertility
  - ☐ Kidney Stones
  - ☐ Urinary Tract Infection
- Procedures / Consultations**
- ☐ Vasectomy Consultation

**Cancers**

- ☐ Prostate Cancer
- ☐ Bladder Cancer
- ☐ Testicular Cancer
- ☐ Kidney Cancer

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

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

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"/> 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"/> Cholecystectomy _____ |
| <input type="checkbox"/> Knee Replacement _____        | <input type="checkbox"/> Colon Resection _____ | <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:  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: |
| ▪ Kidney Cancer:   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: |
| ▪ Prostate Cancer: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: |
| ▪ Testis Cancer:   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: |
| ▪ Kidney Stones:   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Relationship: |

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		

#### 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 missed appointment fee.

Please let our staff know if you wish to opt out of electronic messaging.

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

<b>AUA Symptom Score Scale:</b> 1 – 7 Mild   8 – 19 Moderate   20 – 35 Severe	<b>Total AUA Symptom Score</b> (Add above column totals together)	
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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	Pleased	Mostly Satisfied	Mixed	Mostly disappointed	Unhappy	Terrible
	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

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SEXUAL HEALTH INVENTORY FOR MEN (SHIM)							
PATIENT INSTRUCTIONS							
<p>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.</p> <p>Each question has several possible responses. Circle the number of the response that <b>best describes</b> your own situation. Please be sure that you select one and only one response for <b>each question</b>.</p>							
<b>OVER THE PAST 6 MONTHS:</b>							
		Very Low	Low	Moderate	High	Very High	
<b>1</b>	How do you rate your confidence that you could get and keep an erection?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>2</b>	When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity 0 <input type="checkbox"/>	Almost Never or Never 1 <input type="checkbox"/>	A Few Times (Less than Half the Time) 2 <input type="checkbox"/>	Sometimes (About Half the Time) 3 <input type="checkbox"/>	Most Times (Much More than Half the Time) 4 <input type="checkbox"/>	Almost Always or Always 5 <input type="checkbox"/>
<b>3</b>	During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse 0 <input type="checkbox"/>	Almost Never or Never 1 <input type="checkbox"/>	A Few Times (Less than Half the Time) 2 <input type="checkbox"/>	Sometimes (Less than Half the Time) 3 <input type="checkbox"/>	Most Times (Much More than Half the Time) 4 <input type="checkbox"/>	Almost Always or Always 5 <input type="checkbox"/>
<b>4</b>	During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse 0 <input type="checkbox"/>	Extremely Difficult 1 <input type="checkbox"/>	Very Difficult 2 <input type="checkbox"/>	Difficult 3 <input type="checkbox"/>	Slightly Difficult 4 <input type="checkbox"/>	Not Difficult 5 <input type="checkbox"/>
<b>5</b>	When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse 0 <input type="checkbox"/>	Almost Never or Never 1 <input type="checkbox"/>	A Few Times (Less than Half the Time) 2 <input type="checkbox"/>	Sometimes (About Half the Time) 3 <input type="checkbox"/>	Most Times (Much More than Half the Time) 4 <input type="checkbox"/>	Almost Always or Always 5 <input type="checkbox"/>
<b>Total for each column</b>							

<p>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</p>	<p><b>Total SHIM Score</b>  (Add above column totals together)</p>	
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FIRST NAME	LAST NAME	DATE OF BIRTH
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I acknowledge and understand that 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 of Patient ➡	DATE
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