**Urology Center of Winter Park**

## PATIENT INFORMATION

Patient Name:_____
Home Address:_____
_____Zip_____
Billing Address: Same as above_____
_____Zip_____
Occupation:_____
Employer:_____
Work Phone:_____Ext_____

Home Phone:_____ Cell:_____
SSN:_____
DOB:_____ Age:_____
Gender: ❑ Male ❑ Female
Ethnicity:_____ Language preferred:_____
Hispanic❑ Non-Hispanic ❑ Smoker ❑ Non-Smoker ❑
Marital Status: ❑ Single ❑ Married ❑ Other
Driver's Lic. #:_____ E-mail:_____

Primary Care Physician:_____ Phone:_____
Referring Physician: _____ Phone:_____
Pharmacy: _____ Phone:_____

Emergency Contact:_____
Relationship:_____
Phone:_____

Emergency Contact:_____
Relationship:_____
Phone:_____

### PRIMARY INSURANCE

❑ HMO ❑ PPO ❑ Medicare ❑ Medicaid
Ins. Company Name:_____
Claims Address:_____
_____Zip_____
Phone Number:_____
ID#:_____ Group#:_____
Name of the Insured Party:_____
Insured's SSN:_____DOB:_____
What is the patient's relationship to the Insured Party?
❑ Self ❑ Spouse ❑ Child ❑ Other

### SECONDARY

❑ HMO ❑ PPO ❑ Medicare ❑ Medicaid
Ins. Company Name:_____
Claims Address:_____
_____Zip_____
Phone Number:_____
ID#:_____ Group#:_____
Name of the Insured Party:_____
Insured's SSN:_____DOB:_____
What is the patient's relationship to the Insured Party?
❑ Self ❑ Spouse ❑ Child ❑ Other

**Payment is expected IN FULL at the time services are rendered by the patient or person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide up with complete insurance information at the time of your visit, you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier.**

**I have read and understand the office policy for payment and agree to the terms as stated.**

**Patient or Parent/Guardian Signature**_____ **Date:**_____

**Print Name:**_____

Urology Center
of
Winter Park

**Patient Name: _____ DOB: _____**

## CONSENT FOR EVALUATION OR TREATMENT

**The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.**

_____ _____
**Signature of patient or patient's representative** **Date**

_____ _____
**Patient, Parent, Legal Guardian or Authorized Representative** **Date**

**Printed name of patient's representative:**_____

## INSURANCE ASSIGNMENT

**I hereby authorize my insurance benefits to be paid directly to Urology Center of Winter Park. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.**

**Signature: _____ Date: _____**

## FOR MEDICARE PATIENTS ONLY
## MEDICARE PART B SIGNATURE AUTHORIZATION - LIFETIME

**I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act if correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.**

_____ _____
**Patient Name** **Patient Signature**

_____ _____
**Medicare B #** **Date**

## ADVANCE DIRECTIVE

**I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:**

**{ } I HAVE executed an Advance Directive.**
**(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)**

**Please provide copies of Advance Directive/Living Will to the receptionist to be included in your medical record.**

**{ } I HAVE NOT executed an Advance Directive.**
**(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)**

_____ _____
**Signature** **Date**

Urology Center
of
Winter Park

# PATIENT AUTHORIZATION

**Please Print**

Patient's Name:_____ Date of Birth:_____

Address:_____ Telephone #:_____

Today's Date:_____

## COMMUNICATION USE AND DISCLOSURE AUTHORIZATION

1. Urology Center of winter Park may leave the following messages on answering machines:
   - ☐ Referral Information
   - ☐ Test results
   - ☐ Prescription refill information
   - ☐ Other:_____

2. Urology Center of winter Park may discuss information regarding my treatment and care with the following family members and/or friends:

   _____

3. Urology Center of winter Park may contact me regarding my treatment and care at the following numbers:

   _____

Signature:_____ Date:_____

## AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO UROLOGY CENTER OF WINTER PARK

By signing this Authorization, I hereby authorize and permit the use and/or disclosure of my protected health information for the limited purpose(s), and in the manner, described in this form. In addition, I understand that this authorization is completely voluntary and I am signing it under my own free will. All questions/statements on this form mus be completed.

Physician's office(s) providing the information:_____

Specific description of information to be used/disclosed about me: Demographic information and medical diagnosis.

The patient or the patient's representative must read and initial the following statements:

1. I understand that my health care and the payment for my healthcare will not be affected if I do sign this form.
2. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
3. I understand that this authorization will expire one year from the date I signed this authorization.
4. I understand that I may revoke this Authorization at any time by notifying Urology Center of Winter Park.

_____ _____

Signature of patient or patient's representative Date

Printed name of patient's representative:_____

Witnessed by staff member: _____ Date:_____

**Urology Center of Winter Park**

**Daniel D. Cohen, M.D.**
Urology, Urologic Surgery and Urologic Oncology
**Sean L. Sawh, M.D.**
Urology & Robotic Surgery
**Krissi Reeber, PA-C**

Date: _____

# PATIENT HISTORY FORM
# INITIAL VISIT

NOTE: This is a confidential record and will be kept in your private medical file. The information contained here will not be released to anyone without authorization to do so.

## PLEASE ANSWER ALL QUESTIONS

Last Name:_____ First Name:_____

Date of Birth:_____ Age:_____ Gender: Male_____ Female_____ Married: Y___N___

Why are you here to see the doctor today? _____Children: Yes___ No___Ages:_____

When did this problem begin? _____

How severe is your problem, on a scale of 1 to 10, 10 being most severe? _____

URINARY COMPLAINTS:

| | | | |
|---|---|---|---|
| Do you experience urinary frequency during the day? | N | Y | If yes, how often? |
| Do you wake up at night to urinate? | N | Y | If yes, how often? |
| Have you ever seen blood in your urine? | N | Y | |
| Have you ever had a urinary tract infection? | N | Y | If yes, how often? |
| Do you have to push or strain to begin urination? | N | Y | |
| Does your urinary stream stop and start? | N | Y | |
| Do you experience incomplete bladder emptying? | N | Y | |
| Do you have burning or discomfort with urination? | N | Y | |
| Do you ever have the urge to rush to urinate? | N | Y | If yes, when? |
| Do you ever lose control or leak urine suddenly? | N | Y | |
| Do you ever leak urine when you cough, sneeze, or exercise? | N | Y | |
| Do you wear pads to collect urinary leakage? | N | Y | If yes, how many? |
| Are you bothered by the way that you urinate? | N | Y | |
| Do you have pain associated with your bladder or pelvic area (lower abdomen, vagina, penis, urethra, testicles, or scrotum)? | N | Y | If yes, since when? |

Do you have difficulty:

| | | |
|---|---|---|
| Initiating an erection? | N | Y |
| Maintaining an erection? | N | Y |
| Reaching ejaculation? | N | Y |
| Problem with libido or sex drive? | N | Y |

Rate the quality of your erection 1 to 10 (10 is strongest): 1 2 3 4 5 6 7 8 9 10 (circle one)

Any additional information you would like to tell the doctor? _____

## PAST MEDICAL AND SOCIAL HISTORY
### PLEASE ANSWER ALL QUESTIONS

Please list all of your known medical conditions: _____

Please list all of your past surgeries (including pregnancies): _____

Have you ever had any of the following conditions? Answer *Yes* or *No*

| | | | | | |
|---|---|---|---|---|---|
| High blood pressure | N | Y | High cholesterol | N | Y |
| Diabetes | N | Y | Heart disease | N | Y |
| Heart murmur | N | Y | Stroke | N | Y |
| Cancer | N | Y | HIV | N | Y |
| Kidney stones | N | Y | Kidney infection | N | Y |

Please list all allergies to foods or medications: _____

Are you allergic to IVP dye, Iodine, or shell fish? _____

Please list all medications (with dosage) you are currently taking: _____

_____

Are you currently taking aspirin or products containing aspirin? N Y

Are you taking (circle): Coumadin Plavix Heparin Lovenox Arixtra Persantine Arthritis meds

Have you ever smoked cigarettes? N Y Packs-per-day? _____ Quit date?_____

Do you drink alcohol? N Y Drinks-per-day? _____ Quit date?_____

Do you drink coffee? N Y Cups-per-day? _____

Are you sexually Active? N Y

Any history of sexually transmitted disease (STD) N Y If so, which? _____

Occupation: _____

FAMILY HISTORY:

List all medical conditions that affect any blood-relatives *(specify condition and which relative is affected)*: _____

Is there a family history of: ____prostate cancer ____bladder cancer ____kidney stones

## REVIEW OF SYSTEMS:
### PLEASE ANSWER ALL QUESTIONS

| | | | | | |
|---|---|---|---|---|---|
| **Constitutional Symptoms** | | | **Cardiovascular** | | |
| Fever | Y | N | Chest pain | Y | N |
| Chills | Y | N | Varicose veins | Y | N |
| Headache | Y | N | High blood pressure | Y | N |
| Other:_____ | | | Other:_____ | | |
| **Eyes** | | | **Musculoskeletal** | | |
| Blurred vision | Y | N | Joint pain | Y | N |
| Double vision | Y | N | Neck pain | Y | N |
| Pain | Y | N | Back pain | Y | N |
| Other:_____ | | | Other: _____ | | |
| **Neurological** | | | **Genitourinary** | | |
| Tremors | Y | N | Urinary retention | Y | N |
| Dizzy spells | Y | N | Painful urination | Y | N |
| Numbness/tingling | Y | N | Urinary frequency | Y | N |
| Other:_____ | | | Other:_____ | | |
| **Endocrine** | | | **Respiratory** | | |
| Excessive thirst | Y | N | Wheezing | Y | N |
| Too hot/cold | Y | N | Frequent cough | Y | N |
| Tired/sluggish | Y | N | Shortness of breath | Y | N |
| Other:_____ | | | Other:_____ | | |
| **Gastrointestinal** | | | **Hematologic/Lymphatic** | | |
| Abdominal pain | Y | N | Swollen glands | Y | N |
| Nausea/vomiting | Y | N | Blood clotting problem | Y | N |
| Indigestion/heartburn | Y | N | Other:_____ | | |
| Other:_____ | | | **Females Only** | | |
| **Psychologic** | | | Birth control | Y | N |
| Satisfied with life? | Y | N | Other (Explain):_____ | | |
| Feel depressed? | Y | N | | | |
| Considered suicide? | Y | N | | | |
| Other:_____ | | | | | |

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Urology

# OVERACTIVE BLADDER SHORT FORM QUESTIONNAIRE

Today's Date:_____

Last Name:_____ First Name:_____Date of Birth:_____Age:____

| **OVERACTIVE BLADDER PART A** | **Not At All** | **A Little Bit** | **Some-What** | **Quite A Bit** | **A Great Deal** | **A Very Great Deal** |
|---|---|---|---|---|---|---|
| 1. An uncomfortable **Urge** to urinate? | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. A sudden urge to urinate with **Little or No Warning**? | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. **Accidental Loss** of small amounts of urine? | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. **Nighttime urination**? | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. **Waking up at Night** because you had to urinate? | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. Urine loss associated with a **Strong Desire** to urinate? | 1 | 2 | 3 | 4 | 5 | 6 |
| **TOTAL SCORE, PART A (Lowest = 6, Highest = 36)** | | | | | | |

| **OVERACTIVE BLADDER PART B** | **Not At All** | **A Little Bit** | **Some-What** | **Quite A Bit** | **A Great Deal** | **A Very Great Deal** |
|---|---|---|---|---|---|---|
| 7. Caused you to **Plan "Escape Routes"** to restrooms in public places? | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. Made you feel like there is **Something Wrong** with you? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. Interfered with your ability to get a good **Night's Rest**? | | | | | | |
| 10. Made you frustrated or annoyed about the amount of **Time you spend in the Restroom?** | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. Made you **Avoid Activities** away from Restrooms (e.g. sports exercising) | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. **Awakened** you during Sleep? | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. Caused you to **Decrease your Physical Activity**? (e.g. sports, exercising) | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. Caused you to have **Problems with your Partner or Spouse**? | 1 | 2 | 3 | 4 | 5 | 6 |
| 15. Made you uncomfortable with **Traveling** with others because of needing to stop for a restroom? | 1 | 2 | 3 | 4 | 5 | 6 |
| 16. **Affected your Relationships** with family and friends? | 1 | 2 | 3 | 4 | 5 | 6 |
| 17. Interfered with getting **Amount of Sleep** you needed? | 1 | 2 | 3 | 4 | 5 | 6 |
| 18. Caused you **Embarrassment**? | 1 | 2 | 3 | 4 | 5 | 6 |
| 19. Caused you to **Locate the Closest Restroom** as soon as you arrive at a place you have never been? | 1 | 2 | 3 | 4 | 5 | 6 |
| **TOTAL SCORE, PART B (Lowest = 13, Highest = 78)** | | | | | | |

Urology Center
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# FINANCIAL POLICY

Thank you for choosing Urology Center of Winter Park. We are committed to providing you with the highest quality urologic care. We would like to help you receive the maximum covered benefits offered to you. The following points will help us do that:

1. We must have accurate information from you in order to process your claim correctly.

2. Some services may not be covered by your insurance company as there are many different plans available and not all plans cover all services. It is important that you become familiar with your plan and the coverage it offers you.

3. It is important to know, that even within the same insurance company, different rules apply to different plans, and coverage of services.

4. We believe that the choice for medical treatment should be yours. Should you choose to receive treatment at one of our offices for any service or product not covered by your insurance company, you agree to be responsible for the payment of these charges.

5. Your insurance plan is a contract between you and your insurance company. We file claims to your insurance company as a courtesy to you.

6. Patients with insurances that require authorizations and or referrals (ie. HMO, VA) are responsible to obtain their authorizations and or referrals from their PCP or VA or insurance carrier. Failure to do so may result in cancelled appointment, cancellation fee, or payment responsibility of all services received.

7. Deductibles, co-insurance and or co-payments, as stated in your plan are due at time of service.

8. We may need you to assist us in contacting your insurance carrier to resolve any insurance problems that may arise.

9. Should your insurance company determine a service is non-covered, you will be held responsible for all unpaid balances. If that occurs please refer back to your insurance carrier.

10. SELF PAY patients are responsible for full payment of services at time of service.

11. In case the account is not paid in full within the specified amount of time, it will be rendered to collections. Patient will then be responsible for collection expenses and attorney fees. In addition the account may be charged interest at the legal rate.

12. We require a 24 hour call ahead in case of appointment cancellations, otherwise a **NO SHOW fee** may be assessed.

**We accept CASH, CHECKS, VISA, MASTER CARD, DISCOVER, AND AMERICAN EXPRESS as form of payment. Return check fee is $35.00.**
**The fee to copy Medical Records is $1 per photocopied page plus shipping and handling.**

I have read the above Financial Policy and agree to all terms and conditions as described in it.

Patient's Name:_____

Patient's Signature:_____ Date:_____