Advanced Urology Institute, LLC
Patient Information Sheet

Date: ____________________ SS # ________________________

Date of Birth______________ Age_____ Sex: ___ M___ F Ethnicity __Hispanic/Latino ___ Not Hispanic/Latino

Race: ___White ____Black or African American ___American Indian/Alaskan ___ Asian ___Native Hawaiian ___

Primary Language__________________ Marital Status___ Single___ Married___ Divorced___ Widowed___ Separated

Pt. Name ____
Last Name First Name MI

Address: ____________________________________City______________St _______ Zip________

Summer/Winter Address: ______________________________City______________St_______Zip________

Home Phone ______________________ Cell Phone ______________________ Work Phone ______________________

*Email ________________________________ Employer Name______________________________

Primary Physician: ____________________________ Referring Physician: ____________________________

*Pharmacy:*____________________ *Location:* ____________________ *Phone No.* ____________________

Emergency Contact __________________________ *Address* ______________________*Phone #*____________

Spouse's Name ______________________________ DOB ____________ SS #________________

Address: If different than above ______________________________City______________St _______ Zip________

Home # __________________________ Cell # ______________________ Work # ______________________

Financially Responsible Party: ______________________________________Relationship________________

Primary Ins. Co. ____ Phone ________________
Policy Subscriber Name ______________________________________ DOB ________________
Relationship to Pt.______________SS # __________________Policy # ____________________ Group # ____________

Secondary Ins. Co. ____ Phone ________________
Policy Subscriber Name ______________________________________ DOB ________________
Relationship to Pt.______________SS # __________________Policy # ____________________ Group # ____________

Third Ins. Co. ____ Phone ________________
Policy Subscriber Name ______________________________________ DOB ________________
Relationship to Pt.______________SS # __________________Policy # ____________________ Group # ____________
______________________________ Phone ________________

Authorization to Release Medical Information
I hereby authorize the above physician to release any information
Necessary to process my insurance claim.

Authorization to Pay Benefits.
I hereby authorize lifetime payment of medical benefits to
The above named physician/medical group

Payment for services is expected at the time of service, unless advance payment arrangements have been made. **Insurance is filed as a courtesy.** It does not eliminate the patient's responsibility for payment. I certify the information I have provided is correct.

____
Patient Signature

____
Date

NAME: ______________________
Date of Birth: ______________________
Primary Doctor: ______________________
Who referred you to us? ______________________
Date: ______________________

Reason for Visit:

History:

- Describe Symptoms ______________________
- Describe Previous Treatments ______________________
- Any Recent Lab Tests or X-Rays? ______________________
- Previous Urology Evaluation? ______________________
- Recent ER Visit? ______________________

Allergies:

- List any medicines you are allergic to? ______________________
- Are you allergic to IVP Contrast? Y N
- Are you allergic to Shellfish/Iodine? Y N

Medicine List (Name and Dosage):

- Prescription Drugs ______________________
- Herbal Medicines & Vitamins ______________________
- Do you carry or take Nitroglycerin for Chest Pains/Angina? Y N

Past Medical History:

Diabetes	Y	N	Vasectomy	Y	N
High Blood Pressure	Y	N	Hysterectomy	Y	N
Glaucoma	Y	N	Appendix Removal	Y	N
Kidney Disease	Y	N	Gallbladder Removal	Y	N
Kidney Stones	Y	N	Hernia Surgery	Y	N
Radiation Therapy	Y	N	Chemotherapy	Y	N

- Other Illnesses______________________________
- Other Surgeries______________________________
- Previous Hospitalizations______________________________

Social History:

- Major Occupation (current or previous)____________________
- Are you Retired Y N
- Are you Disabled Y N
- Do you Smoke Y N Quit_____ years ago
  If yes, how many packs per day____________________
  How many years ____________________
- Do you drink Alcoholic Beverages Y N Quit_______years ago
  If yes, how much____________________
- Do you drink Caffeinated Beverages Y N
- If yes, how many per day____________________

Family History:

- Kidney Stones Y N
- Prostate Cancer Y N
- Heart Disease Y N
- Diabetes Y N

Other____________________

Review of Systems: *Circle any of the following symptoms that you have.*

Fever	Chills	Weight Loss	
Blurry Vision	Glaucoma	Cataracts	
Hearing Loss	Sinus Problem/Congestion	Sore Throat	
Chest Pains	Irregular Heartbeats	Swollen Ankles	
Shortness of Breath	Wheezing	Cough	O2 Use
Abdominal Pain	Nausea/Vomiting	Diarrhea	Constipation
Hematuria (blood in the urine)		Urinary Leakage	
Erectile Dysfunction	Decreased Libido		
Chronic Back Pain	Joint Pain	Walks with a Cane or Walker	
Rashes	History of Skin Cancer	Current Skin Lesions	
Numbness	Tingling	Dizziness	Headaches
Depression	Panic Attacks	Poor Memory	

Physician Signature-______________________________ Date-___/___/___

International Prostate Symptom Score (IPSS)

Patient Name:_______________________________ Date:______________

BPH (Benign Prostatic Hyperplasia) is a non-cancerous enlargement of the prostate that occurs in many men over the age of 40.

Determine your BPH Symptoms Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak Stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – 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?	0	1	2	3	4	5
Add Symptom Scores:						

Total International Prostate Symptom Score = ____________

1 - 7 mild symptoms / 8 - 19 moderate symptoms / 20 - 35 severe symptoms.

Regardless of the score, if your symptoms are bothersome you should notify your dector.

Advanced Urology Institute, LLC

Date: __________

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: ____ Date of Birth: __________________

Advanced Urology Institute, LLC is authorized to release protected information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information: Please mark each person/entity that you approve to receive any personal or medical information	**Description of Information to be Released:** Please mark each area of information that may be given to the person/entity listed on the left in the same section.
o Answering Machine	o Messages regarding appointments, lab tests/ x-rays or procedures o Any other information regarding treatment o Any information regarding Medications
o Spouse (Provide Name and DOB) ______________________________	o Billing Information o Financial / Insurance Information o Medical Information (treatments, results, etc)
o Parents/Children (Provide Name and DOB) ______________________________ ______________________________ ______________________________ ______________________________	o Billing Information o Financial / Insurance Information o Medical Information (treatments, results, etc)
o Other (Provide Name and DOB) ______________________________	o Billing Information o Financial / Insurance Information o Medical Information (treatments, results, etc)

EXPIRATION DATE: Provide an expiration date that this authorization will expire. __________________________

If no expiration date is given, this authorization will expire 1 year from the below signature date!

RIGHTS OF THE PATIENT: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Advanced Urology Institute, LLC. I understand that revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____ ______________________

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority: ____

____

ACKNOWLEDGEMENT OF PRIVACY NOTICE

In compliance with HIPPA regulations, I have been given the opportunity to review the Joint Privacy Notice for Advanced Urology Institute, LLC. I understand a copy of this policy is available for me to take home for my records.

____ ______________________

Signature of Patient or Personal Representative Date

Advanced Urology Institute Welcomes the Patient Portal

You will now have the ability to view and maintain your health information online in a secure environment shared between you and your urologist. Please complete and return the form below to get started.

View and Update Your Information.

- Update your address, insurance, and choose a preferred pharmacy to receive your prescriptions
- Update your allergy, medication, and personal history information
- View documentation sent by your urologist such as education material and lab results
- Communicate with your urologist online about future appointments or questions you may have

Patient Portal Sign In Is Easy

The first step is to give us your email address. We will email you instructions on connecting to the patient portal. Sign in to your Patient Portal with the provided temporary password. The temporary password will be valid for 72 hours prior to your appointment, after which a new one will have to be requested.

- Sign in to your Patient Portal account by selecting the link shown below.
- You will be asked to verify your identity.
- Enter your e-mail address and you will be asked to enter a new password. Choose a password that is easy for you to remember. Follow the password rules to make your password more secure.
- The temporary link will be valid for 72 hours from the time of this email, after which a new password will have to be requested.

To set your password type this link or copy and paste it into your browser:
https://patientportal.intrinsiq.com/PatientPortal/Practices/500206/patient/Login

Your temporary password is $PortalPassword

See you online,

Your Patient Portal Team

Name:____

Date of
Birth:____

email:____

FINANCIAL POLICY OF ADVANCED UROLOGY INSTITUTE

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, personal checks, MasterCard, Visa and Discover.

Returned checks are subject to a service charge of $25.00 and you may lose your privilege to write checks in our office

PRIVATE INSURANCE COMPANIES THAT WE "ARE" A PROVIDER WITH. Co-payment and deductible must be paid at the time of service. If we are unable to verify your insurance coverage, you may be responsible for full payment at the time of the service. Because we are under contract with the insurance company, we will file your insurance claim. If payment is not received from your insurance company within a reasonable time, the full balance will be transferred to the responsibility of the patient (or guardian).

If you provide us with incorrect or invalid insurance information and we need to re-enter and resubmit your corrected insurance information, there may be a $20.00 administrative charge for each claim that has to be refiled

PRIVATE INSURANCE COMPANIES THAT WE "ARE NOT" A PROVIDER WITH. You will be responsible for payment in full at the time of service and our office will file the claim form as a courtesy with your insurance company.

MEDICARE. Your deductible and 20% of the allowable charges are due at the time of service. Since we are a Medicare provider, we will file your Medicare. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare processes the claim. If you have a secondary insurance policy, we will file the claim as a courtesy

CHILDREN OF DIVORCED PARENTS. Payment will be due from the person who is with the child today no matter who is responsible by divorce decree.

MISSED APPOINTMENTS. We ask for 24 hour's notice to cancel an appointment. Patients who do not call to cancel an appointment may be charged $25. A third no-show may result in the patient being discharged from the practice.

FORMS AND RECORDS. For completion of any forms ie., Disability, Cancer Policies, FMLA, etc. there will be a $25 charge. For records, the fee is $1 per page for the first 25 pages and .25 thereafter Records will also require a records release signed prior to release. Forms and records will only be released after the payment has been collected.

FINANCIAL AGREEMENT. We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (such as elective sterilization, infertility evaluation, screening lab tests, etc.).

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account after 90 days, including those that your insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our billing department at (386) 274-1947.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the Financial Policy.

Signature (Patient, Guardian, or Power of Attorney) Date

AI 9215 PPI 16

EXPRESS CONSENT FOR DNA COLLECTION, ANALYSIS, AND DISCLOSURE

I understand that DNA analysis is often used in medical diagnosis and treatment, and that my Advanced Urology Institute, LLC (AUI) provider may recommend the collection and retention of a biological sample (including but not limited to urine, blood, saliva, or tissue (for example a biopsy)) for such an analysis. The analysis may be conducted in an AUI lab or sent to a third-party lab. The lab will send the results of your analysis to your AUI provider, who may share it with other providers. Common uses of DNA analysis include assisting in the diagnosis and treatment of urologic cancers or understanding the risk of cancer in patients or their family. Examples of testing that involve DNA analysis include Hereditary Cancer Panels (sometimes called Germline testing), Prostate Cancer genomic testing (Prolaris, Oncotype DX, Decipher, Confirm MDx), Fluorescence in situ hybridization (FISH), and testing for certain genes to aid in treatment choice (for example ARV7 testing in Prostate Cancer, in general known as Somatic testing). I understand that the results of a DNA analysis are my exclusive property, are confidential, and may not be disclosed without my express consent. I understand that I am entitled to receive a clear and prominent disclosure regarding the manner of collection, use, retention, maintenance, or disclosure of a DNA sample or results of a DNA analysis for specified purposes.

I authorize AUI to collect, use, disclose, and re-disclose my DNA sample and the results as needed for treatment, payment, health care operations purposes, and as otherwise permitted by law and AUI's HIPAA Notice of Privacy Practices. I further authorize AUI to use, disclose, and re-disclose my de-identified DNA sample and DNA analysis for quality, operational, educational, research, or commercial purposes. Commercial purposes can include the sale of de-identified data. The term de-identified means that we have removed your name and certain other identifiers required to be excluded by applicable law, but potentially assigning the information a key code in accordance with an institutional review board approved coding system. In no instances will your personally identifiable results be disclosed other than as authorized by you or as required by applicable State and Federal law. The results will be maintained in my records for as long as AUI elects to retain them.

I understand that my DNA sample may be sent to a laboratory for analysis, and I request that the laboratory send the results of my DNA analysis and genetic testing to AUI. Neither AUI nor the laboratory will use my information to grant or deny any insurance, employment, mortgage, loan, credit or educational opportunity, although a *diagnosis* made from genetic test results could affect certain insurance or insurance rates, and laws against genetic discrimination may not apply to the military. My physician may not be able to determine if changes in my genes caused my health condition, or whether they will cause a health problem in the future. Genetic testing and DNA analysis may change over time as technology develops. I understand my samples or results might not be re-analyzed in the future, even if new technology would give different results.

By signing below, I give my DNA sample to AUI, and it may be discarded or retained by AUI or laboratories as they deem appropriate, and I agree that I am giving up any property or other interest in the DNA sample.

I agree that I have received a clear and prominent disclosure regarding the manner of collection, use, retention, maintenance and disclosure of my DNA sample or the results of my DNA analysis for specified purposes.

I expressly consent to the collection and retention of a DNA sample and transmission of the DNA sample to laboratories if my AUI provider so recommends for diagnosis and treatment for a specified purpose.

I expressly consent to the analysis of a DNA sample by AUI or a third-party laboratory if my AUI provider so recommends for diagnosis and treatment for a specified purpose.

I expressly consent to the disclosure of the results of the DNA analysis to AUI and my physicians and/or a third party for specified purposes including treatment, payment, and health care operations. I expressly consent to the use and disclosure of my de-identified DNA sample and DNA analysis for quality, operational, educational, research, or other commercial purposes.

____

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required) RELATIONSHIP TO PATIENT

____

PRINTED NAME OF PATIENT DATE OF BIRTH

DATE:________________ TIME:__________A.M./P.M.

General Consent to Diagnosis and Treatment

I, the undersigned, for myself or another person for whom I have authority to sign, hereby consent to medical care (including disclosing my history, having a physical exam performed upon me, diagnostic testing, and treatment with medication or minor surgery), as ordered by a provider, while such medical care and treatment is provided through Advanced Urology Institute (AUI) on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary. This consent extends to all AUI providers and office locations. I understand that this consent is continuing in nature- even after a diagnosis has been made or treatment begun.

Specific Consent for Genital or Pelvic Examination:
I specifically consent to have a genital exam performed on me if my AUI provider so recommends. For males, this consent includes an examination of the external genitals and the prostate gland; for females, this consent includes a pelvic exam: the external genitals and the internal genitalia (vagina, cervix, uterus, fallopian tubes, ovaries, and rectum). I understand that I will sign a separate consent that is specific to a provider and date, and I may withdraw this consent at any time.

Consent for Specific Procedures
I understand that some specific office or hospital procedures involve additional benefits and risks, and I may be asked to sign a separate consent form for those procedures- if deemed necessary by my AUI provider. I understand that I have the right to discuss a treatment plan with my provider, and I have the right to refuse specific diagnostic tests or treatment procedures.

Consent for Health Information Exchange
I grant permission to my AUI Provider to download and exchange medical information about me- including but not limited to past and current medications, lab and radiology test results, hospitalizations, and visits to other providers participating in such exchanges- in order to ensure that my medical history is complete and accurate. This authorization will remain in effect until my death or the day I withdraw my permission. I understand that AUI may only disclose my protected health information (PHI) according to federal and state laws and the separate authorization to use and disclose PHI.

Consent for DNA Testing

EXPRESS CONSENT FOR DNA COLLECTION, ANALYSIS, AND DISCLOSURE
I understand that DNA analysis is often used in medical diagnosis and treatment, and that my AUI provider may recommend the collection and retention of a biological sample (including but not limited to urine, blood, saliva, or tissue (for example a biopsy) for such an analysis. The analysis may be conducted in an AUI lab or sent to a third party lab. The lab will send the results of your analysis to your AUI provider, who may share it with other providers. Common uses of DNA analysis include assisting in the diagnosis and treatment of urologic cancers, or understanding the risk of cancer in patients or their family. Examples of testing that involve DNA analysis include Hereditary Cancer Panels (sometimes called Germline testing), Prostate Cancer genomic testing (Prolaris, Oncotype DX, Decipher, Confirm MDx), Fluorescence in situ hybridization (FISH), and testing for certain genes to aid in treatment choice (for example ARV7 testing in Prostate Cancer). I understand that the results of a DNA analysis are my exclusive property, are confidential, and may not be disclosed without my express consent. I understand that I am entitled to receive a clear and prominent disclosure regarding the manner of collection, use,

retention, maintenance, or disclosure of a DNA sample or results of a DNA analysis for specified purposes.

I authorize AUI to use, disclose, and re-disclose my DNA sample and the results as needed for treatment, payment, health care operations purposes, and as otherwise permitted by law and AUI's HIPAA Notice of Privacy Practices. The results will be maintained in my records for as long as AUI elects to retain them. I understand that my DNA sample may be sent to a laboratory for analysis, and I request that the laboratory send the results of my DNA analysis and genetic testing to AUI. Neither AUI nor the laboratory will use my information to grant or deny any insurance, employment, mortgage, loan, credit or educational opportunity, although a *diagnosis* made from genetic test results could affect certain insurance or insurance rates, and laws against genetic discrimination may not apply to the military. My physician may not be able to determine if changes in my genes caused my health condition, or whether they will cause a health problem in the future. Genetic testing and DNA analysis may change over time as technology develops. I understand my samples or results might not be re-analyzed in the future, even if new technology would give different results. By signing below, I give my DNA sample to AUI and it may be discarded or retained by AUI or laboratories as they deem appropriate, and I agree that I am giving up any property or other interest in the DNA sample.

I agree that I have received a clear and prominent disclosure regarding the manner of collection, use, retention, maintenance and disclosure of my DNA sample or the results of my DNA analysis for a specific purpose.

I expressly consent to the collection and retention of a DNA sample and transmission of the DNA sample to laboratories if my AUI provider so recommends for diagnosis and treatment for a specified purpose.

I expressly consent to the analysis of a DNA sample by AUI or a third party laboratory if my AUI provider so recommends for diagnosis and treatment for a specified purpose.

I expressly consent to the disclosure of the results of the DNA analysis to AUI and my physicians and/or a third party for a specified purpose including treatment, payment, and health care operations.

I further understand during the course of my care it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis that does <u>not</u> involve the examination of your DNA, but from which DNA could potentially be extracted to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements. It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal. By signing this document, I affirmatively state that it is my intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with AUI to a third party as set forth above.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required):

____

DATE:______________________________TIME:___________________________A.M./P.M.

ADVANCED UROLOGY INSTITUTE

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be used or disclosed
The information covered by the authorization includes:
____
____

Purpose for disclosure: ______________________________

Records requested from:

Dr. ______________________________

Address: ______________________________

Phone #: ______________________ Fax #: ______________________

Records to be sent to:

Dr. ______________________________

Address: ______________________________

Phone #: ______________________ Fax #: ______________________

Expiration Date of Authorization
This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Advanced Urology Institute HIPAA Privacy Officer.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

____
Name of Patient (Print or Type) DOB/Social Security #

____
Signature of Patient Date

____
Signature of Patient Representative Relationship of Patient Representative to Patient

____
Witness Person Completing Request Date Sent