ATLANTA UROCARE, P.C.
REGISTRATION FORM

Today's date:				PCP:	

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Race: (circle one) African American / Asian / Caucasian/ Hispanic / Other /			Ethnicity: Non-Hispanic/ Hispanic

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ( )	

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]
❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ATLANTA UROCARE, P.C. or insurance company to release any information required to process my claims.

____________________ __________
Patient/Guardian signature *Date*

ATLANTA UROCARE, P.C.

OFFICE POLICIES

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance and/or government benefits be paid directly to the physician. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Atlanta UroCare, P.C. to release information, including medical records to my insurance company concerning my illness and/or treatment.

PAYMENT POLICY FOR CONTRACTED INSURANCES

I understand that all co-pays, co-insurance and deductible are due at the time services are rendered. I understand and agree that I am responsible for any additional balance of charges incurred for services rendered once the insurance pays. All services will be filed first with your insurance company. Once the insurance company pays, a total of three statements will be forwarded to you. This balance is due upon receipt of your statement.

ACCOUNT BALANCES

I understand should it be necessary to place my account with an outside collection agency. I will be responsible for the account balance plus a collection agency fee of the outstanding balance.

SELD-PAY PATIENTS OR NON-CONTRACTED INSURANCES

I understand and agree that I am responsible for the full amount of the charges at the time the services are rendered by the physicians.

ADMINISTRATION FORM AND NO SHOW APPOINTMENT FEES

I understand there is a $25.00 fee for following services completed by our office to include but not limited to FMLA forms, Disability forms, Medical records request and other forms requiring the staff completion.

I understand there is a $25.00 fee for confirming an appointment and not cancelling the appointment with the Physician within 24 hours' notice of the appointment time. Same policy applies to surgery appointments; however the fee charged will be $75.00. This charge will not be billed nor paid by your insurance company.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, ______________________________________ acknowledge that I have:

- Received a copy of Atlanta UroCare, P.C. notice of Privacy Practices.
- Declined the offered copy of Atlanta UroCare, P.C. Notice of Privacy Practices. A copy of our Notice of Privacy Practices is available at atlurocare.com.

____

Patient Name

____ ____________________

Patient Signature Date

ATLANTA UROCARE, P.C.

CONSENT TO ROUTINE PROCEDURES AND TREATMENT
Do not sign this form without reading and understanding its contents

During the course of my care and treatment, I understand that various types of test, diagnostic or treatment "Procedures" may be necessary. These "Procedures" may be performed by the Physicians, Nurses, Technicians, or other Allied healthcare professionals. While routinely performed without incidents, there may be material risks associated with each of these procedures. I understand that it is not possible to list every risk for every procedure and that this form only attempts to identify the most common material risks and alternatives (if any) associated with the procedures. I also understand that various Healthcare Professionals may have different opinions as to what constitutes material risks and alternative procedures.

The procedures may include, but are not limited to the following:

1. **Physical tests, assessments, and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range fo motion checks, and other similar procedures. The material risks associated with these types of procedures include, but are not limited to , allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis disfiguring scar, worsening of the condition and death. Apart from using modified procedures and/ or refusal of treatment, no practical alternatives exist.

2. **Needle sticks** such as shots, injections, intravenous lines or injections. The material risks associated with these types of procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

3. **Administration of medications** whether orally, rectally, topically or through the eye, ear, or nose. The material risks associated with these types of procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/ or refusal of treatment, no practical alternatives exist.

4. **Drawing blood, bodily fluids or tissue samples** such as that done for laboratory testing and analysis. The material risks associated with this type of procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/ or refusal of treatment, no practical alternatives exist.

5. **Insertion of Internal Tubes** such as bladder catheterizations, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/ or difficulty urination after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

6. **Looking into the Bladder and Urethra with Telescope (Cystoscopy**). The material risks associated with these procedures include, but are not limited to, infection of bladder requiring antibiotics, finding an unsuspected cancer requiring additional therapy, and mild burning or bleeding after procedure. Alternative therapy may include further x-rays or ultrasound studies.

By signing this form:

- ✔ I consent to Healthcare Professionals performing procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained; and
- ✔ I acknowledge that I have been informed in general terms of the nature and purpose of the procedures; the material risks of the procedures, and practical alternatives to the procedures. I understand that the Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, therefore, I agree to provide accurate and complete information about my medical history at all times.
- ✔ If I have any questions or concerns regarding these procedures, I will ask my Physicians to provide me with additional information. I also understand that my Physician may ask me to sign additional Informed Consent documents. I understand that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES** have been made to me concerning the outcome and/ or result of any procedures.

Signature of Patient (or authorized person to sign): ____

Printed Name of Patient: ____

Reason Patient is Unable to Sign (if applicable) ________________________ **Date** ________________________

ATLANTA UROCARE, P.C.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HIPPA provides specific guidelines to protect patient's privacy and in an effort to provide efficient, quality, patient friendly medical care please complete the following authorization to disclose your medical information.

VOICEMAIL AUTHORIZATION

I authorize Atlanta UroCare, P.C. its Physicians and employees to leave detailed messages on the phone number(s) listed below. I understand that once a voicemail message exists it is no longer covered under HIPPA and therefore is NOT protected from unauthorized access.

Home Voicemail: ☐ Yes ☐ No **Number:** ( ) ____________________________

Work Voicemail: ☐ Yes ☐ No **Number:** ( ) ____________________________

Cell Voicemail: ☐ Yes ☐ No **Number:** ( ) ____________________________

REQUEST FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Atlanta UroCare, P.C., its Physicians and employees to disclose my health information to the following person(s).

Name: ________________________________ **Number:** ________________________ **Relationship:** _____________

Name: ________________________________ **Number:** ________________________ **Relationship:** _____________

Name: ________________________________ **Number:** ________________________ **Relationship:** _____________

MEDICATION HISTORY CONSENT

Atlanta UroCare, P.C. electronically requests access to your medication history which lists the prescription medicines that we or other Physicians have prescribed to you. This list is collected from a variety of sources including your pharmacy and health insurer. An accurate medication history will allow our Physicians to treat you properly and avoid potentially dangerous drug interactions.

☐ I **authorize** Atlanta UroCare, P.C. to electronically request my medication history.

☐ I **do not authorize** Atlanta UroCare, P.C. to electronically request my medication history.

I understand that this authorization can be revoked at any time by submitting a written request to the practice. This authorization to release detailed health information will expire one (1) year from the effective date listed above.

Patient Name (Please Print): ____ **DOB:** _______________________

Patient Signature: ____ **DOB:** _______________________

ATLANTA UROCARE, P.C.
PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Name:____ **DOB:** ___________ **Age:** __________ **Sex:** _________

Primary Care MD: ______________________________ **Referring MD:** __________________________________

HISTORY OF PRESENT ILLNESS

Chief Complaint: ____

Where is the problem? ____

When did you first notice the problem? ____

When does it occur? ____

Does anything help or make the problem worse? ____

Does the problem interfere with your normal functions? (Please circle one) **YES NO** If yes, please explain
____

PAST MEDICAL AND SOCIAL HISTORY

List all serious illnesses in your immediate family. (Example: Diabetes, Heart Disease, High Blood Pressure, Asthma etc.)

____________________________ ____________________________ ________________________________
____________________________ ____________________________ ________________________________
____________________________ ____________________________ ________________________________

List any personal current or past Illnesses and dates they occurred

____________________________ ____________________________ ________________________________
____________________________ ____________________________ ________________________________

List any personal current or past Surgeries and dates they occurred

____________________________ ____________________________ ________________________________
____________________________ ____________________________ ________________________________
____________________________ ____________________________ ________________________________

Do you smoke? (Please circle one) **YES NO How long?** ____ **How much?** _____ **When did you quit?** _____

Do you drink? (Please circle one) **YES NO How long?** _____ **How much?** ____ **When did you quit?** _____

Are you on any medications? (Please circle one) **YES NO** (IF YES, PLEASE LIST ALL INCLUDING OTC MEDICATIONS)

____________________________ ____________________________ ________________________________
____________________________ ____________________________ ________________________________
____________________________ ____________________________ ________________________________
____________________________ ____________________________ ________________________________
____________________________ ____________________________ ________________________________

Do you have any medication allergies? (Please circle one) **YES NO** (IF YES, PLEASE LIST)

____________________________ ____________________________ ________________________________
____________________________ ____________________________ ________________________________

Physician Notes:
____
____
____
____

ATLANTA UROCARE, P.C.

URINARY SYMPTOMS

How often have you experienced the following symptoms?

0-Never 1-Occasionally 2-Less than half 3-Half 4-More than half 5-Almost always

1. **Incomplete Emptying**
   How often have you had a sensation of not emptying your bladder completely after you finished urinating?

   0 1 2 3 4 5

2. **Frequency**
   How often have you had to urinate again less than 2 hours after you finished urinating?

   0 1 2 3 4 5

3. **Intermittency**
   How often have you noticed you stopped and started again several times when you urinated?
   0 1 2 3 4 5

4. **Urgency**
   How often have you found it difficult to postpone urination?
   0 1 2 3 4 5

5. **Weak Stream**
   How often have you had a weak urinary stream?
   0 1 2 3 4 5

6. **Hesitancy**
   How often have you had to push or strain to begin urination?
   0 1 2 3 4 5

7. **Nocturia**
   How many times do you typically get up to urinate from the time you went to bed at night until the time you get up in the morning?
   0-None 1- 1 time 2- 2 times 3- 3 times 4- 4 times 5- 5 times or more

   0 1 2 3 4 5

8. 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?
   0-Delighted 1- Pleased 2- Mostly Pleased 3- Mixed 4- Mostly Dissatified 5- Unhappy 6- Terrible

   0 1 2 3 4 5 6

Do you leak urine? (Please circle one) **YES NO**

For how long? ___________________

Do you wear protective pads? (Please circle one) **YES NO** If yes, how many per day? **1 2 3 4 5 or more**

Do you leak with coughing, laughing, exercising, or etc.? (Please circle one) **YES NO**

Do you leak when running water, standing up, putting a key in a door or infection? YES NO

When urinating, can you stop your stream? YES NO

Do you lose urine while sleeping? YES NO

Are you bothered by a strong sense of urgency to void? YES NO

ATLANTA UROCARE, P.C.

REVIEW OF SYSTEMS

Please circle if you are experiencing any of the following symptoms:

GENERAL:	EYES:	BLOOD/LYMPH:	ENT:
Chills	Blurred Vision	Bleeding	Ear Infection
Fever	Double Vision	Bruising	Sore Throat
Weight Loss	Cataract	Hepatitis	Sinus Problems
Weight Gain	Glaucoma	Wounds won't Heal	Dizziness
Fatigue	Burning	Swollen Glands	Hearing Loss
None	None	None	None

GASTROINTESTINAL:	PULMONARY:	NEUROLOGIC:	PSYCHIATRIC:
Blood in stool	Cough	Headache	Anxiety
Constipation	Oxygen Use	Seizure	Depression
Diarrhea	Shortness of Breath	Stroke	Memory Loss
Hemorrhoids	Sleep Apnea	Weakness	Mood Swings
Nausea	Wheeze	None	None
Pain	Tuberculosis		
None	None		

ENDOCRINE:	MUSCULOSKELETAL:	BREAST:	OB/GYN:
Appetite Changes	Joint Swelling	Lumps	Abnormal Periods
Diabetes	Muscle Loss	Nipple Discharge	Birth Control Pill Use
Heat/Cold Intolerance	Pain	Pain	Hot Flashes
Thirst	Stiffness	Skin Changes	Pregnant
None	None	None	

CARDIOVASCULAR:	SKIN:	GENITOURINARY:
Chest Pain	Color Change	Blood in Urine
Fainting	Hair Loss	Burning with Urination
Palpitations	Moles	Difficulty Urinating
High Blood Pressure	New Lesions	Discharge
None	Rash	Unable to Urinate
	None	Kidney Stones
		Pelvic Pain/Pressure
		Sexual Problems
		Urinary Tract Infection How many per year? 1 2 3 4 5 or more
		None

Physician Notes: ______________________

____

____

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ATLANTA UROCARE, P.C.
777 CLEVELAND AVENUE SUITE 604
ATLANTA, GEORGIA 30315
OFFICE (404) 768-6611
FAX (404) 768-3454

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name____

Patient's Address____

Date of Birth____________________________ **Contact Number**__________________________________

I hereby authorize Atlanta UroCare, P.C. to:

<u>RELEASE</u> all medical records pertaining to me:

(With the exception of alcohol and drug abuse and

Or HIV/AIDS related information)

<u>OBTAIN</u> all medical records pertaining to me from:

Name________________________________

Address ________________________________

Phone________________________________

Fax________________________________

For the purpose of: (Please circle one)

Moving Away **Personal Copy** **Transfer to New Physician**

Second Opinion **Another Treating Physician** **Other**________________________________

The records should be:

______ Sent to my home address on file

______ Sent to Atlanta UroCare, P.C.

______ Sent to the following person (s)

Name____

Address____

City State Zip____

Phone______________________________ **Fax**______________________________

This Authorization shall remain in effect until revoked by me in writing. If not revoked by me in writing, the Authorization shall remain in effect for one (1) year from the date of the signature below. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this Authorization Form. I understand that if I wish to revoke this Authorization, I must do so in writing and present my written revocation to Atlanta UroCare, P.C. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I need not sign this Authorization in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules.

Patient Name **Date of Birth** **Social Security Number**

____

Signature **Date** **Relationship to Patient**

When a representative of the patient signs this form, the representative must provide a description of such representative's authority to act for the patient: ____.