Northeast Urologic Surgery, P.C.

Patient History Form

Today's Date _____/_____/_____

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

Date of Last Physical Exam ____/_____/_____

Last Name _____ First Name_____ Middle _____

Social Security No. _____ Date of Birth _____/_____/_____ Family Physician _____

Chief Complaint—What is the main reason for your visit today? Please describe your problem in detail.

_____

_____

_____

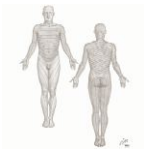
History of Present Illness– Please answer the following questions.

Location of the Problem

Abdomen Back Leg Genitals

Other _____

_ _____



On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other _____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other _____

How long does the problem last?

30 minutes 1 hour It is always there

Other _____

Is anything else occurring at the same time?

Yes No If yes, please explain

Nausea Rash Headaches

Other _____

Is the problem constant or variable?

Dull then sharp Very sharp then leaves Always there

Does the problem interfere with your normal functions? Y N
If yes, please explain_____

_____

Other _____

Past Medical and Social History–

Please list all serious illnesses in your immediate family. (Examples: diabetes, tuberculosis, breast cancer, heart disease, etc…)

_____

If Tuberculosis, confirmation of cure date _____ Smoking? Y- # packs_____N Alcohol: Y- frequency_____N

_____

Please list any **personal past illnesses** and /or surgeries and when they occurred._____
_____
_____
_____
_____
_____
_____

Are you on any medications? If yes, please list all medications:_____/_____
_____ /_____
_____/_____
_____/_____
_____ /_____
_____/_____

Do you have allergies? Y or N If yes, please list all.

Physician's Use Only (comments/Notes)	# Answers	Level of Service
	0	1 or 2
	1—2	3
	3	4—5

Northeast Urologic Surgery, P.C.

Review of Systems

Last Name_____

First Name_____

Do you now have or have you experienced any problems related to the following systems during the last six months? Circle **Yes** or **No**.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other _____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other _____

Allergic / Immunologic

Hay fever	Y	N
Drug allergies	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other _____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/ heartburn	Y	N

Other _____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other _____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other _____

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N

Other _____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other _____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other _____

Hematological/Lymphatic

Swollen glands	Y	N
Blood clotting problems	Y	N

Other _____

Psychological

Are you generally satisfied with your life? Y N

Do you feel severely depressed? Y N

Have you considered suicide? Y N

Other _____

Physician's Use Only (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10 +	4 or 5

Provider _____ Date _____/_____/_____

NORTHEAST UROLOGIC SURGERY, P.C.

STEVEN R. PREVITE, M.D., F.A.C.S.
LIAM J. HURLEY, M.D., F.A.C.S.
GEORGE E. CANELLAKIS, M.D., F.A.C.S.
OSSAMA E. SAKR, M.D., F.A.C.S.
CHRISTOPHER P. IP, M.D.
CHRISTIE KLISZ, A-N.P.

PATIENT'S NAME _____ MALE FEMALE
(FIRST) (LAST) (M.I.)

SOCIAL SECURITY # _____-_____-_____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PH: _____ WORK PH: _____ CELL PH: _____

MARRIED _____ (if yes, spouse's name _____ Date of birth _____)
SINGLE _____ SEPARATED _____ DIVORCED _____ WIDOWED _____

PRIMARY CARE PHYSICIAN _____ REFERRED BY _____

PHARMACY NAME _____ PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

CONTACT (IN CASE OF EMERGENCY) _____ CONTACT PH: _____

RESPONISBLE PARTY (PARENT/LEGAL GUARDIAN) _____ RELATIONSHIP _____
SOCIAL SECURITY # _____-_____-_____ DATE OF BIRTH _____
ADDRESS (IF DIFFERENT THAN ABOVE) _____

LIST ALL INSURANCE PLANS PRIMARY AND SECONDARY

PRIMARY INSURANCE NAME _____

SECONDARY INSURANCE NAME _____

PLEASE SHOW YOUR INSURANCE CARD(S) AND PICTURE IDENTIFICATION TO THE RECEPTIONIST UPON COMPLETION OF FORM.

**********CO-PAYMENT IS DUE AT TIME OF YOUR OFFICE VISIT**********

If a REFERRAL is required by your primary care physician, it is YOUR responsibility to obtain one PRIOR to your visit.

	AUTHORIZATION TO PAY BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO NORTHEAST UROLOGIC SURGERY, PC FOR SERVICES RENDERED. REALIZING I AM RESPONSIBLE TO PAY ANY BALANCE NOT PAID OR NOT COVERED BY MY INSURANCE.	DATE / /
	AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE NORTHEAST UROLOGIC SURGERY, PC TO RELEASE ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS.	DATE / /

Northeast Urologic Surgery, P.C.

HIPAA PRIVACY PRACTICES

We have a legal duty to protect health information about you.

We may use and disclose Protected Health Information or "PHI" about you in the following circumstances:

- We may use and disclose PHI about you to provide health care treatment to you.
- We may use and disclose PHI about you to obtain payment for services.
- We may use and disclose your PHI for health care operations.
- We may use and disclose PHI under other circumstances without your authorization, such as when required by law or for public health activities.
- You can object to certain uses and disclosures.
- We may contact you to provide appointment reminders.
- We may contact you with information about treatment, services, products or health-care providers.
- We may contact you for fundraising activities.

Any other use or disclosure of PHI about you requires your written authorization.

You have the following rights regarding PHI about you.

- You have the right to request restrictions on uses and disclosures of PHI about you.
- You have the right to request different ways to communicate with you.
- You have the right to see and copy PHI about you.
- You have the right to request amendment of PHI about you.
- You have the right to a listing of disclosures we have made.
- You have a right to a copy of this notice.
- You may file a complaint about our privacy practices.

For additional information regarding privacy practices, contact the Office Manager.

This Notice of Privacy Practices is effective as of today's date:_____

Patient's Name:

_____

Parent/Guardian Signature:

_____

NORTHEAST UROLOGIC SURGERY , PC
PATIENT AUTHORIZATION FORM

HIPPA regulations set by the Federal Government requires that we have a signed authorization on file from you each year. The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We need this record to provide you with quality care and to comply with certain legal requirements. Please review our Privacy Document and Your Rights located in our office. A copy is available upon request. Please inform us of the following information:
I, _____hereby authorize Northeast Urologic Surgery, PC to convey or release medical information to the following. *PLEASE INITIAL THE FOLLOWING CHOICES:*

_____*For continuity of medical care information may be given to referring physicians, physician assistants, nurses, qualified medical staff involved in my care*

_____I authorize release of medical information to my insurance company and payment of benefits to Northeast Urologic Surgery, P.C. and for continuity of my care

_____I authorize use of medical interpreters for the continuity of my care

_____I authorize use of appointment confirmation with messages left on my answering machine or another family member

_____I authorize release of medical information to my family or to a specific family member or friend named here:_____

____I authorize medical information to:
Patient to Fill In_____
(Disaster Relief, Funeral Directors, Medical Examiner, Courts, Public Health Activities, Victims of Abuse/ Neglect/Domestic Violence, Worker's Compensation, Health Oversight Activities, Law Enforcement, etc)

THIS DOES NOT COVER SENSITIVE INFORMATION

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law.

I understand that I may inspect or copy the information used or disclosed.

I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that

a. Action has been taken in reliance on this authorization
b. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to consent a claim under the policy.

I understand Northeast Urologic Surgery, P.C. will honor my rights of confidentiality in a reasonable and safe manner within the dictates of their practice policies.

_____

Signed Date

NORTHEAST UROLOGIC SURGERY, P.C.
PRACTICE AGREEMENT

Welcome to Northeast Urologic Surgery, P.C. Thank you for choosing us to participate in your health care. As you join our practice, we would like to bring the following to your attention.

INSURED PATIENTS: We will be happy to process your insurance forms as a service to you. However, we do require that you furnish our office all the necessary insurance information. We will require ten days to process forms.

REFERRALS: It is the patient's responsibility to obtain insurance referrals from their primary care physicians. **This must be done prior to your visit**.

COPAYS: Co-payments are a contractual arrangement between you and your insurance company. **Patients with insurance co-payments are required to make that co-payment at the time of their visit**. There will be a **$5.00 service charge** if we have to bill you.

SELF PAY PATIENTS: If you do not have health insurance, you will be required to make a **$100.00** deposit at the time of your visit. You will also be required to speak with our billing office to make arrangements for the balance on your account.

ACCOUNT BALANCES: The balance of the account is due in full within sixty days of services rendered. Statements will be mailed every thirty days.

RETURNED CHECKS: There will be a $20.00 processing fee for returned checks.

CANCELLATION: A **48 hour notice is required for cancellation of your appointment.**

PRESCRIPTIONS: THERE WILL BE NO PRESCRIPTION REFILLS AFTER 4:00 PM.

MEDICAL RECORD REQUESTS: All medical record requests require a two week notice to be fulfilled and an appropriate medical record release filled out. There will be a
$ 15.00 charge for the first 50 pages and $ .25/per page for every page over 50.

WALK-INS: <u>All patients require an appointment to be seen including laboratory testing</u>.

I have read this agreement and fully understand its content. I understand that my insurance will be billed, but I am responsible for all charges, deductibles, and co-pays in the event that my insurance denies these charges. I have received a copy of this agreement.

_____ _____

Patient's or Responsible Party's Signature Date