



## Form 1 of 3

LastName \_\_\_\_\_ FirstName \_\_\_\_\_

Date of Birth \_\_\_\_\_

- What is the reason for your visit?

1.
2.
3.
4.

- Please list any medical problems or reasons for which you see a doctor, take medicine, have seen a doctor in the past, or taken medicine in the past.

1.
2.
3.
4.
5.
6.
7.
8.

- Please list any surgeries, procedures, or operations you have had on any part of the body with the approximate year of surgery.

1.
2.
3.
4.
5.
6.
7.
8.

- Please list any medicines, foods, or substances to which you have had allergic reactions, and the type of reaction you had.

*(for example Penicillin causes hives)*

1.	
2.	
3.	
4.	



Form 2 of 3

LastName \_\_\_\_\_ FirstName \_\_\_\_\_

Date of Birth \_\_\_\_\_

Do you smoke? NO  YES

If yes how many cigarettes do you smoke each day? \_\_\_\_\_

Did you ever smoke? NO  YES  If YES when did you quit? \_\_\_\_\_

Do you drink alcohol? NO  YES  Daily  Socially

What is your occupation? \_\_\_\_\_

Has anybody in your family (parents, grandparents, siblings) had cancer?

- Has anybody in your family had prostate cancer? NO  YES
- Has anybody in your family had kidney cancer? NO  YES
- Has anybody in your family had bladder cancer? NO  YES
- Has anybody in your family had kidney stones? NO  YES
- Other? \_\_\_\_\_ NO  YES

What is your height? \_\_\_\_\_ ft. \_\_\_\_\_ in. What is you weight? \_\_\_\_\_

- Are there any other serious medical conditions members of your family have had?

1.
2.
3.
4.

- Please list any medications you take along with the dosages and how it is taken (*for example Aspirin 325 mg once daily at bedtime*) Include any over the counter medications, vitamins, or supplements you regularly take.

1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

LastName \_\_\_\_\_ FirstName \_\_\_\_\_

Date of Birth \_\_\_\_\_

**REVIEW OF SYSTEMS**

*(circle those that you have or have recently had)*

**Do you currently or have you recently had any of the following symptoms?**

<u>Genitourinary</u>	Pain with urination	Leakage of urine	Nighttime urination	Difficulty starting urination
	Testicular Pain	Lesion on genitals	Urinary Frequency	Blood in urine (Hematuria)
<u>Constitutional</u>	Weight Loss	Weight Gain	Fatigue	Fever/Chills
<u>Integumentary</u>	Skin lesion	Change in a mole or skin	Itching	Rash
<u>Eyes</u>	Dry eyes	Eye Pain	Blurry Vision	Impaired vision
<u>HEENT</u>	Earache	Sore Throat	Nosebleeds	Hoarseness
<u>Heme/Lymph</u>	Easy bruising	Easy bleeding	Swollen glands	Anemia
<u>Cardiovascular</u>	Abnormal Heartbeat	Palpitations	Chest Pain	Leg swelling
<u>Respiratory</u>	Shortness of Breath	Wheezing	Cough	Sleep apnea
<u>Endocrine</u>	Hot flashes	Weakness	Erectile dysfunction	Hot flashes
<u>Musculoskeletal</u>	Joint pain	Joint swelling	Swelling of limbs	Pain in limbs
<u>Gastrointestinal</u>	Abdominal Pain	Nausea/Vomiting	Constipation	Diarrhea
	Heartburn	Blood in Stool	Anorexia	Bloating
<u>Neurological</u>	Confusion	Dizziness	Weakness	Convulsions



## Uropartners Financial Policy

Uropartners welcomes you to our practice. We work hard to provide the highest quality care to you. Your clear understanding of our Financial Policy is important to our professional relationship. **Please remember that our contract for services is with you, and it is our policy that you are responsible for our fees regardless of insurance coverage.**

### **CO-PAYS: ALL APPLICABLE COPAYS ARE DUE AT THE TIME OF SERVICE.**

**Commercial Insurance Patients:** We submit claims for those patients enrolled in a participating HMO, PPO, EPO and POS provided you have furnished us with **all** the necessary insurance information. This must be furnished at your appointment and include **policy and group numbers and the address of the claims office where your completed insurance form is to be mailed. If you do not provide us with your insurance card, you will be held responsible for the charges at the time of service.** You will receive an explanation of benefits from your insurance carrier determining your financial responsibility as well as receive a billing statement from us when your insurance has paid their portion.

**Managed Care Contracts:** It is the patient's responsibility to call their insurance carrier to obtain pre-certification if required. If you are unsure whether precertification is a requirement, please contact your insurance carrier. In addition, many managed care contracts require a referral from their primary care physician prior to seeing our physician. It is the patient's responsibility to obtain the necessary referral and bring it with them to the visit. If you do NOT have this information before the visit, you may be responsible for some or all of the visit charges that your insurance does not cover.

**Medicare Patients:** Uropartners accepts assignment on Medicare insurance claims. The administrative staff will submit all claims for you and Medicare will pay their portion of your bill directly to the office. Please remember Medicare pays 80% of what they approve and you are responsible for the remaining 20% coinsurance as well as any yearly deductible and/or noncovered services. If you have secondary insurance which may cover this 20%, please submit to us a copy of the card at the time of your appointment so that we may file a claim for you. If you do not have secondary insurance, you may be responsible for the 20% coinsurance amount at the time of service.

**Non-contracted and out-of-network managed care plans:** Patients who have insurance plans that do not have an existing contract with Uropartners are expected to pay in full at time of service.

**Self Pay:** All self pay patients are expected to pay at the time of the visit. We accept several different credit cards, checks or cash. \_

**Account Statements:** Statements are mailed out monthly to patients who have a balance due on their account. Payment of this balance is expected on receipt of the statement. Any payment plans must be arranged with our billing department. Accounts overdue by more than 90 days may be referred to a collection agency.

**Returned Checks:** There will be a \$25 fee for a returned check.

**Missed Appointments:** We reserve the right to charge a missed appointment fee to patients who don't show for a scheduled office visit. We may require this fee to be paid prior to making another appointment.

**Cancellations:** We understand due to different circumstances, patients must cancel appointments from time to time. Please give us 24 hours notice when canceling your appointment. You may always leave a message with our answering service. We reserve the right to charge a cancellation fee for patients who do not cancel their appointment more than 24 hours prior to that appointment. We also reserve the right to charge a cancellation fee for hospital surgeries cancelled within one week of the surgical date.

\*Name (print) \_\_\_\_\_

\*Signature \_\_\_\_\_ Date \_\_\_\_\_



Urology Specialists of Lake County  
 Raza M. Khan, M.D., F.A.C.S.  
 Robert S. Saffrin, M.D., F.A.C.S.  
 Nejd F. Alsikafi, M.D., F.A.C.S.  
 Permissions, Consents, and Responsibilities

Patient Name: \_\_\_\_\_

Consent to treat: I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments, which my physician and I agree are necessary. I understand that no guarantee has been made as to the result of care, treatment and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

Release of information and Assignment of Benefits: I understand that I am responsible for any fees for services rendered for myself and/or for my children (if applicable). I hereby authorize Uropartners to release any medical information to my insurance carrier concerning all conditions including those that may reference drug abuse, alcohol abuse or mental illness in order to process any claims on my behalf. I hereby assign to Uropartners payments made by my insurance carrier.

Contracted Laboratory: Uropartners will send lab tests to the Uropartners Laboratory and several other local labs. I understand that if my insurer mandates that I use a contracted lab, I must supply Uropartners with the name of that lab. If the contracted lab name is not supplied by me, my benefit level may be reduced when the test is submitted to Uropartners or an undesignated lab. If our Uropartners office does not work with the lab required by your insurer, it may be necessary to have your labs drawn at the outside lab. I also understand that it is my responsibility to notify Uropartners of any changes in my contracted laboratory. Name of Laboratory: \_\_\_\_\_

Commitment to your care: I understand that in order to have an effective doctor-patient relationship it is my responsibility to be compliant with the physician's treatment recommendations and office policies. I understand that I may terminate this relationship at any time and request my records to transfer my care to another urologist. I further understand that the Uropartners' physicians may terminate the doctor-patient relationship at any given time by giving 30-day written notice.

Privacy Notice: I hereby give my consent to Uropartners to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my patient record. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice to do so, to that physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. I acknowledge that I have received the Uropartners Notice of Privacy brochure or have received it on a prior visit.

Signature of patient or responsible party \_\_\_\_\_ Date \_\_\_\_\_  
 I wish to be contacted in the following manner (check all that apply)

Home telephone \_\_\_\_\_ written communication  
 \_\_\_\_\_ it is O.K. to leave message with detailed information \_\_\_\_\_ it is O.K. to mail to my home address  
 \_\_\_\_\_ leave a message with call back number only. \_\_\_\_\_ it is O.K. to mail to my work or office address  
 \_\_\_\_\_ it is O.K. to fax to these addresses

Work telephone \_\_\_\_\_  
 \_\_\_\_\_ it is O.K. to leave a message with detailed information  
 \_\_\_\_\_ leave a message with call back number only.

I, \_\_\_\_\_ authorize the disclosure of protected health information to the following:  
 Patient's name

- |          |                    |              |
|----------|--------------------|--------------|
| 1. _____ | Relationship _____ | Number _____ |
| 2. _____ | Relationship _____ | Number _____ |
| 3. _____ | Relationship _____ | Number _____ |

\* \_\_\_\_\_ \*  
*Signature of patient* *Date*