Patient Information

Name____ Home Phone_________________________

Cell Phone______________________________ Work Phone______________________________

Email Address____

Address_____________________________ ________City _________________ State________

Zip Code____________ Sex (circle one) M F Date of Birth ___/___/_______

Social Security # _______-______-__________ Marital Status (circle one) S M D W

Race___________________ Language ____________________

Employer/ Department____

Referring Doctor ________________________ Primary Doctor_________________________

Emergency Contact_________________________ Relationship________________________

Emergency Contact Phone Number ____________________________________

Do you have health insurance ? Y N Insurance ________________________

Who is the primary insurance holder? ____________________ D.O.B_________

What pharmacy do you use ? ______________ Address/Phone______________

Have you received a prescription for any narcotic or pain medications in the past 30 days? Y N If yes, what?____

*NO prescriptions will be called in after hours

Section Below For Medicare Patients only

Medicare Waiver:

Under Section r862 (a)(i) of the Medicare law, Medicare will only pay for services that are deemed to be “reasonable and necessary”. If Medicare determines that a particular service is not necessary, Medicare reserves the right to deny payment of that service. You will be liable for payment of such services.

By signing the following, I have read, understand, and agree to comply with the terms of this document.

Patient’s Signature____________________________________ Date____________________

Advanced Urology of Clarksville Financial Policy

Proof of Insurance ~ Please bring your insurance card with you to every appointment. As a courtesy to you, we will file with all insurances, primary & secondary. It is your responsibility to inform our receptionist of any changes to your insurance coverage. Failure to do so will result in the patient / guarantor being billed for the visit.

Payment for Services ~ All deductibles, co-pays, & non covered services are due at time of service unless payment arrangements have been made in advance. Pre-determined co-pays are due when you check in for your appointment. We accept cash, personal checks, debit cards, MasterCard, Visa, Discover and American Express.

Non Compliance Reporting ~ It is our obligation under many of the managed care contracts to report patients who repeatedly refuse to pay co-pays or deductibles at time of service or who repeatedly "no show" for appointments. In addition, our office will charge a $25.00 fee for "no shows" & appointments cancelled unless 24 hours notice is given. There will be a $100 fee for surgery no shows. Please know that if you are reported, you may lose your health care benefits. Contact Human Resources with your employer for further clarification of your benefits & obligations.

Financial Assistance ~ If you have no insurance, have maximized your benefits, have a high deductible, or are currently financially indigent, please ask to speak with our Office or Billing Manager.

Billing, Payments, & Overpayments ~ If an overpayment is made by you on the account, a refund will only be issued if there are no other outstanding balances on other accounts containing the same guarantor or responsible party. Patient balances unforeseen at time of service will be billed to the address you have provided. It is your responsibility to inform us of any change in address, phone number, or employment. All balances are due in full within 30 days of the billing date. If you cannot pay the balance in full within 30 days, please contact our Office or Billing Manager to see if you qualify for a payment arrangement option.

Past Due or Delinquent Accounts ~ Failure to meet your financial obligations may result in reporting you to the credit bureau, filing for a judgment in small claims court or other collection action against you. Consider the date that you are turned over to collections to be your termination date from our practice. You will be eligible for urgent care only for 30 days from that date. All attorney fees, court costs, and other expenses related to collecting your account will be added to your outstanding balance, not less than 35% collection and / or attorney fees.

_______________________________________ _______________________

Signature *Date*

RECEIPT OF NOTICE OF PRIVACY PRACTICE
WRITTEN ACKNOWLEDGEMENT FORM

I, ____, have reviewed and read a copy of
(Patient Name- Printed)

ADVANCED UROLOGY of CLARKSVILLE's Notice of Privacy Practices.

______________________________ ____________________
Signature of Patient Date

Patient's Name:____
(Last) (First) (MI)

Medical & Social History

Age_____Date of Birth _______________ Primary Dr___________Referring Dr_____________

Past & Present Medical Problems: (Check all that apply)

__High Blood Pressure __Esophageal Hernia __Asthma
__Congestive Heart Failure __Stomach Ulcers __Clots in Legs
__Diabetes __Thyroid Disease __Stroke / TIA
__Emphysema / Bronchitis __Artificial Valves / Joints __Kidney Stones
__ Pulmonary Embolus __High Cholesterol __HIV / AIDS
__Hepatitis __Bleeding Problems __Other__________________

Reason for seeing Dr. Duffin today?____

Please List all current medications. Include the dosage and how many times a day you take the medication:

____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________

Do you take Aspirin? Yes / No Motrin? Yes / No Blood Thinners? Yes / No
Do you have any Drug Allergies? Yes / No ______________________________________
Do you have any Latex allergies? Yes / No
Do you have Allergies to Shrimp, Shellfish, Iodine, IV Contrast? Yes / No
List any past surgeries (please include year) :

____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________

Do you smoke ? Yes / No (______packs per day x ______ years)
Do you use alcohol ? Yes / No ___Daily ___Occasionally __Seldom __Never
History of IV Drug Use? Yes / No
Occupation:____
Marital Status __Single __Married __Divorced __Widowed
Daytime Phone Number ______________________________

Family History (Check all that apply)

Cancer ? Yes / No Type__________________________ Who _____________________
Urinary Infections __ High Blood Pressure__ Heart Disease__
Kidney Stones__ Diabetes__ Stroke__

Females Only

Number of Pregnancies ___ Number of deliveries___
Have you had a hysterectomy ? Yes / No When?_________ Why?_________
Have you had prior Bladder Surgery?____
Do you leak urine with coughing, sneezing, or laughing?___________________________
Do you leak urine with urgency?____

REVIEW OF SYSTEMS

Name :____

Date:____

Please circle any of the following symptoms you may have

CONSTITUTIONAL: chills, fatigue, fever, weight loss, weight gain

EYES: blurred vision, eye pain, sensitivity to light

ENT: hearing problems, ear pain, congestion, nosebleeds, hoarseness, dental problems

CARDIOVASCULAR: chest pain, palpitation, fast heart rate, swelling in extremities

RESPIRATORY: cough, short of breath, blood in sputum

GASTROINTESTINAL: abdominal pain? If so, where___________________how long?______________

heartburn, constipation, diarrhea, stool changes

GENITOURINARY: burning or urination, blood in urine, erectile dysfunction, changes in urinary stream

or flow, difficulty urinating, urinating at night

MUSCULOSKELETAL: joint pain , back pain, muscle strain

SKIN: atypical moles, dry skin, rashes, itchy skin

NEUROLOGIC: dizziness, headaches, weakness

HEMATOLGIC / LYMPHATIC: easy bruising, bleeding, enlarged lymph nodes

ENDOCRINE: hair loss, heat or cold intolerance, increased thirst, increased hunger

ALLERGIC IMMUNOLOGIC: allergies, depression, sleep disturbance, insomnia

PSYCHIATRIC: anxiety, depression, sleep disturbances, insomnia

****NOTE: any of the above symptoms that Dr. Duffin feels are non-urologic, the patient will be counseled to discuss with their primary Medical Doctor or Health Care Provider**