Patient Profile Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions that require we have the following information, or your health insurance claims will not be paid.

Any claims not paid by insurance are the patient's responsibility.

Please complete the following Date: _______________

PATIENT'S INFORMATION

Last Name: _____________________________ First: ___________________________ Middle Initial: ___

Address: ____

City: _____________________________________ State: ___________________ Zip: ________________

Home Ph #: (______) __________________ Cell Ph #: (______) _____________________ Sex: M F

SSN: ______________________ DOB: ________________ Drivers License: _____________________

Email Address: ___________________________ How did you hear about us?_________________________

Preferred language (examples: English, Spanish, Vietnamese):_______________________________

Race/ancestry (examples: White, African American, Vietnamese):_______________________________

Ethnicity/region or culture of origin (examples: American, Mexican):_____________________________

I am in a nursing home, skilled nursing facility or long-term care facility: No Yes
(If yes, which one:____)

Employer Name____ None Retired

Employer Address: ____

City: ______________________________________ State: ____________________ Zip: ____________

Employer Phone Number: (_______) ________________________

Marital Status: Single Married Divorced Widow

Name of Spouse: _______________________________

Spouse's Employer Name: ____ None Retired

Spouse's Employer Address: ____

City: ______________________________________ State: ____________________ Zip: ____________

Spouse's Employer Phone Number: (_______) ________________________

Emergency Contact: Name: ___________________________ Phone Number: _________________________

INSURED'S INFORMATION

Circle one: Mr. Mrs. Miss Ms. Dr.

Last Name: ______________________________ First: ____________________________ Middle Initial: ___

Address: ____

City: _______________________________________ State: ___________________ Zip: _________________

Home Phone: (_________) ______________________ SSN: ________________________________

Date of Birth: _________________________ Sex: Male Female

What is the relationship of the patient to the insured? Self Spouse Child Other

Primary Insurance: ____

Insurance Address: ____

Insurance Phone #**:** **(**_______**)** ________________ GRP# ________________ Policy#________________

Secondary Insurance: ____

Insurance Address: ____

Insurance Phone #: (_______) ________________ GRP# ________________ Policy#________________

I understand that I am financially responsible for all charges incurred for services rendered to the patient list above, me or a minor under my care by Northwoods Urology Associates should my insurance coverage be under a plan in which Northwoods Urology Associates does not participate. If my insurance coverage is under a plan in which Northwoods Urology Associates does participate, including Medicare, I agree to be responsible for all appropriate deductibles, copays, coinsurance payments and denied charges requested by Northwoods Urology Associates.

I further understand that, with the exception of Medicare and Medicaid, Northwoods Urology Associates is not obligated to file claims on my behalf and is doing so as a courtesy. I authorize Northwoods Urology Associates to release my insurance carrier by either paper or electronic means, including fax, any medical information necessary to determine appropriate payment for the services rendered I understand that these records may contain information concerning alcohol, drug abuse, psychiatric care, and HIVor AIDS status.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Northwoods Urology Associates for any services furnished to me by the physician. I authorize any holder of medical information about me be released to Medicare and their agents.

Consent for Treatment: I consent to the use or disclosure of my protected health information by Northwoods Urology Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Northwoods Urology Associates. I understand that diagnosis or treatment of me by any physician, provider or staff member employed by or under contract to Northwoods Urology Associates may be conditioned upon my consent as evidenced by my signature on this document. I have the right to revoke this consent, in writing, at any time, except to the extent that any physician, provider or staff member employed by or under contract to Northwoods Urology Associates, or Northwoods Urology Associates has taken action in reliance on this consent.

Patient Name: ____ Date: _______________

Patient Signature: ____ Date: _______________

(Parent/Guardian if Patient is a minor)

*Entered By:*___________________________________

rev 12/7

NORTHWOODS UROLOGY ASSOCIATES

Initial Medical History

Date: ______________ Name: ____________________________ Age: _______

(please fill out shaded areas)

What is the reason for today's visit: ____

____

Encounter Time: __________________

HOPI: *(Physician use only)*	**Voiding Symptoms** □ dysuria □ urgency □straining □ enuresis □ freq.of urination □ nocturia □ hesitancy □ urge □ small amounts □ urethral discharge □ intermittency □ penile discharge □ hematuria □ incontinence □ force of stream □ sense of incomplete bladder emptying
	Pain / Dimensions □ Abdominal — Loc. □ Flank — Qty. □ Groin — Intensity □ Scrotal — Timing □ Perineal — Context □ Modifying Factors Assoc. sx.

Have you had or do you have any of these:
PMH: Illnesses:

Diabetes	Y	N	Lung problems	Y	N
High blood pressure	Y	N	Asthma	Y	N
Heart disease	Y	N	Hepatitis	Y	N
Kidney disease	Y	N	Bleeding disorder	Y	N
Kidney Stones	Y	N	Thyroid disorder	Y	N
Prostatitis	Y	N	Ulcers	Y	N
Urinary infections	Y	N			
Cancer *(if so specify)*	Y	N ---> *if yes* ______________________________			

Please list any surgeries: ____

____

Please list current medications & dosage: ____

____

Do you have any ***drug allergies***? Y N *Please list:* ____

Social History: **M***arried* **D***ivorce* **S***ingle* **W***idowed* Employment: ______________________________

Have you or do you smoke? Y N When quit? _______ How much? ________________________________

Do you drink alcohol? Y N How much? ____

Immediate Family History – *please list any general medical problems.*

Mother: ______________________________________ Father: ____

Siblings: _____________________________________ Children ____

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle Yes or No. Please explain any yes questions in the space provided.

Constitutional Symptoms
- Fever Y N
- Chills 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
- Headache Y N
- Other ____________________________

Endocrine
- Excessive Thirsty Y N
- Too Hot Y N
- Too 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

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 ____________________________

Hematologic/Lymphatic
- Swollen Glands Y N
- Blood Clotting Problems Y N
- Other ____________________________

Psychologic
- Are you generally satisfied with your life? Y N
- Do you feel severely depressed? Y N
- Have you considered suicide? Y N
- Other ____________________________

Name ____ Date__________ / __________ / __________

Physician: ____

Primary Care Physician:____ Phone Number:_________________________

Referring Physician:____ Phone Number:_________________________

Pharmacy Name:____ Phone Number:__________________________

Pharmacy Location:____ City__________________________________

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVES

I,_____________________________________, give my authorization to release my protected health information including results of my laboratory tests, x-ray and/or other test results to the following designated representative(s):

Patient Initials

___________	My spouse	(Name)	________________________
___________	My Child	(Name)	________________________
___________	Other	(Name)	________________________
___________	May be left on my answering machine at home/work.		
___________	***MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF***		

Patient signature____

Date______________________

Witness____

revision 4/04

Acknowledgment of Financial Policy

I understand that payment of co-payments, deductibles, and percentages not covered by my insurance carrier is due at the time services are rendered.

I understand that you are Medicare providers and will submit all claims to them. If I am a Medicare recipient, I understand that I will be responsible for annual deductibles, 20% co-pays, and any charges that Medicare states that I am responsible for.

I understand that if I do not have insurance coverage I will be responsible for services rendered at time of service.

I understand that a $30.00 service charge will be applied to all returned checks.

I understand that the office will copy my insurance card and drivers license. I further understand that it is my responsibility to notify the office in the event of an insurance coverage change.

I understand that I will receive a separate statement from the Radiologist that interprets my CAT scan, x-ray, and nuclear medical scans.

COLLECTION FOR SURGERY:

I understand that I am responsible for paying my deductible and coinsurance before any inpatient or outpatient surgery. Failure to do so can result in my procedure being rescheduled until payment is made.

FOR INSURANCE BILLING:
I hereby authorize Northwoods Urology Associates to furnish my insurance company with all the information which the insurance company may request concerning my present illness or injury. I hereby assign Northwoods Urology Associates all money to which I am entitled for medical expenses related to the service reported. I understand I am financially responsible to Northwoods Urology Associates for charges not covered by this assignment.

All information that I have provided pertaining to my account is accurate and true to the best of my knowledge

______________________________ ______________________________
Signature Date

If you should have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to call us at (281) 404-3000 between the hours of 8:00 am. to 5:00 pm. Monday through Thursday or 8:00 am. to 1:00 pm. on Friday.