Anne Arundel Urology, PA

Account Number: _____ **Provider:** _____

Last Name	First Name	MI	Birth Date	Age

Address	City	State	Zip Code

Home Phone	Work Phone	Social Security #	Marital Status **M W S SP D**	Gender **M or F**

Cell Phone	Email Address (required for patient portal) **Do you want to receive billing statements via Email? Y N**	Employment Status FT PT RET UNEM	Student Yes No

Emergency Contact Information (Name/Phone Number/Relationship)	Do you have an Advance Directive (Living Will)? Yes _____ No _____

Is the physician listed below still your Primary Care Provider? **YES** _____ **NO** _____

Physician:

Primary Care Physician:

PLEASE COMPLETE THE FOLLOWING SECTION IF GUARANTOR IS DIFFERENT FROM PATIENT

Last Name	First Name	MI	Relationship to Patient

Address	City	State	Zip Code

Home Phone	Work Phone	Social Security #	Birth Date	Gender

Cell Phone	Email Address

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Name		Insurance Name	
Claims Address		Claims Address	
City, State, Zip	Ins Phone No.	City, State, Zip	Ins Phone No.
Employer Group Ins? Yes ☐ No ☐ Employer Name: Employer Address: Employer Phone:		Employer Group Ins? Yes ☐ No ☐ Employer Name: Employer Address: Employer Phone:	
Subscribers Name	Gender M ☐ F ☐	Subscribers Name	Gender M ☐ F ☐
Subscribers ID	Group No.	Subscribers ID	Group No.
Subscribers Birth Date & SSN	Effective Date	Subscribers Birth Date & SSN	Effective Date
Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐		Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	

AUTHORIZATION

Our primary responsibility is to help our patients experience good health. Payment for services is expected to be paid at the time of service, including co-payments. If you do not pay your co-pay on the date of service, your appointment may need to be rescheduled.
Our billing office will submit all claims to your insurance carrier. Any outstanding balances are due at the time of first billing.
I authorize the release of medical records or other information necessary to process my claims, as well as payment of medical benefits to Anne Arundel Urology, P.A./Anne Arundel Urological Surgery Center, LLC. I also acknowledge that I am responsible for any missed appointment or cancellation fees incurred.

I, _____, fully understand that I am responsible for payment of services rendered.

Patient Signature _____Date_____

PATIENT HIPAA COMMUNICATION FORM

PATIENT NAME:_____**BIRTH DATE:**_____ **ACCT. #:**_____

PRIVACY NOTICE TO PATIENTS

By signing below, I acknowledge that I have been provided the opportunity to review the Notice of Privacy Practices that is posted in each clinic location and on the practice website. I understand that a copy of the Privacy Practices will be printed for me at my request.

_____

Patient or Legal Guardian Signature Date

CONFIDENTIAL COMMUNICATION OF PERSONAL HEALTH INFORMATION

It is the policy of AA Urology not to release confidential medical information regarding your treatment to family members or friends without written permission. Please indicate below, who you would like to give access to your personal and confidential personal health information. This includes: picking up prescriptions in office, medical records, referrals, instructions for outside testing, voicemail messages, etc.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

If you do not wish to have your confidential medical information released to anyone other than your insurance, please check the box: ☐

_____

Patient or Legal Guardian Signature Date

The information contained in this medical record document is considered private and confidential patient information. This information can only be used for the medical diagnosis and/or medical services that are being provided by the patient's selected caregivers. This information can only be distributed outside of the patient's care if the patient agrees and signs waivers of authorization for this information to be sent to an outside source or route.

FINANCIAL POLICY

PATIENT NAME:_____BIRTH DATE:_____ ACCT. #:_____

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of all charges for services I receive from this practice, including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay, a previous balance, or an additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.

3. **All co-pays are due at the time of service. This practice may deny service for failure to pay a co-pay at my scheduled visit.**

4. It is my responsibility to provide my current address, telephone number, email address, insurance card(s) and referral, if required, at each visit.

5. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that my payment is due by the date shown on my statement. I also understand that failure to pay could result in my account being sent to an outside collection agency.

6. I understand that I have the *option* of maintaining my preferred payment method on file. I understand that by completing the below section and providing my Card or ACH information, my payment information will be maintained on file digitally for future use by the practice for patient balances due. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.

   Optional: □ Keep my preferred payment method on file for future use

   _____
   Name as it Appears on Card/ACH Account

7. With my prior approval, I authorize the above practice and/or its designated pmt agent to apply charges to my payment card and/or ACH account, using my preferred payment method stored on file, for balances I owe to the practice. This could be for medical visits, procedures, amounts agreed as part of a payment plan, copayments, coinsurance, amounts not covered by insurance or fees (if applicable) charged by the practice for failure to keep an appointment or provide timely notice of appointment cancellation.

8. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid my account being sent to an outside collection agency.

9. Transaction receipts will be provided to me in person if paying on site, mailed if requested, or will be emailed to me if I provide and maintain a valid email address.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

AUTHORIZED SIGNATURE _____ DATE _____

_____

Billing Address City State Zip Code

NEW UROGYN PATIENTS ONLY SEEING DR. GONZALEZ

Please complete the following. Leave items blank that you do not understand.

Name: _____ Date:_____ Age:_____
Telephone:_____ E-Mail:_____
Preferred pharmacy: _____

Why are you here to see Urogyn? _____

Prolapse:
Do you feel a vaginal bulge? ……..……☐ yes....☐ no
Pressure?……..……☐ yes….☐no
Do you have to place your fingers in the vagina or in the rectum to have a bowel movement? .....….☐ yes.....☐ no
Impact to quality of life? (circle) Minimal, Moderate, Severe

Stress Incontinence:
Do you leak urine with cough, sneeze, exercise ☐yes.☐ no
How often do you leak with cough, sneeze, exercise? (circle) Occasional, Weekly, Daily
How much do you usually leak? ☐drops ☐more ☐ soak Do you wear a pad?..☐yes ☐no..If so; light, large, diapers
Impact to quality of life? (circle) Minimal, Moderate, Severe

Urge Incontinence:
Do you often get sudden urges to urinate? ☐ yes.....☐ no
How often do have urges? (circle) Occasional, Weekly, Daily
If so, do you leak with these urges? ……☐ yes.....☐ no
How much do you usually leak?..... ☐drops ☐more ☐ soak
Impact to quality of life? (circle) Minimal, Moderate, Severe

How many times do you go to the bathroom per day?_____
How many times do you go to the bathroom per night?_____

Urinating:
Difficulty starting urination or strain to void?....☐ yes....☐ no
Weak or intermittent stream?……..……☐ yes....☐ no
Incomplete emptying or dribbling?.....☐ yes....☐ no
Pain or burning with urination?.....☐ yes....☐ no

Intake:
How many 8 oz drinks of caffeine per day?..... _____
How many 8oz drinks of liquid (total intake) per day?_____

GI:
Constipation?.....☐ yes.....☐ no
Frequency stools (circle) …. Daily, Less often, More often
Straining for stools……. ☐ yes.....☐ no
Stool consistency (circle) …… Normal, Loose, Hard

Prior therapy:
Ever done pelvic floor physical therapy? …….☐yes….☐no
Trial of medication? ……...☐yes….☐no
Have you ever tried a pessary? .....☐ yes..☐ no

Medical History: Do you have?
Cholesterol?..... ☐yes..☐no Diabetes …….☐yes..☐no
Blood pressure? ☐yes..☐no Recurrent UTIs? ☐yes..☐ no
Sleep Apnea? ☐yes..☐no
List other medical problems: _____
_____
_____

Surgical History: (Please list all surgeries and year performed)
☐ Hysterectomy _____
☐ Bladder Surgery _____
☐ Other: _____
_____

OB/Gyn History:
How many times have you been pregnant? _____
How many deliveries? _____
Vaginally___ Cesarean Section___
What do you use to prevent pregnancy?_____
Are your periods regular?..☐yes...☐no _____
When was the first day of your last period? ___/___/___
Last Pap smear? (year) _____Any abnormal?..☐yes...☐no
Last mammogram?_____ Last colonoscopy?_____

Medications/Vitamins/Supplements:
_____ _____
_____ _____
_____ _____
_____ _____

Drug Allergies: ☐ **None or List (include reaction)**
_____
Latex Allergy.....☐ yes….☐ no
Iodine Allergy.....☐ yes….☐ no

Family History: (list relationship and age at diagnosis)
☐ Breast cancer _____ ☐ Ovarian cancer_____
☐ Colon cancer_____ Other: _____

Social History:
☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed ☐ Domestic Partner
Do you/ have you ever smoke(d) cigarettes? ☐ yes…☐ no
Drink more than 1 alcoholic beverage a day? ☐ yes...☐ no
Occupation? _____

In the past 3 months have you regularly experienced:
☐ Chest pain w/ walking/exercise
☐ Leg pain w/ walking/exercise
☐ Difficulty breathing w/ walking/exercise
☐ Dizziness, falls, or fainting
☐ Unusual headaches
☐ Easy bruising
☐ Problems with vision

Ever leak stool (Accidental Bowel Leakage)?..☐ yes....☐ no

If so, how often? occasional, weekly, daily

If so, do you leak? liquid, solid

Soiling without sensation?.....☐ yes.....☐ no

History of irritable bowel or Crohn's?.....☐ yes.....☐ no

Sexual/Pain:

Are you currently having sex?. (if no, why):....☐ yes.....☐ no

Pain with sex? none, occasional, most times, every time

Pain with sex? none, mild, moderate, severe

Pain with sex? Upon entry, deep thrusting

Sexual Partner:…….. ☐ Male...☐ Female… ☐ Both

Do any of these symptoms interfere with sex? ☐ yes....☐ no

Impact to quality of life? (circle) Minimal, Moderate, Severe

☐Excessive bleeding from cuts, gums, surgery

☐Other: _____