



# Patient Information Form

(please print)

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## Patient Information

Full Name \_\_\_\_\_ Account #: \_\_\_\_\_  
 Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex:  Male  Female Social Security # \_\_\_\_\_  
 Home Address \_\_\_\_\_  
Street City State Zip  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
 Home Email \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Spouse's Full Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
 Spouse's Social Security # \_\_\_\_\_ Spouse's Work Phone (\_\_\_\_) \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Office #: \_\_\_\_\_

## Responsible Party

**If you are providing the information above for a patient under the age of 18 years old, please complete this section:**

Child's Father's Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_  
 Father's Address (if different from above) \_\_\_\_\_  
Street City State Zip  
 Father's Employer \_\_\_\_\_ Father's Work Phone (\_\_\_\_) \_\_\_\_\_  
 Child's Mother's Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_  
 Mother's Address (if different from above) \_\_\_\_\_  
Street City State Zip  
 Mother's Employer \_\_\_\_\_ Mother's Work Phone (\_\_\_\_) \_\_\_\_\_

**Please Note: It is the policy of this office that the parent accompanying the child for treatment will be held responsible for all bills. We cannot bill the other parent.**

## Clinical Information

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  Single  Married  Widow  Divorced

Have you experienced any of the following symptoms listed below over the last two weeks? Please check yes or no.

Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	New bone pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of feeling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Account #: \_\_\_\_\_

### Emergency Information

Name of Nearest Relative NOT LIVING with the patient \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Relative's Address \_\_\_\_\_  
Street City State Zip

Relative's Employer \_\_\_\_\_ Relative's Work Phone (\_\_\_\_) \_\_\_\_\_

### Insurance Information

Do you have medical insurance?

Yes → Please provide copy of card at time of service.

No → Payment is expected at time of service. We accept Cash, Check, Visa, or MasterCard.

Does your insurance require a co-payment?  Yes Amount: \$ \_\_\_\_\_  No

**Please note: Co-payment is required at time of service. We file only primary insurance.**

### Financial Interest Disclosure

One or more Metropolitan Urology physician(s) is/are investors in Physicians' Medical Center, Radiotherapy Clinics of Kentuckiana and Metro Litho (lithotripsy). You may choose to be referred to another entity. Metropolitan Urology physicians are proud of the quality of care these entities provide for our patients.

I authorize the release of any medical or incidental information necessary to provide continuity of my (the patient's) medical care and to process my (the patient's) medical insurance. I also understand that I am financially responsible for any balance.

I agree to receive additional information regarding opportunities in advancing my medical care.

Signed: \_\_\_\_\_  
Patient/Responsible Party

Date: \_\_\_\_\_



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## **Compliance Assurance Notification**

To Our Valued Patients:

Healthcare fraud and abuse have been identified as a national problem costing taxpayers literally billions of dollars each year. We want you to know all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine accurate compensation for our services in accordance with the governmental rules, laws, and regulations. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any service or billing errors.

We also know that we are not perfect! Because of that fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any billing or service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

If you have any questions about our Compliance Program, please contact anyone on our committee at (812) 282-3899 or (800) 557-5586.

Sincerely,

Tammy Arbuckle, Compliance Officer  
Joy Stidam and Ginnie Elmore, Compliance Committee



# Parental Consent

(please print)

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We realize that Parents or Legal Guardians may not always be able to personally bring their child to our office. However, state law dictates that a patient under the age of 18 **cannot** be treated without a Parent or Legal Guardian present. If a Parent or Legal Guardian can not be present, then anyone authorized below can accompany my child and give consent for treatment. This for **must** be completed by a Parent or Legal Guardian. Please inform your authorized person(s) that our staff will ask them for photo identification.

I, \_\_\_\_\_, the Parent or Legal Guardian of  
\_\_\_\_\_, give consent for the following people to have my  
(child's name)

child treated by Metropolitan Urology and its staff:

**Authorized Person(s)**

**Relationship to Patient**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Signature:** \_\_\_\_\_  
(Parent or Legal Guardian only)

**Date:** \_\_\_\_\_



## Notice of Privacy Practices

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The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent of uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes to treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

(over)

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

Account #: \_\_\_\_\_

**Receipt of Notice of Privacy Practices Written Acknowledgement**

I have read and understand the Notice of Privacy Practices provided by Metropolitan Urology, PSC.

\_\_\_\_\_  
Signature of Patient/Parent or Guardian

\_\_\_\_\_  
Date

**My Protected Health Information may be disclosed to:**

**Self Only**

**Spouse/Significant Other:** \_\_\_\_\_  
Name of Spouse/Significant Other

**Parent/Guardian:** \_\_\_\_\_  
Name of Parent/Guardian

**Other:** \_\_\_\_\_  
List Names

**Other:** \_\_\_\_\_  
List Names

**I give permission for Metropolitan Urology, PSC to contact me at work regarding test results.**       **Yes**       **No**

\_\_\_\_\_  
Place of Employment

\_\_\_\_\_  
Phone Number(s)

**I give permission for Metropolitan Urology, PSC to leave a message regarding test results on the following:**

**Home answering machine/voice mail**

**Cell phone voice mail**

**Work voice mail**



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# Patient Medications

Acct. # \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Please list all medications that you currently take on a regular basis.**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_

Are you diabetic?       Yes       No

\_\_\_\_\_  
**Patient Signature**

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



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# Patient Allergies

Acct. # \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Please list all known drug allergies that you currently have.**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_

Are you diabetic?       Yes       No

\_\_\_\_\_  
**Patient Signature**

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