



Patient Information Form

(please print)

We excel at getting you well

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: _____



We excel at getting you well

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



We excel at getting you well

Incontinence Questionnaire for Women

Acct.# _____ Patient Name: _____ Date: _____

How long have you had the problem of urinary leakage? _____

Have you ever been evaluated before for this problem? Yes No

What test did you have performed and do you know the results? _____

Have you been treated for urinary leakage before? Yes No

If so, what treatment (exercises, medications, urgency)? _____

Please list all of your medications including aspirin and vitamins: _____

How many times were you pregnant? _____ How many vaginal deliveries? _____

Please list all of your previous surgical procedures: _____

Have you had a back injury or surgery on your back or spinal cord? Yes No

Do you have any of the following?

chronic cough Yes No double vision Yes No diabetes (sugar) Yes No

Do you have muscle weakness, paralysis, tremors, numbness or tingling in your hand or feet? Yes No

Do you have a history of bladder infections (cystitis)? Yes No

Do you have any problems engaging in intimacy with your partner? Yes No

Do you lose urine with any of the following?

laughing	<input type="checkbox"/> Yes <input type="checkbox"/> No	minimal exercise like walking or light housework	<input type="checkbox"/> Yes <input type="checkbox"/> No
lifting	<input type="checkbox"/> Yes <input type="checkbox"/> No	nervousness or increased anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
active exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	leakage unrelated to any specific cause	<input type="checkbox"/> Yes <input type="checkbox"/> No
sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Is your clothing? damp wet soaking wet

Do you use? sanitary napkins tissue paper diapers

How many protective pads do you change per day? _____

At each change, are they? damp wet saturated

Incontinence Questionnaire for Women (continued)

Patient Name _____

Account #: _____

Do you leave puddles of urine on the floor? Yes No

Do you lose urine by continuous dribbling? Yes No

Do you lose urine in small spurts? Yes No

 If "yes", is the loss of urine related to physical activity? Yes No

Do you lose urine in sudden large amounts as if your whole bladder has emptied uncontrollably? Yes No

When you have the desire to urinate, do you lose urine before you can get to the bathroom or toilet? Yes No

 If "yes", does the urine loss occur? every time half the time occasionally

How has the problem of incontinence affected your quality of life? _____



Bladder Dysfunction Patient Satisfaction Survey

We excel at getting you well

Patient Name: _____ Date: _____

Insurance: _____ Urologist: _____

Which symptoms best describe you? Please check all that apply.

- Frequent urination - day, night, or both
- Leaking with sneezing, coughing, exercising
- Sudden or strong urge to urinate
- Unable to empty the bladder
- Bladder or pelvic pain
- Leaking with urge or with no warning - unable to make it to the bathroom in time

How long have you had these symptoms? _____

Have you tried medications to help with your symptoms? Yes No

If yes, which medications have you tried?

- Detrol LA
- Ditropan XL
- Flomax
- Cardura
- Oxytrol Patch
- Enablex
- Vesicare
- DDAVP
- Sanctura
- Elavil
- Elmiron
- Other _____

Did these medications help your symptoms? (Circle answer)

Little Relief 1 2 3 4 5 6 7 8 9 10 Completely Cured

If you stopped taking your medications, why?

- Did not help
- Side Effects
- Too expensive

Please explain the side effects, if any: _____

What is your level of frustration with your bladder symptoms?

Not frustrated 1 2 3 4 5 6 7 8 9 10 Very frustrated

If these symptoms are affecting your quality of life, would you like to learn about a reversible TEST (Interstim Therapy) that is covered by insurance and may help relieve your symptoms?

- Yes
- No

If yes, please refer this patient to Debbie Johnson at (812) 206-8161.



Notice of Privacy Practices

We excel at getting you well

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



We excel at getting you well

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



We excel at getting you well

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