Florida Urology Center
BOARD CERTIFIED UROLOGISTS

www.floridaurology.com

Greg A. Parr, M.D.
Dane K. Hermansen, M.D.
Jay C. Guido, M.D.
Frank S. Melograna, M.D.
John K. Burgers, M.D.
Shawn W. Thomas, M.D.
Board Certified Urologists

Welcome to our practice. We are pleased you have decided to let us attend to your Urological health.

If you have received paperwork in the mail, please complete it, bring it with you to your appointment and arrive 15-30 minutes early to sign some required forms.

Your primary care physician has either agreed to send us records or given records to you. If you have the records, please mail them or drop them by so we can make sure they include the tests our doctors require.

If you have seen a urologist before, it is important that we have those records also. Please obtain them and send us a copy. We need reports (and films if possible) of any x-rays, KUB(s), IVP(s), PSA(s), urinalysis, pathology, cytology or any surgeries you may have had.

PLEASE BRING YOUR INSURANCE CARDS, PRESCRIPTION CARD AND AN ACCURATE LIST OF THE MEDICINES YOU ARE CURRENTLY TAKING and dosage (include vitamins, aspirin and other over-the-counter medications).

If your insurance company is an HMO, please do not forget to check with your primary care physician's office to make sure that your visit has been pre-authorized.

ABOUT OUR OFFICE: We are open from 8:00 am. to 4:30 pm. Monday through Friday. We do close early the day before holidays and some Friday afternoons.

One of our physicians are always on call and available for emergencies or post-operative questions. Please do not call with routine questions (i.e., prescription requests) when the office is closed.

Prescriptions: Please contact your pharmacy and have them fax (not call) a request for refills. Please do your best to contact your pharmacy at least 2 weeks or more prior to running out of your medications. Most insurance companies are requiring a preauthorization which can be an exceptionally difficult and time-consuming process. Please do not expect to call our office during the day and have the prescriptions available the same day. In most cases, even if no preauthorization is required, we are too busy caring for patients and attending to emergencies to handle refills that quickly. Also, due to time restraints, the potential for error, etc, we do not call prescriptions in to pharmacies such as Merck-Medco.

Communication: We try to get back to patients who call as soon as possible. We do, however, see patients in the hospital and office and to avoid running chronically behind with our appointments, non-emergent calls must be saved and returned within 48 hours. We will call with the test results as soon as we have the report and it has been reviewed by your doctor. This may take up to 2 weeks. If you have an office visit scheduled within a week (or so) of the test, the doctor will discuss the results with you in person at that time. We do not discuss pathology results over the phone.

Cancellations: If you need to cancel an appointment, please give us as much notice as possible. There are always people who have new symptoms or problems and need to be seen. Since we are a surgical practice, our physicians are frequently called away for emergency surgery. If this causes us to reschedule your appointment, we will do our best to contact you as quickly as possible. You will be subjected to a **$50 NO-SHOW fee if the appointment or surgery is not canceled 24 hours prior.**

Payment: If we do not participate with your insurance company, payment will be requested prior to seeing the doctor. If we do participate with your insurance company, your co-pay and/or deductible will be collected at the time of your visit.

HIPAA: Our practice is fully compliant with all HIPAA privacy guidelines. If you would like a copy of our HIPAA Privacy Notice, please don't hesitate to ask.

Cell Phones: Please silence or turn off your cell phone or other electronic device while at the office.

We try our very best to be warm and understanding of your needs, emotions, concerns, etc. Please afford us the same consideration. Our physicians and staff are good, caring people. We are like family here and do not like it if someone is rude or unduly difficult. In fact, we consider rudeness to our staff to be the same as rudeness to our physicians and should it occur, we would undoubtedly feel that it would be in everyone's best interest for that individual to seek his/her urological care elsewhere. By the same token, we also want to be made aware if one of us was less than polite to you.

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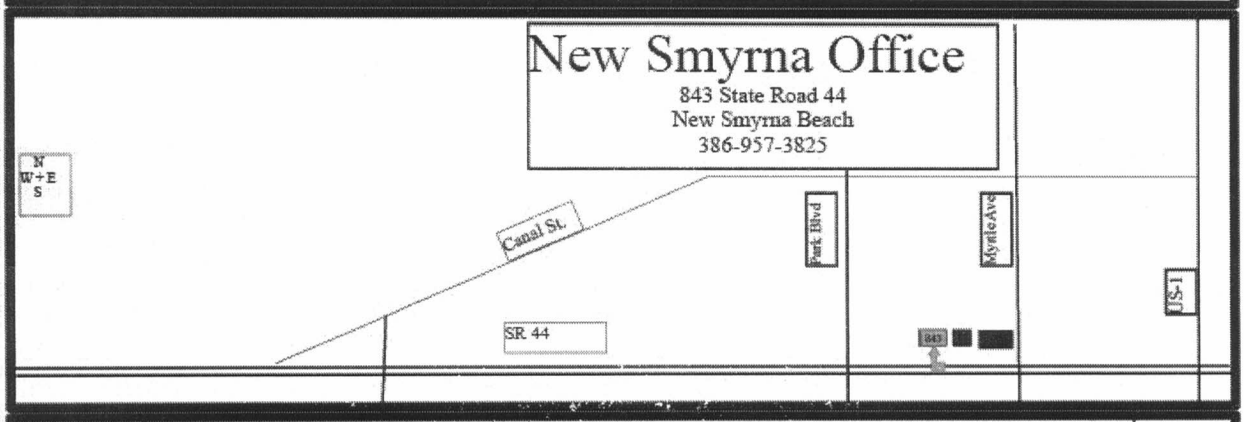

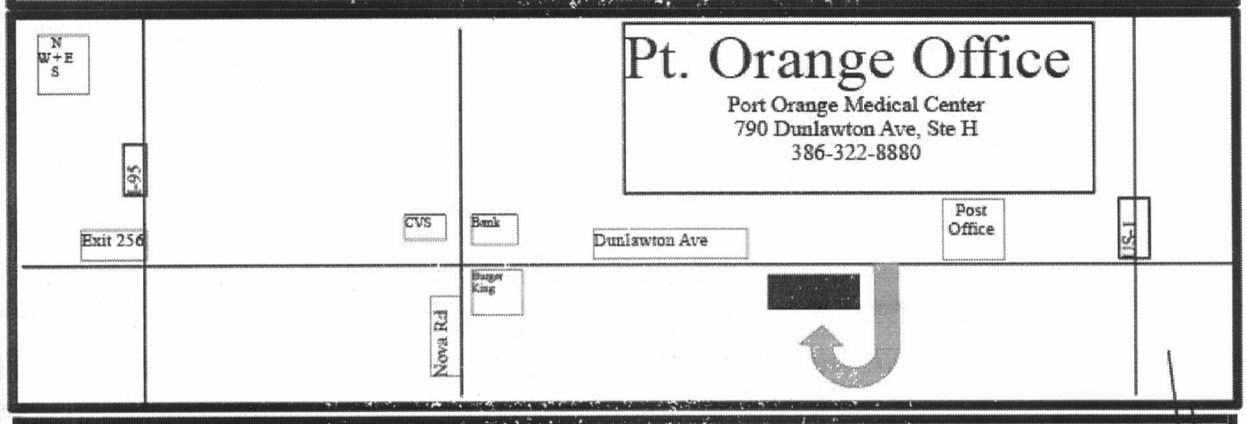

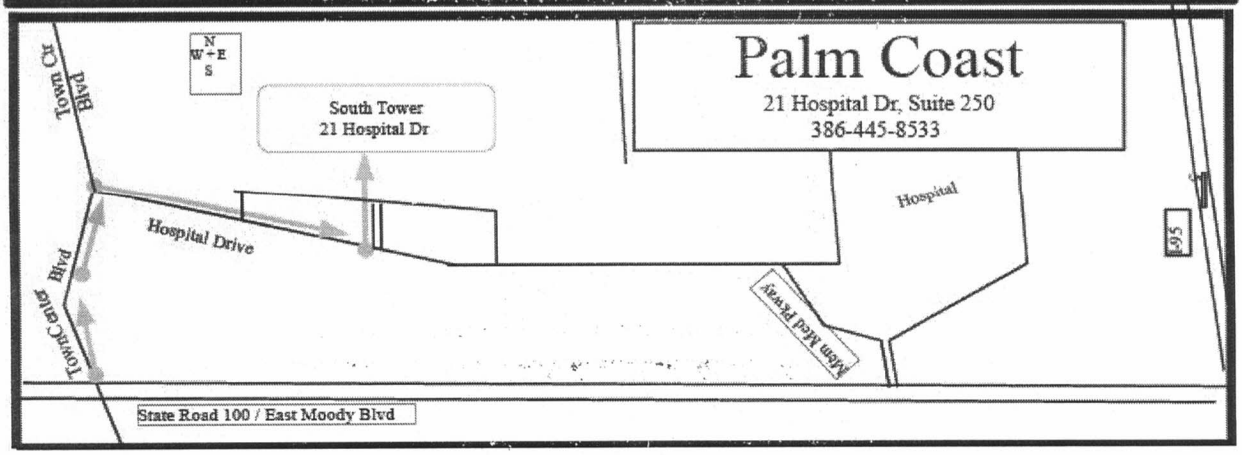

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Prescription Refill Policy

Effective January 1, 2013

Please strive to go to your pharmacy and refill your prescriptions at least 2 weeks or more prior to running out of your medication(s).

Most insurance companies are now requiring a preauthorization for all drugs that are not on their "preferred" lists. Unfortunately, we have no way of knowing what the preferred drugs are for your insurance plan. There are hundreds of insurance plans and they all change their preferred lists or formularies regularly. They are also making the pre-authorization process much more difficult than it used to be. It usually requires one of our staff to sit on hold for 10-15 minutes per call. However, at times it can be much longer (30-45 minutes). We simply do not have the staff to do that on a regular basis. As a result, it can take up to 2 weeks for us to obtain our preauthorization.

In some circumstances, a different drug (that is on your insurance company's current formulary) may be necessary, which will require us to speak with your urologist and obtain his/her approval. If a side effect or drug interaction profile of the alternative drug is substantially different, an office visit to go over them may also be necessary.

You can help us with this process by always refilling your prescription(s) at least 2 weeks early or calling your insurance company (you may also be able to go onto their website as well) and finding out if they prefer a similar drug and letting us know prior to filling your prescription. As noted above, we will consult your doctor and we will give you a new prescription if he/she feels it is appropriate.

Thank you very much!

Port Orange Medical Center
790 Dunlawton Ave
Suite H
Port Orange, FL 32127
386-322-8880

Daytona Office
1620 Mason Ave
Suite E
Daytona Beach, FL 32117
386-673-5100

Ormond Office
300 Clyde Morris Blvd. Suite C
Ormond Beach, FL 32174
386-673-5100
Fax: 386-673-6014

Palm Coast Office
21 Hospital Drive
Suite 250
Palm Coast, FL 32164
386-445-8533

New Smyrna Beach
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Dear _____,

Thank you for scheduling an appointment with Dr. _____.

I have enclosed a patient information sheet for your convenience. It is imperative that you bring the completed information sheet with you at the time of your appointment.

Your appointment is scheduled for: _____ , _____

_____ a.m. / p.m. at the

_____ Office.

Arrival

Please arrive *20 minutes prior to your appointment time* so that we may complete your registration and avoid unnecessary delays.

For All Patients

Please bring any pertinent:

- Medical records
- Imaging Studies- Ct scan, Mri, Xray, etc.
- Test results
- Also bring a photo I.D. and your insurance Card.

Important: If we do not have the actual insurance card, we may not be able to confirm your coverage and you will be responsible for the full cost of the initial visit at the time of service.

For Adult Male Patients

Please come into the office with a full bladder. You will be asked to void into a machine that documents the strength of your urinary flow.

Vasectomy Consultations

The initial visit with the physician is mandatory prior to the procedure being scheduled.

Contacting Us

Thank you and don't hesitate to call if you have any questions or need to reschedule or cancel your appointment.

► See reverse side / next page for maps to the various office.

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2026 New Patient Form

Name:		DOB: / /	Age
SS# - -		Gender: ☐ M ☐ F	
Local Address:	City:	State:	Zip:
Primary Phone: ( ) - Cell ☐		Secondary Phone: ( ) - Cell ☐	
E-mail Address:			
Preferred Contact Method to Confirm Appointments: ☐Voice ☐ Text ☐ Both			

I authorize messages with medical information to be left at the above number(s) _____ (Patient Initials)

Please list below who F.U.C. staff may speak with about your health care:

Emergency Contact:	Relation to Patient	Phone:
Other Contact:	Relation to Patient	Phone:

Employer/Position:	Phone:
Family Doctor:	Phone:
When was your last well visit/annual physical?	Date:
Your Pharmacy:	Phone:
What Lab do you use?	Phone or Email:
Who referred you to our office? (Physician, Phone book, online search)	

Insurance: Primary _____

Insurance: Secondary _____

- If either of the above insurances are offered through a retirement plan, please state the name of the company you worked for prior to retiring: _____
- Do either of your insurance companies require pre-authorization to see a physician? Yes ☐ No ☐
- If authorization is required, did you bring it with you? Yes ☐ No ☐
- If you receive insurance through someone else such as a parent or spouse, please enter the information below:

Name of Insured:	Employer:		Relation to Patient:
Address			SS# - -
City	ST:	Zip:	Insured's DOB: / /

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Financial Policy

Effective January 1, 2026

We are committed to providing you with the best possible care and we would be happy to discuss our fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees or financial policy.

Our office requires payment in full due at the time of service unless we participate with your insurance company, or arrangements have been made prior to the appointment. Co-payments and deductibles are always expected at the time of the service. If it should become necessary to bill you, it is our policy to add a late payment charge of 1.5% per month on all unpaid balances starting 30 days from the date of your first bill.

Also, *please remember that your insurance policy is a contract between you and your insurance company.* You are ultimately responsible for knowing what diagnosis(es) and/or procedure(s) may or may not be considered for payment or require deductible, co-payment, etc.

MISSED APPOINTMENTS: You may be subject to a $50 charge for missed appointments if the appointments are not canceled at least 24 hours in advance.

INSURANCE CHANGES: Please don't forget you must notify us prior to your next visit if your insurance changes or you may be responsible for payment yourself. I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered. I certify that the information I have provided is true and correct to the best of my knowledge. I will notify you of any changes in the information that I have provided.

PATIENT WITH MEDICARE COVERAGE
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician and authorize such physician to submit a claim to Medicare.

NON-MEDICARE PATIENTS
I authorize the release of all medical information to my insurance company(ies) and request that payment of my insurance benefits be sent directly to The Florida Urology Center (unless payment in full has been made at the time of service).

TREATMENT
By signing below, I authorize treatment by The Florida Urology Center's physicians and their staff.

HIPPA
By signing below, I acknowledge I have received a copy of the Notice of Health Information Practices.

CONTACT
By signing below, I authorize all of the phone numbers I have provided (including my mobile number) to be used to communicate with me regarding my treatment, billing or services rendered.

_____ _____

Signature of Patient / Guardian **Date**

Please bring your insurance cards, photo identification and medication list to your appointment.

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Name: _____ Date: _____

What is your reason for seeing the doctor?

What questions would you like to ask the doctor?

Have you ever been treated for alcoholism? ☐Yes ☐No
Have you ever been treated for drug abuse? ☐Yes ☐No
Have you ever had a blood transfusion? ☐Yes ☐No

Personal History	Yes	Surgical History	Yes	Date	Allergy History	Yes
Arthritis		Appendix			Aspirin	
COPD		Gall bladder			Codeine	
Coronary artery disease		Hemorrhoid			Morphine	
Diabetes		Hernia			Mycins	
Gonorrhea / Syphilis		Prostate			Penicillin	
Hay fever / Asthma		Ovary/Ovaries			Sulfa	
Heart Disease / Stroke		Uterus			Tetracycline	
Hernia		Other (explain below)			Cipro	
High/Low Blood Pressure					Latex	
Paralysis					Iodine	
Neuritis					Other: (list below)	
Hernia						
Cancer (explain below)						

Date of last visit with your primary care physician: Date:

LIST ALL MEDICATIONS: PRESCRIPTIONS AND OVER THE COUNTER OR PROVIDE WRITTEN LIST

Medication name	Dosage/Strength	Frequency/how often	Taken orally?

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2026 New Patient: Review of Symptoms | Check All That Apply

CONSTITUTIONAL	Yes
Weight Loss	
Fatigue	
Fever	
EYES	
Glasses / Contacts	
Eye Pain	
Double Vision	
Glaucoma	
Cataracts	
EAR – NOSE - THROAT	
Difficulty Hearing	
Ringing in Ears	
Vertigo	
Sinus Trouble	
Nasal Stuffiness	
Frequent Sore Throat	
Hoarseness	
CARDIOVASCULAR	
Murmur	
Chest Pain	
Palpitations	
Dizziness	
Fainting Spells	
Shortness of Breath	
Difficulty Lying Flat	
Swelling Ankles / Other	
OTHER	
Cancer:	
Diabetes: ❒ Non-Insulin ❒ Insulin	

RESPIRATORY	Yes
Cough	
Coughing Blood	
Wheezing	
Chills	
GASTROINTESTINAL	
Heartburn	
Nausea / Vomiting	
Constipation	
Change in B.M.'s	
Diarrhea	
Difficulty Swallowing	
Jaundice	
Abdominal Pain	
Black Stools	
GENITOURINARY	
Pain Urinating	
Burning	
Frequency	
Nighttime	
Blood in Urine	
Difficulty Urinating	
History of Kidney Stones	
History of Sexually Transmitted disease	
Abnormal Discharge	
ENDOCRINE	
Loss of Hair	
Heat / Cold Intolerance	
Change in Nails	

HEMATOLOGIC / LYMPH	Yes
Easy Bruising	
Gums Bleed Easily	
Enlarged Glands	
Prolonged Bleeding	
MUSCULOSKELETAL	
Joint Pain / Swelling	
Stiffness	
Muscle Pain	
Back Pain	
SKIN	
Rash / Sores	
Lesions	
Itching / Burning	
NEUROLOGICAL	
Seizures	
Weakness / Paralysis	
Numbness	
Tremors	
Memory Loss	
ALLERGIC / IMMUNOLOGIC	
Hay Fever / Asthma	
Hives / Eczema	
PSYCHIATRIC	
Anxiety / Depression	
Mood Swings	
Difficult Sleep	
FEMALE ONLY	
Age of Onset of Periods	
Age of Onset menopause	
Are Periods Regular	Y | N

HABITS	YES
Exercise Adequately	
Coffee ( ) Cups per day	
Alcoholic Beverages ( ) per day	
Cigarettes / Cigars ( ) per day	
Sex-Entirely Satisfactory	

FAMILY HISTORY – PATIENT RELATIONSHIP	YES
Cancer	
Diabetes	
Heart Trouble	
High Blood Pressure	
Stroke	
Kidney Stones	

X-RAY HISTORY / DATE	YES
Chest	
CT Scan	
Bone Scan	
IVP	
KUB	
MRI	

OTHER	
What is your current weight?	Lbs.
What is your height?	Ft. In.

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Florida Urology Center General Consent for Care and Treatment-

MUST SIGN AND DATE BEFORE BEING SEEN

Patient Name: _____

Account#: _____

DOB: _____

1. I consent to examination, diagnosis, and general medical care and treatment (including, but not limited to, physical examinations, administration of medications and vaccinations, recordings and/or photographs for diagnosis and/ or treatment, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, radiation therapy and other minor procedures) to be performed by employees, including, but not limited to, physicians, advanced practice providers, nurses and assistants of Florida Urology Center and its subsidiaries (hereinafter "FLURO").

2. I understand that the nature of and the need for each procedure and treatment will be explained to me beforehand and that I am free to refuse any one or all procedures or treatments if I so choose. I will have the opportunity to ask the doctor questions about the operation/procedure and such questions will be answered to my satisfaction.

3. I consent to the present and future prescription and/or administration of medicines or drugs as may be deemed necessary by my/the patient's physician or others of the Florida Urology Center medical staff in the course of my/the patient's diagnosis and treatment with the understanding that the nature of and the need for such medicines or drugs will be explained to me beforehand and that I shall always be free to refuse each and all of them if I so choose.

4. I understand that the explanation which will be given to me of the nature, intended purpose and the reasonable foreseeable risks, consequences, complications, benefits and alternatives of the examination(s), procedure(s) or treatment(s) which may be performed or used in the course of diagnosing or treating my/the patient's condition will not be exhaustive and that other risks and complications may arise, but the likelihood of occurring is not reasonably foreseeable. I have been advised that if I desire a more detailed explanation prior to my consent, such an explanation will be given to me.

5. I understand that some important tasks may be performed by qualified medical practitioners other than the named surgeon(s)/physician(s) and I consent to their doing so. The specific tasks will be determined based on the practitioner's skill set, scope of practice under the applicable state law and will be performed under the supervision of FLURO surgeon(s)/physician(s). I have been explained what specific tasks these practitioners will perform and I give my consent.

6. I understand that my protected health information will be used by FLURO as necessary for my treatment, to obtain payment for this treatment and for the healthcare operations of FLURO. I also understand that my protected health information will be disclosed to other FLURO affiliates if needed to further my treatment, to obtain payment for treatment and for healthcare operations of FLURO.

7. I understand that FLURO will warn the appropriate authorities and/or other individuals if my FLURO caregiver determines that I am harmful to myself or to others.

8. I consent to receive advanced biomarker or genomic testing based upon my healthcare needs as medically necessary and ordered by my healthcare provider with my informed consent. Additionally, I authorize and consent for FLURO to use my non-identifiable bio-specimens and my data to develop and further support the advancement of science, which includes, but is not limited to, recommendations to participate in clinical trials and the development of products such as tests, drugs or medical devices that could be sold in the future. I understand that my non-identifiable bio-specimens and data may be used to learn about, prevent or treat urologic issues.

9. I understand that performing a medication reconciliation to prevent adverse drug interactions and overdose is a critical aspect to my care. I give Florida Urology Center permission to query and review my medication fill history including drug dose, form, strength, prescriber provider and pharmacy by using Greenway Health EMR.

10. I understand that the medical practice/clinic may utilize an AI medical scribe/virtual scribe during my consultation to assist our healthcare providers in documenting my medical care. All information handled by an AI/virtual scribe is kept confidential and only used if compliant with applicable laws.

I confirm that I have read and fully understand this document, that I have been given the opportunity to ask questions about the operation/procedure and have had my questions answered satisfactorily and that I am eligible to give this consent.

Patient and/or Guardian

Signature: _____

Date: _____

Verbal consent obtained, unable to sign