Patient Name: ____Date of Birth:______________

Sex:Male____Female____ Age: __________ Marital Status:_____________________________

Email Address: ____

How did you hear about us? ____

Primary Care Physician: ___________________________________Occupation: ________________________

Work Status: Presently working _____ Retired _____ Disabled______

Reason for visit today:____

Height __________________ Weight______________

Do You: Smoke? No__Yes__ if yes How Long? _____ Number of Packs per day? ____

Do You: Drink Alcohol? No____ Yes____ if yes how much? ____________________

Preferred Pharmacy: ____

Ongoing medical illnesses (include diagnosis):

____

____

Prior Surgery including Month/Year:

____

____

Other Hospitalizations including Month/Year:

____

____

List current Medications you are taking (including dosage):

____

____

List Medication Allergies and reaction: ____

____

Family History/Diseases: ____

____

****Males Only****

Erectile Dysfunction No______ Yes _____

Urinary Leakage No ______Yes _____ Number of times awakened to urinate at night: _______

****Females Only****

Urinary Leakage: No ____Yes_____ Urinary Frequency: No ____Yes____

Are you pregnant? No ____ Yes ____ # of pregnancies: ________ # of children: _____

Please check if you have now or have had in the past any of the following:

__Anemia
__Gastritis
__Kidney Stones
__Rash
__Anesthesia Issues
__Diverticulitis
__Leg/Foot Disorder
__Rheumatic Fever
__Arthritis
__Emphysema
__ Leukemia

__Sickle Cell
__Shingles
__Asthma
__Eye Disorder
__Paralysis
__Thyroid Condition
__Back Problems
__Gout
__Mental Illness
__Skin Disorders
__Bladder Infections
__Heart Attack

__Heart Murmur
__Nerve Disorder
__Ulcers
__Blood In Urine
__HIV/AIDS
__Osteomylitis
__Stroke
__Bleeding Disorder
__Hypertension
__Prostate Disorder
__Venereal Disease
__Blood Disorders
__Phlebitis

__Tuberculosis
__Bronchitis
__Hepatitis
__Polio
__Vein Clot
__Cancer
__Liver Disorders
__Poor Circulation
__Diabetes
__Kidney Disorder

This information is correct to the best of my knowledge.

____ __________________

Patient's Signature Date

HIPPA Release Form

The **Health Insurance Portability and Accountability Act of 1996** (HIPAA) is a federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

Patient name: ______________________________________ DOB: _________________________

Release of Information

□ I authorize the release of information including the diagnosis, records; examination rendered to me and claims / billing information.

This information may be released to:

Spouse:____________________________________ Phone:____________________________

Child:_____________________________________Phone:____________________________

Other: _____________________________________ Phone: ____________________________

□ Information is not to be released to anyone.

This Release of information will remain in effect until terminated by me in writing.

Messages

Please call/text:

- □ Home: _____________________________
- □ Cell: _______________________________
- □ Work: ______________________________

If unable to reach me:

- □ You may leave a detailed message.
- □ Please leave a message asking me to return your call.
- □ Do not leave a message.

Patient signature: ______________________________________ Date: ______________________

Gulf Coast Urology Consent Form

INSURANCE

Gulf Coast Urology (GCU) is contracted with most insurance plans. Our staff will make a good faith attempt to determine benefit levels & estimate any charges you may incur.

You, as the patient, agree to:

- Provide GCU with accurate health insurance coverage & billing information
- Understand your level of coverage from your insurance company & your out-of-pocket cost
- Understand what medical services are covered by your insurance provider
  - If you consent to receive medical services that are considered a "non-covered benefit", you will be held financially responsible for these charges.
    - *It is your responsibility to be sure that your referral & authorization arrive prior to your visit*

PAYMENT

Unless prior arrangements are made ***all copayments, deductibles & share of costs are due at the time of service.*** For your convenience our office accepts cash, checks, Visa & MasterCard American Express.

RETURNED CHECKS

All returned checks will be subject to three times the amount of the original check or $100 (whichever is greater). Repeat returned checks will result in cash payment being required for future services.

MISSED APPOINTMENTS & LATE ARRIVALS

If you are unable to attend your appointment please call us a minimum of 24 hours prior to cancel or reschedule. **If you fail to show up for a scheduled appointment you will be charged $25.00.** If you are **more than 15 minutes late** without notice you will have to be rescheduled & may be charged as a no-show.

Patient Initials_______________
(*I understand the policy for missed/late appointments)*

AFTER HOURS CARE

If you have a medical emergency, please call 911. If you have a non-emergent question or need, you may call our office & the phone service will contact the physician on call.

FORMS & PHYSICIAN LETTERS

We will gladly complete your disability forms, however please **allow 72 hours** for completion. A fee of $ 25.00 will be collected prior to completion for each form. For Physician letters there will be a fee of $10.00 per physician letter requested.

I understand the above & by my signature below, I acknowledge that I have been given the opportunity to review the GULF COAST UROLOGY CONSENT FORM & NOTICE OF PRIVACY PRACTICES FOR GULF COAST UROLOGY which explain how my medical information will be used & disclosed. I understand that I am entitled to receive a copy of this document.

_______________________________________ Name of Patient or Personal Representative

_______________________________________ Signature of Patient or Personal Representative

_______________________________________ Description of Personal Representative's Authority

_________________________ Date