Florida Urology Partners

Date of Visit : _____

Physician You Are Here to See: _____

Prefix | Last | First | Middle | Suffix

Maiden | Gender | SSN | Marital Status | Date of Birth

Race | Ethnicity | Primary Language

Address Line 1

Zip | City | State | Country

Home Phone | Cell Phone | Work Phone

Please circle preferred contact phone

May we leave updates concerning your care on voice mail at above contact number? **Yes** ☐ **No** ☐

Email

How Did You Hear About Us?

Primary Care Physician | Address | Phone

Preferred Pharmacy | City | Phone | Intersection

Emergency contact not living with you (must be filled out) | Phone

Emergency contact address

Primary Insurance | ID # | Group #

Secondary Insurance | ID # | Group #

Other Health Insurance | ID # | Group #

Primary Policyholder (if not patient) | Phone Number | Relationship

Florida Urology Partners

Policies and Authorizations

Cancellation – Failure to cancel your appointment creates gaps in the physician schedules that could be otherwise used to accommodate patients with urgent problems. Therefore**,** we require a 24-hour notice of cancellation for office visits, and 72-hours notice of cancellations prior to hospital or office surgeries or procedures. If we are not notified within the above timeline, it will result in a fee of $50 for a missed appointment and $150 for a missed surgery or office procedure.

Forms – A $25 fee is applied for each form presented to Florida Urology Partners for completion. As examples, but not limited to: FMLA forms, private disability or cancer policy forms, school or work disability or limitation forms, or financial deferment forms.

Records Request – Patients are entitled to a copy of their own office visit records, and they will be furnished upon request. However, if multiple copies are requested, or if a comprehensive request for records including all associated reports and documents, we will charge $1 per page, not to exceed $10.

Assignment of Benefits – I hereby authorize my insurance benefits to be paid directly to Florida Urology Partners, LLP. I understand that I am responsible for non-covered services and I authorize the release of medical information to my insurance company.

Co-pays – Co-pays and deductibles are due at the time of service. We will make every effort to make an accurate determination of patient responsibility based on your insurance plan and use of the online insurance verification service.

Referrals – If you have an HMO requiring a referral or prior authorization from your Primary Care Physician, please understand that this is the insurance plan you selected and you are responsible for obtaining the referral prior to the office visit. Failure to do so will result in inconvenience to you and the Physician and your appointment being rescheduled.

Lifetime Signature – I authorize the release of medical information to my insurance company to process claims. I authorize this to be used as a lifetime signature to avoid the inconvenience of having to sign individual insurance claim forms at every office visit.

_____ _____

Signature of Patient **Date**

_____

Print

_____ _____

Witness **Date**

Florida Urology Partners

Notice of Privacy for Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office uses and discloses your protected health information for the following reasons:
To share with other treating health care providers regarding your health care.
To submit to insurance companies claims or other payers to verify that treatment has been rendered.
To verify patient's benefits in a health care insurance plan.
Release of information required by State or Federal Public Health Law.
To assist in overcoming a language barrier when caring for a patient.
Business associates providing written assurances that your privacy have been attained.
Situations deemed emergent or medically urgent by the Physician.
Abuse, neglect, or domestic violence in accordance with State and Federal Law.
Appointment reminders to household members or on answering machines.
Sign-in logs may be disclosed to verify office visits.
Occasional photographs and other letters and cards of appreciation from patients that are displayed.

Any other disclosures will only be made with your specific written prior authorization.

You have the right to:
Revoke authorization in writing at any time by specifying who you want restricted and sending it to Florida Urology Partners P.O. Box 26026, Tampa, FL 33623.
Speak to our privacy officer who can be reached at 813-356-0196.
Inspect copy and amend your protected health information as allowed by law.
To render a complaint to our privacy officer or to the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Name of Patient_____

Signature _____

Date_____

Florida Urology Partners

Authorization for Release of Medical Records:

Name_____ Date of Birth _____

Last 4 digits of social security number_____

I authorize and request Florida Urology Partners, LLP to receive copies of medical records from any physician's office, laboratory, and hospital that has any health information on me. The information that is being requested is needed as soon as possible in order to get the proper medical treatment I need at the time the services are rendered.

Specific records or results requested

Physician or facility from where the records are being requested

Please send the records to the following fax number (circle):

Rudolph Acosta, MD
Fax 813-980-3106

Raviender Bukkapatnam, MD
Howard Heidenberg, DO
Malcolm Root, MD
Ross Simon, MD
Mohit Sirohi, MD
Fax 813-258-3535

Frank Mastandrea, MD
Fax 813-872-7356

Alexander Engelman, MD
Nirav Patel, M.D.
Fax 813-353-8602

Reid Graves, MD
Nicholas Laryngakis, MD
Adam Oppenheim, DO
Ankur Shah, MD
Fax 727-822-9211

James Alver, MD
Mark Baker, MD
Alexander Boyle, MD
Brian Cronson, MD
Neil Manimala, MD
Angelo Paola, MD
Jonathan Pavlinec, MD
Fax 813-685-0968

Salim Afridi, MD
Fax 813-719-6398

Sam Fisher, MD
David Hochberg, MD
Drew Palmer, MD
Timothy Weber, MD
Luke Sebel, MD,PHD
Fax 813-879-2015

Alonso Alvarez, MD
Osvaldo Padron, MD
Stephanie Stillings, MD
Fax 813-875-0188

David Buethe, MD
Anisleidy Fambona, MD
Barry Sadler, MD
Kevin Spires, MD
Arnie Tannenbaum, MD
Mark Weitzenfeld, MD
Fax 352-596-5378

Patient Name_____ Signature _____Date_____

Reset Form