Urology Partners

WELCOME TO UROLOGY PARTNERS

LOCATION:

FAIRVIEW HOSPITAL
18099 Lorain Ave.
Ste. 141
Cleveland, OH 44111
P: 216.941.0333
F: 216.941.5257

ST. JOHN MEDICAL CENTER
29101 Health Campus Drive
Ste. 310
Westlake, OH 44145
P: 440.892.6600
F: 440.892.3482

UROLOGY ASSOCIATES
5260 Smith Rd.
Brookpark, OH 44142
P: 216.941.0333
F: 216.941.5257

Your Appointment is with:

☐ Christopher S. Reese, M.D.

☐ James A. Kontak, M.D.

☐ Patrick Irwin, M.D.

Appointment date:

_____

Appointment time:

_____

Thank you for trusting Urology Partners with your care. At Urology Partners, we provide quality urologic services in each of our locations and our staff strives to provide each of our patients with the individualized care they deserve. It is this compassionate approach, combined with our state-of-the art facilities, comfortable environment and commitment to utilizing the most advanced treatment techniques available that help make Urology Partners a premier urology center.

For your first visit, please fully complete and sign all forms included in your packet. You will need to present these forms to the front desk upon your arrival. If you are unable to complete these forms before your first appointment, please arrive 30 minutes early to complete them in office. If you need to reschedule or cancel your appointment, please call at least 24 hours before your scheduled visit.

YOUR FIRST VISIT

To evaluate your health, it is extremely important that we receive your medical records prior to the time of your scheduled visit. Please arrange to have your doctor send these to our office before your initial appointment. To provide you the highest quality of care, your physician will need to review any pathology, surgical reports, x-ray scans, laboratory results, medical notes and in-patient records that are available.

We accept most insurance carriers and our staff will work with you to ensure that you have the coverage you will need.

WE ASK THAT PATIENTS ALWAYS

- Bring insurance cards and photo ID to each visit. If there is a secondary insurance plan, a Medicare supplemental plan, or a prescription plan, please make sure to bring all of your cards.
- Keep us informed of any change to any vital statistics such as address, telephone number, employment status, marital status or insurance.
- Provide a current list of medications at each office visit; it is necessary that we review all prescription and over the-counter medications currently being taken including vitamins, herbs, aspirin, Tylenol, etc. Some patients find it more convenient to bring the medication bottles to the appointment.
- Allow a 72-hour turnaround for prescription refills. Please note that some prescriptions for pain medications do not allow refills, therefore we request that patients contact us prior to running out of any medication.
- Consider the compromised immune systems of other patients and refrain from bringing children to your appointments. If you are feeling ill, please call us prior to your appointment so we can provide guidance.
- Write down any questions or concerns that arise to discuss with the physician. Once a patient has made an appointment, all facets of our services-from the latest research findings to the most advanced technology-will be utilized in providing the highest level of quality medical care.

Again, we welcome you and say thank you for choosing Urology Partners. For further information, please visit our website at www.urologypartners.net.

MRN:

Urology Partners

PATIENT REGISTRATION

PLEASE PRINT CLEARLY Today's Date: _____

Patient Name: _____

DOB: ____ /____ /_____ Age: _____ Gender: ☐ Male ☐ Female ☐ Transgender: ☐ M to F ☐ F to M

SSN: _____ Cell Phone: (_____) _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Language: _____

Ethnicity/Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American
☐ Asian/Pacific Islander ☐ Other

Occupation: _____

☐ Employed/Self Employed ☐ Unemployed ☐ Retired ☐ Disabled

Name of Employer: _____ Work Phone: (_____) _____

Relationship Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Living situation: ☐ Lives Alone ☐ Lives with Family ☐ Lives in Nursing Home
☐ Winter Resident ☐ Year Round Resident

Are you currently receiving home health? ☐ Yes ☐ No

Children: ☐ Yes ☐ No If yes, how many? _____

Primary Care Physician: _____ Phone #: _____

Referring Physician (if different): _____ Phone #: _____

Oncologist: _____ Phone #: _____

Cardiologist: _____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

Patient Initials: _____

MRN:

Urology Partners

PATIENT REGISTRATION

Primary Insurance Carrier: _____

Name of primary policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's employer: _____

Insurance ID #: _____ Group #: _____

Secondary Insurance Carrier: _____

Name of primary policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's employer: _____

Insurance ID #: _____ Group #: _____

Prescription Drug Coverage

Group #: _____ PCN #: _____

BIN #: _____ ID #: _____

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

Signature: _____ Date: _____

Patient Initials: _____

Witness Name: _____ Witness Relationship: _____

Witness Signature: _____

MRN:

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MEDICAL HISTORY FORM

PLEASE PRINT CLEARLY

Patient Name: _____

Reason For This Visit: _____

SURGICAL HISTORY

☐ No Past Surgery

Procedure	Date Performed	By Whom

Do you have an implanted device, such as a pacemaker? ☐ Yes ☐ No
If yes, please provide a copy of your device card for our records

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

Have you had radiation or chemotherapy treatment in the past? ☐ Yes ☐ No

Have you ever had a colonoscopy or colon cancer screen? ☐ Yes ☐ No Date: _____

ALLERGIES AND SENSITIVITES:

(List Allergies you have and how each affects you.)

☐ No known allergies ☐ No known drug allergies ☐ Latex

Allergy	Reaction

Have you ever had a reaction to anesthetic? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY:

Indicate any family members with breast, ovarian, pancreatic, prostate, melanoma, colon, kidney or uterine cancer, blood disease or other disease.

	Age:	Disease:	If deceased, cause of death:
Father:			
Mother:			
Maternal Grandparents:			
Paternal Grandparents:			

MRN:

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MEDICAL HISTORY FORM

MEDICATION LIST:

Please list all medications: Prescription / over the counter / vitamins / supplements
List dosage and how often you take (example: Flomax 0.4mg, 1 tablet a day)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Mail order Name: _____ Phone: (_____) _____ ID #: _____

Local Pharmacy Name: _____ City: _____ Phone: (_____) _____

Patient Initials: _____

SOCIAL HISTORY:

Work Hazards:

Any occupational hazards (like noise or chemical exposures) ☐ Yes ☐ No If yes, what: _____

Tobacco Use: (Present and/or past)

☐ Never smoked

☐ Quit smoking When? _____ How many years did you smoke?___yr(s) Age started: _____
How many packs? _____/day

☐ Currently smoke ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarettes

How many packs? _____/day How many years? _____

☐ Chewing tobacco ☐ Current ☐ Past How long? _____

Alcohol Use: (Present and/or past)

☐ Non drinker

☐ Beer number of bottles _____ per ☐ Day ☐ Week ☐ Month

☐ Wine number of bottles _____ per ☐ Day ☐ Week ☐ Month

☐ Liquor number of bottles _____ per ☐ Day ☐ Week ☐ Month

Signature: _____ Date: _____

Patient Initials: _____

MRN:

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MEDICAL HISTORY FORM

REVIEW OF SYSTEMS:

(Please check any past or current symptoms you have.)

Respiratory:
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Short of Breath
- ☐ Wheezing

HEENT:
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataract
- ☐ Hearing Loss

Endocrine:
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Hormone Replacement

Hematological:
- ☐ Anemia
- ☐ Swollen Lymph nodes
- ☐ Blood Clots
- ☐ Platelet problems
- ☐ Surgical bleeding
- ☐ Abnormal bruising
- ☐ Bleeding gums
- ☐ Blood transfusions
- ☐ Bleeding disorder
- ☐ HIV/AIDS

Cardiovascular:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Heart Attacks
- ☐ Hypertension
- ☐ Heart Failure / Heart Disease
- ☐ Pacemaker
- ☐ Heart Stent
- ☐ Leg / feet swelling
- ☐ Heart Murmur
- ☐ Rhythm Problems
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Diabetes – Type 1 / Type 2

Gastrointestinal:
- ☐ Constipation
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Hepatitis
- ☐ Reflux disease
- ☐ Black stools
- ☐ Bowel changes
- ☐ Abdominal pain
- ☐ Hemorrhoids
- ☐ Nausea

Genitourinary:
- ☐ Urinary Loss
- ☐ Frequent Urination
- ☐ Pain with Urination
- ☐ Blood in Urine
- ☐ Bladder Problems
- ☐ Kidney Stones
- ☐ Incontinence
- ☐ Erectile Problems
- ☐ Lump, Bump or curve with erection

Musculoskeletal:
- ☐ Arthritis
- ☐ Bone pain
- ☐ Gout
- ☐ Osteoporosis
- ☐ Back pain

Neurological:
- ☐ Headache / Migraine
- ☐ Numbness
- ☐ Balance / Dizziness
- ☐ Stroke / TIA
- ☐ Seizure
- ☐ Memory loss
- ☐ Confusion
- ☐ Tingling

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Appetite changes
- ☐ Suicidal thoughts
- ☐ Panic disorder

Integumentary (Skin):
- ☐ Rash
- ☐ Itching
- ☐ Skin Lesions

Gynecologic:
# of Pregnancies: _____
# of Deliveries: _____
# of Cesarean Sections: _____
Abortions / Miscarriages?
☐ Yes ☐ No

OTHER ILLNESS OR MEDICAL PROBLEMS:

(Please list current and past medical problems that you have been treated for AND the physician who treated you.)

Illness / Medical Problem	Physician

Signature: _____ Date: _____

Patient Initials: _____

MRN:

Urology Partners

HEALTH INFORMATION MANAGEMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO Urology Partners AND ITS ASSOCIATES

PLEASE PRINT CLEARLY

PATIENT INFORMATION:

Patient Name: _____ SSN: _____
please print

Telephone Number: _____ DOB: _____

INFORMATION TO BE RELEASED FROM/TO : ☐ FROM ☐ TO

I hereby authorize the release of information in my medical record from/to (Provider Name):

_____

_____ _____ _____ _____
Address City State Zip Code

_____ _____
Phone Fax

Including contents regarding drug or alcohol abuse, psychiatric, psychotherapy notes and HIV related (AIDS) diagnosis and/pr test results. Exclusions to the above: _____

_____

INFORMATION TO BE RELEASED FROM/TO : ☐ FROM ☐ TO

☐ **Fairview Hospital**
18099 Lorain Ave. Ste. 141
Cleveland, OH 44111
Ph: 216.941.0333
Fax: 216.941.1071

☐ **St. John Medical Center**
29101 Health Campus Drive
Ste. 310
Westlake, OH 44145
Ph: 440.892.6600
Fax: 216.941.1071

☐ **Northern Ohio Regional Center**
5260 Smith Rd.
Brookpark, OH 44142
Ph: 216.941.0333
Fax: 216.941.1071

TYPE OF RECORD:

☐ ALL MEDICAL RECORDS (pertinent only) (limited 2 years of information)
☐ History & Physical
☐ Discharge Summary
☐ Operative Report
☐ Consultation Report
☐ Psychotherapy notes only
☐ Radiology reports (Specify): _____
☐ Lab Results
☐ Evidentiary Examination
☐ ER Report
☐ Other Information (Specify): _____

PURPOSE OR NEED FOR THIS INFORMATION IS:

(Please check all that apply)
☐ Medical ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

CONTINUED ON BACK

MRN:

Urology Partners

HEALTH INFORMATION MANAGEMENT

PLEASE PRINT CLEARLY

- I authorize the release of the specified information from my medical records.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPAA). However, under California law the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose my information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- A photocopy of this release is as effective as the original.
- I have received a copy of this authorization.

SIGNATURE: _____ Date: _____

(Patient / Legal Representative / Guardian)

MRN:

Urology Partners

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS

PLEASE PRINT CLEARLY

Patient Name: _____ DOB: _____

Thank you for choosing Urology Partners as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS

I give permission to Urology Partners to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to Urology Partners.

USE OF PHOTOGRAPHY

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-PRESCRIPTION FOR MEDICATION HISTORY

We may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

PATIENT AUTHORIZATIONS

- By my signature below, I hereby authorize Urology Partners to release medical and other information to the necessary insurance companies and third party payers requires for payment or rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to Urology Partners. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits form.

Signature of Patient of Guardian: _____ Date: _____

MRN:

Urology Partners

AUTHORIZATION TO RELEASE HEALTH INFORMATION AND NOTICE OF PRIVACY PRACTICES

PLEASE PRINT CLEARLY

Patient Name: _____

Emergency Contact Name: _____

Relationship: _____ Phone #: (____) _____

Durable Power of Attorney for Healthcare: ☐ Yes ☐ No _____

Relation to you: _____

Living Will for Healthcare: ☐ Yes* ☐ No *Please provide a copy for our records

To protect your privacy, please let us know how you would like us to contact you and who we may release your private health information (PHI) to on your behalf.

☐ No, please do not discuss PHI with anyone. **WARNING: if you choose this option and you become ill and unable to call or come into the office for assistance we may, in our professional judgment, disclose necessary PHI to another medical professional to ensure you are given appropriate medical care.**

☐ Yes, allow communication with:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

What kind of PHI may we discuss with your designated family members and/or others involved with your care?

☐ Medical Care ☐ Billing and Payment Information

I _____ , understand the above authorization will remain in effect until I change it in writing. I have been given a copy of the Notice of Privacy Practice for Urology Partners.

_____	_____	_____
Patient Signature	Print Name	Date

Date of Birth: _____

MRN:

Urology Partners

COMMUNICATION AUTHORIZATION TO RELEASE HEALTH INFORMATION

ELECTRONIC COMMUNICATIONS

For your convenience our office communicates through different electronic means including our secure patient portal, phone, and text messaging for appointment reminders.

May We Contact you at:

Home? ☐ Yes ☐ No Number _____ Work? ☐ Yes ☐ No Number _____

Cell? ☐ Yes ☐ No Number _____

Via Email? ☐ Yes ☐ No Email Address _____

May we send appointment reminder via text? ☐ Yes ☐ No

May we leave a message on your answering machine or cell? ☐ Yes ☐ No

Any information? ☐ Yes ☐ No

Limit information to the following: _____

May we leave a message with a family member or other person at your home? ☐ Yes ☐ No

Any information? ☐ Yes ☐ No

Limit information to the following: _____

Please check below if you do NOT want to be contacted by Urology Partners in any of the following methods of communication:

☐ Cell Phone ☐ Text Message ☐ Home Phone ☐ Secure Email ☐ Online Patient Portal

Is it okay to leave a detailed message on your voicemail? ☐ Yes ☐ No

_____ _____

Signature of Patient of Representative Date

MRN:

Urology Partners

PATIENT PAYMENT POLICY

Dear Patient,

Thank you for choosing Urology Partners as your health care provider. We are committed to providing you with quality health care. We have developed a payment policy to help you understand your responsibility and that of your insurance carrier (if applicable). Please read the policy and sign in the space provided. A copy will be provided to you upon request. If you have questions, please let us know.

1. **Insurance.** Your insurance policy is an agreement between you and your insurance company. We are not a party to your contract. As a courtesy, we will bill your insurance plan for you, if you provide us with accurate information. Please contact your insurance company with any questions you may have regarding coverage.
    a. Non-contracted insurances: if we are not contracted with your insurance company, please be advised that your out-of-pocket costs may be greater than originally anticipated. We will give you an estimate of your costs but the final amount due will be determined by reimbursement from your insurance company.
2. **Non-covered services.** Please be aware that some of the services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurers.
3. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that charges for services received are your responsibility whether or not your insurance company pays your claim.
4. **Proof of insurance.** All patients must complete a patient information form before seeing the doctor. We will ask for a copy of your current valid insurance card(s) as proof of insurance.
5. **Coverage changes.** If your insurance changes, please notify our office immediately so we can make the appropriate changes to your billing information. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all incurred charges.
6. **Co-Payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.
7. **Nonpayment.** Please be aware that if you fail to pay your portion of your bill, we may refer your account to a collection agency and you may be discharged from this practice.
8. **Financial Counselor.** We have a Financial Counselor available as a resource to our patients. If Financial Assistance is available for you, our counselors will complete the necessary application(s) on your behalf.

I have read and understand the payment policy and agree to abide by these guidelines. I understand that I am responsible for any portion of my bill that is not covered by my insurance company.

Signature of Patient or Responsible Party _____ Date _____

Print Name _____ Relationship to Patient _____