Today's Date: ____/____/____

Date of Birth: ____/____/____

CHART#:_____

URO-MEDIX

A Division of 21st Century Oncology, LLC

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Board Certified Urology and Urological Surgery

Ref. Phys. #: _____

Fax #: _____

UROLOGIC CONSULTATION RECORD

Patient's Name: _____ Age: _____ Referring Physician: _____

Chief complaint: What is the main reason for our visit today? *(Describe your problem in detail)* _____

_____

_____

HISTORY OF PRESENT ILLNESS

Please answer the following questions

Location of the problem:_____

_____

_____

Which number best describes your problem on a scale of 1-10, with 10 being the most severe? _____

When did you first notice the problem?
2 days ago_____ 2 weeks ago_____1 month ago_____

How long does the problem last?
30 minutes_____1 hour_____It is always there_____
Other_____

Do you have allergies to medications? ☐ Yes ☐ No
(if yes, explain)

_____

( ) Penicillin ( ) Iodine
( ) Sulfa ( ) Other _____
( ) Antibiotics _____

LIST ALL MEDICATIONS THAT YOU ARE TAKING:

_____ _____ _____

_____ _____ _____

Do you take Aspirin? ☐ Yes ☐ No

Do you pre-medicate with antibiotics for procedures such as Dental cleanings? ☐ Yes ☐ No

Voiding Frequency *(indicate number)* __ Day __ Night
Burning with urination? ☐ Yes ☐ No
Do you lose control and leak urine? ☐ Yes ☐ No
If Yes, it happens while:
Coughing _____ Sneezing _____ Urgency_____
Blood in urine? ☐ Yes ☐ No
Difficulty voiding? ☐ Yes ☐ No
Most recent PSA: _____
Are you sexually active? ☐ Yes ☐ No

LIST ALL SURGERIES YOU HAD IN THE PAST:

Type _____ Year _____
Type _____ Year _____
Type _____ Year _____
Type _____ Year _____

Do you personally have a medical history of any of the following?

☐ Heart disease
☐ High blood pressure
☐ Cancer _____
☐ Mitral valve prolapse
☐ Diabetes
☐ Glaucoma
☐ Hypothyroidism
☐ Pacemaker
☐ HIV / AIDS
☐ Hepatitis
☐ Gout
☐ Ulcer disease
☐ Strokes
☐ Kidney Stones
☐ High Cholesterol
☐ Parkinson's
☐ Kidney Failure
☐ Other _____

Physicians Comments/Therapy:

Impressions:

Recommendations:

Physician: _____ Date ___/___/___

REV. 6/12

Patient's Name _____

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REVIEW OF SYSTEMS

Do you now have or have you had any problems related to the following systems? Circle **Yes** or **No**

Please explain any YES answers in the space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other:_____	Y	N

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other:_____	Y	N

Ears, Nose, Throat, Mouth

Hearing Loss	Y	N
Nose Bleeds	Y	N
Sore Throat	Y	N
Dentures	Y	N
Other:_____	Y	N

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/Tingling	Y	N
Other:_____	Y	N

Psychiatric

Depression	Y	N
Drug Addiction	Y	N
Anxiety	Y	N
Other:_____	Y	N

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/sluggish	Y	N
Other:_____	Y	N

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion	Y	N
Other:_____	Y	N

Other: (Explain)

_____

_____

Do you use and protective pads or garments?
Yes **No** **How many per day?**_____

Has any family member ever had a history of the following:

☐ Diabetes ☐ Heart disease
☐ Kidney stones ☐ Other
☐ Prostate cancer _____

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other:_____	Y	N

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other:_____	Y	N

Integumentary (skin or breast)

Rashes	Y	N
Birthmarks	Y	N
Lumps in breast/nipple	Y	N
Other:_____	Y	N

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other:_____	Y	N

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other:_____	Y	N

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problem	Y	N
Other:_____	Y	N

Allergic/Immunologic

HIV/AIDS	Y	N
Eczema	Y	N
Hives/Itching	Y	N
Other:_____	Y	N

Females Only

Birth Control	Y	N

GYN's Name: _____

Date of Last Menses: _____

Gynecologic Surgery Y N

Explain: _____

# of Pregnancies ____ Vaginal ____C-Section ___

Have you ever smoked? Yes No Quit __ years ago
If yes, how much and how many years?

_____

Do you drink alcohol? Yes No
If yes, how much? _____

Physicians Comments:

Physician: _____ Date: ___/___/___

Uro-Medix – A division of 21st Century Oncology, LLC
P.O. Box 86215, Orlando, FL 32886--2152
PATIENT IDENTIFICATION INFORMATION

Today's Date_____ **PLEASE PRINT** Chart # _____

NAME: LAST_____FIRST_____Initial____ Male____Female_____

Date of Birth : MONTH _____Day____ Year_____ Social Security Number: _____ _____ _____

Address: Street:_____ Apartment#_____

CITY : _____STATE_____ZIP CODE _____

Out of Area Address? : _____STATE_____ZIP CODE _____

Home Phone : Area Code & #_____ _____ _____Cell # _____ _____ _____Work #____ ____ _____

Employer if Applicable : _____Daytime work # _____ ____ _____

Spouse's/ Name or Emergency Contact Name:_____Emergency Contact # _____ ____ _____

ASSIGNMENT OF BENEFITS/RIGHT TOPAYMENT, PATIENT RESPONSIBILITY & RELEASE OF INFORMATION

I, the undersigned, irrevocably assign to the provider entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to the Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment toward the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claims for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____Date:_____
Signature of Patient/Person Legally Responsible

_____ _____
PRINT Name of Patient/Person Legally Responsible Relationship to Patient (If signed by Person Legally Responsible)

Revised 5/2013

Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Medical Record Number

Address (Street, City, State, ZIP Code)	Telephone Number

I request that my health information or medical billing record be disclosed or restricted, as follows:

I authorize the names listed below to have access to my medical Information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

Authorized Name	**Relationship to Patient**

***DO NOT** discuss or provide information to the following individuals or entities:

Restricted Name/Entity	**Relationship to Patient**

*I request the use of **ONLY** the following address and/or phone number(s) to contact me regarding my health or billing information:

_____

_____

_____

Patient Rights: Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient

_____

THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY

DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:

*Granted _____ Denied _____

*If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s).

Reason(s) for Denial, if Applicable _____

_____

_____

Physician Office Representative: Date:

Assignment of Benefits/Right to Payment, Patient Responsibility and Release of Information Form

21st Century Oncology, LLC
Uro-Medix
PO BOX 86215 ORLANDO, FL 32886-2152

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ Date: _____
Signature of Patient/Person Legally Responsible

_____
Print Name of Patient/Person Legally Responsible

_____
Relationship to Patient
(If signed by Person Legally Responsible)

21st Century Oncology, LLC
Uro-Medix

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge: A copy of the Notice of Privacy Practices was given to me.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

****

FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgment was not obtained:

- ❑ Patient/family member received notice but refused to sign acknowledgment
- ❑ Emergency treatment situation
- ❑ Patient was incapacitated and no family member was present
- ❑ Unable to communicate due to language barriers
- ❑ Other (please describe below)

_____

_____

_____ _____

Signature of Employee Date