UROLOGY OF GREATER ATLANTA, LLC

Name: ______________________________ Date of Birth: __________ Age: ________ Sex: _______

Primary Care MD: ______________________ Referring MD: ______________________

HISTORY OF PRESENT ILLNESS

Chief Complaint: ______________________________

Where is the problem? ______________________________

When does it occur? ______________________________

For how long? ______________________________

How severe? ______________________________

What worsens or relieves it? ______________________________

Associated symptoms: ______________________________

MD NOTES

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Patient Signature: ___________________________________ Date____

Physician Signature: _________________________________ Date: ____

UROLOGY OF GREATER ATLANTA, LLC

REVIEW OF SYSTEMS

Any inpatient hospital stays with the last 30 days? ☐ Yes ☐ No
Have you received a flu shot in the past 12 months? ☐ Yes ☐ No
If you are 65 years or older, do you have an Advance Directive? ☐ Yes ☐ No

Check if you are experiencing any of the following symptoms.

BREAST:
- ☐ Breastfeeding
- ☐ Breast pain
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Skin changes
- ☐ None

CARDIOVASCULAR:
- ☐ Chest discomfort
- ☐ Fainting
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Tightness
- ☐ None

ENDOCRINE:
- ☐ Diabetes
- ☐ Heat/cold intolerance
- ☐ Increase in appetite
- ☐ Thirst
- ☐ Thyroid issues
- ☐ None

ENT:
- ☐ Discharge
- ☐ Dizziness
- ☐ Earache
- ☐ Ear ringing
- ☐ Hay fever
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Sinus pain
- ☐ Sore throat
- ☐ Voice change
- ☐ None

EYES:
- ☐ Blurred vision
- ☐ Burning
- ☐ Cataracts
- ☐ Double vision
- ☐ Glasses/contacts
- ☐ Glaucoma
- ☐ None

GASTROINTESTINAL:
- ☐ Bowel habit change
- ☐ Change in appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Pain
- ☐ Rectal bleeding
- ☐ None

GENERAL:
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss
- ☐ None

GENITOURINARY:
- ☐ Blood in urine
- ☐ Burning with urination
- ☐ Difficulty with urination
- ☐ Discharge
- ☐ Frequency of urination
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Pain postponing urination
- ☐ Pelvic pain/pressure
- ☐ Sexual problems
- ☐ Sexually transmitted
- ☐ Unable to urinate
- ☐ Urgency of urination
- ☐ Urinary tract infection
- ☐ None

HEMATOLOGIC:
- ☐ Ease of bleeding
- ☐ Ease of bruising
- ☐ Hepatitis
- ☐ Masses/nodules
- ☐ Wounds won't heal
- ☐ None

MUSCULOSKELETAL:
- ☐ Joint swelling
- ☐ Muscle loss
- ☐ Pain
- ☐ Stiffness
- ☐ Trauma
- ☐ None

NEUROLOGIC:
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Numbness
- ☐ Paralysis
- ☐ Seizures
- ☐ Stroke
- ☐ Tingling
- ☐ Tremors
- ☐ Weakness

OBGYN:
- ☐ Abnormal periods
- ☐ Birth control pill use
- ☐ Hot flashes
- ☐ Pregnant
- ☐ None

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss
- ☐ Mood swings
- ☐ None

RESPIRATORY:
- ☐ Cough
- ☐ Coughing up blood
- ☐ Oxygen use
- ☐ Severe snoring
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Sputum
- ☐ Tuberculosis
- ☐ Wheezing
- ☐ None

SKIN:
- ☐ Color change
- ☐ Hair loss
- ☐ Moles
- ☐ New lesion (s)
- ☐ Rash
- ☐ None

____
Patient or Guardian Name

____
Relationship if other than self

____
Signature

____
Date

____
Physician Signature

____
Date

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HIPAA has specific guidelines to protect patient's privacy specifically restricting health information. In an effort to provide efficient, patient friendly care please complete the following authorizations outlining your communication preferences.

VOICEMAIL AUTHORIZATION

I authorize Urology of Greater Atlanta, LLC, it's physicians and employees to leave detailed messages on the phone number(s) listed below. I understand that once a voicemail message exists, it is no longer covered under HIPAA and therefore is **not** protected from unauthorized access. I understand it is my responsibility to provide updated contact information if my contact numbers change in the future.

Home Voicemail: ☐ Yes ☐ No Number: ____________________

Work Voicemail: ☐ Yes ☐ No Number: ____________________

Cellular Voicemail: ☐ Yes ☐ No Number: ____________________

____________________ ____________________
Patient or Guardian Name Relationship if other than self

____________________ ________ ________
Signature Date Birthdate

REQUEST FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Urology of Greater Atlanta, LLC, it's physicians and employees to disclose my health information to the following person(s). Further, I acknowledge the following regarding the Notice of Privacy Practices.

☐ I received a copy of Urology of Greater Atlanta, LLC's Notice of Privacy Practices

☐ I declined the offered copy of Urology of Greater Atlanta, LLC's Notice of Privacy Practices. A copy of the notice is available at www.ugatl.com.

Name: ____________ Number: ____________ Relationship: ________

Name: ____________ Number: ____________ Relationship: ________

____________________ ____________________
Patient or Guardian Name Relationship if other than self

____________________ ________ ________
Signature Date Birthdate

MEDICATION HISTORY CONSENT

An accurate medication history will allow our physicians to treat you properly and avoid potentially dangerous drug interactions. Our practice electronically requests access to your medication history which lists the prescription medicines that we or other physicians have prescribed to you. This list is collected from a variety of sources including your pharmacy and health insurer. I hereby authorize Urology of Greater Atlanta, LLC to electronically request my medication history. I understand that this authorization can be revoked at any time by submitting a written request to the practice. This authorization to release detailed health information will expire one (1) year from the effective date listed above.

____________________ ____________________
Patient or Guardian Name Relationship if other than self

____________________ ________ ________
Signature Date Birthdate

ELECTRONIC COMMUNICATION CONSENT

I understand that Urology of Greater Atlanta, LLC utilizes electronic communication processes to deliver information to its patients in a timely and cost effective manner. Cellular telephone calls, text messages, emails and the online patient portal are utilized to convey information such as appointment reminders, preventive care reminders, patient recalls, patient billing information and statements, practice announcements and practice newsletters.

Electronic communications will not be used for marketing of products or services. Information is not sold or distributed outside of our practice. Patients can opt out of the electronic text communication and/or email communication at any time. ***Patients opting out of electronic communications will not receive appointment reminders and therefore will be subject to a $25 missed appointment fee.***

I understand it is my responsibility to provide updated contact information if my email address or cellular telephone number changes in the future.

I opt to receive cellular telephone text messages. ☐ Yes ☐ No

Cellular Number:____

I opt to receive e-mail communications. ☐ Yes ☐ No

E-Mail Address:____

____________________ Patient or Guardian Name	____________________ Relationship if other than self

____________________ Signature	__________ Date	__________ Birthdate

PRACTICE POLICIES

If insured, Urology of Greater Atlanta, LLC will submit insurance claims on my behalf. I understand I'm ultimately responsible for payment of all services rendered to me including uninsured services, non-covered services, copayments, co-insurance and deductibles. I understand it is my responsibility to provide any referral required by my insurance carrier to the office prior to my visit. I understand that failure to do so may result in denial of my insurance claim. I understand that patients with past due balances and/or collection balances may be restricted from scheduling non-emergent services.

I understand it is my responsibility to update my address, telephone number, email address and insurance information at each visit.

I understand there is a $25 fee for FMLA forms, disability forms, medication prior authorizations and for copies of medical records not sent to another treating physician.

I understand that should it be necessary to place my account with an outside collection agency a collection agency fee of twenty-eight (28%) of the outstanding balance will be added to my account. I understand that I will be assessed a $30 fee for returned checks and credit/debit card chargebacks.

____________________ Patient Name	____________________ Patient Birthdate
____________________ Patient (Guardian) Signature	____________________ Date

UROLOGY OF GREATER ATLANTA, LLC

CONSENT FOR ROUTINE PROCEDURES AND TREATMENT

Important: Do not sign this form without reading and understanding its contents

During the course of my care and treatment, I understand that various types of tests, routine screening or diagnostic procedures (“procedures”) may be necessary. While routinely performed without incident, there may be material risks associated with each of these procedures. I understand that it is not possible to list every risk for every procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the procedures.

The procedures may include, but are not limited to the following:

1) **Physical tests, assessments and treatments** including vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these procedures include, but are not limited to allergic reaction, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition or death. Apart from using modified procedures, no practical alternative exists.
2) **Needle sticks**, such as shots and injections have material risks that may include, but are not limited to, nerve damage, infection infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis, partial paralysis or death. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
3) **Drawing blood and bodily fluid or tissue samples** that are done for laboratory testing and analysis. The material risks associated with these procedures include, but are not limited to paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.
4) **Administration of medications** whether orally, rectally, topically or through the eye, ear, or nose. The material risks associated with these types of procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.
5) **Insertion of internal tubes** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, and enemas. The material risks associated with these types of procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

By signing this form:

- ♦ I acknowledge that I have been informed in general terms of the nature and purpose of the procedures, the material risks of the procedures, and practical alternatives to the procedures. If I have any questions or concerns regarding these procedures, I will ask my physician to provide me with additional information. I also understand my physician may ask me to sign additional informed consent documents.
- ♦ I understand that the healthcare professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the procedures. Therefore, I agree to provide accurate and complete information about my medical history.
- ♦ I consent to Urology of Greater Atlanta, LLC’s healthcare professionals performing procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. I understand that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES** have been made to me concerning the outcome and/or result of any procedures.

______________________________	______________
Signature of Patient or Authorized Representative	**Date**
Reason Patient is Unable to Sign (if applicable)	**Relationship to Patient**

Urology of Greater Atlanta, LLC

Payment Options

Please choose one option.

1. Enroll in the e-billing process by placing a payment method on file and authorizing a future charge up to a maximum of $250 per visit for amounts owed by me as determined by my insurance company. Amounts owed by me may include (i) copayments, (ii) coinsurance, (iii) deductibles, (iv) non-covered or out-of-network services or (v) fees (if applicable) charged by the practice for forms, medical records, appointment cancellations, NSF fees, credit card charge backs, etc.

   ☐ **I elect to enroll in the e-billing system.**

2. Pay your estimated co-insurance and deductible at the time of service. We have an office visit estimation tool that will allow us to estimate your co-insurance and deductible.

   ☐ **I elect to pay my estimated patient responsibility prior to my visit today.**

I have had the opportunity to review the financial policy of Urology of Greater Atlanta, LLC. I confirm that I have received a copy of the policy for my records or that I have declined a copy. I understand that I am ultimately responsible for payment of services rendered to me and/or my dependents. I have indicated my preferred method to handle patient responsibility above.

______________________________	______________________
Patient Name	Patient Birthdate
______________________________	______________________
Patient (Guardian) Signature	Date