PRECISION UROLOGY

Today's Date

Patient Name | Date of Birth | Gender | Marital Status

Patient Mailing Address | City | State | Zip code

Social Security Number | Email | Preferred Contact Phone Number

Alt Contact Phone Number | Employer | Work Number

Appointment Reminders: *(Please select the option you wish to receive appointment reminders.)*

☐ I request to receive appointment reminders via Text Message reminder.

☐ I **DECLINE** to receive any appointment

☐ I request to receive appointment reminders via Email

Provider Information:

Primary Care Provider | Phone: | Cross Streets

Referring Provider: Who referred you here? | Phone: | Cross Streets

Policy Holder Information:

Primary Insurance | ID Number | Group Number | Address *(PO Box listed on back)*

Phone Number | Policy Holder Name | Relationship to Patient | Date of Birth

Secondary Insurance | ID Number | Group Number | Address *(PO Box listed on back)*

Phone Number | Policy Holder Name | Relationship to Patient | Date of Birth

Pharmacy Information:

Pharmacy- Local | Phone | Cross Streets

Pharmacy- Mail Order | Phone | Cross Streets

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Patient Contact List

Emergency Contact: Indicate any person who should be notified in case you experience a medical emergency while at our office.

Emergency Contact Name	Date of Birth	Phone	Relationship to
_____	_____	_____	_____

Non-Emergent Contact: Indicate persons who we may contact if we are having difficulty reaching you. Note: Unless you authorize the following individuals to access your protected health information (PHI), they may not receive test results or office visit information on your behalf.

Non-Emergency Contact #1	Date of Birth	Phone	Relationship to patient
_____	_____	_____	_____

Non-Emergency Contact #1	Date of Birth	Phone	Relationship to patient
_____	_____	_____	_____

Do you have an advanced directive? Yes No
Do you have a living will? Yes No
Do you have surrogate/decision maker? Yes No

If you wish to list individual(s) in your advance care plan and or your surrogate/decision maker, please write information below.

Surrogate/ Decision Maker Name	Date of Birth	Phone	Relationship to patient
_____	_____	_____	_____

Surrogate/ Decision Maker Name	Date of Birth	Phone	Relationship to patient
_____	_____	_____	_____

Patient Name:	Date of Birth
_____	_____

Patient Signature/ Representative:	Date:
_____	_____

Social History:

Do you have children? Yes No If yes, how many? _____

Do you currently smoke? Yes No If yes, how often? _____

Are you a former smoker? Yes No If yes, how many years? _____

Do you chew tobacco? Yes No If yes, how long? _____

Have you ever used illegal drugs? Yes No If yes, what kind? _____

Do you drink alcohol? ☐Socially ☐1-2 per day ☐ 3-4 per day ☐ over 4 per day

Are you sexually active? Yes No

Have you ever had a sexually transmitted disease (STD)? Yes No
If so list what kind and when: _____

PRECISION UROLOGY

Authorization to Share Health Information with Family Members or Friends

Many of our patients allow family members such as their parent(s), grandparents, guardians or others to call and discuss their medical/billing information, request prescriptions; medical records and results of tests also pick up forms, etc. Under the requirements of HIPAA, we are not permitted to release this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members or friends, you must sign this form.

☐ I decline to have my medical information discussed with family and friends.
☐ I give permission to Precision Urology PLLC to discuss my health information listed above to the following individuals:

Name: _____Relationship: _____
Name: _____Relationship: _____
Name: _____Relationship: _____
Name: _____Relationship: _____

Authorization Regarding Messages
(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments
____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information
____ I authorize you to leave a message with anyone who answers the phone
____ Messages may only be left with _____

I understand I must sign a separate authorization form releasing copies of my medical record to another individual.
I understand I have the right to revoke my permission at any time except where Precision Urology PLLC has already made disclosures in reliance upon this request. I understand this this permission remains in effect until the time I revoke in writing.

_____ _____
Patient Signature or Personal Representative of Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practice

Precision Urology is committed to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our Practice and outlines your rights regarding your health information. Please sign this form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Precision Urology, LLC.

_____ _____
Printed Name of Patient or Personal Representative Date

_____ _____
Signature of Patient or Personal Representative Date

PRECISION UROLOGY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____ Contact Number _____

Patient Mailing Address: _____ City _____ State _____ Zip code _____

I hereby authorize: _____ _____
(Provider, Hospital, Urgent Care, etc.) Fax

Address _____ City, State & Zip Code _____ Phone _____

To release information to:
Precision Urology PLLC
9225 N 3rd Street Suite 302 Phx. AZ 85020
Phone: 602-844-2254 **| Fax: 602-844-2253**

To be included:
□ My Diagnosis
□ My Progress
□ Office Notes
□ Hospital Reports
□ Other:_____
□ Lab and Diagnostic Studies
□ Radiographic Films and Reports
□ Emergency Treatment Reports
□ Operative Reports

Medical Records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

☐ **I DO** authorize the release of this type of information.

☐ **I DO NOT** authorize the release of this type of information.

This authorization specifically authorizes you to disclose records of alcohol abuse and substance abuse. This authorization specifically authorizes you to disclose HIV test results or diagnosis and AIDS and AIDS-related conditions.
I also understand that I may revoke this authorization at any time. To revoke my authorization, I must submit a written request to Precision Urology PLLC via fax 602-844-2253. Unless I revoke the authorization earlier, it will expire upon its completion or 365 days from the date of signature, whichever comes first. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I release the provider, its employees, officers and directors, medical staff members, and business associate's information to the extent indicated and authorized herein.

_____ _____
Patient Signature or Personal Representative of Patient Signature Date

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Surgical History:

Surgical History: (Please list surgeries/ Hospitalizations ◯ None	**Dates**

Medications:

◯ No, I do not take medications
◯ Yes, I do take medications. (please list below your current medications including over the counter supplements)

Medication Name:	**Dosage & How often taken**	**Reason for taking Medication**

Allergies:

◯ No known drug allergies
◯ Yes, I do have allergies. (Medications and reactions listed below.)

Medication Name:	**Reaction**

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Review of Systems

Constitutional Symptoms

Appetite Change		No		Yes
Weight Gain		No		Yes
Weight Loss		No		Yes
Fatigue		No		Yes
Fever		No		Yes
Chills		No		Yes

Skin

Hives		No		Yes
Itching		No		Yes
Rash		No		Yes

Allergy/ Immune

Cancer		No		Yes
Seasonal Allergies		No		Yes

Ears/Nose/Mouth/Throat

Hearing Changes		No		Yes
Nose Bleeds		No		Yes
Tinnitus		No		Yes

Eyes/Head

Dizziness		No		Yes
Headaches		No		Yes
Vision Changes		No		Yes

Respiratory

Shortness of Breath		No		Yes
Cough		No		Yes
Wheezing		No		Yes
Other:		No		Yes

Cardiovascular

Edema		No		Yes
Chest Pain/Discomfort		No		Yes
Syncope/Loss of consciousness		No		Yes

Gastrointestinal

Bloody Stool		No		Yes
Bowel Changes		No		Yes
Abdominal Pain		No		Yes
Nausea		No		Yes
Heartburn		No		Yes
Diarrhea		No		Yes

Genitourinary

See HPI		No		Yes
Decreased flow/force		No		Yes
Vaginal Discharge		No		Yes
Penile Discharge		No		Yes
Pain with Urination		No		Yes

Endocrine

Diabetes		No		Yes

Musculoskeletal

Bursitis		No		Yes
Gout		No		Yes
Osteoporosis		No		Yes
Muscle/Joints Stiffness		No		Yes
Back Pain/Injuries		No		Yes
Arthralgias/Arthritis		No		Yes

Neurological

Epilepsy		No		Yes
Palsy		No		Yes
Speech		No		Yes
Stroke		No		Yes
Tingling		No		Yes

Hematologic/Lymphatic

Anemia		No		Yes
Easy Bruising		No		Yes

PRECISION UROLOGY

To: All Male Patients

From: Precision Urology

Insurance Payment Guidelines for Erectile Dysfunction, Impotence and Infertility, Vasectomy Consults and Vasectomy

As you prepare for your visit with our Physicians, we must make you aware of a potential situation regarding insurance coverage for certain diagnoses and conditions which are commonly treated by Urologists.

Specifically, it is possible that treatment for erectile dysfunction, impotence, infertility, sterilization and related conditions may not be reimbursed by your insurance carrier. **BCBS of Arizona and Golden Rule** typically do not cover these services.

BCBS of Arizona typically does not cover TESTOPEL pellets or Testosterone Injections and considers those experimental. **United Health Care Community Plan** (formerly APIPA) does not cover TESTOPEL pellets. Please contact your insurance to find out your individual plans benefits. In this case, you will be responsible for payment for any treatment you receive related to these conditions.

While some insurance plans do cover such treatment, there is no way for us to know in advance whether your carrier will, in fact . cover you. You may wish to contact your carrier prior to your visit to determine what their policy is.

If you are a Medicare patient, you should know that these diagnoses are generally covered.

Also, many plans do not cover medications to treat Erectile Dysfunction. Samples are extremely limited and may only be distributed up to one time as deemed necessary by the Physician.

We ask you to sign the following statement so that there is no confusion regarding this issue:

"I understand that if I am ever treated for erectile dysfunction, impotence, infertility, sterilization or a related diagnosis, and that any of my insurance carriers refuse payment for this treatment, I am fully responsible for paying all charges incurred during the course of my treatment. I also understand ED samples **(Viagra, Cialis, Levitra)** are very limited and my insurance may not cover such medications."

_____

Signature Date

PRECISION UROLOGY

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Precision Urology, PLLC (**we/us**) as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, phone number, name, insurance information, etc.)

Because insurance coverage varies, it is important that you understand your individual health plan and what it covers, including deductibles, coinsurance and copays. We recommend that you call the customer service number on the back of your insurance card for any questions regarding your health insurance plan.

Patient Financial Responsibilities: We will bill your primary insurance company and any secondary insurance as a courtesy to you. In order to properly bill your insurance company, you must timely and accurately disclose all insurance information, including primary and secondary insurance plans, as well as any change of insurance information. Failure to provide timely, accurate and/or complete insurance information may result in you being responsible for the entire bill. We do our best to estimate your financial responsibility up front, but please understand this is only an estimate.
Although we may **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits.

Copayments, Coinsurance, and Outstanding Balances: Copayments, coinsurance, deductibles and balances not covered by insurance are due prior or at the time services are rendered. Inability to pay at the time of service may result in having to reschedule your appointment. Payment can be made by check, cash, MasterCard, VISA, and Discover.

We cannot waive co-payment, deductibles, co-insurance or any service amounts defined as patient responsibility under the terms of our contractual agreement with your insurance plan. We are required to bill for services rendered. You will be asked to pay on any estimated out-of-pocket costs and past due balances at the time of check-in.

Account Balances: Our billing office will provide you with a monthly statement of all account activity including our charges, payments and contractual adjustments from your insurance carrier along with payments made by you. Please be aware that you will be charged a returned check fee of $50.00 for all payments, made by a personal check, that have been returned by your banking institution for any reason. Please note that failure to pay outstanding balances that are your responsibility may result in having to reschedule future appointments until the balances are paid in full. In addition, any unpaid delinquent balance may: (a) delay scheduling of future appointments; (b) result in your account being forwarded to a collection agency or collection attorney of our choice; (c) reporting you to one or more third-party credit reporting agencies; and/or (d) termination from Precision Urology PLLC.

Referrals: Certain insurance plans require referrals to see a Specialist. It is your responsibility to obtain a referral from your primary care physician. Referrals must be presented at the time services are rendered, if applicable. As a courtesy, we will make efforts to obtain referrals and prior authorizations on your behalf. If you need to have a referral faxed to us, our office will provide you with our fax number. If your insurance plan requires you to have a referral or other authorization, and you fail to provide that to us, your appointment will be rescheduled or your claim for that date of service will be processed via optout benefits, if applicable.

Surgical procedures: You will be required to pay estimated out-of-pocket costs associated with your surgical procedure prior to the procedure. The amount you will be required to pay will be determined based upon your individual insurance

plan and will include any deductibles, co-payments and co-insurance which your insurance carrier indicates that you will owe. We do our best to estimate your financial responsibility up front, but please understand this is only an estimate. In addition, you will be required to make arrangements to pay any other outstanding balances that you may owe to us at that time. Failure to do so may result in rescheduling your procedure. You may receive separate bills for services related to your surgical procedure provided by third-parties, which may include hospital fees, anesthesiology fees, surgical assist fees, laboratory fees, and/or radiology fees.

For self-pay patients, payment is due at check-in. The account balance is expected to be paid in full. We do our best to estimate your financial responsibility up front, but please understand this is only an estimate.

Diagnostic Testing: During the course of your medical treatment with Precision Urology PLLC, your urologist may request a tissue, blood or urine specimen be obtained for diagnostic testing. This testing is being performed in order to assist your urologist in the diagnosis and management of your urologic condition. Depending upon the requirements of your insurance coverage, these specimens may be processed at Precision Urology PLLC in-house pathology laboratory or at a third-party laboratory, for example Quest or LabCorp. The costs of these laboratory tests vary depending upon the nature and complexity of each test. The cost for a diagnostic test, including the cost that you will be required to pay, if any, depends on your insurance carrier and the type of insurance coverage you have. Please note: 1) All charges for specimens processed at Precision Urology PLLC laboratory will be included in the statement you receive 2) Charges for specimens processed at a third-party laboratory will be billed to you directly by that laboratory.

FMLA/Disability Form Completion: $50.00 charge

Patient Authorizations: By my signature below:

- I hereby authorize Precision Urology PLLC and the physicians, staff, labs and facilities associated with Precision Urology PLLC to release necessary medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- I hereby assign my financial benefits directly to Precision Urology PLLC for all items and services rendered by or on behalf of Precision Urology PLLC, to the maximum extent permitted by law. I understand that I am financially responsible for charges not covered by this assignment.
- I understand the physicians that treat me may have a financial interest in the facility they refer me to including, but not limited to, surgery centers, lithotripsy centers, pathology labs, and other medical and non-medical related entities.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Agreement:

X_____ X_____
Printed Name of Patient Date of Birth

X_____ X_____
Signature of Patient or Guardian Date

PRECISION UROLOGY

International Prostate Symptom Score (IPSS)

Determine Your BPH Symptoms **Circle your answers and add up your scores at the bottom.**

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

Total International Prostate Symptom Score = _____

Quality of Life (QoL)

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms
Regardless of the score, if your symptoms are bothersome you should notify your doctor.

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)									
1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

Would you be interested in learning about a minimally invasive option that could allow you to avoid or discontinue enlarged prostate medications?	Yes	No

PRECISION UROLOGY

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: _____ **TODAY'S DATE:** _____

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you, and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. **TOTAL:** _____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED **8-11 Moderate ED** **12-16 Mild to Moderate ED** **17-21 Mild ED**