Amarillo Urology Associates, LLP

PATIENT DEMOGRAPHIC INFORMATION

DATE: _____

NAME _____ **SSN:** _____
LAST FIRST MI

DOB _____ **AGE** _____ **MALE** ☐ **FEMALE** ☐ **MARITAL STATUS:** MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ PARTNER ☐

ADDRESS: _____
STREET CITY, STATE ZIP

HOME PHONE _____ **CELL PHONE** _____ **WORK PHONE** _____

EMAIL ADDRESS: _____ **PREFERRED CONTACT METHOD:** HOME PHONE ☐ CELL PHONE ☐ TEXT ☐ WORK PHONE ☐ EMAIL ☐

EMERGENCY CONTACT _____
NAME PHONE NBR RELATION

ETHNICITY _____ **PREFERRED LANGUAGE** _____

EMPLOYER _____ **OCCUPATION** _____

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN** _____

INSURANCE INFORMATION (only if card not available):

INSURANCE CARRIER _____ POLICY # _____

GROUP # _____ GROUP NAME _____

POLICY HOLDER INFO (required, unless same as patient)**:** RELATION TO PT _____

NAME _____ DOB _____ SSN _____

GUARANTOR INFO (required for minors)**:** RELATION TO PT _____

NAME _____ DOB _____ SSN _____

CURRENT UROLOGY ISSUE (main reason for today's visit) _____

PREFERRED PHARMACY _____
NAME **LOCATION**

LAB We perform prostate screening and low testosterone labs in-house. All other labs will be sent to **PPL, LabCorp, BSA, or NWTH.** If your insurance requires you to use a specific lab, please indicate below and notify the clinical staff assisting you and a written order form will be given to you to take to the lab of your choice.

INS REQUIRED LAB _____

PREFERRED OUTSIDE IMAGING CENTER: PREFERRED IMAGING ☐ OPEN AIR MRI ☐ NWTHS ☐ BSA ☐ ADVANCED IMAGING ☐
**ALL IMAGING WILL BE PERFORMED IN-HOUSE WHEN AVAILABLE

CARE TEAM:

CARDIOLOGIST _____ NEPHROLOGIST _____

OBGYN _____ ONCOLOGIST _____

PULMONOLOGIST _____ ENDOCRINOLOGIST _____

DRUG ALLERGIES:

DRUG NAME	TYPE OF REACTION

CURRENT MEDICATIONS: (if you have an updated list, please provide to the staff for a copy)

DRUG NAME	DOSAGE	DIRECTIONS

If more room is needed, please use the back.

CURRENT FLU SHOT? YES ☐ NO ☐ WHEN ADMINISTERED? _____

CURRENT PNEUMONIA SHOT? YES ☐ NO ☐ WHEN ADMINISTERED? _____

COVID VACCINATION? YES ☐ NO ☐ WHEN ADMINISTERED? _____

LOCATION OF PROBLEM: ABDOMEN ☐ KIDNEY ☐ PELVIS ☐ BACK ☐ GENITALIA ☐ OTHER ☐

HOW LONG DOES THE PROBLEM LAST? 15 MINS ☐ 30 MINS ☐ 1 HOUR ☐ OTHER ☐

DESCRIPTION OF PAIN: DULL ☐ SHARP ☐ DULL THEN SHARP ☐ SHARP THEN GONE ☐

ONSET DATE OF PROBLEM? _____

FAMILY HISTORY: MEDICAL ISSUES:

FATHER: LIVING? YES ☐ CURRENT AGE _____ CANCER YES ☐ NO ☐ ORGAN _____
NO ☐ AGE DECEASED _____ OTHER _____

MOTHER: LIVING? YES ☐ CURRENT AGE _____ CANCER YES ☐ NO ☐ ORGAN _____
NO ☐ AGE DECEASED _____ OTHER _____

OF BROTHERS: _____ AGES OF THOSE LIVING _____ AGES AT TIME OF DEATH _____

MEDICAL ISSUES: _____

OF SISTERS: _____ AGES OF THOSE LIVING _____ AGES AT TIME OF DEATH _____

MEDICAL ISSUES: _____

Amarillo Urology Associates, LLP

SOCIAL HISTORY:

EMPLOYED? NO ☐ YES ☐ **EMPLOYER** _____

OCCUPATION _____ **MARITAL STATUS** MARRIED ☐ SINGLE ☐ DIVORCED ☐

EDUCATION LEVEL < 8TH ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 2 YEAR ☐ 4 YEAR ☐ POST GRADUATE ☐ WIDOWED ☐ SEPARATED ☐ PARTNER ☐

ALCOHOL INTAKE: NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY ☐

CAFFEINE INTAKE: NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY ☐

ILLICIT DRUGS: YES ☐ NO ☐ **IV DRUG USE:** YES ☐ NO ☐

DOES THE PATIENT HAVE AN ADVANCED DIRECTIVE? YES ☐ NO ☐

TOBACCO USE: NEVER USED ANY TOBACCO PRODUCTS: ☐

CIGARETTES/CIGARS: FORMER SMOKER ☐ CURRENT EVERY DAY SMOKER ☐ CURRENT SOME DAY SMOKER ☐

HOW MUCH: 1 PPW ☐ 2 PPW ☐ ¼ PPD ☐ ½ PPD ☐ 1 ½ PPD ☐ 2 PPD ☐ 3+ PPD ☐

SMOKELESS TOBACCO: FORMER USER ☐ SNUFF USER ☐ CHEWS TOBACCO ☐

HOW MUCH: 1 PER DAY ☐ 2-4 PER DAY ☐ 5+ PER DAY ☐

E-CIGARETTES/VAPE: FORMER USER ☐ CURRENT USER ☐

OF YEARS OF TOBACCO USE: _____ HAS SMOKED SINCE AGE: _____

PARTICIPATED IN A SMOKING CESSATION PROGRAM? YES ☐ NO ☐ WHEN? _____

SURGICAL PROCEDURES: List all past surgical procedures and the year they were performed

PATIENTS AGE 50 & OVER: HAVE YOU HAD A COLONOSCOPY? YES ☐ NO ☐ WHEN: _____

PROCEDURE	DATE	PROCEDURE	DATE

PAST MEDICAL HISTORY:

CONDITION	YES	NO	CONDITION	YES	NO
BLEEDING DISORDER			HEART DISEASE		
CANCER			HIGH BLOOD PRESSURE		
DIABETES			HIGH CHOLESTROL		
DIVERTICULITIS			KIDNEY STONES		
EMPHYSEMA			MENTAL HEALTH DISORDER		
ENLARGED PROSTATE			SEIZURES		
HIV/HEPATITIS			STROKE		

Please mark any symptoms that you are currently experiencing today.

CONSTITUTIONAL: ☐ FEVER ☐ NIGHT SWEATS ☐ WEIGHT GAIN _____ lbs ☐ WEIGHT LOSS ____ lbs
☐ EXERCISE INTOLERANCE ☐ SEDATION ☐ LETHARGY ☐ CHILLS ☐ MALAISE

EYES: ☐ WEARS GLASSES/CONTACT LENSES
☐ DRY EYES ☐ IRRITATION ☐ VISION CHANGE ☐ EYE DISEASE/INJURY

EARS: ☐ WEARS HEARING AIDS ☐ DIFFICULTY HEARING ☐ EAR PAIN

NOSE: ☐ FREQUENT NOSEBLEEDS ☐ NOSE PROBLEMS ☐ SINUS PROBLEMS

MOUTH/THROAT: ☐ SORE THROAT ☐ BLEEDING GUMS ☐ SNORING ☐ DRY MOUTH ☐ ORAL ABNORMALITIES
☐ MOUTH ULCER ☐ TEETH ABNORMALITIES ☐ MOUTH BREATHING ☐ RINGING IN EARS ☐ SINUSITIS

CARDIOVASCULAR: ☐ CHEST PAIN ON EXERTION ☐ ARM PAIN ON EXERTION ☐ SHORTNESS OF BREATH WHILE WALKING
☐ SHORTNESS OF BREATH WHEN LYING DOWN ☐ PALPITATIONS ☐ KNOWN HEART MURMUR
☐ LIGHT-HEADED ON STANDING ☐ ANKLE SWELLING

RESPIRATORY: ☐ COUGH ☐ WHEEZING ☐ SHORTNESS OF BREATH ☐COUGHING UP BLOOD ☐ SLEEP APNEA

GASTROINTESTINAL: ☐ ABDOMINAL PAIN ☐ NAUSEA ☐ VOMITTING ☐ CONSTIPATION ☐ CHANGE IN APPETITE
☐ BLACK OR TARRY STOOLS ☐ FREQUENT DIARRHEA ☐ VOMITING BLOOD ☐ DYSPEPSIA ☐ GERD

GENITOURINARY: ☐ URINARY LOSS OF CONTROL ☐ DIFFICULTY URINATING ☐ INCREASED URINARY FREQUENCY
☐ HEMTURIA ☐ INCOMPLETE EMPTYING

MUSCULOSKELETAL: ☐ MUSCLE ACHES ☐ MUSCLE WEAKNESS ☐ ARTHRALGIAS/JOINT PAIN ☐ BACK PAIN
☐ SWELLING IN THE EXTREMITIES ☐ NECK PAIN ☐ DIFFICULTY WALKING ☐ CRAMPS ☐ OSTEOPOROSIS
☐ FRACTURES

SKIN: ☐ ABNORMAL MOLE ☐ JAUNDICE ☐ RASH ☐ ITCHING ☐ DRY SKIN ☐ GROWTHS/LESIONS ☐ LACERATIONS ☐ NON-HEALING AREAS ☐ CHANGES IN HAIR/NAILS ☐ PSORIASIS ☐ CHANGE IN SKIN COLOR ☐ BREAST LUMP

NEUROLOGIC: ☐ LOSS OF CONSCIOUSNESS ☐ WEAKNESS ☐ NUMBNESS ☐ SEIZURES ☐ DIZZINESS ☐ FREQUENT OR SEVERE HEADACHES ☐ MIGRAINES ☐ RESTLESS LEGS ☐ TREMOR ☐ GAIT DYSFUNCTION ☐ PARALYSIS

PSYCH: ☐ DEPRESSION ☐ SLEEP DISTURBANCES ☐FEELING UNSAFE IN RELATIONSHIP ☐RESTLESS SLEEP ☐ ALCOHOL ABUSE ☐ ANXIETY ☐ HALLUCINATIONS ☐ SUICIDAL THOUGHTS ☐ MOOD SWINGS ☐ MEMORY LOSS ☐ AGITATION ☐ DEMENTIA ☐ DELIRIUM

ENDOCRINE: ☐ FATIGUE ☐ INCREASED THIRST ☐ HAIR LOSS ☐ INCREASED HAIR GROWTH ☐ COLD INTOLOERANCE

HEMATOLOGIC/LYMPHATIC: ☐ SWOLLEN GLANDS ☐ EASY BRUISING ☐ EXCESSIVE BLEEDING ☐ ANEMIA ☐ PHLEBITS

ALLERGY/IMMUNOLOGIC: ☐ RUNNY NOSE ☐ SINUS PRESSURE ☐ ITCHING ☐ HIVES ☐FREQUENT SNEEZING

Patient Consent

- I consent to treatment necessary for the care of named patient.
- I acknowledge full financial responsibility for services rendered by Amarillo Urology Associates, L.L.P.
- I understand that payment of charges is due at the time of service unless other arrangements have been made prior to treatment.
- I authorize release of information to my insurance company in order to process claims and authorize payment to be made to Amarillo Urology Associates, L.L.P.
- I authorize release of my medical information to any other facility that I am referred to by this office.
- I authorize the use of my photo as part of my permanent medical record.
- I understand there may be times I am asked to see a mid-level practitioner at Amarillo Urology Associates. I consent to the services of a Physician Assistant/ Nurse Practitioner for my healthcare needs.

I have read and understand the Patient Consent and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____

Signature of Patient or Responsible Party for Minor Date

_____

Printed Name of Patient

Patient Financial Policy Sheet

To reduce misunderstanding between our patients and practice, we have adopted the following financial policies. We are dedicated to providing the best possible care and service and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Full payment is due at the time of service. For your convenience we accept cash, check, VISA, MasterCard, Discover and American Express, and Care Credit.

Your Insurance

- **In-network policies**: We have made prior arrangements with these health plans to accept an assignment of benefits. We will bill those plans and will require you to pay the authorized copay/deductible at the time of service. This office's policy is to collect this when you arrive for your appointment. Any balance left by the health plan is your responsibility and is due upon receipt of a statement from our office.
- **Out of network policies**: We will prepare and send the claim for you on an unassigned basis as a courtesy if desired. Since we do not have an agreement with the health plan, the charges for your care and treatment are due at the time of the service. Please know, there will be no contractual adjustment for these policies.
- If our doctors are not listed in your plan's network, you will be responsible for partial or full payment. Due to the many different insurance products, our staff cannot guarantee your eligibility/coverage. Be sure to check with the member benefits department about services and physicians before your appointment.
- You are responsible for obtaining a properly dated referral if required by your insurance and responsible for payment if your claim rejects for the lack of one.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

No Insurance – Self Pay Discount

- A patient with no insurance will be required to make a deposit (New patient-$300; Established $150) prior to seeing a provider and will be billed the remaining amount due or receive a refund if actual charges differ.
- A patient who has no insurance will automatically receive a 25% discount off of billed charges.
- A self-pay patient who pays with **Care Credit** will receive a 15%, rather than 25%, discount.
- If a patient claims to have health insurance coverage but is not able to produce verifiable insurance identification, he or she will be designated as a self-pay patient. If insurance is provided later and billed, the self-pay discount will be null.

Lab Work

- For lab work drawn at AUA, it's the patient's responsibility to notify us where your health plan dictates blood be sent.

Minor Patients

- For all services rendered to minor patients, we will look to the parent/guardian accompanying the patient for payment.

Payment Plans

- In certain instances, payment plans are available. It is required to put a credit/debit card on file for automatic payments each month. If no card is available, it is the responsibility of the patient to make the payment by the due date every month until the balance is paid in full. If a previous payment plan has been defaulted, a payment arrangement will no longer be an option and full payment will be due at the time of service.
- Any amount due for services provided after the payment plan is initiated will be due at the time of service. Any amount due over the amount paid, will be added to the existing payment plan.
- If patients are on a payment plan and fail to make a payment for two (2) payments or payment declines two months without communication with our business office, the account will be turned over to the collection agency representing this medical practice.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____

Signature of Patient or Responsible Party of Minor Date

Notice of Privacy Practice

I have been informed that Amarillo Urology Associates, L.L.P. has a Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that upon request, I am entitled to receive a copy of this document.

I authorize that my medical information can be released to:

Name	Name
Relation to Patient	Relation to Patient
Name	Name
Relation to Patient	Relation to Patient
Name	Name
Relation to Patient	Relation to Patient
Name	Name
Relation to Patient	Relation to Patient

Patient Signature

Date

I understand that **no** information, including appointment information, will be released to anyone **not** listed on this form.

Initial here

Amarillo Urology Associates, LLP

Patient Acknowledgement
Appointment Cancellation/No Show Policy

Dear Patient,

Amarillo Urology Associates, LLP has implemented an Appointment Cancellation/No Show Policy. A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need.

To remain consistent with our dedication to our patients, we have implemented the following policy:

1. Please provide our office a 24-hour notice in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left with the answering service or on the scheduling voicemail.

2. A missed appointment, without proper 24-hour notification, is considered a "No Show" and will be marked as such. If a patient accrues 3 "no show" appointments, it may result in termination of the physician/patient relationship. This will require the patient to obtain an Urologist outside of Amarillo Urology Associates, LLP.

3. If you are 15 or more minutes late for your appointment, the appointment may be cancelled and rescheduled.

4. As a courtesy, we make reminder calls, for appointments, one to two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. A copy of this policy will be provided to you, upon request. Please sign and date below your acknowledgement.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Patient/Guarantor signature _____ Date _____

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