



Providence Medical Park / 3841 Piper Street, Suite T300 / Anchorage, AK 99508
Alaska Regional Campus / 2925 DeBarr Road, Suite 250 / Anchorage, AK 99508
Ph: (907)-563-3103 F: (907)-561-1862

Mat-Su Regional Medical Plaza / 2490 S. Woodworth Loop, Suite 401 / Palmer, AK 99645
Ph: (907)-745-9300 Fax: (907)-745-9301
www.alaskaurology.com

PATIENT INFORMATION RECORD

Title: (please circle) Mr. Mrs. Ms. Dr. other: Suffix: I II III IV Jr. Sr.

Last Name: First Name: Middle Name:

Preferred Name: Maiden Name: Date of Birth: / /

Referred by: Primary Care Physician:

Preferred Pharmacy: Pharmacy Location:

SEX: Male Female Other: Age: Marital Status: M W D S

Race: Ethnicity: Primary Language:

Physical Address: City: State: Zip:

Mailing Address: City: State: Zip:

Home Phone: ( ) - \* Is it ok to call you at this number? Y N Leave a message? Y N

Work Phone: ( ) - \* Is it ok to call you at this number? Y N Leave a message? Y N

Cell Phone: ( ) - \* Is it ok to call you at this number? Y N Leave a message? Y N

Preferred Method of Communication: Home Work Cell Other:

Preferred Appointment Reminder Method (May Choose Multiple): Phone Call Text Message Email

E-mail Address:

Employer: Occupation: Date of Hire:

In case of Emergency, contact: Last Name: First Name:

Emer. Contact Phone# ( ) - Date of Birth: / / Relationship:

INSURANCE INFORMATION

Is this related to a Work Comp claim? Yes No -or- Motor Vehicle Accident? Yes No

Primary Insurance Carrier: Policy Holder: Last First MI

Insurance ID#: Group#: Policy Holder DOB:

Secondary Insurance Carrier: Policy Holder: Last First MI

Insurance ID#: Group#: Policy Holder DOB:

**PRESCRIPTION HISTORY CONSENT**

For safe, effective medication prescribing, Electronic Health Records enables us to identify all of your current medications electronically. Alaska Urology automatically utilizes electronic prescriptions to and from pharmacies. Your consent is automatically authorized unless you sign below to OPT out.

\_\_\_\_\_  
Signature *Opting out* of Electronic Prescriptions \_\_\_\_\_  
Date

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize Alaska Urology and its employees, agents or associated healthcare practitioners to disclose my protected health information to the following individuals:

Name _____	Name _____
Date of Birth _____	Date of Birth _____
Phone _____	Phone _____
Relationship _____	Relationship _____

**PATIENT CONSENT/ASSIGNMENT:** I hereby authorize Alaska Urology to release any information acquired in the course of my treatment to/from my insurance company, physician's office, hospital or any other treatment facility. I agree to be fully responsible for all expenses incurred for medical treatment. I assign to Alaska Urology any and all insurance benefits due to me, the full financial obligations for medical treatment that I have not paid for.

**Printed Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**IF the above patient is a CHILD, has a SPOUSE, has a LEGAL GUARDIAN, or is NOT RESPONSIBLE FOR THE BILL, PLEASE COMPLETE the information requested in the section below:**

**Please check one:**

Parent of Child       Spouse       Legal Representative       Party responsible for the bill

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SEX: Male \_\_\_\_\_ Female \_\_\_\_\_ Other: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: **M W D S**

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**NON-PAYMENT...** If your account is thirty (30) days past due, you may be contacted by our billing department asking for payment in full. If your balance is unpaid after six (6) months, we may refer your account to our collection agency and you may be discharged from this practice.

**PAYMENT OPTIONS...** We accept Cash, Check, Money Order, Visa, MasterCard, and Discover. Please note there will be a \$30 charge for checks returned for non-sufficient funds.

**MISSED APPOINTMENTS...** Please assist us by keeping your appointment or cancelling with a minimum of one (1) business days' notice. Appointments cancelled with less than one (1) business days' notice will be considered a "no-show". Patients who "no-show" twice (2) on any scheduled appointment will only be allowed to schedule appointments within specific time frames.

The limited appointment scheduling will be reevaluated after one-calendar year since the last "no-show" event.

If a patient is a "no-show" for three scheduled appointment they may be discharged from the practice.

Due to the increased volume, we will only contact "no-show" appointments to be rescheduled if medically necessary.

We reserve the right to request a deposit for scheduling appointments.

We highly encourage patients to use our automated appointment reminder service which will notify patients via their selected method (phone, text, and or email) of upcoming appointments. These notifications are sent multiple times prior to a scheduled appointment.

**PATIENT CONSENT/ASSIGNMENT...** I hereby authorize Alaska Urology to release any information acquired in the course of my treatment to/from my insurance company, physician's office, hospital or any other treatment facility. I agree to be fully responsible for all expenses incurred for medical treatment. I assign to Alaska Urology any and all insurance benefits due to me, the full financial obligations for medical treatment that I have not paid for.

Our practice is committed to providing the best urological care to our patients. Thank you again for choosing Alaska Urology. Please let us know if you have any questions or concerns.

**I have read and understand the Alaska Urology payment policy and agree to adhere to its guidelines.**

**I also hereby acknowledge that I have received Alaska Urology's Notice of Privacy Practices.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: (if different than patient) \_\_\_\_\_ DOB: \_\_\_\_\_



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## FINANCIAL POLICY

Thank you for choosing Alaska Urology. We are committed to providing you the best urological healthcare available. You are required to read and sign our financial policy prior to any treatment. Please feel free to ask any questions and a copy of this policy will be provided to you upon request. As a courtesy to our patients, we bill all insurance types.

**INSURANCE...** We are participating providers for Medicare, Medicaid, Blue Cross/Blue Shield, Aetna, MultiPlan/BeechStreet and Cigna. It is **your responsibility** to know your insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions. All patients with insurance coverage of any type must show their insurance card for us to bill your insurance. If you do not provide proof of insurance, you will be expected to **pay in full** at the time of service and will be considered a self-pay patient until the appropriate billing information is provided to our office. If you are not insured, **payment in full** is expected at the time service is rendered.

**COPAYMENTS/COINSURANCE/DEDUCTIBLES...** All patient responsibility for services must be paid at the time of service. This is part of your contractual obligation with your insurance company.

**NON-COVERED SERVICES...** Please be aware that some or all of the services provided may not be covered or not considered reasonable or necessary by some insurers. It is your responsibility to pay in full for these services at the time of your visit.

**USUAL & CUSTOMARY...** Our prices are representative of the usual and customary charges for our geographic area. You are expected to pay in full for any balance after insurance. At our discretion, Alaska Urology may assist you in appealing your insurance determination and/or appeal benefits on your behalf.

**PROOF OF INSURANCE...** All patients must complete our patient information forms and sign where indicated before being seen. We must obtain a copy of your insurance card(s) and a copy of a photo ID for billing. Failure to provide us with correct information will result in you being responsible for the balance of your claim.

**CLAIMS SUBMISSION...** As a courtesy to our patients, we will submit claims and assist you in a reasonable way to get your claims paid. Your insurance company may need you to supply certain information directly to them. It is **your responsibility** to comply with their request. Please understand and be aware that the balance of your unpaid claim(s) is your responsibility.

**SURGERIES...** All patient responsibility for surgeries must be paid in advance.

**COVERAGE CHANGES...** If your insurance changes, please notify us as soon as possible, so we can make the appropriate changes to help you receive your maximum benefits. **If your insurance does not pay your claim**, the balance may be billed to you.



## ADULT REVIEW OF SYSTEMS

### 1. Constitutional Symptoms

Fever	No	Yes
Chills	No	Yes
Unexplained change in weight	No	Yes

### 2. Cardiovascular

Chest pain	No	Yes
Irregular heartbeats	No	Yes
Leg Swelling	No	Yes

### 3. Respiratory

Shortness of breath on exertion	No	Yes
cough	No	Yes
TB exposure	No	Yes

### 4. Gastrointestinal

Nausea	No	Yes
Vomiting	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Abdominal Pain	No	Yes

### 5. Genitourinary

Urgent need to urinate	No	Yes
Do you void > 6 times a day ?	No	Yes
Do you void > 2 times at night ?	No	Yes
Painful urination	No	Yes
Visible blood in urine	No	Yes
Involuntary loss of urine	No	Yes
- related to urgency	No	Yes
- related to cough, sneeze	No	Yes
Unable to urinate	No	Yes
Urine slow to start	No	Yes
Weak urinary stream	No	Yes
Dribbling after urinating	No	Yes
Decreased sex drive	No	Yes
Pain during intercourse	No	Yes
Genital sores	No	Yes

### *Female :*

Vaginal discharge	No	Yes
Vaginal dryness	No	Yes

### *Male:*

Erectile dysfunction	No	Yes
- Difficulty obtaining erection	No	Yes
- Difficulty maintaining erection	No	Yes
Scrotal pain/mass	No	Yes
Penile discharge	No	Yes
Blood in semen	No	Yes
Curvature of penis	No	Yes

### 6. Skin

Do you currently have a rash?	No	Yes
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### 7. Neurological

Tingling or numbness	No	Yes
Muscular weakness	No	Yes

### 8. Musculoskeletal

Bone Pain	No	Yes
Back Pain	No	Yes
Muscle Pain	No	Yes

### 9. Endocrine

Breast Enlargement	No	Yes
Always thirsty	No	Yes
Heat/cold Intolerance	No	Yes

### 10. Psychiatric

Anxiety	No	Yes
Difficulty sleeping	No	Yes

### 11. Hematologic/Lymphatic

Easy Bleeding	No	Yes
Bruise easily	No	Yes

### 12. Allergic-Immunologic

Allergy resulting in rash	No	Yes
Allergy causing difficulty breathing	No	Yes

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_



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**Patient Medication List**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Local Preferred Pharmacy: \_\_\_\_\_

(Please include Prescription, Vitamins, and Over-the-counter Medications)

Medication	Dose	Time of Day (morning, noon, night)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

**Allergies**

(Please list all known allergies, reactions and cause)

\_\_\_\_\_ No Known Drug Allergies (X or initials)

1.
2.
3.
4.
5.

## Medical History Sheet

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**General Physician:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**Reason for Today's Visit:** \_\_\_\_\_

**Medical History: (please mark all you have ever been treated for or are currently being treated)**

- No Medical History

*General*

- Bleeding Disorder
- Glaucoma
- HIV/AIDS
- MRSA
- Rheumatic Fever
- Systemic Lupus Erythematosus
- Transplant Recipient, Organ: \_\_\_\_\_

*Cardiovascular*

- Aortic Abnormality: \_\_\_\_\_
- Atrial Fibrillation
- Blood Transfusion, Date: \_\_\_\_\_
- Congestive Heart Failure
- Coronary Artery Disease
- Clot in Leg or Lung
- Heart Attack
- Heart Murmur
- Heart Valve Disorder, Type: \_\_\_\_\_
- High Blood Pressure

*Endocrine/Metabolic*

- Diabetes
- Hyperthyroidism
- Hypothyroidism
- Low Testosterone

*Respiratory*

- Asthma
- COPD
- Emphysema
- Sleep Apnea
  - Use CPAP

*Gastrointestinal*

- Acid Reflux/GERD
- Crohn's Disease
- Hepatitis
- Stomach Ulcer
- Ulcerative Colitis

*Genitourinary*

- Chronic Kidney Disease
- Genital Herpes
- Genital Warts
- Interstitial Cystitis
- Kidney Stones
- Renal Failure
- STD: \_\_\_\_\_
- Urinary Tract Infections

*Men's Health*

- BPH
- Hydrocele/Spermatocele
- Prostatitis

*Women's Health*

- Endometriosis
- Uterine Fibroids

*Musculoskeletal*

- Arthritis
- Artificial Joints
- Chronic Back Pain
- Fibromyalgia
- Gout

*Neuro/Psych*

- Alzheimer's Disease
- Anxiety
- Parkinson's Disease
- Multiple Sclerosis
- Psychiatric Diagnosis: \_\_\_\_\_
- Spinal Cord Injury, Level: \_\_\_\_\_
- Stroke/TIA

*Cancer*

- Bladder
- Colon/Rectal
- Female, Type: \_\_\_\_\_
- Kidney
- Penile
- Prostate
- Testicular
- Other: \_\_\_\_\_

Other Medical History: \_\_\_\_\_

**Immunizations:**

Is the patient up to date on immunizations? Yes No

**Female Health History:**

Date of Last Menstrual Period: \_\_\_\_\_ Post-Menopausal: Yes No  
Pregnancies# \_\_\_\_\_ Live Births# \_\_\_\_\_ Abortions (elective or spontaneous)# \_\_\_\_\_

**Male Health History:**

Date of Last PSA: \_\_\_\_\_  
Date of Last Prostate Exam: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

**Recent Studies or Labs:**

What: \_\_\_\_\_ Where: \_\_\_\_\_ Date: \_\_\_\_\_  
What: \_\_\_\_\_ Where: \_\_\_\_\_ Date: \_\_\_\_\_

**Surgical History: (please list ALL surgeries you have ever had) \*if additional space needed, please ask.**

Vasectomy Date: \_\_\_\_\_ Hysterectomy Date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History: (please list type of cancer) \*if additional space needed, please ask**

Condition	Relative(s)	Age of Diagnosis	Living/Passed
Cancer:			
Cancer:			
Diabetes			
Heart Attack			
Heart Disease			
High Blood Pressure			
Kidney Stones			
Kidney Failure			
Other:			

**Social History: (circle or fill in appropriate response)**

Marital Status:  
\_\_\_ Single \_\_\_ Divorced # of Children: \_\_\_\_\_  
\_\_\_ Married \_\_\_ Widowed

Current Alcohol Consumption: No Yes \_\_\_\_\_ drink per day  
History of Alcohol Abuse: No Yes \_\_\_\_\_ days/months/years sober

Current Tobacco Use: No Yes cigarettes/cigars/chew \_\_\_\_\_ packs per day  
History of Tobacco Use: No Yes Age start? \_\_\_\_\_ Age stop? \_\_\_\_\_

Recreational Drug Use:  
\_\_\_ None \_\_\_ Current, name substance(s) \_\_\_\_\_  
\_\_\_ Former, name substance(s) \_\_\_\_\_ days/mos/yrs sober

Daily Fluid Intake:  
\_\_\_\_\_ 8 oz. cups of coffee per day \_\_\_\_\_ 8 oz. glasses of milk per day  
\_\_\_\_\_ 8 oz. glasses of tea per day \_\_\_\_\_ 8 oz glasses of water per day

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse/MA Signature: \_\_\_\_\_ Date: \_\_\_\_\_





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## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

**1. Uses And Disclosures We May Make Without Written Authorization.** We may use or disclose your health information for certain purposes without your written authorization, including the following:

**Treatment.** We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

**Payment.** We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

**Healthcare Operations.** We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

**Other Uses or Disclosures.** We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

**2. Disclosures We May Make Unless You Object.** Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
- To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition, and location in our facility. We may also disclose your religious affiliation to clergy.
- To contact you to raise funds. You may opt out of receiving such communications at anytime by notifying the Privacy Officer identified below.

**3. Uses and Disclosures With Your Written Authorization.** Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

**4. Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

**5. Changes To This Notice.** We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

**6. Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

**7. Contact Information.** If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer:	Bryan Shields
Phone:	907-563-3103
Address:	3841 Piper Street, Suite T300 Anchorage, AK 99508
E-mail:	bshields@alaskaurology.com

**8. Effective Date.** This Notice is effective September 23, 2013.