ALASKA UROLOGY

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: _____

Preffered 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? **Y**es _____ **N**o _____ -or- Motor Vehicle Accident? **Y**es _____ **N**o _____

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

Authorization to disclose Protected Health Information (PHI) is provided upon patient's request with a completed distinct form. We are required to have expiration dates on these forms and are required to be updated yearly by the patient. The Privacy Rule generally requires HIPAA covered entities (health plans and most health care providers) to provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. This includes the right to inspect or obtain a copy, or both, of the PHI, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice. Individuals have a right to access this PHI for as long as the information is maintained by a covered entity, or by a business associate on behalf of a covered entity, regardless of the date the information was created; whether the information is maintained in paper or electronic systems onsite, remotely, or is archived; or where the PHI originated (e.g., whether the covered entity, another provider, the patient, etc.).

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:

☐ **Parent of Child** ☐ **Spouse** ☐ **Legal Representative** ☐ **Party responsible for the bill**
Please check one:

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: _____

ALASKA UROLOGY

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

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.

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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:_____

_____

Please write on back side if needed

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: _____

_____ **Date:** _____

_____ **Date:** _____

_____ **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 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 disclosure 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 contact you by email, phone 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 3, 2023.

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Authorization to Use Disclose Protected Health Information

Patient Name: _____ DOB: _____

Address: _____

_____

Telephone: _____

Other names under which the Patient has been treated: _____

I authorize Alaska Urology and its employees, agents or associated healthcare practitioners to use or disclose the Patient's protected health information as described below.

1. **Relevant Time Period.** Alaska Urology may use or disclose information relating to healthcare provided during the following time period:
   - ☐ Anytime.
   - ☐ Healthcare provided between *(date)* _____ and *(date)* _____

2. **Types of Information.** Alaska Urology may use or disclose the following type(s) of information:
   - ☐ Any information concerning the Patient's healthcare or payment during the relevant time period.
   - ☐ Medical records concerning the Patient's healthcare during the relevant time period, including:
   - ☐ Records from the Patient's chart *(e.g.,* history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, *etc.)*
   - ☐ Diagnostic images, films or other recordings *(e.g.,* x-rays, MRI scans, CT scans, *etc.)*
   - ☐ Psychotherapy notes ***[Note: These cannot be combined with authorization for other records]***
   - ☐ Billing and payment records for healthcare rendered during the relevant time period.
   - ☐ Other: _____

3. **Persons to Whom Disclosure Allowed.** Alaska Urology may disclose the information to the following:

   Name or description: _____

   Address: _____

   Phone number: _____

   Fax number: _____

Name or description:_____

Address: _____

Phone number: _____
Fax number: _____

Name or description:_____

Address: _____

Phone number: _____
Fax number: _____

4. **Purpose.** Alaska Urology may use or disclose the information for the following purpose(s):

☐ The disclosure is made at the Patient's request.

☐ For a potential or pending legal proceeding.

I understand that I have the right to revoke this authorization at any time except to the extent that PROVIDER has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:

Alaska Urology
3841 Piper St. Suite T300
Anchorage, AK 99501

I understand that information disclosed by Alaska Urology pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

This authorization will expire (may not exceed five-years). _____

If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

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

Patient Name: _____ DOB: _____

Date: _____

Electronic or Wet Signature: _____

Name: (if different than patient) _____ DOB: _____

Authority or relationship to patient_____

By signing the form you are agreeing to the terms of the Release of Information (ROI) contained in this document.