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

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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

Pediatric Medical History Form

Last Name: _____ **First:** _____ **Middle:** _____

Date of Birth: _____ **Pediatrician:** _____

Chief Complaint: (Reason for visit today) _____ **Severity (scale from 1-10)** _____

Duration of Problem: _____ **Associated Signs/Symptoms:** _____

List anything that Improves or Worsens the problem: _____

Medications (Currently Taking)

Name	Amount	Times/Day

List Any Allergies

Latex: Y N

Medication Allergies : Y N

Please list:

_____

_____

_____

_____

Does your child have any siblings?

Name	Age

Social History

Special Diet?	Y	N
Special Needs (wheelchair, braces, etc.)	Y	N
Age of Toilet Training: _____		
Who does the child live with? _____		

What does your child drink for breakfast? _____ **lunch?** _____ **dinner?** _____

Does your child drink… **soda?** Y N **tea?** Y N **juice?** Y N

Is the patient up to date on immunizations? Y N

Child's Medical History

Cerebral Palsy	Y	N	Hepatitis	Y	N
Prenatal Hydronephrosis	Y	N	Asthma	Y	N
Heart Murmur	Y	N	Constipation	Y	N
Urinary Tract Infection	Y	N	Hypertension	Y	N
Developmental Delay	Y	N	Spina Bifida	Y	N
Seizure Disorder	Y	N	VP Shunt	Y	N
Bleeding Disorders	Y	N	Autism	Y	N
Premature	Y	N	ADHD / ADD	Y	N
Cancer	Y	N	Type of Cancer:		
Other					

Family History **Family Member**

Vesicoureteral Reflux	Y	N	
Kidney Disease	Y	N	
Nighttime Wetting	Y	N	
Urinary Tract Infection	Y	N	
Kidney Failure	Y	N	
Diabetes	Y	N	
Kidney Stones	Y	N	
Cancer	Y	N	
Anesthesia Problems	Y	N	

List Any Past Surgeries / Hospitalizations

Type	Date (Year Only)

Has your child had any X-rays of the urinary tract or the current problem? (Test, Date, Hospital Where Performed)

Type	Date	Hospital

Does your child have any other medical problems that we should know about? Y N Please list below:

_____

_____

_____

_____

Parent / Guardian Signature: _____ Date: _____

ALASKA UROLOGY

Pediatric Review of Systems

Patient Name: _____ **DOB:** _____/_____/_____

1. **Constitutional Symptoms**

Fever	No	Yes
Chills	No	Yes
Weight loss	No	Yes
Weight gain	No	Yes
Fatigue	No	Yes
Loss of appetite	No	Yes
Body aches	No	Yes
Night sweats	No	Yes
Birth history of prematurity	No	Yes
Is your child exposed to cigarette smoke	No	Yes
Is child in foster care	No	Yes
Do you have concerns about your child's sexual development	No	Yes

2. **Eyes**

Blurred vision	No	Yes
Eye pain	No	Yes
Glasses/contacts	No	Yes
Impaired vision	No	Yes

3. **Head, Ears, Nose, Throat**

Sinus congestion	No	Yes
Sore throat	No	Yes
Dental problems	No	Yes
Recent head injury	No	Yes
Hydrocephalus	No	Yes
Ear infections	No	Yes

4. **Breasts**

Tenderness	No	Yes

5. **Cardiovascular**

Cardiac murmurs	No	Yes
Irregular heartbeats	No	Yes
Shortness of breath on exertion	No	Yes
Lower extremity swelling	No	Yes
Congenital heart defects	No	Yes

6. **Respiratory**

Shortness of breath	No	Yes
Wheezing	No	Yes
Cough	No	Yes
Sleep apnea	No	Yes
Anesthetic problems	No	Yes
TB exposure	No	Yes
Asthma	No	Yes

7. **Gastrointestinal**

Nausea	No	Yes
Vomiting	No	Yes
Change in abdominal girth	No	Yes
Diarrhea	No	Yes
Constipation	No	Yes
Abdominal pain	No	Yes
Jaundice	No	Yes
Blood in stool	No	Yes
Fecal incontinence	No	Yes

8. **Genitourinary**

Urgency	No	Yes
Frequency	No	Yes
Painful urination	No	Yes
Blood in urine	No	Yes
Change in urine color	No	Yes
Incontinence	No	Yes
Urinary retention	No	Yes
Difficulty urinating	No	Yes
Decreased stream	No	Yes
Painful periods	No	Yes
Scrotal pain	No	Yes

9. **Integument**

Rash	No	Yes
Itching	No	Yes
New skin lesions	No	Yes
Pigmentation changes	No	Yes
Excessive hair growth in unusual places	No	Yes

Please complete other side

10. **Neurologic**

Muscular weakness	No	Yes
Memory difficulties	No	Yes
Speech difficulties	No	Yes
Headache	No	Yes
Seizures	No	Yes
Tremors	No	Yes
Loss of balance	No	Yes

11. **Musculoskeletal**

Back pain	No	Yes
Joint pain	No	Yes
Muscle pain	No	Yes
Limitation of motion	No	Yes
Muscular weakness	No	Yes

12. **Endocrine**

Excessive urination (volume)	No	Yes
Always thirsty	No	Yes
Central obesity	No	Yes

13. **Psychiatric**

Anxiety	No	Yes
Depression	No	Yes
Difficulty sleeping	No	Yes

14. **Hematologic/Lymphatic**

Easy bleeding	No	Yes
Bruise easily	No	Yes
Lymph node enlargement	No	Yes

15. **Allergic-Immunologic**

Sinus allergy symptoms	No	Yes
Skin allergy resulting in rash	No	Yes

Patient/Guardian 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 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 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.