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 Fax: (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

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Patient Information

Name:_____ Date: _____

Street Address:_____ City / State: _____

Zip Code:_____ Date of Birth:_____ Gender: _____

Phone Number (day):_____ Phone Number (day): _____

Email Address: _____

Emergency Contact: _____

Preferred Language:_____ Race:_____ Ethnic Group:_____

Insurance Information

Primary Insurance Company:_____ Policy Number: _____

Group Number:_____ Contact Number: _____

Street Address:_____ City / State: _____

Zip Code:_____ Policy Holder Name:_____ Policy Holder DOB: _____

Relationship to Policy Holder:_____

IF above patient is a child, spouse, or has a legal Guardian or not responsible bill, complete the following

Relationship_____ (Parent, Legal Representative, Responsible Party)

Name:_____ Date: _____

Street Address:_____ City / State: _____

Zip Code:_____ Date of Birth:_____ Gender: _____

Phone Number (day):_____ Phone Number (day): _____

Email Address: _____

Emergency Contact: _____

Preferred Language:_____ Race:_____ Ethnic Group:_____

Chief Complaint

Chief Complaint_____

Duration:_____ Severity (1 to 10): _____

Referring Provider:_____ Other Symptoms: _____

Other Medical problems that we should be made aware of _____

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Past Medical History

Please write yes or no for the following:

Medical History	Yes	No
Arthritis		
COPD – Chronic obtrusive pulmonary disease		
Depression		
Diabetes mellitus		
ESRD – End stage renal disease		
History of hypertension		
HIV – Human immunodeficiency virus infection		
High cholesterol		
Leukemia		
Lymphoma		
Colon Cancer		
Poor Vision		
Active tuberculosis		
Alzheimer's disease		
Anxiety disorder		
Asthma		
Atrial fibrillation		
BPH – benign prostatic hyperplasia		
Blood clot		
Cardiac pacemaker in situ		
Stroke		
Chronic back pain		
Chronic interstitial cystitis		
Chronic kidney disease		
Complications due to anesthesia during surgery		
Congestive heart failure		
CAD – coronary artery disease		
Crohn's disease, colon		
Low Testosterone		
Emphysema		

Medical History	Yes	No
Endometriosis		
Fibromyalgia		
Stomach Ulcer		
Gastroesophageal efflux disease		
Genital herpes simplex type 2		
Genital warts		
Glaucoma		
Gout		
History of artificial joint		
History of blood transfusion		
History rheumatic fever		
History of tuberculosis		
Hearing loss		
Heart murmur		
History of anaphylaxis		
History of calculus of kidney		
History of prostatitis		
History of sexually transmitted disease		
History of surgical corrected congenital heart defect		
History of undescended tested		
HIV – Human immunodeficiency virus		
Hyperthyroidism		
Hypothyroidism		
Immunosuppression		
Hepatitis		
Breast Cancer		
Malignant tumor of kidney		
Malignant tumor of lung		

Medical History	Yes	No
Malignant tumor of pancreas		
Malignant tumor of prostate		
Malignant tumor of testis		
Malignant tumor of urinary bladder		
MRSA		
Multiple sclerosis		
Heart Attack		
Parkinson's disease clinic		
Premature pregnancy delivered		
Prosthetic heart valve in situ		
Radiation therapy treatment management		
Recurrent urinary tract infection		
Seizure disorder		
Sleep apnea		
Spinal cord injury		
SLE - Systemic lupus erythematosus		
Transplant recipient		
Transplantation of bone marrow		
Ulcerative colitis		
Uterine fibroid polyp		

Preferred Pharmacy

Pharmacy Name: _____ Street Address:_____

City / State:_____ Zip Code:_____

Fax Number:_____

Past Surgeries

Please write yes or no for the following:

Surgical History	Yes	No
History of colectomy		
None		
Other		
Biopsy of prostate		
CABG - Coronary artery bypass graft		
Entire transplanted kidney		
ESWL - Extracorporeal shockwave lithotripsy of calculus of kidney		
H/O: colostomy		
H/O: tubal ligation		
History of appendectomy		
History of cholecystectomy		
History of total cystectomy		
History of transurethral prostatectomy		
Hysterectomy		
Lumpectomy of breast		
Mechanical heart valve replacement		
Percutaneous extraction of kidney stone with fragmentation procedure		
Prostatectomy		
Splenectomy		
Total nephrectomy		
Total orchidectomy		
Ureteroscopy and electrohydraulic lithotripsy of calculus of ureter		

Past Urological History

Have you had any of the following?

- ☐ Prostate nodule
- ☐ Cancer (Bladder)
- ☐ Cancer (Kidney)
- ☐ Cancer (Penile)
- ☐ Cancer (Prostate)
- ☐ Cancer (Testicular)
- ☐ Cystinuria
- ☐ Elevated PSA
- ☐ Hematuria
- ☐ Heredtiary Lelomyomatous Renal Cell Carcinoma
- ☐ Birt-Hogg-Dube Syndrome
- ☐ Beckwith Weidemann Syndrome
- ☐ Hydronephrosis
- ☐ Infertility
- ☐ Li Fraumeni Syndrome
- ☐ Neurogenic Bladder
- ☐ Polycystic kidney disease
- ☐ Priapism
- ☐ Prostatitis
- ☐ Renal Insufficiency
- ☐ Renal Tubular Acidosis
- ☐ Sexual dysfunction
- ☐ Sexually transmitted disease
- ☐ Genitorourinary trauma
- ☐ Tuberculosis
- ☐ Tuberous Sclerosis
- ☐ Undescended testis
- ☐ Urethral stricture
- ☐ Urinary incontinence
- ☐ Urinary retention
- ☐ Urinary tract infection
- ☐ Urolithiasis
- ☐ Vesicoureteral Reflux (VUR)
- ☐ Von Hippel Lindau
- ☐ NONE
- ☐ Other

_____

_____

Urological Surgical History

- ☐ Burch Colposuspension
- ☐ Cystectomy
- ☐ Extracorporeal Shock Wave LIthotripsy
- ☐ Herniorraphy (with mesh?)
- ☐ Hysterectomy
- ☐ Insertion of artificial urinary sphincter
- ☐ Insertion of penile prosthesis
- ☐ Marshall-Marchetti-Krantz urethropexy
- ☐ Midurethral sling
- ☐ Nephrectomy
- ☐ Orhiectomy
- ☐ Percutaneous Nephrostolithotripsy
- ☐ Pelvic Irradiation
- ☐ Penile reconstruction
- ☐ Prostate biopsy
- ☐ Prostate radiation therapy
- ☐ Prostatectomy
- ☐ Renal ablation
- ☐ Transobturator Tape
- ☐ Transurethral Resection of Bladder Tumor
- ☐ Transurethral Resection of Prostate
- ☐ Transvaginal Tape
- ☐ Ureteral stent placement
- ☐ Ureteroscopy
- ☐ Urethroplasty
- ☐ NONE
- ☐ Other

_____

_____

Family History

- ☐ Birt-Hogg-Dube Syndrome
- ☐ Cancer (Bladder)
- ☐ Cancer (Kidney)
- ☐ Cancer (Prostate)
- ☐ Cancer (Testicular)
- ☐ Cystinuria
- ☐ Herditary Leiomyomatous Renal Cell Carcinoma
- ☐ Polycystic Kidney Disease
- ☐ Renal Insufficiency
- ☐ Renal Tubular Acidosis
- ☐ Urolithiasis
- ☐ Von Hippel Lindau
- ☐ Other _____
- ☐ NONE

Medications

List all current medications:

_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

Occupation and Workplace:

Place of Residence:

Family History (First Degree Relatives)

Review of Systems

Please write yes or no for the following:

Symptom	Yes	No
Allergy to Adhesive		
Allergy to Lidocaine		
Blood Thinners		
FEMALES ONLY: pregnant/planning pregnancy/ breastfeeding		
Taking Coumadin (Warfarin)		
Fever of 100 degrees or more		
Chills		
Unintentional weight loss?		
Chest Pain		
Shortness of breath with exertion/exercise		
Swelling in the legs/ankles		
Cough		
Shortness of breath at rest		
Abdominal Pain		
Nausea		
Vomiting		
Constipation		
Diarrhea		

Symptom	Yes	No
Involuntary loss of stool/stool incontinence		
Bloody Stool		
Jaundice		
Urgent desire to urinate		
Urinate more than 6 times/DAY		
Urinate more than 2 times/NIGHT		
Painful urination		
difficulty urinating/incomplete emptying of bladder		
blood in the urine		
weak/slow urinary stream		
difficult/slow start of urinary stream		
dribbling after urination		
leak urine with coughing or exercise		
leak urine due to urgency		
other form of urinary leakage		
decreased sex drive		
pain during sexual activity		
rash/lesions in genital area		
FEMALES ONLY: vaginal discharge		
FEMALES ONLY: vaginal dryness		
MALES ONLY: difficulty getting an erection		
MALES ONLY: difficult keeping an erection		
MALES ONLY: scrotal/testicular pain		
MALES ONLY: scrotal swelling/enlargement		
MALES ONLY: lump/bump/hard area ON testicle		

Symptom	Yes	No
MALES ONLY: penile discharge		
MALES ONLY: blood in semen or ejaculate		
MALES ONLY: bend or curve of penis		
breast enlargement		
always thirsty		
heat or cold intolerance		
tingling or numbness		
muscle weakness		
anxiety		
difficulty sleeping		
Other		
Other		
Other		

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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, United Health Care, and Cigna. It is the patient's responsibility to know their 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 provide valid insurance information such as an insurance card for us to bill your insurance. If you do not provide valid insurance information prior to your appointment you may be removed from the schedule until this information is provided. You may agree to proceed without providing valid insurance information, but you will be considered a self-pay and **payment in full** is expected at the time service. You will remain self-pay until you provide valid insurance information.

If you do not have insurance, you are considered self-pay will be expected to **pay in full** at the time of service.

OUT OF NETWORK INSURANCE:

We will do our best to inform you if we are not in-network with your insurance carrier. It is the patient's responsibility to know their insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions.

If we are out of network with your insurance carrier as a courtesy to our patients, we will submit claims and assist you in a reasonable way to get your claims paid. We will balance bill patients for amount that the insurance carrier doesn't pay.

MEDICARE ADVANTAGE PLANS:

We are not in-network with any Medicare Advantage Plan. Please read the section above regarding out of network insurance.

HEALTHSHARE, MEDI-SHARE, OR OTHER HEALTH SHARING PLANS:

These are not considered insurance. Patients who present HealthShare, Medi-Share, or other Health Sharing plans will be considered self-pay and responsible for entire balance at the time of service. It is the patient's responsibility to seek reimbursement from their plan.

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:

Alaska Urology may seek payment from patient for services that are not covered by the subscriber's agreement with their medical insurance plan. In cases where the subscriber's medical insurance plan determines services not to be medically necessary or in keeping with plan care management standards or accepted standards of care the patient assumes financial responsibility. This determination by the subscriber's medical insurance may occur prior to or as part of post clinical review conducted by the subscriber's medical insurance company. Alaska Urology makes no guarantees of services being approved, it is the patient's responsibility to understand their specific insurance plan and benefits.

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 valid insurance information(s) such as a copy of your insurance card and a copy of a photo ID for billing prior to your appointment. Failure to provide us with correct information will result in being removed from the schedule until this is provided and or you being responsible for the balance of your claim.

PAYMENT PLANS:

As a courtesy to our patients, we offer a payment plan. A medical payment plan usually does not have interest attributed to the amount owed unless the balance goes unpaid and is forwarded to a collection agency. Payment is required to be made automatically on a monthly basis via credit card and that information must be on file with the office.

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.

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: _____