

UROLOGY ASSOCIATES OF KINGSPORT, P.C.

Arthur T. Wyker, MD • Jim R. Littlejohn, MD
James R. Herman, MD, PhD • Hugh M. Sullivan, MD • Anthony L. Broglio, MD
822 Broad Street • Kingsport, TN 37660 • (423) 246-6251

Appointment Date _____

Name: _____ DOB _____ Date: _____

Social Security Number _____

Which Doctor in our office are you here to see? _____

Referring Doctor: _____ Family Doctor: _____

Why are you seeing the doctor today? _____

How long have you had this problem/pain? _____

What improves/worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous, or does it come and go? _____

What is the nature of the pain? (sharp, dull, etc.) _____

Have you tried any medicine/treatment or seen a doctor for this problem before this visit? _____

Review of Genitourinary Systems

Please answer Yes (Y) or No (N) if you have or have ever had any of the following:

Back pain	Y	N	Up at night to urinate	Y	N	Urine Retention	Y	N
Bedwetting	Y	N	Prostate Infection	Y	N	Urologic Cancer	Y	N
Blood in urine	Y	N	Sexual Dysfunction	Y	N	Urologic Surgery	Y	N
Dribbling	Y	N	Sexually Transmitted Diseases	Y	N	Vaginal Bleeding	Y	N
Burning on urination	Y	N	Suprapubic Pain	Y	N	Vaginal Discharge/Problems	Y	N
Erection/Ejaculation Problems	Y	N	Testes/Scrotal Swelling	Y	N	Weak Stream	Y	N
Flank pain	Y	N	Urgency	Y	N	Other _____		
Kidney Failure	Y	N	Urinary Frequency	Y	N	_____		
Kidney Infections	Y	N	Urinary Hesitancy	Y	N	_____		
Kidney stones	Y	N	Urinary Incontinence	Y	N			
Leak after voiding	Y	N	Urinary Tract Infections	Y	N			

For each of the eight questions below, please check the one box that best describes your symptoms.

The International Scientific Committee (SCI), under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (IJC), has agreed to use the symptom index for BPH, which has been developed by the American Urological Association (AUA) Measurement Committee, as the official worldwide symptoms assessment tool for patients suffering from prostatism.	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
1. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None (0)	1 Time	2 Times	3 Times	4 Times	5+ Times	
8. Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Past Medical History Please answer Yes (Y) or No (N) if you have any of the following diseases or conditions:

CARDIOVASCULAR

Anemia Y N
 Angina Y N
 Aortic Aneurysm Y N
 Arrhythmia Y N
 Atrial Fibrillation Y N
 Bleeding disorder Y N
 Congestive Heart Failure Y N
 Deep Vein Thrombosis Y N
 Heart attack Y N
 Heart murmur Y N
 Hypertension Y N
 Mitral Insufficiency Y N
 Mitral Valve Prolapse Y N
 Rheumatic Fever Y N
 Stroke Y N

ENDOCRINE / METABOLIC

Diabetes Melitus Y N
 Gout Y N
 Impaired Glucose Tolerance Y N
 Thyroid Disorder Y N
GENERAL
 Hepatitis A, B, C Y N
(If yes, please circle type)
 Sleep Apnea Y N
 Chronic Fatigue Y N
GI
 Colitis Y N
 Constipation Y N
 Crohn's Disease Y N
 GERD Y N
 Hemorrhoids Y N
 Hiatal hernia Y N

Irritable Bowel Disease Y N
 Peptic ulcer Y N
GU
 Bladder infection Y N
 Kidney disease Y N
 Kidney infection Y N
 Kidney Stone Y N
 Prostatitis Y N
 Prostate cancer Y N
 Renal cell cancer Y N
MUSCULOSKELETAL
 Arthritis
 Fibromalgia Y N
 Osteoporosis Y N
NEUROLOGICAL/PSYCHOLOGICAL
 Alcoholism Y N
 Alzheimer's disease Y N
 Anxiety Y N

Depression Y N
 Epilepsy Y N
 Migraine Y N
 Parkinson's Disease Y N
 Herniated disc Y N
RESPIRATORY
 Asthma Y N
 Bronchitis Y N
 Emphysema Y N
 Tuberculosis Y N

OTHER

Surgical History

Please list all surgeries you have had and note the date:

Family History

Please indicate which family member has / had any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bedwetting _____ | <input type="checkbox"/> Bladder cancer _____ | <input type="checkbox"/> Breast cancer _____ |
| <input type="checkbox"/> Cervical cancer _____ | <input type="checkbox"/> Colon cancer _____ | <input type="checkbox"/> Diabetes mellitus _____ |
| <input type="checkbox"/> Kidney Cancer _____ | <input type="checkbox"/> Kidney Stones _____ | <input type="checkbox"/> Prostate Cancer _____ |

Social History

Marital Status

- Single Married Separated Divorced Widowed Life Partner Common Law Spouse

Dependents

Please indicate # of each, if you have living with you:

___ Sons ___ Daughters ___ Stepchildren ___ Adopted ___ Foster ___ Parents ___ Grandparents

Women: Last Menstrual Period (date): _____ Are you pregnant? ___ Yes ___ No

Men and Women: Are you sexually active Yes No

Occupation:

Please circle one that applies: None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, or Other _____

Alcohol Consumption: ___ None ___ Yes ___ Occasional/social ___ # of drinks per day

Tobacco per day: ___ None ___ Yes ___ # Packs /day ___ Cigarettes /day ___ Smokeless Tobacco
If you previously stopped, when? _____

Recreational drugs: ___ None If yes, please list: _____

Caffeinated beverages: ___ None ___ Low ___ Moderate ___ High/Excessive

Recent Foreign Travel (please circle all that apply)

None

Americas: Canada, Mexico, Latin America, South America, Other _____

World Wide: Europe, Africa, Middle East, Asia, Australia, Other _____

Current Medications

Please list ALL medications you are currently taking. Include any over-the-counter drug (s).

Drug Name	Strength	Directions/How you take it
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Pharmacy Name: _____ **Phone #:** _____

Allergies: Please list ALL types (drug, seasonal, pets, animals, environmental, foods)

Review of Systems: Please answer Yes (Y) or No (N), if you have.

Constitutional

- Fever Y N
- Chills Y N
- Hot Flashes Y N
- Night Sweats Y N
- Fatigue Y N
- Weight Loss Y N
- Other _____

Eyes

- Blindness Y N
- Blurred vision Y N
- Other _____

Neurological

- Stroke Y N
- Headache Y N
- Dizzy spells Y N
- Numbness/tingling Y N
- Leg or arm weakness Y N
- Memory loss Y N
- Other _____

Endocrine

- Diabetes Y N
- Pituitary disease Y N
- Thyroid disease Y N
- Other _____

Gastrointestinal

- Acid reflux Y N
- Indigestion/heartburn Y N
- Nausea/vomiting Y N
- Abdominal pain Y N
- Bloody stools Y N
- Diarrhea Y N
- Constipation Y N
- Rectal bleeding Y N
- Tarry stools Y N
- Other _____

Cardiovascular

- Chest pain/angina Y N
- Shortness of breath Y N
- Heart attack Y N

- Heart failure Y N
- Heart murmur Y N
- High blood pressure Y N
- Irregular heartbeat Y N
- Other _____

Skin

- Skin rash Y N
- Other _____

Musculoskeletal

- Back pains Y N
- Joint pains Y N
- Muscle cramps Y N
- Arthritis Y N
- Osteoporosis Y N
- Other _____

Ears/Nose/Throat

- Problems swallowing Y N
- Hearing Problems Y N
- Other _____

Respiratory

- Asthma Y N
- Emphysema-Bronchitis Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other _____

Hematologic/Lymphatic

- Swollen glands Y N
- Blood clotting problem Y N
- Bleeding problems Y N
- Hepatitis - A, B, or C Y N
(If yes, please circle type)
- HIV (AIDS) Y N
- Sickle Cell Y N
- Other _____

Psychological

- Anxious Y N
- Depressed Y N
- Other _____

Update _____

PATIENT NAME: _____ **DATE** _____

ADDRESS: _____

City State Zip
BIRTHDATE: _____ AGE _____ SEX: Male Female

PHONE # (HOME) _____ (WORK) _____

MARITAL STATUS: _____ SOCIAL SECURITY # _____

PLACE OF EMPLOYMENT: _____ RETIRED? YES NO

ADDRESS OF EMPLOYMENT: _____

SPOUSE'S NAME: _____ **BIRTHDATE:** _____

SPOUSE'S SOCIAL SECURITY # _____

SPOUSE'S PLACE OF EMPLOYMENT: _____ RETIRED? YES NO

IN CASE OF EMERGENCY NOTIFY: _____ PHONE# _____

PERSON RESPONSIBLE FOR ACCOUNT: _____

ADDRESS: _____ PHONE# _____

PLACE OF EMPLOYMENT: _____ PHONE # _____

PRIMARY INSURANCE: _____ MEMBER'S NAME _____
POLICY NUMBERS ID # _____ GROUP# _____ ****EFFECTIVE DATE** _____

SECONDARY INSURANCE _____ MEMBER'S NAME _____
POLICY NUMBERS ID# _____ GROUP# _____ ****EFFECTIVE DATE** _____

DID EITHER OF THESE POLICIES BECOME EFFECTIVE AFTER YOUR RETIREMENT? YES NO N/A

INSURED SOCIAL SECURITY # _____ BIRTHDATE: _____

FAMILY PHYSICIAN: _____ PHONE# _____
ADDRESS: _____

I authorize the release of medical information necessary to process insurance claims and authorize payment of medical benefits to UROLOGY ASSOCIATES OF KINGSPORT, P. C.:

PATIENT'S OR GUARANTOR'S SIGNATURE _____ **DATE** _____

PLEASE COMPLETE OTHER SIDE

UPDATED: _____

Urology Associates of Kingsport, P. C.
822 Broad Street
Kingsport, TN 37660

ACKNOWLEDGEMENT OF NOTICE

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notices and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I authorize Urology Associates of Kingsport to leave messages regarding appointment information on my answering machine, with a family member, or individual allowed to receive information on my behalf in the event that I cannot be reached by phone.

Yes _____
Initial

No _____
Initial

Signature of Patient or Legal
Representative

Witness

Date

FINANCIAL POLICY

Thank you for choosing us to provide healthcare for you. Our staff is committed to providing you with the best medical care possible and to assisting you with the administrative process. The following is our financial policy. ***Please read and sign.***

The following applies to every visit:

- **Bring your insurance card.**
- **Be prepared to pay your co-pay or deductible if we par with your insurance. If self pay, full amount of your visit is expected. We accept cash, check, MasterCard and Visa.**
- **For medical care not covered by your insurance, payment in full is due at the time of your visit.**

INSURANCE:

Our office participates in a variety of insurance plans, which we will file with your insurance company. We cannot bill your insurance company without the proper information. Please make sure all of your insurance information is up to date, including your address and phone numbers. We will not be responsible for any liability insurance (i.e. Disability, FMLA, cancer policies, etc.) Payment for services on any liability claims is due and payable at the time of service.

REFERRALS:

As a specialty office we see new patient with a referral from their primary care physician. Many insurance plans also require your primary care physician to make the referral to the specialist. To avoid delays, please call our office prior to your appointment to confirm we have the referral or bring any required referral for treatment at the time of your visit. If you do not have a referral your visit may be rescheduled or you may be financially responsible.

COPAYMENTS and DEDUCTIBLES:

All co-payments and deductibles for office visits are due at the time of check-in. Co-payments and deductible for surgery will need to be paid at the time of your pre-operative appointment. If your insurance plan changes from the time you see the physician for the preoperative visit and/or surgery, please notify our office so necessary changes can be made prior to your surgery. You will be financially responsible if this is not done.

High Deductible Plans: If you have a high deductible plan you may use a credit card for the entire balance that is payable. We do not accept credit card for partial payments.

If you request to pay by cash, debit card or check we will arrange a three month or less installment plan.

SELF PAY:

Patients having no health insurance are required to pay at the time of service unless other arrangements are made prior to your visit. If you are unable to pay in full for necessary medical care at the time of service, our Patient Accounts Representative will attempt to assist you in setting up a short-term payment plan.

BILLING:

Statements will be mailed monthly and the payment is due within 30 days. If you have not paid your bill, or have not arranged for a payment plan, we may ask for the assistance of an outside collection agency. If your account is turned over to a collection agency, you will be dismissed from our practice. We will try to work with you to avoid this.

NO-SHOW/CANCELLATIONS:

To cancel or reschedule please call 48 hours prior to your appointment. You may receive a \$20.00 charge for failure to keep an office visit appointment. On missed procedures in our office, you may be charge \$50.00. This fee will be your responsibility, not your insurance. Failure to call us in a timely manner results in other patients needing to see the physician being denied access to an appointment. We appreciate your assistance.

Thank you for understanding the need for our financial policy. Please feel free to contact us with any questions and/or concerns you may have. We are here to work with you in any way that we can.

I have read and understand this financial agreement

Signature of patient and/or responsible party

Date

Please print patient's name

Your right to privacy restricts our office's methods of contacting you without your permission. Please answer the following questions in order for us to contact you regarding your medical treatment.

- **Urology Associates has my permission to leave messages on my answering machine at home.**

Yes

No

- **Urology Associates has my permission to leave messages on my answering machine at work.**

Yes

No

- **To whom may we release your medical information (i.e. spouse, children, doctor, relatives, friends)? Please list name and relation:**

Patient's Name _____ **Date:** _____

Patient's Signature: _____

Thank you for your assistance in helping us maintain your privacy.

If at any time you need to change this information, please contact our office.

Urology Associates of Kingsport, P. C.

Arthur T. Wyker, M. D. Jim R. Littlejohn, M. D.
James R. Herman, M. D. Hugh M. Sullivan, M. D.
Anthony L. Broglio, M. D.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Urology Associates of Kingsport, P.C. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE

DATE

PRINT NAME

MEDICARE NUMBER

MEDIGAP

I request that payment of authorized Medigap benefits be made on my behalf to Urology Associates of Kingsport, P. C. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits.

SIGNATURE

DATE

PRINT NAME

MEDIGAP POLICY