



Dear Patient:

Thank you for choosing Urology Associates of New River Valley, PC for your urological needs. Please read and complete the following forms prior to your scheduled appointment to ensure your registration will proceed quickly.

You will need to bring your insurance card(s), a picture ID and physician referral forms (if required by your insurance) with you on the day of your appointment.

In addition, it is important that you bring a complete list of your current prescription and over-the-counter medications, including dose and frequency. Also, please bring any recent x-rays or appropriate records you may have.

Each of the providers at Urology Associates participate with Medicare, Anthem, and other insurance carriers. Patients who require a referral from their PCP are responsible for obtaining these PRIOR to their appointment. Failure to do so may result in the rescheduling of your appointment. Our staff is NOT responsible for obtaining your referral for you at the time of your appointment.

Co-pays, co-insurance and deductible amounts are collected at **each visit**. Unpaid balances remaining after your insurance has paid are due within 60 days. Urology Associates will not be responsible for negotiating a disputed claim with your insurance company. Our staff will file a maximum of two insurances.

Uninsured patients are expected to pay in full for services at the time of their appointment, with a minimum payment requirement of \$75.00. A budget agreement must be signed for the remaining balance.

There is a \$25.00 fee for returned checks.

A \$10.00 fee will be charged for the completion of additional insurance forms (such as disability, FMLA).

A reasonable fee is charged for copies of patient medical records.

Our office must be notified the day prior if you are unable to keep your appointment. Failure to do so will result in a \$25.00 fee.

Our goal is to provide quality medical services to our patients. We realize that unexpected medical bills can create a financial hardship. Our office will work with you to develop a budget agreement and/or make payment arrangements for larger charges and overdue accounts.

Please call our office (540) 382-3440 if you have additional questions.



# Urology Associates of New River Valley, P.C

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

Race: \_\_\_\_\_ Ethnicity: (Circle) Hispanic or Latino / Non Hispanic or Latino / Declined / Unknown

Does the Patient Need an Interpreter? (Circle) NO YES Type: \_\_\_\_\_

**Preferred Pharmacies:**

<u>Name</u>	<u>Location (Street, City)</u>
1. _____	_____
2. _____	_____

Mail Order Pharmacy: \_\_\_\_\_

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

Are you having Pain? No \_\_\_\_ Yes, (on scale of 1-10) \_\_\_\_ Last Menstrual Period: \_\_\_\_ N/A \_\_\_\_

**Current Medications List:** (Include Over the Counter Medications and Supplements)

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

**Past Medical History:** (Check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Acid Reflux /Stomach Ulcers     | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Pacemaker/ Defibrillator              |
| <input type="checkbox"/> Anxiety                         | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Seizures                              |
| <input type="checkbox"/> Bleeding Problems               | <input type="checkbox"/> Gout or Arthritis   | <input type="checkbox"/> Sexual Dysfunction                    |
| <input type="checkbox"/> Breathing Problems/COPD, Asthma | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Sleep Apnea                           |
| <input type="checkbox"/> Cancer Type /Location:<br>_____ | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Frequent Urinary Tract Infections     |
| <input type="checkbox"/> Coronary Artery Disease         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other Genitourinary Problems<br>_____ |
| <input type="checkbox"/> Depression                      | <input type="checkbox"/> HIV                 |  |
|  | <input type="checkbox"/> Kidney Stones       |  |

**Past Surgical History:** (List Procedures and Year Performed)

- |   |          |          |
|---|----------|----------|
| <input type="checkbox"/> Prostate Surgery _____ | 1. _____ | 4. _____ |
| <input type="checkbox"/> Bladder Surgery _____  | 2. _____ | 5. _____ |
| <input type="checkbox"/> Kidney Surgery _____   | 3. _____ | 6. _____ |
| <input type="checkbox"/> Hysterectomy _____     |          |          |

Were Ovaries Removed? Yes / No

**Family History:****Health Problems****Age( If Deceased, Age at Death)****Cause of Death**

Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

**Men:** Do you have a family history of Prostate Cancer? No / Yes, what relation? \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bladder Cancer       | <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> Bleeding / Clotting Disorder |
| <input type="checkbox"/> Kidney Cancer        | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Diabetes                     |
| <input type="checkbox"/> Malignant Lymphoma   | <input type="checkbox"/> Renal Failure       | <input type="checkbox"/> Mental Illness               |
| <input type="checkbox"/> Other Type of Cancer | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Stroke                       |
| Location: _____                               | <input type="checkbox"/> High Blood Pressure | Other: _____  |

**Social History:**

Occupation: \_\_\_\_\_ Retired: No \_\_\_\_\_ Yes \_\_\_\_\_

Smoking: Never a Smoker / Former Smoker / Current Smoker ( Do you smoke daily? No / Yes )

Alcohol Use: None \_\_\_\_\_ Yes \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Amount / Type \_\_\_\_\_

Caffeine Use: No \_\_\_\_\_ Yes \_\_\_\_\_ Amount / Type \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Domestic Partner \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

**Allergies: No Known Allergies (check):** \_\_\_\_\_

LATEX Allergy: No \_\_\_\_\_ Yes \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

X-Ray Contrast / Dye: No \_\_\_\_\_ Yes \_\_\_\_\_ Type of Reaction: \_\_\_\_\_

Medication Allergy:

Type of Reaction:

- |          |          |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |
| 4. _____ | 4. _____ |

Non -Medication Allergy: (Peanuts, Shellfish, Dairy, etc.)

Type of Reaction:

- |          |          |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |

**Clinical Staff Use:** Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ B/P \_\_\_\_\_

# Review of Systems

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

Account # \_\_\_\_\_

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

Do you now, or have you had any problems related to the following systems? Circle **Yes** or **No**.  
Please explain any Yes answers in the space provided.

## Constitutional Symptoms

Fever Y N  
Chills Y N  
Headache Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Integumentary

Skin rash Y N  
Boils Y N  
Persistent itch Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Eyes

Blurred vision Y N  
Double vision Y N  
Pain Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Musculoskeletal

Joint pain Y N  
Neck pain Y N  
Back pain Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Allergic/Immunologic

Hay Fever Y N  
Drug allergies Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Ear/Nose/Throat/Mouth

Ear infection Y N  
Sore throat Y N  
Sinus Problems Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Neurological

Tremors Y N  
Dizzy spells Y N  
Numbness-tingling Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Genitourinary

Urine leakage Y N  
Painful urination Y N  
Urinary frequency Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Endocrine

Excessive thirst Y N  
Too hot/cold Y N  
Tired/sluggish Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Respiratory

Wheezing Y N  
Frequent cough Y N  
Shortness of breath Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Gastrointestinal

Abdominal pain Y N  
Nausea/vomiting Y N  
Indigestion/heartburn Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Hematologic/Lymphatic

Swollen glands Y N  
Blood clotting problem Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Cardiovascular

Chest pain Y N  
Varicose veins Y N  
High blood pressure Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_

## Psychologic

**Are you generally satisfied with your life?** Y N  
Do you feel severely depressed? Y N  
Have you considered suicide? Y N  
Other \_\_\_\_\_  
Explain \_\_\_\_\_



Patient Information Sheet

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Street Address \_\_\_\_\_ County \_\_\_\_\_

(No PO Boxes)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Which phone number should we call to verify appointments? \_\_\_\_\_

Is the above address the same as your mailing address?  YES  NO If no, please provide your mailing address:

Mailing Address \_\_\_\_\_

\*If the patient is a **child or student**, who is the responsible parent or guardian? \_\_\_\_\_

Is their street address and/or mailing address the same as above?  YES  NO. If no, please complete the following:

Street Address \_\_\_\_\_ County \_\_\_\_\_

(No PO Boxes)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Mailing Address \_\_\_\_\_

(If different than street address)

Referring MD \_\_\_\_\_ Family MD \_\_\_\_\_

Are you employed?  YES  NO

Employer \_\_\_\_\_ Emp's Phone # \_\_\_\_\_

Are you married?  YES  NO

Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Is your spouse employed?  YES  NO

Spouse's Emp \_\_\_\_\_ Emp's Phone # \_\_\_\_\_

Alternate Phone # (Someone not living with patient) \_\_\_\_\_

Name of Person at Alternate # \_\_\_\_\_ Their Relationship to Patient \_\_\_\_\_

\*\*\*\*\*

**Primary Insurance** \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Emp's Phone # \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

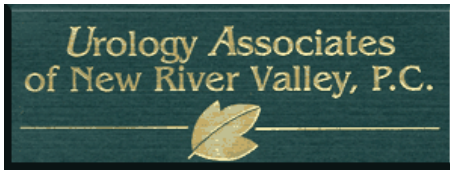
Claim's Address \_\_\_\_\_ Phone # \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Emp's Phone # \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Claims Address \_\_\_\_\_ Phone # \_\_\_\_\_



## Agreement to Pay and Assignment of Benefits

In exchange for medical services rendered to me or to any member of my family, for whom I am responsible, I agree to be personally responsible for the full payment of all bills and charges for medical services and other services rendered to me or such family member by **Urology Associates of New River Valley, P.C.**

I hereby authorize the release of any and all medical and billing information contained in my medical record to Medicare and/or Medicaid and/or to any other insurance company or health plans directly or indirectly responsible for payment for or review of services rendered to me by **Urology Associates of New River Valley, P.C.**

I request that payment of authorized Medicare/Medicaid benefits or benefits due from any other insurance company or health plan be made on my behalf for any services furnished to me by **Urology Associates of New River Valley, P.C.** I assign benefits payable for physician or medical services to **Urology Associates of New River Valley, P.C.** and authorize the practice to submit a claim to Medicare and/or Medicaid or any other insurance company or health plan for payment on my behalf. I understand that I am responsible for any deductibles, co-payments and any applicable percentage of remaining charges.

I understand and agree that all bills for medical treatment, including any co-payments required from me, shall be due and payable at the time treatment is rendered. If any indebtedness by me is placed for collection, I also agree to be responsible for payment of reasonable collection costs and attorneys fees.

I am acknowledging that I have received the *Patient Letter* which is included with the patient information forms.

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Signature of Patient (or Representative)

Date

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Relationship of Representative

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Signature of Parent or Guardian (if patient is under 18 yrs)

Date

# Urology Associates of New River Valley, P.C.

120 Akers Farm Road, NE  
Christiansburg, VA 24073

## 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.**

Effective April 14, 2003

Last Revision: September 1, 2011

**Urology Associates of New River Valley, P.C.** is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We realize that these laws are complicated, but we must provide you with the following important information.

### **Uses and Disclosures of Health Information**

Federal law provides that we may use your health information for treatment, payment and health care operations without specific notice to you, or written authorization by you. Please review the following statements that explain this in more detail.

**Treatment.** We may use and disclose health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose health information to doctors, dentists, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. This will also include if our office refers you to another provider. We will furnish that provider with your medical information that relates to that problem so that you will receive proper medical care.

**Payment.** We may use and disclose your health information so that we or others, may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so they will pay for your treatment, such as a diagnosis code for your visit and a description of the services rendered.

**Health Care Operations.** We may use and disclose your health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. These activities include, but are not limited to, third party "business associates" that perform various activities for the practice such as billing and transcription services, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. This information may also be used for risk reduction or quality assurance purposes. In addition, we may use a sign-in sheet at the registration desk and we may call you by name in the waiting room when your provider is ready to see you.

We may use or disclose your health information, without further notice to you, or specific authorization by you, where:

1. Required by law;
2. Required for public health purposes;
3. Required by law to report abuse or neglect;
4. Where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. Required by law in judicial or administrative proceedings;
6. Required by law enforcement purposed by a law enforcement official;
7. Required by a coroner or medical examiner
8. Permitted by law to a funeral director;
9. Permitted by law for organ donation purposes;
10. Permitted by law to avert a serious threat to health or safety;
11. Permitted by law and required by military authorities if you are a member of the U.S. armed forces.

We may contact you by mail or phone, including cell phone, at your residence or work place, in reference to your appointment scheduling, billing issues, test results or other medical information that we may need to provide proper medical care. Unless you instruct us otherwise in writing, we may leave a message for you on any answering device or with any person who answers the phone at your residence. You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give, at any time, in writing, except to the extent that **Urology Associates of New River Valley, P.C.** has already taken an action relying on the use of your previously signed authorization.

### **Rights That You Have**

You have the right to request restrictions on certain uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions. For additional details see the long form of the Notice of Privacy Practices.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged). You must make this request in writing and allow a reasonable amount of time to prepare.

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

You have the right to obtain a paper copy of this notice from our office.

### **Obligations That We Have**

We are required by law to maintain the privacy of health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice and to make a new notice effective for all health information we maintain. Any revised notice will be posted in our office and copies will be available there.

You may file a complaint with us. Complaints should be directed to our **Privacy and Security Officer, Karen Nunn**. You can contact her at **(540) 382-3440**, if you desire further information, or have any questions or concerns.

If you are not satisfied with how our office handled your complaint, you may also submit a written complaint to:

**Secretary of the Department of Health and Human Services  
200 Independent Avenue, S.W.  
Washington, D.C. 20201**

We support your right to the privacy of your protected health information. We will not retaliate or penalize you in any way if you choose to file a complaint with us, or the Department of Health and Human Services. Your medical health and privacy rights will always be important to us.

# **Urology Associates of New River Valley, P.C.**

## **Acknowledgement of Receipt of Notice of Privacy Practices**

By signing below, I am acknowledging that I have been provided with a copy of **Urology Associates of New River Valley, P.C.**'s Notice of Privacy Practices dated September 1, 2011 pursuant to the Health Information Portability and Accountability Act of 1996 (HIPAA).

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient or Representative

\_\_\_\_\_  
Relationship of Representative to Patient

**Evidence of the authority of the patient's representative must be attached to this acknowledgment**

If patient is unable to sign please document the reason and initial: \_\_\_\_\_

- I hereby give **Urology Associates of New River Valley, P.C.** permission to leave messages on my telephone answering machine/voicemail or to whomever answers the telephone regarding appointment, billing and/or medical information.
- I do not give **Urology Associates of New River Valley, P.C.** permission to leave messages on my telephone answering machine/voicemail or to whomever answers the telephone regarding appointment, billing and/or medical information.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient or Representative

\_\_\_\_\_  
Relationship of Representative to Patient