DAVID M. RODIN, MD
Diplomate of the American Board of Urology

PATIENT INFORMATION

WE WILL ASK FOR A URINE SAMPLE AT EVERY VISIT – THANK YOU

Social Security #: ____________-____________-____________

Last Name: __________________________ First Name: __________________________ MI: ________

Address: ____

City: ____________________________________ State: _______________ Zip: ______________

Home #: (______)______-________ Work #: (______)______-________ Cell #: (______)______-________

Sex: Male Female DOB: _______________ Email: ______________________________

Referring Doctor: ____________________________________ PCP: ______________________________

Marital Status: Single Married Divorced Widowed Separated

IF PATIENTS INSURANCE IS NOT THROUGH EMPLOYER OR PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION.

Last Name: __________________________ First Name: __________________________ MI: ________

Address: ____

City: ____________________________________ State: _______________ Zip: ______________

Home #: (______)______-________ Work #: (______)______-________ Cell #: (______)______-________

Sex: Male Female Date of Birth : ______/______/______ Social Security #: _____-_____-________

Responsible Party Employer: ____

Relationship to Patient: ____

MEANINGFUL USE DATA

Race: African American Asian Caucasian Hispanic Indian Native American Pacific Islander

Ethnicity: Hispanic Non-Hispanic Preferred Language: English Spanish Other: ______________

IN CASE OF EMERGENCY

Relative/Friend: ____ Relationship: __________________

Home #: (______)______-________ Work #: (______)______-________ Cell #: (______)______-________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Coastal Urology of Stuart or my insurance company to release any information required to process my claims.

PATIENT SIGNATURE: ____________________________________ **DATE:** __________________

COASTAL UROLOGY OF STUART

PF-3000 (b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting LaToya Mills, Front Desk .

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

______________________________ ______________________________

PRINT PATIENT'S NAME **PATIENT MRN NUMBER**

______________________________ ______________________________

Patient or Legally authorized individual signature Date Time

______________________________ ______________________________

Printed Name if signed on behalf of the patient Relationship to Patient

(Notation, if any, by staff)

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DESCLOSED:

______________________________ ______________________________

Print Name of person/organization Relationship to Patient

______________________________ ______________________________

Print name of person/organization Relationship to Patient

OFFICE APPOINTMENT CANCELLATION POLICY

**Our office policy states that patients who do not cancel their appointment 24 hours in advance, will be charged $25.00.
** $75.00 will be charged to patients who do not cancel their procedures (ie: Cystoscopy, prostate biopsies, Testopel insertion, etc.) 24 hours in advance.
** If the patient fails to keep his/her appointments 3 times, he/she will be terminated from the practice.

Please sign below that you have read the above policy:

______________________________ ______________________________

Patient or (Guardian) Date

Policy Effective Date: October 23, 2012

COASTAL UROLOGY of Stuart PA

Who referred you to this office? ____________________ **Medical Doctor/PCP:** ______________________________

Why are you seeing the physician today: ____

When did your problem start: ______________________ **Pharmacy** (Name & Number):__________________________

My Main Problems are:

❑ Blood in urine ❑ Bladder Cancer ❑ Bladder Infection ❑ Bladder Pain ❑ Dropped Bladder
❑ Kidney Stones ❑ Interstitial Cystitis ❑ Leak Urine ❑ Overactive Bladder
❑ Other ____

Drug Allergies: Please list all drug allergies

____

Medications: Please list ALL medications, including any antibiotics, supplements and vitamins you are currently taking.

____
____
____

My Urinary Symptom(s) are:
❑ Frequency ❑ Urgency ❑ Leakage ❑ Straining ❑ Abdominal Pain ❑ Bladder Pain
❑ Pain in Side Right / Left ❑ Not Emptying Bladder ❑ Urinating at Night #_________

Surgical History ❑ Appendectomy ❑ Back/Hip/Knee ❑ Bladder Tack ❑ C – Section # ______ ❑ Cystoscopy
❑ Gallbladder ❑ Heart Bypass ❑ Hysterectomy ❑ Kidney Stone Surgery ❑ Lithotripsy ❑ Sling (TVT)
❑ Vaginal Deliveries # ____ ❑ Other ________________________________ ❑ **No Changes**

Medical History ❑ Diabetes ❑ Emphysema ❑ Heart Attack ❑ Heart Murmur ❑ Hepatitis
❑ Hernia ❑ Hypertension ❑ Last Period: ______________ ❑ Menopause ❑ Parkinson's
❑ Pregnant #_____ ❑ Strokes ❑ **No Changes**
Cancer: ________________________________ Other ________________________________

Family History ❑ Bladder Cancer ❑ Kidney Cancer ❑ Kidney Stones ❑ Heart Disease

Social History (Circle One)
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Smoke: ❑ Yes ❑ Not Anymore ❑ Never
Drink Alcohol: ❑ Yes ❑ Not Anymore ❑ Never ❑ Socially Daily Caffeine Intake: *0 1 2 3 4+*
Blood Transfusion: ❑ YES ❑ NO

My Symptom(s) are:

General/Constitutional	❑ Fever	❑ Weight Loss	❑ Chills
Eyes	❑ Blurry Vision	❑ Double Vision	❑ Cataracts
Ears, Nose, Mouth, Throat	❑ Hearing Loss	❑ Nasal Stuffiness	❑ Sore Throat
Cardiovascular	❑ Chest Pains	❑ Swollen Ankles	❑ Irregular Heartbeat
Respiratory	❑ Shortness of Breath	❑ Wheezing	❑ Chronic Cough
Gastrointestinal	❑ Abdominal Pain	❑ Nausea/Vomiting	❑ Change in Bowels
Genitourinary	❑ Incontinence	❑ Painful Urination	❑ Blood in Urine
Musculoskeletal	❑ Chronic Back Pain	❑ Chronic Neck Pain	❑ Sore Muscles
Integumentary/Skin	❑ Rash	❑ Persistent Itching	❑ Skin Cancer History
Neurologic	❑ Numbness	❑ Tingling	❑ Dizziness
Hematologic/Lymphatic	❑ Swollen Glands	❑ Abnormal Bleeding	❑ Transfusion History

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Financial Agreement

For services rendered to the patient named below, I, the undersigned, agree to pay all professional and/or outpatient charges not covered by insurance. This includes any co-payments, co-insurance and deductibles that may be owed. **I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.**

Patient and /or Guardian Signature ____________________ Date ____________

Authorization to Release Medical Information and payment of Insurance Benefits

I hereby authorize Coastal Urology of Stuart or my attending physician to release or disclose to insurance companies and/or outpatient benefits programs information from my medical record pertaining to my treatment as needed to process insurance claims. Furthermore, I hereby assign payment directly to Coastal Urology of Stuart benefits wherein specified and otherwise payable to me but not to exceed Coastal Urology of Stuart regular charges for medical treatment. I understand that I am financially responsible for charges not covered by this authorization.

Patient and /or Guardian Signature ____________________ Date ____________

Statement to Permit Payment of Medicare Benefits to Physician (Medicare Patients Only)

I certify that the information given by me in applying for payments under the Title XVII of the Social Security Administration or it intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payment for physician services to the physician or organization furnishing the services, and authorize such physician or organization to submit claims to Medicare for payment.

Patient and /or Guardian Signature ____________________ Date ____________

Prescription Refills

Telephone prescription refills must be requested on Monday – Friday between the hours of 8:30 am and 4:00 pm. Please allow 24 – 48 hours for your prescription to be called in. Telephone prescription refills may be delayed due to necessity for the physician to review your record and determine the appropriate medicine to prescribe. Also, please note that it is our belief that narcotic pain relievers are, in general, for short-term use only. Likewise, prescriptions **will not** be called in after hours and on weekends.

Patient and /or Guardian Signature ____________________ Date ____________

Return Phone Calls

The clinic staff at Coastal Urology of Stuart will return patient phone calls received before 4:30 pm Monday through Friday before the clinic closes that day. Calls after this time will be returned the next business day. If you believe your medical situation is urgent in nature, please proceed to a hospital emergency room for immediate treatment.

Patient and /or Guardian Signature ____________________ Date ____________

PHONE 772-288-3301 **FAX** 772-288-3312 **www.coastalurologyofstuart.com** 905 SE Monterey Commons Blvd, Stuart, FL 34996

Authorization for Release of Information

Name of Practice: ______________________________

Patient Name: ______________________ **Date of Birth:** ____________

Previous Name: ______________________________

I. My Authorization

You may use or disclose the following health care information (check all that apply)

- ☐ My health information relating to the following treatment or condition: ____________
- ☐ My health information for the date(s): ____________
- ☐ Other: ____________

You may disclose this health information to:

Name (or title) and organization **David Rodin M.D. Fax Number 772-288-3312**

Address: **905 SE Monterey Commons Blvd** City: **Stuart** State: **FL** Zip: **34996**

Reason(s) for this authorization (check all that apply):

- ☐ at my request
- ☐ other (specify) ____________

This authorization ends:

- ☐ on (date) ____________
- ☐ when the following event occurs ____________

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was obtain insurance. Two way to revoke this authorization are:

- Fill out a revocation form. The form is available from the office; or
- Write a letter to the office.

______________________ ____________ ____________

Patient or Legally authorized individual signature   Date   Time

______________________ ______________________

Printed name if signed on behalf of the patient   Relationship (parent, legal, guardian, personal representative, Etc)