COASTAL UROLOGY of Stuart PA

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:

❑ Enlarged Prostate	❑ Blood in urine	❑ High PSA	❑ Bladder Infection	❑ Kidney Stones
❑ Prostate Infection	❑ Urinary Incontinence	❑ Bladder Cancer	❑ Prostate Cancer	❑ Erectile Dysfunction
❑ Overactive Bladder	❑ Infertility	❑ Lump in Testicle	❑ 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):

❑ Incomplete Emptying ❑ Frequency ❑ Intermittency ❑ Weak Stream ❑ Straining
❑ Testicle Pain ❑ Pain in Side Right / Left ❑ Urinating at Night # _____

Surgical History ❑ Appendectomy ❑ Back/Hip/Knee ❑ Cystoscopy ❑ Gallbladder ❑ Heart Bypass
❑ Kidney Stone Surgery ❑ Lithotripsy ❑ Prostate Biopsy ❑ Prostate Seed ❑ Prostate Surgery
❑ Other _____ ❑ **No Changes**

Medical History ❑ Diabetes ❑ Emphysema ❑ Heart Attack ❑ Heart Murmur ❑ Hepatitis ❑ Hernia
❑ Hypertension ❑ Parkinson's ❑ Strokes
Cancer: ❑ Bladder ❑ Prostate ❑ Kidney ❑ Testis ❑ Other _____ ❑ **No Changes**

Family History ❑ Prostate Cancer ❑ Kidney Cancer ❑ Kidney Stones ❑ Heart Disease
If yes to any, please list family member: _____

Social History (Circle One)

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

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

International Prostate Symptom Score (IPSS)

Patient Name: Date of Birth: Today's Date:

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – 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	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:		+	+	+	+	+

Total International Prostate Symptom Score = _____

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	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

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)									
1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No

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Name/Date _____

Sexual Health Inventory for Men (SHIM)

This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that best describes your own situation. Please be sure that you select one and only one response for each question.

Over the Past 6 Months:

1. How do you rate your confidence that you could get and keep an erection?

Very Low	1	High	4
Low	2	Very High	5
Moderate	3		

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

No sexual activity	0	Sometimes	3
Almost never Or never	1	Most times	4
A few times (much less than half the time)	2	(much more than half the time) Almost always or always	5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Did not attempt intercourse	0	Sometimes	3
Almost never or never	1	Most times	4
A few times (much less than half the time)	2	(much more than half the time) Almost always or always	5

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Did not attempt intercourse	0	Difficult	3
Extremely difficult	1	Slightly difficult	4
Very difficult	2	Not difficult	5

5. When you attempted sexual intercourse, how often was it satisfactory for you?

Did not attempt intercourse	0	Sometimes (about half the time)	3
Almost never or never	1	Most times	4
A few times (much less than half the time)	2	(much more than half the time) Almost always or always	5

Add the numbers corresponding to questions 1-5
Total: _____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1 - 7	Severe ED
8 - 12	Moderate ED
12 - 16	Mild to Moderate ED
17 - 21	Mild ED

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

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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 _____

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)