

FLORIDA UROLOGICAL INSTITUTE
6450 38 AVENUE NORTH, SUITE 110
ST PETERSBURG, FL 33710
TEL 727-345-2274 FAX 727-381-1618

PATIENT INFORMATION FORM

TODAYS DATE _____ AGE _____ SEX _____

NAME _____ DATE OF BIRTH _____

SOC. SEC. # _____ DRIVER'S LICENSE # _____

HOME ADDRESS _____

CITY, STATE, ZIP _____

EMAIL _____

HOME PHONE _____ CELL PHONE _____ MARITAL STATUS _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORKPHONE _____

SPOUSE _____ SPOUSE'S SOC. SEC. # _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORKPHONE _____

EMERGENCY CONTACT _____ PHONE _____

PRIMARY INS. _____ SECONDARY INS. _____

REASON FOR VISIT _____ REFERRED BY _____

OTHER MEDICAL PROBLEMS _____

CURRENT MEDICATIONS _____

MEDICATION ALLERGIES _____

PHARMACY _____ PHONE # _____

FAMILY DOCTOR _____ PHONE # _____

SIGNATURE _____

*****THIS AUTHORIZES THE DOCTOR TO TREAT YOU*****

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION
SIGNATURE ON FILE

NAME OF BENEFICIARY/PRIMARY CARD HOLDER _____

INSURANCE CARRIER _____

HEALTH INSURANCE CLAIM NUMBER (ID NUMBER) _____

I REQUEST THAT THE PAYMENT OF AUTHORIZED MEDICARE/INSURANCE BENEFITS BE MADE EITHER TO ME ON MY BEHALF OR TO **FLORIDA UROLOGICAL INSTITUTE** FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN. I HEREBY AUTHORIZE PAYMENT TO **FLORIDA UROLOGICAL INSTITUTE** BENEFITS SPECIFIED AND OTHERWISE PAYABLE TO ME FOR ANY SERVICES RENDERED BY THE PRACTICE SUBSEQUENT TO THIS DATE AND FOR SUCH OTHER CHARGES AS MAY BE MADE BY SAID PRACTICE. I HEREBY AGREE TO PAY THE SAME AND ALSO AGREE THAT IN THE EVENT THAT PAYMENT BY A THIRD PARTY FOR ANY INDIVIDUAL VISIT EXCEEDS THAT NECESSARY TO COVER CHARGES INCURRED DURING THAT VISIT, ANY OVERAGE MAY BE APPLIED TO OUTSTANDING CHARGES OWED TO THE PRACTICE FOR OTHER SERVICES RENDERED TO MYSELF, MY SPOUSE, OR LEGAL DEPENDENTS OF MYSELF OR SPOUSE AT THE TIME.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. THE PRACTICE MAY DISCLOSE ALL OR PART OF THIS PATIENT'S MEDICAL RECORD TO ANY INSURANCE COMPANY, ASSOCIATION OR THE FEDERAL OR STATE GOVERNMENT AS MAY BE NECESSARY FOR THE COMPLETION OF ALL PRACTICE CLAIMS. I UNDERSTAND THAT THE INFORMATION TO BE RELEASED MAY INCLUDE INFORMATION PERTAINING TO MENTAL OR PSYCHIATRIC RELATED CONDITIONS AND/OR DRUG OR ALCOHOL ABUSE. A COPY SHALL BE AS VALID AS THE ORIGINAL. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND THE NON-COVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE/INSURANCE CARRIER.

DESIGNATION OF A PERSONAL REPRESENTATIVE

A PERSONAL REPRESENTATIVE MAY BE THE SPOUSE, ADULT CHILD, OR OTHER MEMBER OF THE PATIENT'S FAMILY. A PERSONAL REPRESENTATIVE ALSO MAY BE A CLOSE PERSONAL FRIEND, OR ANY INDIVIDUAL WITH POWER OF ATTORNEY OR OTHER LEGALLY RECOGNIZED AUTHORITY TO MAKE MEDICAL DECISIONS ON BEHALF OF THE PATIENT IF HE OR SHE IS INCAPACITATED OR OTHERWISE UNABLE TO MAKE DECISIONS.

NAME (S) OF PERSONAL REPRESENTATIVE (S) (PRINT) _____

I, THE UNDERSIGNED, CERTIFY THAT I HAVE READ OR HAD READ TO ME THE FOREGOING, AND AM THE PATIENT, OR AM DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT IT'S TERMS.

PATIENT NAME
(PRINT) _____

SIGNATURE _____ **DATE** _____

WITNESS _____

PATIENT NAME _____ DATE _____

PAST MEDICAL HISTORY

POLIO _____	HYPERTENSION _____	MEASLES _____
TONSILLITIS _____	JAUNDICE _____	MUMPS _____
PLEURISY _____	KIDNEY TROUBLE _____	SURGERY _____
RUBELLA _____	PNEUMONIA _____	MALARIA _____
CHICKEN POX _____	RHEUMATIC FEVER _____	TYPHOID _____
SCARLET FEVER _____	CARDIAC _____	VENEREAL DISEASE _____
DIABETES _____	TUBERCULOSIS _____	MENTAL ILLNESS _____

OTHER (PLEASE LIST) _____

SOCIAL HABITS (DAILY)	WATER _____	BOWELS _____	ALCOHOL _____
	COFFEE _____	MEALS _____	EXERCISE _____
	DRUGS _____	SLEEP _____	TOBACCO _____

SERIOUS INJURIES _____

SURGERY/PROCEDURES _____

FAMILY HISTORY	MOTHER	FATHER	SISTER	BROTHER
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# SISTERS _____				
# BROTHERS _____				
ALIVE	_____	_____	_____	_____
DECEASED	_____	_____	_____	_____
TUBERCULOSIS	_____	_____	_____	_____
CANCER	_____	_____	_____	_____
VENEREAL DISEASE	_____	_____	_____	_____
HEART DISEASE	_____	_____	_____	_____
ARTHRITIS	_____	_____	_____	_____
TOBACCO	_____	_____	_____	_____
DIABETES	_____	_____	_____	_____
RHEUMATISM	_____	_____	_____	_____
ALCOHOL	_____	_____	_____	_____
STROKES	_____	_____	_____	_____
RHEUM. FEVER	_____	_____	_____	_____
SLEEP PROBLEMS	_____	_____	_____	_____
RENAL DISEASE	_____	_____	_____	_____
OBESITY	_____	_____	_____	_____
EMPHYSEMA	_____	_____	_____	_____
ALLERGY	_____	_____	_____	_____
MIGRAINE	_____	_____	_____	_____
HYPERTENSION	_____	_____	_____	_____
ANEMIA	_____	_____	_____	_____
EPILEPSY	_____	_____	_____	_____

PATIENT NAME _____ DATE _____

SYSTEMS REVIEW - DESCRIBE AT RIGHT

HEAD

ACNE _____
DIZZINESS _____
FAINTING _____
HAIR LOSS _____

EARS

ACHE _____
DISCHARGE _____
HEARING _____
TINNITUS _____

MOUTH

TEETH _____
GUMS _____

CHEST

PAIN _____
COUGH _____
SPUTUM _____
HEMOPTYSIS _____

GASTROINTESTINAL

BOWEL HABITS _____
PAIN _____
NAUSEA _____
APPETITE _____
BELCHING _____
VOMITING _____

MENSTRUAL

ONSET _____
LMP _____
DURATION _____
CYCLE _____
PAIN _____
AMOUNT _____
MENOPAUSE _____
OTHER _____

BONES, JOINTS, EXTREMITIES

ARTHRITIS _____
BACKACHE _____
VARICOSE _____
NEURITIS _____
PHLEBITIS _____
EDEMA _____
DEFORMITY _____
OTHER _____

EYES

VISION _____
PAIN _____
GLASSES _____
SCOTOMA _____

NOSE

DISCHARGE _____
CONGESTION _____
SINUS _____
CORYZA _____

THROAT

SORENESS _____
HOARSENESS _____
DYSPHAGIA _____
INFECTIONS _____

HEART

PAIN _____
ORTHOPNEA _____
CYANOSIS _____
DYSPNEA _____

GENITOURINARY

NOCTURIA _____
FREQUENCY _____
HEMATURIA _____
URGENCY _____
INCONTINENCE _____
DYSURIA _____

REPRODUCTIVE

CHILDREN _____
MISCARRIAGE _____
STERILITY _____
ABORTION _____

GENERAL

WEIGHT LOSS/GAIN _____
FATIGUE _____
FEVER _____
CHILLS _____
PULSE _____
BLOOD PRESSURE _____

OTHER

SOCIAL HISTORY _____
ENDOCRINE _____
TOBACCO ABUSE _____
NEUROLOGICAL _____
SEXUAL _____
ALCOHOL ABUSE _____

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Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Florida Urological Institute or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Florida Urological Institute may or may not agree to restrict the use or disclosure of your protected health information.

If Florida Urological Institute agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Florida Urological Institute reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Florida Urological Institute to use and disclose my health information in accordance with it.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

Witness

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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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Florida Urological Institute**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Florida Urological Institute Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office receptionist.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Florida Urological Institute
6450 38 Avenue North, Suite 110
St. Petersburg, FL 33713

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

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