SUNCOAST UROLOGY

Patient Name: ___________________________________ Date: _________________

Age: ______ Date of Birth:________________ Referring Physician: ________________

State the reason or symptom that brought you to the Urologist today.

____

Have you seen a Urologist before or had urologic problems requiring treatments in the past?

____

List past and current medical conditions | Past surgical procedures (list date)

Date:		Date:	

Current medications with dosage (include over the counter items such as: aspirin, anti-inflammatory, vitamins, herbal supplements, etc.)

Please list allergies to medications and reactions:

Medications	Reactions

Are you allergic to seafood or Iodine dye? Yes No

Have any members of your family had urologic problems? (For example: kidney stones, prostate issues, kidney, or bladder cancer, uti's etc.)

____

Please list your family medical history, please include your relation to that member. (for example, Diabetes, Heart Disease, Cancer, etc.)

____

	Yes	No	Amount
Are you a former smoker?			
Do you currently use Tobacco?			
Alcohol Consumption:			
Caffeine Consumption:			
Citrus Products:			

Review of Systems

Please review and CIRCLE any current issues.

Constitutional Symptom
Fever
Chills
Headache
Weight Change

Gastrointestinal
Abdominal Pain
Nausea/Vomiting
Indigestion/Heartburn
Bowel Changes

Eyes
Blurred Vision
Double Vision
Pain
Other__________

Musculoskeletal
Joint Pain
Neck Pain
Back Pain
Other______________

Cardiovascular
Chest Pain
Varicose Veins
High Blood Pressure
Other___________

Respiratory
Wheezing
Frequent Cough
Shortness of Breath
Other__________

Allergic/Immunologic
Hay Fever
Drug Allergies
Other____________

Endocrine
Excessive Thirst
Too hot/cold
Tired/Sluggish
Other___________

Integumentary
Skin Rash
Boils
Persistent Itch
Other__________

Hematologic/Lymphatic
Swollen Glands
Blood Clotting Problem
Other___________

Neurological
Tremors
Dizzy Spells
Numbness/Tingling
Other___________

Psychologic
Are you generally satisfied with your life?
Other______________

Ear/Nose/Throat/Mouth
Ear Infection
Sore Throat
Sinus Problems
Other_______________

MEDICAL RECORDS REQUEST/RELEASE

TO: ________________________________

PHONE: ___________________ FAX: ___________________

I hereby request that my medical records be released to/from:

David D. Buethe, M.D.

Ani Fombona, M.D.

Barry T. Sadler, M.D.

Kevin S. Spires, M.D.

Arnie B. Tannenbaum, M.D.

Mark Weitzenfeld, M.D.

Hudson
7614 Jacque Rd, Suite A.
Hudson, FL 34667
(727) 862-8548

Brooksville
11373 Cortez Blvd, Suite 209
Brooksville, FL 34613
(352) 596-0786

Spring Hill
10441 Quality Dr, Suite 201
Spring Hill, FL 34609
(727) 862-8548

Fax: (727) 863-4530 OR (352)596-5378

Email: Hudsonmr@suncoasturology.com

If fax does not work, please email records

Date: ________________

Patient Name: _______________________________ Date of Birth: __________________

Patient Signature: ____________________________

********PLEASE ONLY PERTAINING TO UROLOGY********

Labs____ PSA____UA____C &S____CYTOLOGY____

OFFICE NOTES (**LAST OV NOTE**) _____ CT ABD/PEL _______

ULTRASOUNDS_____ XRAYS______MRI______PATHOLOGY____OP REPORTS_____

Patient has appointment on _________________________.

if records are not received 24 hours prior to appointment date, patient may need to be rescheduled

David D. Buethe, M.D. | **Ani Fombona, M.D.** | **Barry T. Sadler, M.D.**

Kevin S. Spires, M.D. | **Arnie B. Tannenbaum, M.D.** | **Mark Weitzenfeld, M.D.**

PATIENT INFORMATION

NAME: ____

Last First M.I.

ADDRESS: ____

CITY: _____________________________ STATE: ____________ ZIP CODE: _________________

PRIMARY PHONE: __________________________________ CELL PHONE: _________________________________

SEX: ________ MARITAL STATUS: _________ OCCUPATION: _______________ DATE OF BIRTH:___/___/____

SOCIAL SECURITY NUMBER: _____________________ EMAIL ADDRESS_____________________________________

PRIMARY CARE PHYSICIAN____

PHARMACY: ___________________________________ PHARMACY PHONE NUMBER: _____________________

EMERGENCY CONTACT: _____________________________ PHONE: _______________________________________

INSUARNACE INFORMATION

Primary Insurance: __________________________________ ID#: ______________________________________

Group #: __________________________________ Phone #: ______________________________________

Subscriber Name (if patient write self): ____

Subscriber Date of Birth (if applicable): ___/___/____ Subscriber Social Security (if applicable): _______________

Secondary Insurance: ________________________________ ID#: ______________________________________

Group #: __________________________________ Phone #: ______________________________________

HIPPA MEDICAL RELEASE INFORMATION

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Please list names of any person(s) whom we may inform about your general medical Condition and your diagnosis (including treatment, payment, and healthcare operations).

Name: ____________________ Relationship: _____________ Phone#: __________________

Name: ____________________ Relationship: _____________ Phone#: __________________

Name: ____________________ Relationship: _____________ Phone#: __________________

Please indicate if you want correspondence from our office sent in a Sealed envelope marked "Confidential". YES NO

Can confidential messages (i.e., appointment reminders, lab results, etc.) be left on answering machine or voice mail. YES NO

Allow access to pharmacy thru ePrescription. YES NO

PATIENT NAME: ____

PATIENT OR GUARDIAN SIGNATURE: ____

DATE: _________________________

We are required by Law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of this change, copies will be made available.

If you receive no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.

LIFETIME AUTHORIZATION, INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASEINFORMATION

***I. TREATMENT AUTHORIZATION* –** I, the below named patient, do hereby give Suncoast Urology consent for medical treatment.

***II. RELEASE OF INFORMATION* –** I do hereby authorize any physician of this group examining and/or treating me to release to any third-party payor (such as an insurance company or governmental agency, i.e., Medicare, Medicaid), any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis. **I have been offered a copy of the privacy policy by Requesting it verbally or by a written request. Our privacy policy is posted in our waiting room.**

***III. PHYSICIAN INSURANCE ASSIGNMENT* –** I hereby authorize payment directly to any physician of this group examining or treating me any surgical and/or medical benefits herein specified and otherwise payable to me for their services and described but not to exceed the reasonable and customary charge for these services.

***IV. MEDICARE/MEDICAID* – Patient's certified authorization to release information and payment request.** I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act it corrects. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Children and Families or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

V. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIAN OFFICE. This assignment will remain in effect until revoked by mein writing.

We are committed to providing you with the best possible care. If you have medical insurance, we will be glad to help you receive your maximum benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Your insurance is an agreement between you and the insurance company- not an agreement between the doctor and the insurance company. As the patient, you further understand that you are ultimately responsible for the charges for medical care being rendered to you.

Our fees are generally considered to fall within the acceptable range by most companies. Our fees are considered USUAL, CUSTOMARY AND REASONABLE by most insurance companies.

This is to inform you that one or all the physicians may have a partnership in the following Bay Area Partners, LTD, UMS, South Florida Mobile Lithotripsy, and or Bayonet Point Surgery Center.
This is to inform you if you do not show up for your scheduled appointment there will be a $25.00 charge, which you will be responsible for, unless you give a 24-hour notice.

We bill all Medicare claims as well as PPO, HMO, and managed care plans that we participate with. Patients will be asked to pay all deductibles and co-pays at time of service. It is also the patient's responsibility to obtain all referrals and/or authorization numbers as required by their insurance plan. Changes in your insurance coverage must be given to the receptionist prior to your appointment.

PATIENT NAME: ______________________________ PATIENT SIGNATURE: ____

GUARANTOR NAME: ____

GUARANTOR SIGNATURE (IF OTHER THAN PATIENT): ____________________________________ DATE: __________________

LIFETIME AUTHORIZATION, MEDIGAP (SECONDARY INSURANCE) SIGNATURE

PATIENT NAME	HEALTH INSURANCE COMPANY	POLICY NUMBER

I request that payment of authorized MEDIGAP/Secondary Insurance benefits be made on my behalf to Suncoast Urology for any services furnished me by Suncoast Urology. I authorize any holder of medical information about me to release to ____ any information needed to determine benefits or the benefits payable for related services.
(MEDIGAP/SECONDARY INSURANCE CO)

PATIENT NAME	DATE

To Our Patients:

We are very pleased that you have chosen to seek Urological care in our practice. We would like to tell you a bit about the practice. As Urologists, we are required to take emergency call at the hospital. Due to the unpredictable nature of urological emergencies and the functioning of the operating room itself, we can be delayed in surgeries. In the worst-case scenario, we have had to cancel office hours to care for a critically ill patient. As a result of the above, it is not uncommon for the office to run behind schedule.

We will treat all patients, friends, and family members that enter our office with dignity and respect. We believe in being courteous, acknowledging concerns, and being honest and sincere. Asthese are our beliefs, we expect the same in return.

As a practice, we have decided that to optimize patient care, we will utilize our Nurse Practitioners. Therefore, you should expect to see a Nurse Practitioner on some of your visits. To provide the best patient care, you will receive communication through a staff member on whom you will be seeing before each visit.

In terms of narcotic pain management, we will not prescribe narcotics unless a patient is undergoing surgical treatment. After surgery, if you should require medication for a longer period than initially prescribed, it is your responsibility to make alternate prescribing arrangements with your primary care physician or another provider. If you have been on a complicated regimen for an extended period prior to being seen in this practice, the expectation is that the prescribing physician will continue to prescribe even after surgery.

Please sign below to signify that you have read and agree with the policies above. Thank you again for choosing urological practice.

Respectfully,

David D. Buethe, M.D.

Ani Fombona, M.D.

Barry T. Sadler, M.D.

Kevin S. Spires, M.D.

Arnie B. Tannenbaum, M.D.

Mark Weitzenfeld, M.D.

______________________________ ________________________

Patient Signature Date