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Patient Information Sheet

Last:	First:		MI:
Social Security #:	Date of Birth:		Sex:
Address:			Apartment #:
City:	State:		ZIP:
Race:	Language:	Ethnicity:	Marital Status:
Primary Care/Family Physician:		Referring Physician:	
Home Phone: ( ) -		Cell Phone: ( ) -	
Work Phone: ( ) -		Email:	
Employer:		Occupation:	

SPOUSE AND/OR RESPONSIBLE PARTY INFORMATION

Last:	First:		MI:
Social Security #:	Date of Birth		Sex:
Address:			Apartment #:
City:	State:		ZIP:
Race:	Language:	Ethnicity:	Marital Status:
Primary Care/Family Physician:		Referring Physician:	
Home Phone: ( ) -		Cell Phone: ( ) -	
Work Phone: ( ) -		Email:	
Employer:		Occupation:	

BUREAU OF WORKERS COMPENSATION (BWC)

Is this a BWC claim? ☐ Yes ☐ No	Who is your MCO (e.g., Careworks, Sheakley, etc.)?
Claim #:	If applicable, please provide a copy of your C9.

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK STAFF)

Primary Insurance	**Secondary Insurance (If Applicable)**
Plan Name:	Plan Name:
Policyholder's Name:	Policyholder's Name:
Policyholder's DOB:	Policyholder's DOB:
Policy/ID #:	Policy/ID #:
Group #:	Group #:

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Patient History Form

PATIENT INFORMATION				
First:	MI:	Last:		
Birthdate:	Age:	Sex:	Weight:	Height:

HISTORY OF PRESENT ILLNESS

COMPLAINT – What is the reason for your visit today?

_____

When did you first notice the problem? _____

Does the problem interfere with your normal functions? Yes No

Does anything make the problem worse? _____

Do you have any of the following symptoms? (check all that apply)

☐ Blood in urine ☐ Burning with urination ☐ Urine leakage ☐ Decreased urine stream ☐ Straining to urinate

☐ Waking up to urinate - how many times a night? _____ ☐ Urinary frequency - how many times a day? _____

SOCIAL HISTORY			
Do you use tobacco? Yes No Former	Type:	Packs/Day:	Years:
Ever tried to quit? Yes No	Year Quit:		
Do you drink alcohol? Yes No	Type:	Amount:	Frequency:
Caffeine? Yes No	Type: Coffee Soda Tea Other	Amount:	Frequency:
History of illegal drug use? Yes No	Type:		

ALLERGIES

Please list name and reaction (example: penicillin-hives). Also list anesthesia problems.

1.	Reaction:
2.	Reaction:
3.	Reaction:
4.	Reaction:
5.	Reaction:

MEDICATIONS

Please list current medications (including over-the-counter) and dosages. Continue on back if needed.

1.	Reason:	9.	Reason:
2.	Reason:	10.	Reason:
3.	Reason:	11.	Reason:
4.	Reason:	12.	Reason:
5.	Reason:	13.	Reason:
6.	Reason:	14.	Reason:
7.	Reason:	15.	Reason:
8.	Reason:	16.	Reason:
Do you take aspirin regularly?		If yes, how much?	

PHARMACY INFORMATION			
Pharmacy Name:	Pharmacy Phone #: ( ) -		
Address:	City:	State:	Zip:

_____ _____

Patient/Guardian Signature Date

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Family History

Date: _____

Print Patient Name: _____ DOB: _____

Please check if applicable. Please state your family members' relation to you.

Condition	Family Member(s)
☐ Blood Disease	☐ Paternal ☐ Maternal Relation:
☐ BPH (Enlarged Prostate)	☐ Paternal ☐ Maternal Relation:
☐ Cancer: Type:	☐ Paternal ☐ Maternal Relation:
☐ Crohn's Disease	☐ Paternal ☐ Maternal Relation:
☐ Diabetes	☐ Paternal ☐ Maternal Relation:
☐ Eczema (Skin Disorder)	☐ Paternal ☐ Maternal Relation:
☐ Gout	☐ Paternal ☐ Maternal Relation:
☐ Hearing Impairment	☐ Paternal ☐ Maternal Relation:
☐ Heart Disease: Type:	☐ Paternal ☐ Maternal Relation:
☐ High Blood Pressure	☐ Paternal ☐ Maternal Relation:
☐ High Cholesterol	☐ Paternal ☐ Maternal Relation:
☐ Kidney Failure	☐ Paternal ☐ Maternal Relation:
☐ Kidney Stones	☐ Paternal ☐ Maternal Relation:
☐ Migraines	☐ Paternal ☐ Maternal Relation:
☐ Seizure Disorder	☐ Paternal ☐ Maternal Relation:
☐ Stroke	☐ Paternal ☐ Maternal Relation:
☐ Urinary Tract Infections	☐ Paternal ☐ Maternal Relation:
☐ Other:	☐ Paternal ☐ Maternal Relation:

PAST MEDICAL/SURGICAL HISTORY

Please circle and include the approximate year you were diagnosed or surgery performed

PATIENT NAME _____ DOB_____

Medical History	Year	Surgical History	Year
Anemia		Adrenalectomy	
Asthma		Appendectomy	
BPH (Benign Prostatic Hyperplasia)		Colon Surgery or Bowel Surgery	
Bleeding Disorders		Coronary Artery Bypass Grafting (CABG)	
Cancer Type:		Coronary Stent	
Chest Pain		Gall Bladder	
Chronic UTIs		Gastric Bypass	
COPD (Chronic Obstructive Pulmonary Disease)		Green Light PVP	
Congestive Heart Failure		Hernia Repair: Inguinal, Umbilical, Incisional	
Depression		Laparoscopy Type:	
Diabetes		Nephrectomy Partial or Total	
DVT/ PEs		Pacemaker	
Heart Attack		Penile Prothesis	
Heart Disease		Prostate Brachytherapy/Radiation	
Hepatitis C		Transurethral Resection of Prostate (TURP)	
High Blood Pressure		Other	
High Cholesterol			
Inflammatory Bowel Disease			
Kidney Disease			
Kidney Stones			
Liver Disease			
Neurologic Disease			
Osteoarthritis			
Osteoporosis			
Peptic Ulcer Disease			
Peripheral Vascular Disease			
Seizure Disorder			
Stroke			
Valvular Heart Disease			
Other			

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Patient HIPAA and Notice of Privacy

PATIENT INFORMATION		
Last Name:	First Name:	M.I.:
DOB: / /		

NOTICE OF PRIVACY PRACTICES

☐ I have received a copy of the Notice of Privacy

Patient / Guardian Signature _____ Date _____

HIPAA AND MEDICAL RECORDS CONSENT

I hereby give permission to Central Ohio Urology Group to disclose my name, contact information, social security number, progress notes, laboratory test results, radiology reports, Individually Identifiable Health Information and Protected Health Information (PHI) to other physicians, health care practitioners, providers and laboratories that work with your physicians with respect to my treatment, and to health plans with respect to payment for my treatment.

I give permission to Central Ohio Urology Group to use my PHI for its Health Care Operations. I also give permission to release my medical and billing records to myself or to my guardian.

Patient / Guardian Signature _____ Date _____

Is there something you do not want us to disclose? _____

Is it okay to leave a Voicemail Message about your care? ☐Yes ☐No

Cell:	Home:	Work:

Please list any additional people that we are allowed to discuss your medical information with:

☐	Spouse	Name:	Phone:
☐	Child	Name:	Phone:
☐	Other	Name:	Phone:
☐	Other	Name:	Phone:

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Financial Policy

We are committed to providing you with the best possible medical care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our practice participates with a variety of insurance plans. It is your responsibility to:
   - **Bring your current insurance card at every visit**. We consider an insurance card similar to a credit card because you are asking us to bill another party for charges for the services you have been provided. If you do not bring your insurance card, you should be prepared to pay for your services in full on that date.
   - **Be prepared to pay your copay at each visit**. We are required by your insurance plan to collect copays on the date of service. Payment can be made by cash, check or credit card. If you do not bring proper payment to your visit, you will need to reschedule your appointment except in the case of a medical emergency.
   - **Verify that we are an in-network provider for your insurance at our facilities.** If we are NOT an In-Network provider and you receive treatment, you WILL be held liable for any charges**.** Please be aware that we may be an in-network provider at one location but an out-of-network provider at another.
2. For medical care **not covered** by your insurance, deductible and coinsurance limits that have not been satisfied, or for patients that have no insurance, payment in full is due at the time of the visit.
3. If you have insurance that we do not participate in, upon request our billing office will provide you with a form with itemized charges that you can use to file to that plan for reimbursement. However, payment in full is expected on the date of service.
4. If you have secondary insurance coverage, you must provide that information on the date of service. You will be expected to pay any copay required by your primary insurance on the date of service. If you do not provide us with your secondary insurance information in order to file a timely claim, you will be responsible for any balance due after your primary insurance pays.
5. If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is your responsibility to inform us prior to your visit.
6. Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.
7. If the patient is a minor (under 18 years of age), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance card.
8. A "Facility Fee" may be charged according to our contracts with certain commercial and government plans. If you are covered by any of those plans, you will be responsible for any portion of the "Facility Fee" that is not paid by those plans according to your benefits.
9. If you have any questions about insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company customer service department (the number is on your insurance card).
10. If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collections agency. You will be responsible for the fees assessed by the collections agency.

Our practice believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the office where you regularly receive services.

Please sign that you have read and agree to the Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Patient Name Patient Date of Birth

Updated 11/2021

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General Consent for Care and Treatment

Patient Name_____ Account #_____ DOB_____

1. I consent to examination, diagnosis, and general medical care, surgical care and treatment (including, but not limited to, physical examinations, administration of medications and vaccinations, recordings and/or photographs for diagnosis and/ or treatment, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, radiation therapy, surgery and other minor procedures) to be performed by employees, including, but not limited to, physicians, nurses and assistants of Central Ohio Urology Group, LLC and its subsidiaries (hereinafter "COUG").
2. I understand that the nature of and the need for each procedure and treatment will be explained to me beforehand, and that I am free to refuse any one or all procedures or treatments if I so choose. I will have the opportunity to ask the doctor questions about the operation/procedure, and such questions will be answered to my satisfaction.
3. I consent to the present and future prescription and/or administration of medicines or drugs as may be deemed necessary by my/the patient's physician or others of the COUG medical staff in the course of my/the patient's diagnosis and treatment with the understanding that the nature of and the need for such medicines or drugs will be explained to me beforehand, and that I shall always be free to refuse each and all of them if I so choose.
4. I understand that the explanation which will be given to me of the nature, intended purpose and the reasonable foreseeable risks, consequences, complications, benefits and alternatives of the examination(s), procedure(s) or treatment(s) which may be performed or used in the course of diagnosing or treating my/the patient's condition will not be exhaustive and that other risks and complications may arise, but the likelihood of their occurring is not reasonably foreseeable. I have been advised that if I desire a more detailed explanation prior to my consent, such explanation will be given to me.
5. I understand that some important tasks may be performed by qualified medical practitioners other than the named surgeon(s)/physician(s), and I consent to their doing so. The specific tasks will be determined based on the practitioner's skill set, scope of practice under the applicable State law and privileges granted will be performed under the supervision of COUG surgeon(s)/physician(s). I have been explained what specific tasks these practitioners will perform, and I give my consent.
6. I understand that my protected health information will be used by COUG, as necessary, for my treatment, to obtain payment for this treatment and for the healthcare operations of COUG. I also understand that my protected health information will be disclosed to other COUG affiliates if needed for the purpose of furthering my treatment, to obtain payment for treatment and for healthcare operations of COUG.
7. I understand that COUG will warn the appropriate authorities and/or other individuals if my COUG caregiver determines that I am a harm to myself or to others.
8. I consent to the photographing, videotaping, televising or other observation of the operation/procedure as COUG may deem useful or appropriate for scientific and/or educational purposes, with the understanding that my/patient's identity will remain confidential.
9. I consent to the presence during the operation/procedure of a visitor or visitors, which may include a visiting physician and/or a vendor representative whose presence has been requested by the COUG physician(s). I understand that the visitor(s) will at all times be under the supervision and direction of COUG physician(s) and other personnel, and subject to all relevant COUG policies and procedures.
10. I consent to receive advanced biomarker or genomic testing based upon my healthcare needs as medically necessary and ordered by my healthcare provider, with my informed consent. Additionally, I authorize and consent for COUG to use my non-identifiable biospecimens and my data to develop and further support the advancement of science, which includes but is not limited to, recommendations to participate in clinical trials, and the development of products, such as tests, drugs or medical devices that could be sold in the future. I understand that my non-identifiable biospecimens and data may be used to learn about, prevent, or treat urologic issues.

I confirm that I have read and fully understand this document, that I have been given the opportunity to ask questions about the operation/procedure and have had my questions answered satisfactorily, and that I am eligible to give this consent.

Patient Signature_____ **Date:** _____

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

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to provide you with this notice about our privacy practices, our legal duties, and your rights concerning your health information. This Notice takes effect June 2018 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice, provided such changes are permitted by applicable HIPAA laws enacted in 1996, and revised in 2013. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy or view the Notice on line.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations:

- **Treatment:** Use or disclose your health information to a physician or other healthcare provider treating you.
- **Payment:** Use and disclose your health information to obtain payment for services we provide to you.
- **Healthcare Operations:** Use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person Involved in Care: We may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-ray, or other similar forms of health information.

Information Concerning Decedents: We may disclose to a family member, other relative, close personal friend, or other person previously identified by you, protected health information directly relevant to such person's involvement with your health care or payment related to that health care unless doing so is inconsistent with any prior expressed preference that was made known to us. We will safeguard your protected health information for at least fifty years in accordance with HIPAA regulation 45 CFR 160.103.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law. This may include approved and lawful uses for public health and safety, for health oversight activities, or for judicial or administrative procedures (subpoena, court order, or search warrant).

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your information to the extent necessary to avert a serious threat to your health, safety, or the health or safety of others.

National Security & Law Enforcement: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your information to provide you with reminders (such as voicemail, electronic messages, postcards, or letters).

Sale of Protected Health Information: Sale of protected health information is prohibited without your written authorization. Any such authorization will include a statement that the disclosure will result in remuneration to us.

Research: Dependent upon the specific use, your permission may or may not be required dependent upon the research meeting privacy laws.

Workers' Compensation: For job related injuries or illnesses, we may use or disclose your information to the extent authorized for care, or as required by state law.

PATIENTS RIGHTS

Access: You have the right to inspect and obtain a copy of your protected health information, with limited exceptions. By law, you do not have a right to access psychotherapy notes, information compiled in reasonable anticipation of, or for use in, civil, criminal, or administrative proceedings; and protected health information which is subject to a law which prohibits access to protected health information. We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger you or another person, or is likely to cause substantial harm to another person referenced within the protected health information. You have the right to request a review of denial to access. Federal and state laws allow healthcare providers 30 days to respond to written request for records. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to your protected health information must be made in writing. Protected health information that is maintained electronically in one or more designated record sets will be provided to you in an electronic format if: (1) you request that such information be provided to you electronically, and (2) if the protected health information is readily producible in the requested electronic form or format. If the protected health information is not maintained in the requested form or format, we will provide you with the protected health information in a readable electronic form or format agreed to by both parties.

Access to Third Parties: We will provide your protected health information to third parties at your request. This request must be in writing and signed by you. The designated third party must be clearly identified by you, and you must provide information on where to send your protected health information.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. You must make your request in writing. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. Except as described in the paragraph below, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing.

Right to Limit Disclosure to your Health Plan: You have the right to limit disclosure(s) to your health plan if the disclosure is for the purpose of payment or health care operations and is not otherwise required by law, if the service(s) has been paid out of pocket in full by yourself or someone else on your behalf.

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Alternative Communication: You have the right to request that we place additional restrictions on our use or disclosure of your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location of your request. We may deny your request under certain circumstances.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Right to Express Complaints: You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services, Office of Civil Rights, if you believe that your privacy rights have been violated. If you wish to complain to us, you must do so in writing, and direct your complaint to the Privacy Officer.

Right to Obtain a Paper Copy of this Privacy Notice: You may request a copy of our Notice at any time.

Right to Notice: We will contact you in the event of a breach and your protected health information, and will provide pertinent information regarding the breach.

QUESTIONS AND COMPLAINTS

For any questions about our privacy practices, contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office of Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint please contact the applicable party:

Chief Compliance Officer
Central Ohio Urology Group
701 Tech Center Drive, Suite250
Gahanna, OH 43230
(614) 396-2684

U.S. Department of Health and Human Services, Office of Civil Rights
http://www.hhs.gov/ocr/privay/hipaa/complaints/index.html