

NEW PATIENT INFORMATION

DATE _____

PATIENT'S FULL NAME

Last	First	Middle	Marital Status S M W D	SEX M F
NAME OF SPOUSE (OR PARENT IF PATIENT IS A MINOR)			Name & Address of Closest Relative Not Living with you	
Patient's street address			Primary Care Physician	
City	State	Zip Code	Patient's Employer and Occupation	
Age	Birthdate		Work Phone	Cell Phone
Drug Allergies, if any			Home Phone	Social Security #

INSURANCE COMPANIES	Group# & Employer	Policy Certificate or I.D. #	POLICY HOLDER NAME
MEDICARE			
BLUE SHIELD			

DOES YOUR INSURANCE REQUIRE A SECOND OPINION? _____
 PRE-ADMISSION AUTHORIZATION? _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE _____ M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE _____ SIGNATURE _____

REMARKS:

FOR OFFICE ONLY

ACCOUNT TYPE _____	ACCOUNT LETTER _____	ACCOUNT # _____
INSURANCE CO. #'S _____	ACCOUNTS COVERED _____	POLICY HOLDER # _____
1. _____		
2. _____		

St. Louis Urological Surgeons
PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

LAST NAME _____ FIRST NAME: _____ DOB: _____ DATE: _____

Why are you consulting a Urologist? _____ REFERRING PHYSICIAN: _____ AGE: _____

When did you first notice the problem? _____

Do you have pain or discomfort? ___ Yes ___ No Where? _____

What makes the problem worse? _____ Better? _____

How would you describe your condition? Mild _____ Moderate _____ Severe _____

Please answer the following questions:

1. Do you leak urine? ___ No ___ All the time ___ With cough or sneeze ___ With exercise ___ At Night
2. Do you limit the fluids you drink? ___ Yes ___ No
3. How many times do you get up at night to urinate? _____
4. Do you limit activities because you have to urinate frequently (8 or more times in 24 hours)? ___ Yes ___ No
5. Do you have strong sudden urges to urinate? ___ Yes ___ No
6. How many pads or liners do you wear a day to protect your clothes from wetness? _____

Past Medical History

Medical (*High Blood Pressure, Stroke, Diabetes, etc.*) _____

Surgery _____

Pregnancy History (if applicable)

Number of pregnancies _____

Number of births _____

Immunizations: Up to date? _____

Pneumonia shot _____ Flu shot _____

Allergies to medications? **None** (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.) _____

Current prescription medicines **None** _____

OTC medicines: (Advil, vitamins, herbals, aspirin, etc.) _____

Physician's Comments: _____

Practitioner Signature: _____ Date _____

Family History

Family History of:	Yes	No	Family Member	Yes	No	Family Member
1. Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Gastrointestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History

Smoke? Yes No Quit When did you stop smoking? _____ If yes, how much? ___ # of pack/day ___ # of years ___

Alcohol? Yes No Quit If yes, how much? _____

Occupation: _____

Coffee - how much? _____ Tea - how much? _____ Soda - how much? _____

Have you ever used recreational drugs? (i.e. marijuana, cocaine) Yes No If yes, what and when _____

Review of Systems

Do you now or have you recently had any problems related to the following systems?

Circle Yes or No.

Constitutional Symptoms			(Comments)	Genitourinary			(Comments)
Weight change	Y	N		Change in stream	Y	N	
Chills	Y	N		Urinary frequency >8 times/day	Y	N	
Fever	Y	N		Blood in urine	Y	N	
Night sweats	Y	N		Flank or side pain	Y	N	
Other				Burning or pain with urination	Y	N	
				Other			
Eyes				Musculoskeletal			
Glaucoma	Y	N		Muscle weakness	Y	N	
Cataracts	Y	N		Joint pain (swelling)	Y	N	
Glasses/contacts	Y	N		Back pain	Y	N	
Other	Y	N		Other			
Cardiovascular				Neurological			
Chest pain/pressure	Y	N		Tremors	Y	N	
Irregular heartbeat	Y	N		Dizzy spells	Y	N	
Swelling in ankles	Y	N		Numbness/tingling	Y	N	
Other				Paralysis	Y	N	
Hematologic/Lymphatic				Respiratory			
Swollen glands	Y	N		Wheezing	Y	N	
Blood clotting problem	Y	N		Frequent cough	Y	N	
Bruise easily	Y	N		Shortness of breath	Y	N	
Other				Other			
Endocrine				Gastrointestinal			
Excessive thirst	Y	N		Abdominal pain	Y	N	
Too hot/cold	Y	N		Nausea/vomiting	Y	N	
Tired a lot	Y	N		Indigestion/heartburn	Y	N	
Other				Constipation/Diarrhea	Y	N	
Psychiatric				Sexual History			
Do you feel depressed?	Y	N		Change in sex drive?	Y	N	
Do you feel anxious?	Y	N		Sexual response satisfactory?	Y	N	
				Other			

NOTICE OF PRIVACY PRACTICES ST. LOUIS UROLOGICAL SURGEONS, INC.

Effective April 14, 2003

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.

We will not disclose your protected health information to third parties without your written authorization or other authority under the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Regulations"). We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our privacy notice and to make the new notice provisions effective for all protected health information we maintain. In the event we should change our privacy notice, we will provide you with a revised notice at your next visit. We must promptly revise and distribute this notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in this notice. Except when required by law, a material change to any term of this notice may not be implemented prior to the effective date of the notice in which such material change is disclosed to you.

Your written authorization and specific provisions of the Privacy Regulations govern disclosure of your protected health information. Disclosures not described in this and the next paragraph may be made only with your written authorization, which you may revoke in writing as provided in the Privacy Regulations. The practice is permitted under the Privacy Regulations to use and disclose protected health information for treatment, payment and health care operations. For example, protected health information may be disclosed from one physician to another within the practice for consultation. The practice uses an outside billing agency to process payment and reimbursement requests, subject to a confidentiality agreement and the governing law under the Privacy Regulations.

Subject to requirements of the Privacy Regulations, we may use and disclose protected health information for purposes of complying with legal requirements; public health activities; reporting abuse, neglect and domestic violence; cooperation with health oversight by government agencies and as required by the Secretary of Health and Human Services for compliance with the Privacy Regulations; for judicial and administrative procedures; for law enforcement; with respect to decedents; regarding cadaveric organ, eye and tissue donation; for certain research conducted by our staff; serious threats to health or safety; specialized government functions; and incident to a use or disclosure otherwise permitted or required by the Privacy Regulations, as provided under the Privacy Regulations. We may also disclose protected health information pursuant to your agreement to persons indicated by you for involvement in your health care and for notification purposes.

Missouri state laws with respect to genetic information and to human immunodeficiency virus infection status are more stringent than the Privacy Regulations and protected health information regarding these matters will be disclosed only in accordance with the governing Missouri statutes.

You have certain rights with regard to the handling of your protected health information, as provided in the Privacy Regulations. These are as follows. You may request restrictions on certain uses and disclosures of protected health information, however, we are not required to agree to a requested restriction. You may receive confidential communications of protected health information as provided by the Privacy Regulations. You may inspect and copy your protected health information, pursuant to a written request, subject to certain restrictions in the Privacy Regulations. You have a right to appeal a denial of access to your records. You may request an amendment of protected health information and demographic information, pursuant to a written request, subject to certain limitations in the Privacy Regulations. You have a right to contest a denial of an amendment. You may receive an accounting of certain disclosures of protected health information. You may obtain a paper copy of this notice upon request and a copy of your written acknowledgement of receipt of this notice.

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. If you wish to contact us for further information or to complain, please contact Richard Ault, Executive Director, tel. 434-6130. We will not take any action against you for filing a complaint or for exercising your rights under the Privacy Regulations.

I, _____, hereby acknowledge receipt
(Please print full name)

from St. Louis Urological Surgeons, Inc. of the above Notice of Privacy Practices.

(Signature)

(Date)

(Witness)

(Date)



ST. LOUIS UROLOGICAL SURGEONS

Richard A. Blath, M.D.
David E. Bryan, M.D.
James L. Carpenter, M.D.
Stephanie Cogan-Levy, M.D.
Ronald K. DeGuerre, M.D.
Anthony E. Fathman, M.D.
Kendall A. Itoku, M.D.
Ronan Y. Lev, M.D.
Joseph Levy, M.D.
John F. McCarthy, M.D.
Enrique P. Perinetti, M.D.
Asim Razzaq, M.D.
Ralph J. Torrence, M.D.

Nurse Practitioner

Lorri Brown, R.N., A.N.P.
Gina Powley, R.N., A.N.P.

Executive Director

Richard Ault, M.H.S.A.

Physicians Emeritus

Byron Beare, M.D.
Richard Parsons, M.D.
Carl Wattenberg, M.D. (dec.)

St. Luke's Hospital

224 S. Woods Mill Road
Suite 510-S
Chesterfield, MO 63017
(314) 434-3433
Fax: (314) 434-6813

**Christian Northeast
Hospital**

11155 Dunn Road
Suite 309-E
St. Louis, MO 63136
(314) 741-9010
Fax: (314) 741-5102

**DePaul Community
Health Center**

12277 DePaul Drive
Suite 501-S
Bridgeton, MO 63044
(314) 739-8844
Fax: (314) 739-5431

St. Peters Office

112 Piper Hill Drive
Suite 12
St. Peters, MO 63376
(636) 939-9202
Fax: (636) 939-9113

O'Fallon Office

5551 Winghaven
Suite 200
O'Fallon, MO 63368
(636) 561-5020
Fax: (636) 561-5024

Administrative Office

224 S. Woods Mill Road
Suite 510-S
Chesterfield, MO 63017
(314) 434-6130
Fax: (314) 434-1277

www.stluurology.com

TO: All New Male Patients

FROM: St. Louis Urological Surgeons

SUBJECT: Insurance Payment Guidelines

As you prepare for your visit to the physician we must make you aware of a potential situation regarding insurance coverage for certain diagnoses and conditions which are commonly treated by urologists. Specifically, it is possible that treatment for erectile dysfunction, impotence, infertility, and related conditions may not be reimbursed by your insurance carrier. In this case, you will be responsible for payment for any treatment you receive related to these conditions.

While some insurance plans do cover such treatment, there is no way for us to know in advance whether your carrier will, in fact, cover you. You may wish to contact your carrier prior to your visit to determine what their policy is.

If you are a Medicare patient you should know that these diagnoses are generally covered, though you may have a secondary insurance which would not pay.

We ask you to sign the following statement so that there is no confusion regarding this issue:

"I understand that if I am ever treated for erectile dysfunction, impotence, infertility, or a related diagnosis, and that any of my insurance carriers refuse payment for this treatment, I am fully responsible for paying all charges incurred during the course of my treatment."

Signature

Date