Patient Information

PLEASE PRINT AND FILL OUT COMPLETELY

Date:_____

Patient Name:_____ Date of Birth:_____

Home Address:_____ Home Telephone:_____

City: _____State:_____ Zip Code: _____Cell Phone:_____

SS#:_____ Marital Status: S M W D (circle one)

Email:_____ Language:_____

Race:_____ Ethnicity:_____

Patient's Occupation:_____ Work Telephone:_____

Employers Address:_____ City:_____ State:_____

Patient Allergies:_____

Patient's Family Doctor:_____ **Phone #:**_____

Referred By:_____

Patient's Pharmacy Name:_____ **Phone #:**_____

Pharmacy Address:_____ **City:**_____

Emergency Contact: (Name, address, and telephone of person NOT living at your address)

Name:_____ Telephone:_____

Address:_____ City:_____ State:_____ Zip:_____

Spouse's Name:_____ **Date of Birth**:_____

Employer:_____ Work Phone:_____ Cell:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

IF PATIENT IS A MINOR OR UNDER LEGAL GUARDIANSHIP, PLEASE COMPLETE

Father or Guardian

Name:_____
Address:_____
City:_____ State:_____Zip:_____
Home Telephone:_____
Date of Birth:_____
SS#:_____
Employer:_____
Employer Address:_____
City:_____ State:_____ Zip:_____
Work Phone:_____
Cell Phone:_____

Mother or Guardian

Name:_____
Address:_____
City:_____ State:_____Zip:___
Home Telephone:_____
Date of Birth:_____
SS#:_____
Employer:_____
Employer Address:_____
City:_____ State:_____ Zip:_____
Work Phone:_____
Cell Phone:_____

Complete this section only if you would like another person to have access to your medical information

Authorized Representative Name	Relationship of Patient Representative
Authorized Representative Name	Relationship of Patient Representative

1. Comprehensive Urology may leave appointment reminder messages on your answering machine (if applicable) and/or with the individual answering the telephone number you have provided. **If you do not wish us to do so, please check this box**

2. Comprehensive Urology will contact the guarantor/insured person regarding your account. **If you do not wish us to do so, please check this box**

3. Comprehensive Urology may leave a message on home or cell phone with test results, or clinical information. **If you do not wish us to do so, please check this box**

If you authorize Comprehensive Urology to call or send an email as noted above, please sign below

Sign Here: _____

(For Office Use Only Below)

Documentation of Attempt to Obtain Acknowledgement
Of Receipt of Notice of Privacy Practices (PF-2100)

Attempt to obtain Acknowledgement:
An Attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because

- The patient was undergoing emergency treatment
- The patient declined to sign the acknowledgement
- Other: _____

_____
Signature of Privacy Officer

_____
Name of Patient (print) Name of Privacy Officer Date

Acknowledgement of Review of Privacy Practices

HIPAA Privacy Rule and Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations

I, _____ understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test records, diagnosis, treatment and plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who may contribute to my care.
- A source of information for applying diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A toll for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the *Notices of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my PHI to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my PHI as specified below for these purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the use and disclosure of PHI for Treatment, Payment, or Healthcare Operations

I understand that:

- I have the right to review this facility's *Notice of Privacy Practices* prior to signing this consent.
- That this facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested.
- I have the right to object to the use of my health information for directory purposes.
- I have the right to request restrictions as to how my PHI may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance based on this consent form.

Signature of Patient Name of Patient Date

Signature of Patient Representative Relationship of Patient Representative

(required only if patient is a minor or an adult who is unable to sign this form)

Comprehensive Urology – Affiliates Division

33545 Cherry Hill Rd, Westland, MI 48186 4870 Clark Rd, Ste 102 Ypsilanti MI 48197
2421 Monroe St, Ste 200 Dearborn MI 48124 1600 S Canton Center Rd, Ste 2200 Canton MI 48188
12701 Telegraph Ste. 201 Taylor MI 48180 7575 Grand River Ave., Ste 202 Brighton MI 48114

FINANCIAL POLICIES AND INSURANCE AUTHORIZATION

Patient Name _____ SSN_____

Thank you for choosing us as your health care provider. This document is a summary of our financial policies, an explanation of your responsibilities and an authorization to bill your insurance on your behalf for services provided to you. You will be responsible for co-payment, deductibles, co-insurance and any services provided which may not be considered a covered benefit under your policy. Your insurance may deny claims for a variety of reasons that may include but is not limited to:

1. The service provided is not a covered benefit
2. You may have exhausted your benefit(s) for the services provided
3. Medical necessity or medically necessary; this generally means a determination based upon criteria and guidelines developed by the insurance carrier in consideration of generally accepted standards and practices. This service must meet all the following criteria:
    a. It is generally accepted as necessary and appropriate for the patient's condition, given the symptoms, and is consistent with the diagnosis; and
    b. It is essential or relevant to the evaluation or treatment of the disease, injury, condition or illness and is not mainly for the convenience of the member of Physician; and
    c. It is reasonably expected to improve the patient's condition or level of functioning or in the case of diagnostic testing, results are used in the diagnosis and/or management of the patient's care.

To Our Medicare Patients Only

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of the Medicare law. However if Medicare determines that a particular service is not "reasonable and necessary" under their guidelines, payment may be denied. Medicare's guidelines for medical necessity are similar to those listed above.

Lifetime Benefit Claim Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Affiliates in Urology for any services furnished to me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agent any information needed to determine these benefits payable to related services. I understand my signature request that payment be made to my physician and authorize the release of medical information necessary to pay the claim. If other health insurance coverage is indicated on approved claim forms or electronically submitted clains, my signature authorized the releasing of the information to the insurer or agency shown. My physician agrees to accept the payment determination of the Medicare carrier as the full payment, consistent with the fee schedule applicable to the year in which the date of service occurred and I am responsible only for the annual deductibles(s), coinsurance and non-covered services. Co-insurance and deductible are based on the charge determination of the Medicare or MAC carrier.

Patient/Responsible Party Statement

If my physician does not participate with my insurance company, or my insurance company does not pay for the services provided, I agree to be personally and fully responsible for any payment due. I also accept responsibility for any co-payment, co-insurance, and/or deductibles to be collected at the time of service.

I understand that a statement of charges will be sent to my mailing address unless I otherwise indicate. I take responsibility to make sure this office is informed of any changes in my mailing address, telephone number and/or insurance information.

I understand that there will be a $50.00 charge for returned checks.

I understand that any outstanding balance not paid within the 30 days net of the date of service may be subject to a $15.00 late fee.

I understand that there is a no-show, late cancellation charge related to the appointment type should I fail to notify this office less than 24 hours prior to my scheduled appointment.

I understand that an appropriate fee will be charged if a collections agency is needed to collect unpaid financial obligations.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Witness Date

New Patient Checklist

Please bring these items with you at the time of your appointment:

Name of Primary Care Physician (Family Doctor) and their:
- Address
- Telephone Number
- Fax Number

Pharmacy Name and their
- Address
- Telephone Number
- Fax Number

List of Medications you are taking. Please include any over-the-counter medications such as vitamins and herbal supplements.

List of allergies, if any

Past medical and surgical history

Any current laboratory or imaging reports/films, if applicable (x-ray, CT, MRI, etc.)

Complete and current insurance information

Photo identification

If your insurance policy requires you to have a referral, bring this to prevent having to reschedule your appointment. We cannot see you without the proper authorization.

We verify coverage and benefits on each patient for every visit. Please be prepared to satisfy any co-pays, co-insurance, and/or deductibles. For your convenience, we accept cash, money orders, personal checks, and all major credit and debit cards.

Thank you,
The Physicians and Staff of Comprehensive Urology – Affiliates Division

Mahmood A. Hai, M.D. Muzammil M. Ahmed, M.D. Vijay K. Kotha, M.D.
Kashif Siddiqi, M.D. Amarnath Rambhatla, M.D.
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2421 Monroe St. Ste 200, Dearborn MI 48124 313.359.9880 Fax 313.359.9870
12701 S. Telegraph, Ste 201, Taylor MI 48180 734.287.8444 Fax 734.287.8497
4870 Clark Rd., Ste 102, Ypsilanti MI 48197 734.714.2600 Fax 734.714.2606
1600 S Canton Center Rd, Ste 2200, Canton MI 48188 734.595.1166 Fax 734.595.6821
7575 Grand River Ave., Ste 202, Brighton MI 48114 734.595.1166 Fax 734.595.6821
www.affiliatesinurology.com

WELCOME TO OUR OFFICE

We are pleased to have you as a new patient and are looking forward to meeting you. Your appointment is scheduled for: _____ at _____ am/pm.

Please fill out all of the enclosed forms completely and either send these papers back to our office or simply bring them in with you to your appointment.

Please bring with you, your insurance information, picture id, a list of current medications and any other pertinent medical reports.

If your insurance is an HMO, please call your primary care physician for a referral. Please bring your referral with you to your appointment. If you do not have a referral, we will NOT be able to see you and your appointment will be rescheduled.

If you do not have insurance or you have insurance that requires a co-pay, payment is expected at the time of service. We accept cash, check, money order, debit cards, Visa, MasterCard and Discover.

If for some reason you are unable to keep your scheduled appointment please contact our office as soon as possible to cancel. You will be billed $50.00 if the appointment is not cancelled or rescheduled within 24 hours.

Please keep in mind that we try to see patients at their appointed times, but due to surgeries or other emergencies, delays may occur.

With your well being in mind,
Drs. Hai, Ahmed, Kotha, Siddiqi, Rambhatla and Staff

Symptom Score _____ QOL Score _____ Name _____ Date_____	Not at all	Less than 1 time in 5	Less than half the time	About Half the time	More than half the time	Almost Always	Your Score
Incomplete emptying Over the past month, how often have you had the sensation of not emptying your bladder after you finished urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than two hours after your finished urinating?	0	1	2	3	4	5	
Intermittency Over the past month, how often does your stream of urine start and stop while you are urinating?	0	1	2	3	4	5	
Urgency Over the past month, how often have you found it difficult to hold your urine when you feel the sensation to urinate?	0	1	2	3	4	5	
Weak Stream Over the past month, how often have you found it difficult to hold your urine when you feel the sensation to urinate?	0	1	2	3	4	5	
Straining Over the past month, how often do you have to push or strain to start urinating?	0	1	2	3	4	5	
Dribbling Over the past month, how often does urine leak out when you feel you have finished emptying your bladder?	0	1	2	3	4	5	
Leakage Over the past month, do you experience any leakage of urine with coughing, sneezing, activity, or when you have to go?	0	1	2	3	4	5	
Pain Over the past month, do you have any pain with urination?	0	1	2	3	4	5	
Nocturia Over the past month, how many times do you get up at night to urinate?	0	1	2	3	4	5	
Erections Do you have any problems getting and/or keeping erections?	0	1	2	3	4	5	
Scrotum Do you have any pain or swelling in your scrotum/testicles?	0	1	2	3	4	5	

Quality of Life If you had to spend the rest of your life with your present urinary condition, how would you feel about that?	0 ◉	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
	Delighted	Pleased	Mostly Satisfied	Mixed/Equally satisfied & not	Mostly Dissatisfied	Unhappy	Terrible