Denver Urology Clinic, P.C.

Jeremy L. Weiss, DO ◆ John L. Logan, MD

PATIENT INFORMATION (Patient to fill out)

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ Apt/Suite #: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Social Security #: ____-____-____ Marital Status: M / D / S / W Sex: M / F

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

☐Ok to get text messages regarding appointment reminders

Employer: _____

How did you hear about us? Insurance / Internet / Friend / Doctor / Other _____

Email Address: _____ How do you prefer to be contacted? _____

Pharmacy: _____ Pharmacy Phone: (____) _____

Emergency Contact: Name _____ Relationship _____ Phone _____

GUARANTOR INFORMATION (Patient or Guardian to fill out)

If other than patient: Name: _____ Date of Birth: _____ Social Security #: _____

Address: _____ Apt/Suite #: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

PROVIDER INFORMATION (Patient to fill out)

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Other Physician: _____ Other Physician: _____

INSURANCE INFORMATION (Staff to fill out)

Primary Insurance Plan: _____ Effective Date: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____ Copay $: _____

Secondary Insurance Plan: _____ Effective Date: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____ Copay $: _____

CONSENT TO TREAT

I voluntarily consent to medical treatment and procedures that may be performed on me during visits. This includes, but is not limited to, medical or surgical care, tests, medications, injections, laboratory tests, or other services which may be ordered by the provider participating in my care.

ASSIGNMENT OF BENEFITS, PAYMENTS, AND RELEASE OF MEDICAL RECORDS

I hereby authorize payments of medical benefits to Denver Urology Clinic, P.C. I further authorize the release of any medical / surgical information necessary for determining the extent of third party coverage and for processing an insurance claim on my behalf. I permit a copy of this authorization to be as valid as the original. I understand that I may ultimately be responsible for and agree to pay all charges and expenses of the clinic for services and supplies furnished to me which are not paid through benefits for prepaid healthcare and insurance plans. If for any reason my account is forwarded to a collection agency or attorney for non-payment, I agree to pay all collection costs, court costs, attorney's fees and other reasonable costs incurred if I am found liable for amounts due to Denver Urology Clinic, P.C.

This authorization must be signed by the patient or responsible party / guarantor in the case of a minor or when the patient is physically or mentally incompetent.

X _____ _____

Patient or Responsible Party / Guarantor Signature Date

Name: _____ Age ___ Height _____ Weight _____ Today's Date: _____

Reason's for today's visit: _____

PAST MEDICAL HISTORY: Please select all that apply:

☐ High blood pressure ☐ High cholesterol ☐ Heart attack ☐ Heart failure ☐ Asthma ☐ COPD

☐ Esophageal reflux (GERD) ☐ Cirrhosis ☐ Hepatitis A/B/C ☐ Irritable bowel syndrome ☐ Colitis

☐ Crohn's Disease ☐ Stroke ☐ Epilepsy/Seizures ☐ Multiple sclerosis ☐ Head Injury ☐ Depression

☐ Anxiety Disorder ☐ Diabetes ☐ Hypothyroidism ☐ Anemia ☐ Clotting or bleeding problems

☐ Lupus ☐ DVT ☐ Fibromyalgia ☐ HIV / AIDS ☐ Arthritis (type) _____

☐ Gonorrhea ☐ Tuberculosis ☐ Syphillis ☐ Mumps ☐ Herpes ☐ Recurrent UTIs

☐ BPH ☐ Overactive bladder ☐ Cancer (type) _____ ☐ Other _____

☐ Other _____ ☐ Other _____ ☐ Other _____

PAST SURGICAL HISTORY: Please list all operations you have had:

Operation	Date	Operation	Date

MEDICATIONS: Please list any medicines (including aspirin and herbal remedies) that you now take:

ALLERGIES: Are you allergic to any medicines, iodine, tape, or anesthesia? Yes No If yes, please list below:

Allergy	Reaction	Allergy	Reaction

SOCIAL HISTORY:

What is/was your occupation? _____ Marital Status: Single Married Divorced Widowed

Do you currently smoke? Yes No If yes, how much and how often? _____ If you stopped, when did you stop? _____

Have you ever smoked? Yes No

Do you drink alcohol? Yes No If yes, how much and how often? _____

Do you use any other drugs? Yes No

If 65 years or older, do you have an Advanced Care Plan or surrogate decision maker? Yes No

If yes, does your primary care physician have this document on file? Yes No

Are your parents alive? Yes No If yes, age of mother? _____ Age of father? _____

If no, cause of death of mother? _____ Age at death? _____

If no, cause of death of father? _____ Age at death? _____

Do you need to take antibiotics prior to dental procedures (for heart murmur or other reason)? Yes No

Have you had any unexplained weight changes? Yes No Describe: _____

FAMILY HISTORY: Please indicate if any family member has had the following:

□ Kidney cancer	□ Prostate cancer	□ Bladder cancer
□ Kidney stones	□ High blood pressure	□ Bleeding or clotting problems
□ Kidney disease	□ Heart disease	□ Problems with anesthesia
□ Kidney infections	□ Stroke	□ Other

REVIEW OF SYSTEMS:

Number of pregnancies _____ Number of live births _____ Vaginal deliveries ____ C-Sections _____

Constitutional: ☐ Fever ☐ Chills ☐ Malaise/fatigue ☐ Night sweats ☐ Unexpected weight gain/loss

Eyes: ☐ Blurred vision ☐ Double vision ☐ Photophobia ☐ Glaucoma ☐ Eye pain ☐ Redness of eyes

Ears: ☐ Hearing loss ☐ Ear pain ☐ Sensation of room spinning ☐ Tinnitus

Nose: ☐ Nasal congestion ☐ Abnormal sneezing ☐ Nose bleeds ☐ Postnasal drip

Mouth/Throat: ☐ Oral ulcers ☐ Oro-dental problems ☐ Sore throat ☐ Swollen glands (neck) ☐ Sensation of lump in throat

Cardiovascular: ☐ Chest pain ☐ Heart murmur ☐ Palpitations ☐ Claudication ☐ Dyspnea ☐ Orthopnea ☐ Edema ☐ Last EKG: _____

Respiratory: ☐ Cough ☐ Shortness of breath ☐ Chest tightness ☐ Hemoptysis ☐ Asthma ☐ Wheezing

Gastrointestinal: ☐ Nausea/vomiting ☐ Bowel habits change ☐ Diarrhea ☐ Constipation ☐ Abdominal pain ☐ Difficulty swallowing ☐ Blood in stools ☐ Hemorrhoids ☐ Heartburn

Genitourinary: ☐ Blood in urine ☐ Excessive nighttime urination ☐ Urinary frequency ☐ Hesitancy ☐ Urinary urgency ☐ Dribbling urine ☐ Decreased urine stream ☐ Abnormal discharge ☐ Burning ☐ Itching ☐ Dyspareunia ☐ UTI / bladder / kidney infection ☐ Hot flashes/night sweats ☐ Breast tenderness ☐ Breast lumps ☐ Abnormal vaginal discharge ☐ Pain in testicles ☐ Lumps in testicles ☐ Difficulty with erection/ejaculation ☐ Abnormal discharge from penis

Musculoskeletal: ☐ Joint pain ☐ Neck pain ☐ Shoulder pain ☐ Back pain ☐ Upper extremity pain ☐ Lower extremity pain ☐ Sensation of numbness/tingling in extremities

Integumentary (Skin): ☐ Itching ☐ Rashes ☐ Change in skin color ☐ Change in hair/nails ☐ Varicose veins

Neurological: ☐ Seizures ☐ Headache ☐ Dementia ☐ Weakness ☐ Tremors ☐ Loss of balance ☐ Head injury ☐ Paralysis ☐ Decrease in cognitive skills

Psychiatric: ☐ Difficulty concentrating ☐ Insomnia ☐ Changes in socializing ☐ Irritability ☐ Mood changes ☐ Suicidal thoughts/attempts ☐ Anxiety ☐ Depression ☐ Nervousness ☐ Forgetfulness ☐ Adequate/sound sleep ☐ Previous use of psychotropic medication

Endocrine: ☐ Excessive urination ☐ Cold intolerance ☐ Change in hat/glove size ☐ Nocturia ☐ Glandular/hormonal problems ☐ Dry skin

Hematologic: ☐ Anemia ☐ Easy bruising ☐ Malaise/fatigue ☐ Night sweats ☐ Slow healing wounds ☐ Past transfusions ☐ Phlebitis

Activities of Daily Living: ☐ Bladder incontinence ☐ Bowel incontinence ☐ Able to go to toilet independently ☐ Able to feed self independently ☐ Able to dress self independently ☐ Able to bathe independently ☐ Needs wheelchair ☐ Able to prepare meals independently ☐ Able to shop independently ☐ Able to manage medications independently ☐ Able to handle money matters independently ☐ Able to use telephone independently ☐ Able to do light work unassisted ☐ Able to do heavy work unassisted ☐ Able to travel independently

Have you been screened for colon cancer with a colonoscopy? ☐ Yes ☐ No Date: _____

Have you ever received a pneumococcal vaccine? ☐ Yes ☐ No Date: _____

Have you received a flu vaccine within the last year? ☐ Yes ☐ No Date: _____

Have you ever been screened for breast cancer? ☐ Yes ☐ No Date: _____

Women: Have you ever been screened for cervical cancer? ☐ Yes ☐ No Date: _____

Denver Urology Clinic

9141 Grant Street
Suite 245
Thornton, CO 80229
Phone: (303) 388-9321 Fax: (303) 388-3910

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OFFICE POLICIES

MISSED APPOINTMENTS

In order to better serve all our patients, we ask that if you need to cancel or reschedule an appointment, you provide a minimum of 24 hours notice. In the event that you do not provide the 24 hours notice prior to cancelling an appointment, you will be charged a missed appointment fee of $35.00. This fee is not billable to insurance and will require payment prior to your next scheduled appointment.

MEDICAL RECORDS PROCESSING

Should you require copies of your medical records, please be aware that there is a medical records processing fee. The fee is determined in accordance with HIPPA. "Reasonable fees" are defines as:

- $18.53 for the first 10 pages
- $0.85 for the next 30 pages
- $0.57 for each additional page

Additionally, the medical provider may charge the actual postage, electronic media costs, if applicable, and applicable taxes as well of a fee of $10 for certification of the medical records.

Colorado Revised Statutes § 25-1-801

PAPERWORK PROCESSING

Should you require any paperwork to be filled out including, but not limited to, insurance paperwork or FMLA paperwork, please allow 3 business days. The charge for this service will be $25.00. Should you require paperwork to be filled out the same business day, the charge will be $75.00.

Patient Signature: _____ Date: _____

Patient Name (Please Print): _____ DOB: _____

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RELEASE OF INFORMATION

I, _____, give permission for Denver Urology Clinic to leave messages regarding **confirmation, change, and/or cancellation of my office appointment** on the answering machine, with a family member, or any adult person answering my telephone.

I give permission to leave **voicemail messages** regarding my **diagnosis, lab/radiology results** at the following numbers

Home: (_____) _____

Cell: (_____) _____

Work: (_____) _____

I further give permission for the office to release any medical information, including, but not limited to, **medical information concerning my diagnosis, lab/radiology results**. I authorize the release of my protected medical/personal information to the following person(s):

Name: _____ Relationship: _____

Contact Phone: _____

Name: _____ Relationship: _____

Contact Phone: _____

_____ _____

Patient or Responsible Party Signature Date

DENVER UROLOGY CLINIC, P.C.

Patient's Name: _____ Date of Birth: _____

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I received, or was offered, the Notice of Privacy Practices.

_____ _____

Signature of patient or patient representative Date

Documentation of Good Faith Efforts to obtain patient's acknowledgement that they received provider's Noticy of Privacy Practices

(For use when acknowledgement cannot be obtained from the patient.)

The patient presented to the office on ____/____/____ and was provided with a copy of the Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Patient was unable to sign or initial because:

  _____

  _____

  _____
- ☐ The patient had a medical emergency and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ☐ Other reason (describe below):

  _____

  _____

  _____

_____ _____

Signature of employee completing form Date

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Notice of Privacy Practices for Protected Health Information (PHI)

Effective Date: April 13, 2015

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!

The office is permitted by federal privacy laws to make uses and disclosures of your health information for the purposes of treatment, payment and health care operations. Protected health information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A medical assistant obtains treatment information about you and records it in a health record.

- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Examples of Use of Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Health Information for Health Care Operations:

- We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office – we are not required to grant the request, but we will try to comply with any request granted;

- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full – we must comply with this request;

- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information (“Notice”) by making a request at our office;

Public Health: As authorized by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect: We may disclose your PHI to public authorities as allowed by law to report abuse or neglect.

Employers: We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions: If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose your PHI for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight: Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversite activities.

Judicial/Administrative Proceedings: We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat: To avert a serious threat to health or safety, we may disclose your PHI consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Government Functions: We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses: Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under “Your Health Information Rights”.

YOUR HEALTH INFORMATION RIGHTS (Continued)

- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering a request to our office.

- Appeal a denial of access to your PHI, except in certain circumstances;

- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:

    - Was not created by us, unless the person or entity that created the information is no longer available to make this amendment;

    - Is not part of the health information kept by or for the office;

    - Is not part of the information that you would be permitted to inspect and copy; or,

    - Is accurate and complete.

      If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;

- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.

- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Julie Hutchings at 303-388-9321, in person or in writing, during regular business hours. She will inform you of the steps that need to be taken to exercise your rights.

OUR RESPONSIBILITIES

This office is required to:

- Maintain the privacy of your health information as required by law;

- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;

- Abide by the terms of this Notice;

- Notify you if we cannot accommodate a requested restriction or request; and,

- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions in our privacy practices and access practices and to enact new provisions regarding the PHI we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our Notice, or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Julie Hutchings, Practice Manager,** at **303-388-9321**.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Julie Hutchings. You may also file a complaint by mailing it or emailing it to the Secretary of Health and Human Services, whose street address and email address are:

Office for Civil Rights – U.S. Department of Health and Human Services
200 Independence Avenue S.W., Room 509F, HHH Building
Washington, D.C. 20201
Secretary@HHS.gov

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family: Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification: Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition or death.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Disaster Relief: We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations: Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA): We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products, and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation