

# UROLOGY GROUP OF ATHENS

[WWW.urologygroupofathens.com](http://WWW.urologygroupofathens.com)

## ***Bethlehem Office***

426 Exchange Blvd. Ste 300  
Bethlehem, GA 30620  
678-900-1839

## ***Athens Office***

1500 Oglethorpe Ave.  
Suite 2000  
Athens, GA. 30606  
706-543-6261 (phones)  
706-543-7060 (All faxes)

## ***Royston Office***

930 Franklin Springs St.  
Royston Diagnostic Center  
Royston, GA 30662  
706-246-1907 (phones)

Dear New Patient,

We would like to take this opportunity to welcome you as a patient. It is our desire to make your visit smooth and efficient. We thank you in advance for your cooperation.

We are sending you these forms to be completed **before** your visit. We no longer use paper charts – all information in your medical record is entered electronically.

The doctor cannot see you until your medical history, family history and medications are entered into our EMR system. Therefore, we strongly suggest you return your **COMPLETED** paperwork at least 2 to 3 days before your appointment so that your medical record can be electronically created before you arrive. **If you have not returned the forms prior to the day of your visit, please come 30 minutes before your scheduled time. Do not come for your appointment and expect to complete these forms when you arrive.** We may have no choice but to reschedule. We hope you understand and will comply with this important aspect of your new patient visit.

You may return the completed forms by fax, US Mail to the Athens office, or scan and e-mail. Please note if you choose to e-mail, we do not have a secure e-mail connection. Our email address is **UGofA.frontdesk@gmail.com**.

If you have been referred to our practice and your insurance requires a referral from your PCP, please contact your PCP and make sure that they get the proper paperwork to us. Please check with us in advance to ensure it has been received. **Failure to have a referral upon arrival will result in rescheduling your appointment.**

***Please also note that any payments not covered by your insurance carrier will be due at or before time of service. All New Patient co-payments will be collected before you see the provider.***

Thank you,  
Urology Group of Athens

Thomas H Oliver MD

John C Blankenship MD

Catherine Schwender MD

**UROLOGY GROUP OF ATHENS**

1500 Oglethorpe Ave.

Suite 2000

Athens, GA 30606

706-543-6261 FAX-706-543-7060

Email: UGofA.frontdesk@gmail.com

www.urologygroupofathens.com

**ALL INFORMATION IS MANDATORY  
PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Social Security # \_\_\_\_\_ - - - - - Birthday \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home # \_\_\_\_\_ FULL LEGAL NAME Work # \_\_\_\_\_ REQUIRED Cell/Other \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ IF DIFFERENT FROM ABOVE City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Race \_\_\_ Marital Status \_\_\_ Spouse Name \_\_\_\_\_ Spouse Date of Birth \_\_\_\_\_

Disabled Y \_\_\_ N \_\_\_, if yes why: \_\_\_\_\_ Nursing Home Y \_\_\_ N \_\_\_, Hospice Y \_\_\_ N \_\_\_

\*\*\*\*\*

Primary Physician \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_ Location \_\_\_\_\_

Drivers License # \_\_\_\_\_ Email \_\_\_\_\_

Employer Name/Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PARENT OR RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Phone # \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_ - - - - -

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I hereby assign all medical and/or surgical benefits to which I am entitled, including major medical, Medicare, Medicaid, private insurance and any other health plan to Urology Group of Athens. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

**PAYMENT IS EXPECTED AT TIME OF SERVICE**

A finance charge of 1.5% per month will be applied to all past due balances.

**\$5.00 will be charged for each statement sent.**

**\$30.00 RETURNED CHECK CHARGE.**

**IF SENT TO A COLLECTION AGENCY, A 40% RECOVERY FEE CHARGE  
WILL BE ADDED TO THE ACCOUNT BALANCE.**

**YOU MAY BE CHARGED \$50.00 FOR APPOINTMENT NO-SHOWS.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Regional 1<sup>st</sup> Care Bldg.  
340 Exchange Blvd.  
Bethlehem, GA 30620  
877-302-8136



UROLOGY  
GROUP OF  
ATHENS

930 Franklin Springs St.  
Royston Diagnostic Center  
Royston, GA 30662  
706-246-1907

**PATIENT CONSENT OF PROTECTED HEALTH INFORMATION (PHI) DISCLOSURES**

In general, the **HIPPA PRIVACY RULE** gives individuals the right to request a restriction of uses and disclosures of their protected health information (**PHI**). The individual is also provided the right to request confidential communication.

This form is used as a guide to how we may contact you regarding appointments, test results and/or any other **PHI**.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please list the person(s) we may discuss your medical information with:

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
Ok to discuss: ( ) Appointments ( ) Test Results ( ) Billing Information

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
Ok to discuss: ( ) Appointments ( ) Test Results ( ) Billing Information

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
Ok to discuss: ( ) Appointments ( ) Test Results ( ) Billing Information

I wish to be contacted in the following manner: (check all that apply):

Home Telephone \_\_\_\_\_  
Ok to leave message ( ) Yes ( ) No

Work Telephone \_\_\_\_\_  
Ok to leave message ( ) Yes ( ) No

Cellular phone \_\_\_\_\_  
Ok to leave message ( ) Yes ( ) No

Other \_\_\_\_\_  
Ok to leave message ( ) Yes ( ) No

I, \_\_\_\_\_, have received a copy of Urology Group of Athens' notice of Privacy Practices and have read and understood its contents.

\_\_\_\_\_  
Patient Signature Date \_\_\_\_\_



UROLOGY GROUP OF ATHENS

## **APPOINTMENT CANCELLATION POLICY**

Effective November 1, 2012, patients needing to cancel their appointment are asked to notify our office 24 hours in advance or a \$50.00 late cancellation/no show fee will be charged to their account.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# RECORDS TRANSFER REQUEST

## **Urology Group of Athens**

1500 Oglethorpe Ave.

Suite 2000

Athens, Georgia 30606

Phone: 706-543-6261 Fax: 706-543-7060

Thomas H. Oliver, MD, F.A.C.S

John C. Blankenship, MD

Catherine Schwender, MD

I \_\_\_\_\_ (printed name), do hereby authorize the release of my medical records or copies of such and request that they be transferred to Urology Group of Athens.

\_\_\_\_\_  
Signature (Patient, Parent or Guardian)

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

.....  
For Office Use Only

To: \_\_\_\_\_

Doctor/Hospital

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_



# UROLOGY GROUP OF ATHENS

Name: \_\_\_\_\_ Date of birth: \_\_\_/\_\_\_/\_\_\_ Today's date: \_\_\_/\_\_\_/\_\_\_

**History of Present Illness**

What is the reason for your visit? \_\_\_\_\_  
 Where is your problem located? \_\_\_\_\_  
 How severe is your problem? \_\_\_\_\_  
 How long have you had this problem? \_\_\_\_\_  
 When does this problem occur? \_\_\_\_\_  
 Where were you when this problem started? \_\_\_\_\_  
 What other things happen with this problem? \_\_\_\_\_  
 \_\_\_\_\_

**Patient Past Medical History.**

Have you ever had the following:

Acute Infections.....	No	Yes	Hypertension.....	No	Yes
Arthritis.....	No	Yes	Kidney Stones.....	No	Yes
Cancer – Type_____	No	Yes	Latex Allergy.....	No	Yes
Convulsion.....	No	Yes	Pace Maker.....	No	Yes
Coronary Artery Disease.....	No	Yes	Thyroid Disease.....	No	Yes
Diabetes.....	No	Yes	Venereal Disease.....	No	Yes
Hepatitis.....	No	Yes			

**LIST ALL PRIOR SURGERIES/RECENT HOSPITALIZATIONS**

Surgery: \_\_\_\_\_ Hospital: \_\_\_\_\_ Date: \_\_\_\_\_  
 Surgery: \_\_\_\_\_ Hospital: \_\_\_\_\_ Date: \_\_\_\_\_  
 Surgery: \_\_\_\_\_ Hospital: \_\_\_\_\_ Date: \_\_\_\_\_  
 Surgery: \_\_\_\_\_ Hospital: \_\_\_\_\_ Date: \_\_\_\_\_  
 Surgery: \_\_\_\_\_ Hospital: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Social History**

Marital Status:  Divorced  Married  Separated  Single  Widowed  
 Use of alcohol:  Never  Rarely  Moderate  Daily  
 Use of tobacco:  Never  Previously but quit  Current packs per day \_\_\_\_\_  
 Use of drugs:  Never  Type/frequency \_\_\_\_\_

**Family Medical History:**

	Age	Disease Type and Diagnosis date	Cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

# REVIEW OF SYSTEMS

## CONSTITUTIONAL

Fever..... No Yes  
Chills..... No Yes  
Fatigue..... No Yes

## EYES

Changes in vision..... No Yes  
Blurred vision..... No Yes

## HENT

Sore throat..... No Yes  
Nasal congestion..... No Yes  
Sinus pain..... No Yes  
Headaches..... No Yes

## BREAST

Lumps..... No Yes  
Swelling..... No Yes  
Tenderness..... No Yes  
Nipple discharge..... No Yes  
Additional symptoms..... No Yes

## CARDIOVASCULAR

Chest pains..... No Yes  
Cardiac murmurs..... No Yes  
Irregular heartbeat..... No Yes  
Painful respiration..... No Yes

## RESPIRATORY

Wheezing..... No Yes  
Shortness of breath..... No Yes

## GASTROINTESTINAL

Loss of appetite..... No Yes  
Nausea..... No Yes  
Vomiting..... No Yes  
Abdominal bloating..... No Yes  
Diarrhea..... No Yes  
Constipation..... No Yes  
Blood in stool..... No Yes

## GENITO-URINARY

Urgency..... No Yes  
Frequency of urination..... No Yes  
Dysuria (painful urination)..... No Yes  
Nocturia (frequent urination at night)..... No Yes  
Incontinence..... No Yes  
Retention..... No Yes  
Difficulty voiding..... No Yes  
Decreased stream..... No Yes  
Post void dribbling..... No Yes  
Decreased sex drive..... No Yes  
Dysmenorrhea (painful periods)..... No Yes  
Vaginal discharge..... No Yes  
Impotence..... No Yes  
Scrotal pain..... No Yes

## NEUROLOGICAL

Numbness or tingling sensation..... No Yes  
Incoordination..... No Yes  
Headaches..... No Yes  
Seizures..... No Yes

## MUSCULOSKELETAL

Bone pain..... No Yes  
Back pain..... No Yes  
Joint pain..... No Yes  
Muscle pain..... No Yes

## ENDOCRINE

Excessive urination..... No Yes  
Excessive thirst..... No Yes  
Cold intolerance..... No Yes  
Heat intolerance..... No Yes  
Weight gain..... No Yes  
Weight loss..... No Yes

## HEMATOLOGY/LYMPHATIC

Easy bleeding..... No Yes  
Easy bruising..... No Yes  
Lymph enlargement..... No Yes

## ALLERGIC-IMMUNOLOGIC

Sinus allergy symptom..... No Yes  
Allergic dermatitis..... No Yes  
Frequent illness..... No Yes

PATIENT NAME: \_\_\_\_\_



**NOTICE OF PRIVACY PRACTICES:**  
Confidentiality of your health care information

**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.**

This notice is required by law to tell you how Urology Group of Athens, P.C. protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's health care history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Urology Group of Athens receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Urology Group of Athens program and we will notify you of how you can receive a copy of this notice every three years.

**Permitted Uses and Disclosures of Your PHI**

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Urology Group of Athens in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Urology Group of Athens in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers' compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

**Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Health Care Operations**

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- o Uses and/or disclosures of PHI in facilitating treatment.
- o Uses and/or disclosures of PHI for payment.
- o Uses and/or disclosures of PHI for health care operations.

**Disclosures Without an Authorization**

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Urology Group of Athens may disclose your PHI without your prior authorization in response to the following:

- o Court order;
- o Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- o Subpoena in a civil action;
- o Investigative subpoena of a government board, commission, or agency;
- o Subpoena in an arbitration;
- o Law enforcement search warrant; or
- o Coroner's request during investigations