UROLOGY GROUP OF ATHENS

WWW.urologygroupofathens.com

Bethlehem Office
Regional 1st Care Bldg.
340 Exchange Blvd.
Bethlehem, GA 30620
877-302-8136 (phones)

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

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Suite 2000
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706-543-6261 FAX-706-543-7060
Email: UGofA.frontdesk@gmail.com
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ALL INFORMATION IS MANDATORY
PATIENT INFORMATION

Patient Name________________________ Social Security #____-____-________ Birthday____/____/____
FULL LEGAL NAME REQUIRED
Home #____________________ Work #______________________ Cell/Other____________________

Street Address____________________________ City____________________ State____ Zip__________

Mailing Address____________________________ City____________________ State____ Zip__________
IF DIFFERENT FROM ABOVE

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**______________________

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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.

____________________________________ Date__________________
Patient Signature

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:__________________

PATIENT MEDICATION LIST

PATIENT ____

ALLERGIES ____

____

DATE	DRUG	DOSAGE	DIRECTIONS

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.

- Uses and/or disclosures of PHI in facilitating treatment.
- Uses and/or disclosures of PHI for payment.
- 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:

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