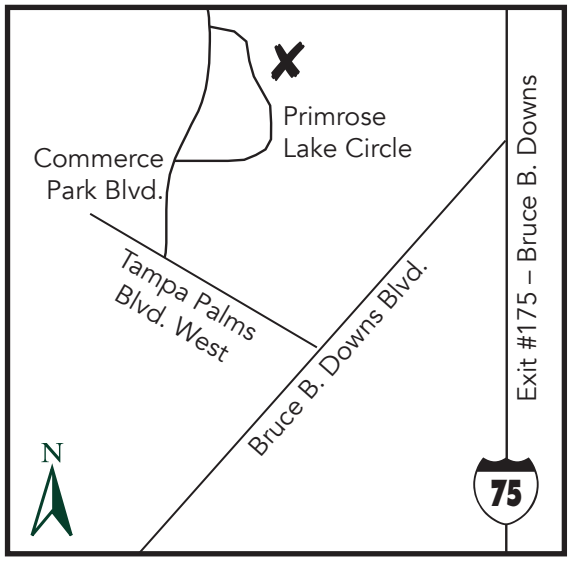
NEW TAMPA UROLOGY

LOCATION: 5332 Primrose Lake Circle
Tampa, FL 33647

PHONE: (813) 558-9091

Appt. Time: _____

Appt. Date: _____



DIRECTIONS: *Please use these directions as the internet and GPS maps may be incorrect.*

New Tampa Urology is located in the Tampa Palms areas of northeast Tampa, near the I-75 overpass of Bruce B. Downs Blvd.

FROM THE SOUTH (via I-275):
Take I-275 North to the Bearss exit, head right (east). When Bearss ends, veer to the north (left) onto Bruce B. Downs north for several miles, until you reach the **second** Tampa Palms W. This is just before I-75. (There is a sign for USAA; BJ's is across the street to your right.) Turn left on Tampa Palms Blvd. W., take the first right after the shopping center onto Commerce Park Blvd. After you pass USAA, take the next right onto Primrose Lake Circle. Follow Primrose Lake Circle for 1/2 mile. You will see New Tampa Urology on the right side of the road.

FROM THE SOUTH (via I-75):
Take I-75 North to the Bruce B. Downs exit. Go south on Bruce B. Downs (to the left) to Tampa Palms Blvd. W. (there is a sign for USAA; BJ's is across the street to your right). Turn left on Tampa Palms Blvd. W., take the first right after the shopping center onto Commerce Park Blvd. After you pass USAA, take the next right onto Primrose Lake Circle. Follow Primrose Lake Circle for 1/2 mile. You will see New Tampa Urology on the right side of the road.

FROM THE NORTH:
Take I-75 south towards Tampa. Get off on Bruce B. Downs exit. Head south. Turn right on Tampa Palms Blvd. W., take the first right after the shopping center onto Commerce Park Blvd. After you pass USAA, take the next right onto Primrose Lake Circle. Follow Primrose Lake Circle for 1/2 mile. You will see New Tampa Urology on the right side of the road.

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

Name _____ Date _____

Address _____

Age_____ ☐ Male ☐ Female Date of Birth_____/_____/_____ SS#_____-_____-_____

Phone (_____)_____ Cell (_____)_____ Work (_____)_____

Email Address _____ Marital Status _____

Primary Care Physician _____ Phone (_____)_____

Emergency Contact _____Phone (_____) _____ Work (_____) _____

INSURANCE INFORMATION

Primary Insurance Company_____ Phone (_____)_____

ID # _____Group # _____

Secondary Insurance Company _____ Phone (_____)_____

ID # _____Group # _____

Pharmacy Name, Phone and Location _____

I hereby authorize my insurance benefits to be paid directly to New Tampa Urology, P.A. I understand that I am responsible to pay non-covered services and I authorize the release of medical information to my insurance company.

Because of the high cost of billing, we ask for payment at the time of your visit. Co-pays and deductibles are due. I understand that I am financially responsible for all charges whether or not covered by my insurance company. **A referral or authorization must be presented at the time of service if required by your insurance company. If a referral/authorization is not provided the appointment will be rescheduled or the patient may elect to pay the total amount at the time the services are rendered**. I understand that if my account is assigned to a collection agency or an attorney. **I WILL BE RESPONSIBLE FOR THE 40% ADMINISTRATION FEE.**

I authorize New Tampa Urology, P.A. to disclose information in my medical records, including current and previous medical records from other practices and practitioners, hospitals and/or clinics which are a part of my medical record, to other physicians, and health care providers who may have referred me to New Tampa Urology and to physicians and providers to whom New Tampa Urology, P.A. may refer.

I understand that if I am fifteen (15) minutes late, I will be rescheduled. I also understand that I may be charged for any appointments that are **not cancelled in advance**. I also understand that two (2) missed appointments can terminate my relationship with New Tampa Urology, P.A. and Dr. Jeffrey B. Starling.

24 HOURS IN ADVANCE

Routine Office Visit: $50.00
Cystoscopy: $75.00

72 HOURS IN ADVANCE

Biopsy & Ultrasound: $150.00
Vasectomy: $150.00

Patient Signature _____ Date _____

OFFICE POLICIES

The doctor and staff at New Tampa Urology would like to welcome you to our Practice. Our goal is to provide excellent medical care and make your visits as convenient as possible.

By signing below you confirm that you have read this policy and understand it:

- It is the patient's responsibility to inform the office of any address or telephone changes.

- The patient's account must be kept current. All self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service. Payable by cash or credit card. **Checks are not accepted in the office**.

- Any checks received via mail for account balance and resulting in a returned check, will receive a minimum service charge of $25.00 and checks will not be accepted for future payment(s). Unpaid returned checks will be turned over to the state attorney's office.

- **If the patient does not have their payment(s), the appointment will be rescheduled.**

- Due to time allowed for each patients may be asked to schedule another appointment for issues other than the reason of the original appointment.

- There is a $25.00 minimum for all forms (FMLA, medical reports, physical forms, disability forms or any other special reports or letters requested).

- Medical records copy fee $1.00 per page or copies up to 25 pages and $0.25 per page for copies of 26 pages and greater. In addition to the fee for records, there will be a $15.00 processing fee added (cost of supplies, labor and postage).

- There is a minimum of thirty (30) business days to request medical record copies or any medical forms and archived records, sixty (60) business days.

- A request for review of your medical record(s) requires an appointment with a minimum of thirty (30) days notice.

- 24 hours notice must be given to reschedule or cancel appointment to avoid cancel/no show charge. If the proper notice is not given, there is a $25.00 for a 15 minute appointment, and a $40.00 charge for 30 minute appointments or procedures.

- Prescription refills require a seven (7) business day notice. No narcotics will be called in, script will need to be picked up during office hours.

- **If your insurance requires a referral it is your responsibility** to get all information to the primary care doctor for processing within seven (7) business days. If the correct time is not allowed you may need to reschedule to allow for that time.

- Claims will be submitted, however **we must emphasize that as medical providers, the relationship is with you the patient, NOT the insurance companies**. Although we attempt to verify benefits with insurance policies, please be advised this is only an estimate of the coverage based on the information given at the time of inquiry.

- It is the patient's responsibility to inform us of any changes in their insurance.

- Not all services are covered benefits with all insurance plans. It is the patient's responsibility to be aware of the services provided, and the covered benefits under their insurance policy.

- Although filing insurance claims is a courtesy extended to the patient, all charges are always the patient's responsibility from the date services are rendered.

- Any unpaid balances older than 30 days may be subject to a 1.5% interest per month.

- If a patient's account is turned over to a collection agency, the patient will be responsible for any costs incurred in collection agency, the patient will be responsible for any costs incurred in collection of the balance, which will include collection agency fees, court cost, and attorney fees.

- In the event that a patient does not meet their financial obligation, the patient will be discharged from the practice.

I have read and understand the office policies:

_____ _____

Signature of Patient Date

_____

Signature of Witness

NEW TAMPA UROLOGY

HIPPA ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient _____ Date_____

I hereby acknowledge that I received New Tampa Urology's (Dr. Jeffrey B. Starling) notice of privacy practices. I hereby give New Tampa Urology and its staff authorization to give medical information to the following person/persons. I understand that I am not limiting what information the designated person/persons can receive. Below is the designated person/persons to receive this information:

_____

_____

_____

_____

_____ _____

Signature of Patient Date

_____

If not signed by Patient, Relationship to Patient

_____

Witness

DOCUMENTATION OF GOOD FAITH EFFORTS

- Patient refused to sign (reason) _____
- Patient unable to sign or initial (reason) _____
- Patient had emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

_____

Signature of employee completing form

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

✻ ONLY ✻

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

✻ NAME OF PATIENT		SS#	

TO: ***(NAME, ADDRESS, PHONE OF RECIPIENT OF RECORDS)***		
NAME		PHONE
ADDRESS		
CITY/STATE/ZIP		

RECORDS FROM: ***(WHO IS RELEASING THE RECORDS)***		
NAME		PHONE
ADDRESS		
CITY/STATE/ZIP		

FOR THE FOLLOWING PURPOSES:

☐ Continued Medical Care	☐ Personal Information	☐ Legal Follow-up
☐ Disability Insurance	☐ Other:	

By checking the boxes below, I specifically authorize the Use and/or Disclosure of the Following Health Information and/or Medical Records, if such information and/or records exist:

☐ **Please send the entire Medical Record(s) (all information) to the above named recipient.**		
☐ Office Notes and Reports	☐ Most recent one year history	☐ Most recent three year history
☐ Rx History	☐ Transcribed hospital reports	☐ Laboratory Reports
☐ Billing Statements	☐ Diagnostic Reports	☐ Diagnostic Films
☐ Others Listed Here:		

The following items must be initialed to be included in the Use and/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

_____ Mental Health Information and/or Records

_____ Domestic Violence

_____ Genetic Testing Information and/or Records

_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed). Describe:

_____

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations. The information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization. Finally, I understand that **I may revoke this authorization** in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire in six (6) months from the date of signing or until (insert date) _____.

✻ Print Patient's Name _____ **Date**_____

✻ Signature of Patient or Patient's Legal Representative_____

Print Name of Legal Representative (if applicable) _____

Relationship to Patient _____

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.

Today's date_____/_____/_____ Date of last physical exam_____/_____/_____

Last Name _____ First Name _____ Middle _____

SS#_____-_____-_____ Date of Birth_____/_____/_____

Chief Complaint: What is the main reason for your visit today? *(Describe your problem in detail)*

_____

_____

_____

History of Present Illness

Please answer the following questions.

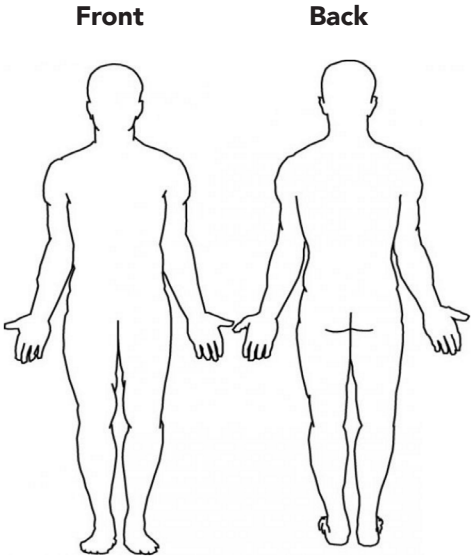
Location of problem:

☐ Abdomen ☐ Back ☐ Leg

Other:_____

_____

_____



- On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem:

  1 2 3 4 5 6 7 8 9 10

- When did you first notice the problem:

  ☐ 2 days ago ☐ 2 weeks ago ☐ 1 month ago

  Other:_____

- Does anything help or make the problem worse:

  ☐ Moving around ☐ Standing up ☐ Lying on my side

  Other:_____

- How long does the problem last?

  ☐ 30 minutes ☐ 1 hour ☐ It is always there

  Other:_____

- Is anything else occurring at the same time? ☐ Yes ☐ No

  ☐ Nausea ☐ Rash ☐ Headaches

  If yes, please explain.

  Other:_____

- Does the problem interfere with your normal functions?

  ☐ Yes ☐ No

  If yes, please explain.

  Other:_____

PHYSICIAN USE ONLY: (Comments / Notes)

If Answers 1-3 / 4+

Level of Service - 1 or 2 / 3 - 5

PAST MEDICAL & SOCIAL HISTORY

List all serious illnesses in your immediate family.

(Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

RELATIONSHIP *(Example: Mother, Father, Sister, Brother, Aunt, Uncle, Grandmother, Grandfather)*	**ILLNESS**

List any personal past illnesses and/or surgeries and when they occurred.

PAST ILLNESSES AND/OR SURGERIES	**DATE**

- Do you smoke? . . . . . ☐ Yes ☐ No If yes, how much? _____
- Do you drink?. . . . . ☐ Yes ☐ No If yes, how much? _____
- Are you on a special diet? . . . ☐ Yes ☐ No If yes, please explain: _____
- Are you on any medications?. ☐ Yes ☐ No *If yes, please list on Medication form, medication section*
- Do you have allergies?. . . . . ☐ Yes ☐ No *If yes, please list on Medication form, allergies section*

PHYSICIAN USE ONLY: (Comments / Notes)

If Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 - 5

BLADDER HEALTH QUESTIONNAIRE

- How often do you urinate during the day? _____
- How often to you get up at night to urinate? _____
- Is the amount you pass:. . . . . ☐ Large ☐ Average ☐ Small
- Do you usually have a strong sense of urgency to urinate? . . . . . ☐ Yes ☐ No
- Do you have to hurry to empty your bladder when full?. . . . . ☐ Yes ☐ No
- Do you ever not make it and leak urine?. . . . . ☐ Yes ☐ No
- Can you overcome the sensation of urgency to urinate? . . . . . ☐ Yes ☐ No
- Do you have a warning before losing urine?. . . . . ☐ Yes ☐ No
- Do you ever accidently wet the bed while you sleep? . . . . . ☐ Yes ☐ No
- Do you feel that you are completely emptying your bladder? . . . . . ☐ Yes ☐ No
- Do you notice dribbling of urine after voiding? . . . . . ☐ Yes ☐ No
- Were you ever catheterized because you were unable to void?. . . . . ☐ Yes ☐ No
- Do you have pain on urination? . . . . . ☐ Yes ☐ No
- Have you been treated for 3 or more urinary infections? . . . . . ☐ Yes ☐ No
- Have you been treated for an infection within 6 months? . . . . . ☐ Yes ☐ No
- Do you leak urine while coughing, sneezing, laughing or lifting?. . . . . ☐ Yes ☐ No
- Do you find it necessary to use some type of protection (pads)? . . . . . ☐ Yes ☐ No

MEDICATIONS

Name _____ Date_____

PLEASE LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING

	MEDICATION	DOSE	HOW OFTEN TAKEN
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			

PLEASE LIST ALL ALLERGIES

1		5	
2		6	
3		7	
4		8	