Abraham S. Hawatmeh, M.D., F.A.C.S.
Frederick P. Walters, M.D., F.A.C.S.
Salim I. Hawatmeh, M.D., F.A.C.S.

Welcome to our practice! Thank you for choosing South County Urological, Inc.
Our commitment to excellence demands that we treat each patient and family member with mutual respect, dignity, and compassion. We are committed to providing you with mutual respect, dignity, and compassion. We are committed to providing you with outstanding medical care.

In addition to seeing a physician in our office, you may be seen by other health care providers, if needed, for the treatment of your condition. These providers would include physician assistants, nurses, etc.

Enclosed you will find an appointment card confirming your appointment time with your doctor. Please review your appointment information. If your records reflect a different date or time, please call our office at 314-843-8000.

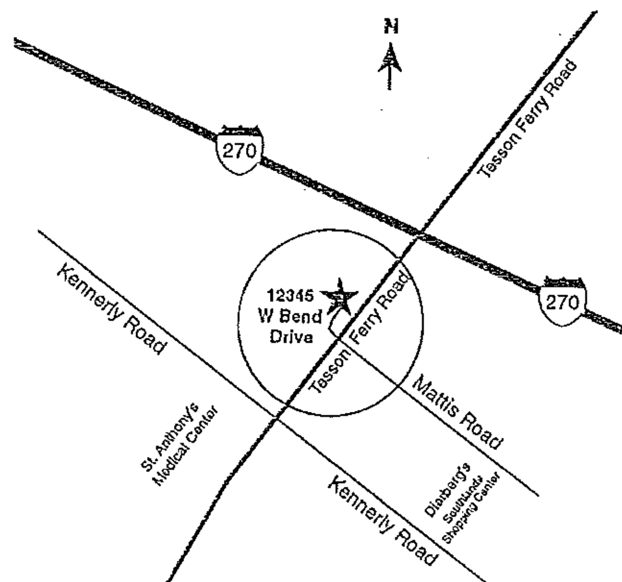
Also enclosed is a patient information packet. Please **complete this paperwork and mail it back in the self-addressed stamped envelope enclosed.** If you have a health insurance plan that requires a referral to see a specialist, please bring your referral with you. We will take a copy of your insurance card when you get here, so please bring your current health insurance identification card with you, as well as another form of ID.

South County Urological, Inc. is located at the corner of Tesson Ferry and West Bend Drive directly across from the Shell gas station. Our address is 12345 West Bend Drive, Suite 200. If you need further directions, please do not hesitate to call.

Again, thank you for choosing South County Urological for all you urological needs. We look forward to meeting you.

Sincerely,

South County Urological



12345 West Bend Drive • Suite 200 • St. Louis, Missouri 63128 • phone: 314/843-8000 • fax: 314/843-3004 • *www.southcountyurological.com*

South County Urological, Inc.

Please print the following information:

Today's Date: ______________________ SS#: ___________________________

Patient Name: _________________________________ Birth Date: _____________

Home Address: ____

City: __________________________ State: _________ Zip Code: ___________

Mailing address if different than above: _____________________________________

Home Phone: (___) __________Email Address:_____________________________

Primary Doctor:______________Who referred you to our office?: _________________

Employer: __________________________ Phone: ________________________

Employer's Address: ____

Spouse's Name: __________________________ SS#: ______________________

Spouse's Employer: _______________________ Phone: ____________________

Spouse's Birth Date: _______________________

Please circle the appropriate choice:

RACE	ETHNICITY	PEFERRED LANGUAGE
African American	Hispanic	Arabic
Asian	Latino	English
Middle Eastern	Not Hispanic or Latino	German
Pacific Islander		Greek
White		Serbo-Croatian
Other Race		Spanish
		All Others

Insurance Information

Primary Insurance: ____

Subscribers Name: ________________________ Subscriber's DOB: _____________

ID#:________________________________ Group#: ______________________

Secondary Insurance: ____

Subscriber's Name: _______________________ Subscriber's DOB: _____________

ID Number:___________________________ Group#: ______________________

Emergency Contact: ______________________ Phone: ______________________

Relationship to the above contact: _______________________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

SETION A

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Patient Name: ______________________________ Social Security Number: ___________________________

Persons/organizations providing the information:
South County Urological, Inc.

Persons/organizations receiving the information:
Please list the name and relationship to you of family, members and friends with whom we may discuss your protected health information:

Name: _______________________________ Relationship to you: __________________________________

Name: _______________________________ Relationship to you: __________________________________

Name: _______________________________ Relationship to you: __________________________________

Name: _______________________________ Relationship to you: __________________________________

Name: _______________________________ Relationship to you: __________________________________

Specific description of information:
Information contained in all billing and medical records.

Purposes of Use or Disclosure: **Treatment, administrative operations of South County Urological, Inc. or answering inquiries by the parties listed above.**

SECTION B

Please read carefully:

1. I understand that this authorization will expire when a time period of two (2) years has run without me receiving treatment from this practice.
2. I understand that I may revoke the authorization at any time by notifying the providing organization in writing, except the extent the organization has taken action in reliance on the consent.

____ ___________________________
Signature Patient/Patient's Representative Date

____
Printed Name of Patient's Representative

Basis of representative's authority to act for patient: ____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
NOTICE OF PRIVACY PRACTICES OF SOUTH COUNTY UROLOGICAL, INC

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.

Uses and Disclosures of Health Information:

Without your consent, we may use health information about you for treatment (such as sending your medical record information to a specialist physician as part of a referral, to obtain payment for treatment (such as sending billing information to a health insurance plan), and for administrative purposes (such as comparing patient data to improve treatment methods).

We may also use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give your health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, research, studies, coroners, funeral arrangements and organ donation, workers' compensation purposes, judicial/administrative proceedings/specialized governmental functions to relatives/friends involved in you treatment and payment for your treatment (if you do not object) and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also contact you about alternative treatment or we may contact you about appointment reminders. If we cannot reach you regarding appointment reminders we may leave a limited message on your answering machine or with the person who answers your telephone. **Please inform us if you do not want to receive appointment reminders in any of these ways.** In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at anytime. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area, in each examination room, and on our Web site. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights:

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about your care. An example of when you may not have access to your health information is when you are participating in a research study. You may receive access after the research study is complete. You also have the right to receive a limited list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes, If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.

You may request in writing that we not disclose your information for treatment, payment, or administrative purposes. We will consider your request but are not legally required to accept it.

Complaints:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. Under no circumstances will you be retaliated against for filing a complaint.

Our Legal Duty:

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints regarding privacy, please contact:

Theresa Hammack

Title:	Privacy Official	RECEIPT ACKNOWLEDGED: ______________________
Telephone:	(314) 843-8000	Printed Patient Name: ______________________
Effective Date:	April 14, 2003	Date: ______________

Thank you for choosing South County Urological, Inc. as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All co-pays and coinsurance are due at the time of service. We accept cash, checks, Visa/MasterCard and Discover. There will be a $25.00 processing fee for all returned checks.

Financial Policy – Professional Fees

1. The patient or guardian (if patient is a minor) is responsible for the account regardless of insurance coverage.
2. In order to keep our fees down, payment is expected at each office visit. Patients who have a coinsurance or copayment are expected to pay this at the time of the office visit. This is part of your contract with the insurance company and noncompliance may result in your insurance company canceling your policy. We do report non-payment of coinsurance and copayments if they cannot be resolved within 30 days of the date of the first statement.
3. Accounts with a balance due over 30 days will be assessed a processing fee of $5.00 of every 30 days it is past due. This may or may not apply to those who have payment arrangements.
4. There may be a $25.00 charge to any account for appointment that is not canceled within 24 hours of the appointment time.

Insurance and Insurance Forms

1. Please remember that insurance is considered a method of reimbursing you, the patient, for fees paid to the doctor and is not a substitute for payment. The patient is responsible for payment of health care regardless of the status of his/her claim. Reduction or rejection of your claim by your insurance company does not relieve you of the financial obligation incurred for medical services rendered. It is your responsibility to obtain benefit information and to pay all deductibles, coinsurances, or other balance not covered by your insurance.
2. We are Medicare participating and therefore accept assignment from Medicare. We do not accept assignment from other insurance companies unless we are contracted with them. We will however, be happy to assist you in filing claims for reimbursement from other insurance companies.
3. South County Urological, Inc. is a provider for many managed care plans. However, it is the responsibility of the patient to obtain a referral for each visit if it is required by the insurance company and the patient will be responsible for payment at the time of service.
4. It is the patient's responsibility to inform the office staff if a precertification, authorization, or if a second surgical opinion is required by your insurance before admission to the hospital. It is also the responsibility of the patient to inform the office staff if your insurance required you to utilize a specific hospital for medical services rendered or ordered by this office.
5. It is the responsibility of the patient to inform the office staff of any changes in insurance coverage and provide the necessary information to file a claim with the insurance. If this information is not provided the balance of the account will be the responsibility of the patient.

Assignment of Benefits

I authorize the release of any medical information necessary to process this claim and request payment of insurance benefits be made to the physician for services described on the insurance form. I understand that I am financially responsible for all charges whether or not paid by said insurance. A photo copy of this assignment is to be considered a valid as the original.

I have read in full, understand, and agree with the financial policies of South County Urological, Inc.

Signature ______________________________ Date: ____________________

Time: ____________________

SOUTH COUNTY UROLOGICAL

We would like you to help us learn more about our patients.
Please complete this form and return to the receptionist.

Patient Name____ Date____________________

How did you hear about us?

My friend/relative ________________________ recommended the doctor.

My physician ____________________________ recommended the doctor.

I heard/saw about you on:

PBS – channel 9

KSDK – channel 5

Other TV station _________

South County Urological Website

The Point 105.7

Radio Station ____________

Yellow Pages

Referred from hospital/emergency department

I attended the lecture on ________________________ at ____________________.
(topic) (event)

Other (please specify)____.

Name: ______________________________ Date: ____________________

Date of Birth: ______________________

By what method did you choose our practice: Referring Physician: ______________________

____Friend ______Yellow Pages _____Insurance Company ______TV Ad _____Internet

Other (Please explain) ______________________________

Why are you seeing the doctor today? ______________________________

Have any tests been performed for this problem? Yes or No What was done? ____________________

Where and when were the test performed? ______________________________

How long have you had this problem? ______________________________

What improves or worsens the problem/pain? ______________________________

Are there any symptoms that go along with the problem/pain? ______________________________

Is the problem/pain continuous or does it come and go? ______________________________

Describe the pain (dull/sharp, etc.) ______________________________

Have you tried medicine/treatment for this problem/pain? ______________________________

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following Diseases or conditions:

ADD
ADHD
Alcoholism
Allergies
Alzheimer's
Anemia
Aneurysm
Angina
Anorexia
Anxiety Disorder
Arthritis
Arrhythmia
Aortic Aneurysm
Aortic Stenosis
Aortic Insufficiency
Asthma
Atrial Fibrillation
Back Pain
BPH
Bi-polar Disorder
Bladder Cancer
Bleeding Disorder
Blindness
Brain Tumors
Breast Cancer
Bronchitis
Cataracts
Cerebrovascular Disease
Cholecystitis
Cholelithiasis

Chronic Fatigue Syndrome
Chronic Liver Disease
Chronic Liver disease
Chronic Renal Insufficiency
Chronic Renal Failure
Colitis
Constipation
Colon Cancer
Colon Condition
Congenital Heart Disease
Congenital Heart Failure
Crohn's Disease
Deafness
Deep Vein Thrombosis
Depression
Diabetes non-ins dependant
Diabetes insulin dependant
Diabetes uncontrolled
Diarrhea
Eating Disorder
Ear Infections
Elevated PSA
Emphysema
Enlarged Heart
Epilepsy
Fibrocystic Breast Disease
Fibromyalgia

Gastric Cancer
GERD
Glaucoma
Goiter
Gout
Hay Fever
Heart Attack
Heart Disease
Heart Valve Problem
Heart Murmur
Hemorrhoids
Hepatitis
Herniated Disc
Hiatal Hernia
High Cholesterol
High Blood pressure
Impaired Glucose Tol
Infertility
Irritable Bowel Disease
Inflam Bowel Disease
Kidney Disease
Kidney Infection
Kidney Stones
Infectious Disease
Laryngeal Cancer
Leukemia
Liver Disease
Lung Disease
Lung Cancer
Lymphoma

Malaise
Melanoma
Mental Illness
Migraine
Mitral Stenosis
Mitral Insufficiency
Mitral Valve Prolapse
Mumps
Nervous Breakdown
Obesity
Osteoporosis
Pancreatitis
Peptic Ulcer
Phlebitis
Polio
Prostate Cancer
Prostatitis
Pulmonary Embolism
Rectal Fissure
Rectal Cancer
Rheumatic Fever
Sexually Trans. Disease
Sickle Cell Anemia
Stroke
Suicide Attempt
Testicular Cancer
Thyroid Disease
Tuberculosis

Other: ______________________________

____

Name: ________________________________ Date: ___________________________

Date of Birth: __________________

SURGICAL HISTORY

Please CIRCLE if you have had any of the following surgeries and date of surgery:

Amputation
Angioplasty
Aortic Aneurysm Repair
Appendectomy
Arthroscopic Surgery
Back Surgery
Bariatric Surgery
Bladder Surgery
Bowel Resection
Brachytherapy
Brain Surgery
Breast Surgery
Biopsy of Prostate
CABG
Carotid Artery Surgery
Carpal Tunnel Surgery (R or L or Both)
Cataract Surgery (R or L or Both)
Cervical Spine Surgery
Cholecystectomy
Circumcision
Colon Resection
Colonoscopy
Corneal Surgery (R or L or Both)
Cystoscopy
Cysto-TUR Fulguration
Cyst Removal
Deliveries (Vaginal or C-Section)
Ear Surgery (R or L or Both)
EGD
Epididymectomy
ESWL

Eye Surgery (R or L or Both)
Facial Surgery
Foot Surgery (R or L or Both)
Gastric Surgery
Hand Surgery (R or L or Both)
Hysterectomy
Heart Surgery
Heart Transplant
Hemorrhoidectomy
Hip Surgery (R or L or Both)
Hydrocelectomy
Ileal Conduit
Ileostomy
Indigo Laser Surgery
Inguinal Herniorrhaphy
Knee Surgery (R or L or Both)
Laminectomy
Laparoscopy
Laparatomy
Leg Surgery (R or L or Both)
Liver Surgery
Lumpectomy
Lung Surgery
Lymphatic Node Dissection
Lysis Adhesions
Mastectomy
Mastoid Surgery
Meatotomy
Nasal Surgery
Ventral Hernia
Needle Biopsy

Nephrectomy
Nephrolithotomy
Orchiectomy
Pacemaker Insertion
Parathyroidectomy

Penile Implant
PEG
PE Tubes
Pilondial Cyst Incision
Radical Prostatectomy
Renal Transplant
Rotator Cuff Surgery
Septoplasty
Sinus Surgery
Skin Grafting
Spermatocelectomy
Splenectomy
Stomach Surgery
Tonsil Surgery
Thryoid Surgery
TMJ Sugery
TUMT Prostate
TUR Prostate
Umbilical Hernia
Ureteroscopy
Variococelectomy
Vasectomy
Vein Stripping
VLAPP

Other: ____

____

FAMILY HISTORY

Please list which family member has/had any of the following: (Mother, Father, Siblings,Grandparents)

Arthritis ________________
Bedwetting ______________
Bladder Cancer ___________
Cancer (site unknown) _________
Crohn's Disease ___________
Depression ______________
Diabetes ________________

Gout ____________________
Heart Attack ______________
Hypertension _____________
Kidney Disease ____________
Kidney Stones _____________
Leukemia ________________
Malignant Melanoma _________

Multiple Sclerosis ___________
Laryngeal Cancer ___________
Pancreatic Cancer ___________
Prostate Cancer ____________
Stroke ___________________
Thyroid Disease ____________
Tuberculosis _______________

Other: ____

____

Name: ______________________________ Date: ______________

Date of Birth: ______________________

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicated years ________

____Single ____Married ____Separated ____Divorced ____Widowed ____Life Partner ____Common Law Spouse

Dependants: Please indicate # of each, if you have:

____Sons ____Daughters ____Stepchildren ____Adopted ____Foster ____Parents ____Grandparents

Occupation: Please circle one that applies:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, Other

Hobbies: Please Circle any that apply to you:

None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball

Alcohol Consumption: Do you drink alcohol? ______Yes ______ No

If Yes: Occasionally/Socially ____________ # of drinks per week ____________ How long? ____________

Tobacco: Do you smoke? ________ #_____Packs/day _____ Cigarettes/day _________Smokeless Tobacco

Have you ever smoked? _________ #______Packs/day _____Cigarettes/day ________Smokeless Tobacco

If you previously smoked, When? ______________________ How long? ______________________

Recreational Drugs: _____None If yes, please list: ______________________________

Caffeinated beverages: None Low Moderate Excessive

ALLERGIES-Please list ALL types (Drugs, Seasonal, Pets, Environmental, Foods)

____.

____.

Recent Foreign Travel: None Americas ____________________ Worldwide ____________________

CURRENT MEDICATIONS – Please list ALL medications you are currently taking including over the counter meds

Drug Name:	Strength:	Directions/How you take it:

Attach list if necessary

Do you grant us permission to import your medications from your pharmacy? ________Yes ________No

Pharmacy Name: ______________________________ Location ______________________________

Name: ______________________________ Date: ____________________

Date of Birth: ______________________________

REVIEW OF SYSTEMS: PLEASE CIRCLE ALL THAT APPLY

Constitutional
Aches/Pains
Appetite Changes
Bruises easily
Fever
Chills
Hot Flashes
Night Sweats
Fatigue
Generalized Weakness
Insomnia
Swollen Glands
Anorexia
Weight Loss
Other

Eyes
Blindness
Blurred Vision
Double Vision
Eye Pain
Other

Allergic/ Immunologic
Seasonal
Drug
Animal
Environmental
Other

Endocrine
Diabetes
Pituitary Disease
Thyroid Disease
Excess Thirst
Tired/Sluggish
Heat/Cold Intolerance
Other

Neurological
Lack of Awareness
Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Problems
Tremors
Other

Gastrointestinal
Acid Reflux
Indigestion/Heartburn
Nausea/Vomiting
Abdominal Pain
Bloody Stools
Abdominal Cramps
Diarrhea
Constipation
Change in Bowel Habits
Hemorrhoids
Flatulence
Gas
Rectal Bleeding
Tarry Stools
Other

Cardiovascular
Chest pain/angina
Dyspnea on Exertion
Edema
Hardening of the arteries
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Low Exercise Tolerance
Mitral Valve Prolapse
Orthopnea
Pain/cramps w/exercise
Palpitations
Skipped Heart Beats
Swelling
Other

Skin
Acne
Boils
Persistent Itch
Skin Rash
Changing Moles
Pigment Changes
Other

Musculoskeletal
Back Pains
Joint Pains
Neck Pain/stiffness
Muscle Cramps
Arthritis
Muscle Weakness
Other

Ears/Nose/Throat
Ear Infection
Sinus Problem
Sore Throat
Other

Genitourinary
Back Pain
Bedwetting
Blood in urine
Dribbling
Burning on Urination
Erection Problems
Premature Ejaculations
Flank Pain
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Nocturia
Prostate Infection
Sexual Dysfunction
Low Desire
Sexually Transmitted
Diseases
Stranguria
Suprapubic Pain
Testes/Scrotal Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine Retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge
Weak Stream
Other

Respiratory
Asthma
Tuberculosis
Emphysema/Bronchitis
Environmental Allergies
Frequent Cough
Shortness of Breath
Wheezing
Other

Hematological/ Lymphatic
Swollen Glands
Blood clotting problems
Bleeding Problems
Hepatitis
HIV (AIDS)
IV Drug Use
Sickle Cell
Others

Psychological
Not satisfied with life
Anxious
Depressed
Considered Suicide
Other

Patient Signature: ______________________________ Date: ____________________