South County Urological

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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.

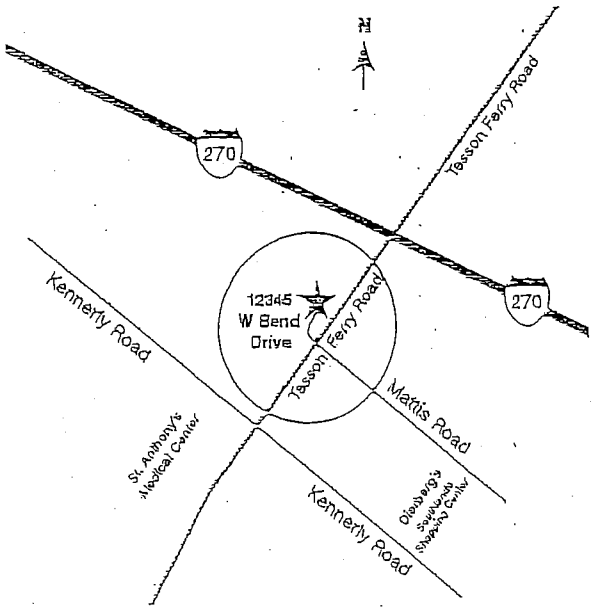
Also enclosed is a patient information packet. Please complete this paperwork and mail it back in the self-addressed stamped envelope enclosed. If you have a health insurance plan that requires a referral to see a specialist, please bring your referral with you. We will take a copy of your insurance 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



South County Urological, Inc.

Today's Date: _____ SS#: _____

Patient Name: _____ Birth Date: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address if different than above: _____

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

Email Address: _____

Preferred Method of Contact (Circle One) Home Cell Work

Can we leave a message on this phone number: Yes No

Email communication is available upon request, however there may be some level of risk, meaning regular email can be read/intercepted by someone else.

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**	**PREFERRED LANGUAGE**	
African American	Hispanic	Arabic	Serbo-Croatian
Asian	Latino	English	Spanish
Middle Eastern	Not Hispanic or Latino	German	
Pacific Islander		Greek	Other: _____
White Other Race			

Insurance Information

Primary Insurance: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____

ID# _____ Group: _____

Secondary Insurance: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____

ID# _____ Group: _____

Emergency Contact: _____ Phone: ( ) _____

Relationship to the above contact: _____

South County Urological, Inc

AUTHORIZATION TO COMMUNICATE INFORMATION TO OTHERS

I hereby authorize the use of 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.

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 Patient: _____ Contact #: _____
May Discuss Diagnosis/Treatment Yes___ No ___ May Discuss Billing Info Yes ___ No ___

Name: _____ Relationship to Patient: _____ Contact #: _____
May Discuss Diagnosis/Treatment Yes___ No ___ May Discuss Billing Info Yes ___ No ___

Name: _____ Relationship to Patient: _____ Contact #: _____
May Discuss Diagnosis/Treatment Yes___ No ___ May Discuss Billing Info Yes ___ No ___

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

I understand that these authorizations are voluntary and that I can refuse to sign this authorization. I understand I may revoke this authorization at any time. I understand I do not have to sign this form to receive care. I understand it is my responsibility to update this list in order to keep accurate who can obtain information about my health. I understand that this authorization will expire when a period of two (2) years has run without me receiving treatment from this practice.

_____ _____
Patient/Legal Representative Date

Patient unable to sign form due to _____

SIGN BELOW ONLY IF YOU WISH TO REVOKE YOUR AUTHORIZATION
I hereby revoke this authorization_____ Date _____

South County Urological, Inc

FINANCIAL AGREEMENT

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 will require you to read and sign prior to any treatment.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE PHYSICIAN. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND A PHOTO I.D. FOR YOUR FILE. ANYTIME YOU CHANGE INSURANCE PLEASE UPDATE US WITH YOUR NEW INSURANCE INFORMATION SO WE CAN PROPERLY FILE YOUR CLAIM.

APPOINTMENTS – 24 hours' notice must be provided in the event you cannot keep an appointment, a cancellation fee of $25.00 may then be added to your account. Cancellations for Procedures or Ancillary Services will have a higher fee.
REFERRALS/AUTHORIZATION– If your plan requires a referral from your from primary care physician, it is **YOUR** responsibility to obtain it prior to your appointment. If you do not have a referral you may be asked to reschedule your appointment until you obtain a proper referral. It is your responsibility to inform the office staff if your insurance requires you to utilize a specific hospital/lab/facility for medical services rendered or order by this office.
CO-PAYMENTS – By law we MUST collect the copay designated by your insurance carrier. This is part of your contract with the insurance company and noncompliance may result in your insurance company cancelling your policy.
SURGERY DEPOSITS – If you and your physician determine that your course of care requires surgery, a surgical deposit may be collected at the time of scheduling. Our Billing/Scheduling Coordinators will work with your to determine estimated insurance payment and estimated patient responsibility. Any procedure performed in this office could be deemed surgical by your insurance company and all copays and deductibles will apply.
MEDICARE/INSURANCE – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one. We are a Medicare participating Group 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. 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. The patient or guardian (if patient is a minor) is responsible for the account regardless of insurance coverage.
SELF-PAY PATIENTS – Payment is expected at the time of service.
INSUFFICIENT FUND CHECKS – A $35.00 fee will be charged to patient's account for checks returned due to non-sufficient funds.
**Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize medical benefits to South County Urological, Inc, for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize South County Urological, Inc. to release medical information about me to my insurance company concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administrating claims and benefits.
**Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to South County Urological, Inc for any services furnished to me. I authorize South County Urological, Inc to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AND DISCOVER. Thank you for taking the time to review our policies.

Patient name: _____ Date of Birth: _____
Responsible Party Signature: _____ Date: _____

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 _____

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 of Birth _____

Today's Date _____

REVIEW OF SYSTEMS:

Constitutional:	Aches/Pains	Anorexia	Appetite Changes	Bruises Easily
	Chills	Fatigue	Fever	Generlized Weakness
	Hot Flashes	Insomnia	Loss of Energy	Night Sweats
	Swollen Glands	Weight Gain	Weight Loss	
Eyes:	Blind	Blurry Vision	Double Vision	Eye Pain
Ears, Nose, Mouth, Throat:	Dry Mouth	Hearing Loss	Sinus Problems	Sore Throat
Cardiovasular:	Chest Pain/Angina	Hardening of the Arteries	Heart Murmur	High Blood Pressure
	Irregular Heartbeat	Pain/Cramps With Exercise	Palpitations	Swelling
	Skipped Heartbeat			
Respiratory:	Cough	Shortness Of Breath	Wheezing	
Gastrointestinal:	Abdominal Cramps	Abdominal Pain	Acid Reflux	Bloody Stools
	Change In Bowels	Constipation	Diarrhea	Gas
	Hemorrhoids	Indigestion/Heartburn	Nausea/Vomiting	Rectal Bleeding
	Tarry Stools			
Genitourinary:	Bedwetting	Blood In Urine	Burning On Urination	Dribbling
	Erection Problems	Flank Pain	Kidney Infection	Kidney Failure
	Low Desire	Nocturia	Premature Ejaculations	Prostate Infection
	Sexual Dysfunction	Sexually Transmitted Diseases	Suprapubic Pain	Testes/Scrotal Pain
	Urgency	Urinary Frequency	Urinary Incontinence	Urinary Hesitancy
	Urine Retention	Urinary Tract Infections	Weak Stream	
Musculoskeletal:	Arthritis	Back Pain	Joint Pain	Muscle Cramps
	Muscle Weakness	Neck Pain/Stiffness	Sore Muscles	
Integumentary/Skin:	Rash	Dry Skin	Bruising	Lesions/Ulcers
Neurological:	Balance Problems	Disoriented	Dizzy Spells	Headache
	Memory Loss	Lack Of Alertness	Lack Of Awareness	Leg or Arm Pain
	Numbness/Tingling	Tremors		
Hematologic/Lymphatic:	Bleeds Easily	Blood Clots	Hepatitis C	HIV (AIDS)
	Swollen Glands			
Allergy/Immunologic:	Animal	Drug	Environmental	Seasonal
Endocrine:	Diabetes	Excess Thirst	Heat/Cold Intolerance	Pituitary Disease
	Tired/Sluggish	Thyroid Disease		
Psychological:	Anxious	Considered Suicide	Depressed	Not Satisfied with Life