COASTAL CAROLINA UROLOGY

MRN: _____ *(Office Use Only)*

PATIENT INFORMATION

Social Security #: _____-_____-_____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Sex: ☐ Male ☐ Female DOB: _____ Email: _____

Referring Doctor: _____ PCP: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

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PRIMARY INSURANCE: _____ **Policy #** _____ **Group #** _____

Name of Subscriber (if other than patient) _____

Patient's Relationship to Insured ☐Self ☐Spouse ☐Child ☐Other _____ Subscriber's Gender ☐ Male ☐ Female

Subscriber's Date of Birth _____ Subscriber's Social Security # _____

SECONDARY INSURANCE: _____ **Policy #** _____ **Group #** _____

Name of Subscriber (if other than patient) _____

Patient's Relationship to Insured ☐Self ☐Spouse ☐Child ☐Other _____ Subscriber's Gender ☐ Male ☐ Female

Subscriber's Date of Birth _____ Subscriber's Social Security # _____

MEANINGFUL USE DATA

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Indian ☐ Native American ☐ Pacific Islander

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

IN CASE OF EMERGENCY

Relative/Friend: _____ Relationship: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Coastal Carolina Urology Group or my insurance company to release any information required to process my claims.

PATIENT SIGNATURE: _____ **DATE:** _____

COASTAL CAROLINA UROLOGY

MRN: _____ *(Office Use Only)*

Patient Name: _____ Date of Birth: ____/___/_____

Prescription Refills

Telephone prescription refills must be requested on Monday – Friday between the hours of 8:30 am and 4:00 pm. Please allow 24 – 48 hours for your prescription to be called in. Telephone prescription refills may be delayed due to necessity for the physician to review your record and determine the appropriate medicine to prescribe. Also, please note that it is our belief that narcotic pain relievers are, in general, for short-term use only. Likewise, prescriptions **will not** be called in after hours and on weekends.

_____ _____

Patient and /or Guardian Signature Date

Return Phone Calls

The clinic staff at Coastal Carolina Urology Group will return patient phone calls received before 4:30 pm Monday through Friday before the clinic closes that day. Calls after this time will be returned the next business day. If you believe your medical situation is urgent in nature, please proceed to a hospital emergency room for immediate treatment.

_____ _____

Patient and /or Guardian Signature Date

COASTAL CAROLINA UROLOGY

MRN: _____ *(Office Use Only)*

Patient Name: _____ Date of Birth: ____/___/_____

IF YOU HAVE INSURANCE WITH ONE OF THE FOLLOWING INSURANCE COMPANIES, please check the appropriate box. We ask that you pay at the time of service on the balance that would be your responsibility (co-pay or co-insurance) or on any deductible amount that has not been met. You are responsible to present updated referral authorizations from your insurance carrier when required:

- ☐ Blue Cross Blue Shield PPO
- ☐ Blue Cross State
- ☐ Blue Cross Federal
- ☐ Cigna
- ☐ Medicare Part B
- ☐ Railroad Medicare
- ☐ Tricare

IF YOU HAVE COVERAGE WITH AN INSURANCE COMPANY NOT LISTED ABOVE. If you provide us with a copy of your insurance card, we will file for insurance as a courtesy to you. We ask that you pay the entire balance at the time of service and we will refund you for any overpayment once your insurance carrier submits payment for service. This policy applies to your primary insurance carrier as well as your secondary carrier, if you have one.

IF YOU DO NOT HAVE HEALTH INSURANCE. You are responsible for payment of your bill at the time of your visit. We accept personal checks, credit cards, and cash. A payment of $100 is due before your visit and the balance will be due when your visit is complete.

IF YOU HAVE BEEN INJURED ON THE JOB AND YOUR EMPLOYER HAS WORKERS COMPENSATION COVERAGE. We must have information approving the claim from your employer and an accurate billing address to send the claim for processing. Without this, we will consider payment for this visit to be your responsibility. Coastal Carolina Urology follows the South Carolina State Worker's Compensation fee schedule and is not a member of any Worker's Compensation PPO's.

It is the policy of Coastal Carolina Urology to file for insurance as a courtesy to you. If we participate with your insurance carrier, we ask that you pay at the time of service on the balance that would be your responsibility (co-pay or co-insurance) or on any deductible amount that has not been met. If we do not participate with your carrier, we ask that you pay the entire balance at the time of service and we will refund you for any overpayment once your insurance carrier submits payment for service. This policy applies to your primary insurance carrier as well as your secondary carrier, if you have one. If you do not have any insurance, we require that you make payment in full as you check out after each visit.

I have read and agree to the above policy of Coastal Carolina Urology.

_____ _____

Signature Print Name

COASTAL CAROLINA UROLOGY

MRN: _____ *(Office Use Only)*

Patient Name: _____ Date of Birth: ____/___/_____

MEDICAL RELEASE AUTHORIZATION AND INSURANCE ASSIGNMENT

I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to Coastal Carolina Urology Group, LLC. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account.

I request that payment for authorized Medicare benefits be made either to me or on my behalf to Coastal Carolina Urology Group, LLC for any services or supplies furnished to me by Coastal Carolina Urology Group, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information to my insurance company in order to determine insurance benefits to which I may be entitled. I may revoke this authorization at any time in writing.

I authorize Coastal Carolina Urology Group, LLC to release and/or send medical information regarding my case to other consulting and/or referring physicians.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that my insurance is a contract between the insurance carrier, and me and not between the insurance carrier and this office, and that I am still fully responsible for all fees. Late fees will be assessed on balances not paid by due date. Should timely payments of this account not be made, I authorize Coastal Carolina Urology Group, LLC to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such action shall become an additional liability for which I assume responsibility.

I understand that if I cancel an appointment with less than 24 hours' notice, I will be charged a fee of $25.00 for an office appointment, and $100.00 for a procedure appointment.

I understand that I will be charged an administrative fee of $15.00 by Coastal Carolina Urology Group, LLC for completion of any forms required by you or your insurance provider. These forms include, but are not limited to statements of medical necessity, prescription refills requiring these statements, life insurance forms, disability insurance forms and any non-claim insurance forms.

_____
Print Full Name

_____ _____
Signature *Date*

MRN: _____ *(Office Use Only)*

Patient Name: _____Date of Birth: ____/___/_____

I consent to the use or disclosure of my protected health information by Coastal Carolina Urology Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Coastal Carolina Urology Group. I understand that diagnosis or treatment of me by Dr. **Adams/Plzak** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Coastal Carolina Urology Group is not required to agree to the restrictions that I may request. However, if Coastal Carolina Urology Group agrees to a restriction that I request, the restriction is binding on Coastal Carolina Urology Group and **Dr. Adams/Plzak**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Adams/Plzak** or Coastal Carolina Urology Group has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Coastal Carolina Urology Group's Notice of Privacy Practices prior to signing this document. Coastal Carolina Urology Group's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Coastal Carolina Urology Group. The Notice of Privacy Practices for Coastal Carolina Urology Group is provided at the front desk. This Notice of Privacy Practices also describes my rights and Coastal Carolina Urology Group's duties with respect to my protected health information.

Coastal Carolina Urology Group reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

COASTAL CAROLINA UROLOGY

MRN: _____ *(Office Use Only)*

Patient Name: _____ Date of Birth: ____/___/_____

PERMISSION TO DISCUSS YOUR MEDICAL CARE OR FINANCES

I. Persons to whom your Medical Information may be disclosed

EXCEPT for other physicians in connection with your ongoing care, insurance companies in connection with billing, state or federal healthcare agencies, or law enforcement agencies (which are allowed by federal law), and workers compensation agencies, we cannot release ANY of your medical information to any person or organization (including family members, spouse, etc.) unless you list their name below. You agree that information described above may be disclosed to the following persons or organizations:

_____
Name of Person/Organization

_____
Name of Person/Organization

II. The purpose and type of information to use or disclosure:

☐ Reporting of laboratory or other medical test results
☐ General information (your current medical condition, prognosis, medications, etc.)
☐ Financial details of your billing activity or charges

III. Expiration Date of Authorization

Your permission is effective *(Please select only one)*

☐ Indefinitely
☐ Date Specified ____________ unless revoked or terminated in writing by you or your representative.

IV. You have the Right Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Coastal Carolina Urology.

V. Potential for Re-disclosure by another health care provider

Information that is disclosed under this authorization may possibly be disclosed again by the other person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations. Coastal Carolina Urology has no control over disclosures by other persons or business entitles with whom we may lawfully share this information.

VI. You may revoke permission to share your medical information

I understand that this authorization will remain in effect until I give written notice to Coastal Carolina Urology to remove any of the persons listed above.

_____ _____
Signature of Patient Name of Patient (Print)

COASTAL CAROLINA UROLOGY

John B. Adams, II, M.D. Louis F. Plzak, III, M.D.

Patient Name: _____ Date of Birth: ____/___/_____

HEALTH QUESTIONNAIRE

The following information is very important to your health.
Please take time to fully and completely fill out this important information.

PATIENT NAME: _____ DATE: _____

Date of Birth: _____ Height: _____ Weight: _____

PRIMARY CARE PHYSICIAN: _____

PHARMACY NAME: _____ TELEPHONE: _____

WHY ARE YOU HERE TO SEE THE DOCTOR? _____

PLEASE LIST ANY DRUG ALLERGIES: _____

PLEASE LIST ANY AND ALL MEDICATIONS AND SUPPLEMENTS YOU TAKE REGULARLY (INCLUDING DOSE):

DO YOU TAKE ANY ASPIRIN PRODUCTS? NO _____ YES _____ IF YES, HOW OFTEN? _____

PLEASE LIST ANY PRIOR SURGERY:

FEMALES ONLY (CIRCLE): Bladder Tack Hysterectomy Sling (TVT) Number of Deliveries _____ C-Section
MALES ONLY (CIRCLE): Prostate Biopsy Prostate Seed Prostate Surgery

OTHER SURGERIES (PLEASE LIST)

PLEASE CIRCLE ANY MEDICAL PROBLEMS THAT YOU HAVE?

Bladder Cancer
Bladder Pain
Flank Pain
Frequency of Urination
Hematuria
Incontinence
Kidney Cancer
Kidney Stone
Neurogenic Bladder
Overactive Bladder
Renal Insufficiency
Urgency of Urination
Urinary Retention
Urinary Tract Infection

Atrial Fibrillation
COPD
Dementia
Depression
GERD
Gout
Heart Disease
High Cholesterol
Hypertension
Parkinson's Disease
Sleep Apnea
Stroke/TIA
Myocardio Infarction

OTHER Medical Problems:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

COASTAL CAROLINA UROLOGY

Patient Name: _____ Date of Birth: ____/___/_____

HEALTH QUESTIONNAIRE PAGE 2

DOES ANYONE IN YOUR FAMILY HAVE: ☐ PROSTATE CANCER ☐ KIDNEY CANCER ☐ KIDNEY STONES
☐ HEART DISEASE ☐ DIABETES

SOCIAL HISTORY:

WHAT IS YOUR OCCUPATION? _____

DO YOU SMOKE: YES _____ WHEN DID YOU START? _____ HOW MUCH? _____

PREVIOUSLY _____ IF YES, WHEN DID YOU QUIT? _____

NEVER _____

DO YOU DRINK ALCOHOL? NO _____ YES _____ IF YES, HOW MUCH? _____

DO YOU DRINK CAFFEINATED DRINKS NO _____ YES _____ IF YES, HOW MUCH? _____

WHAT ARE YOUR UROLOGICAL SYMPTOMS (CIRCLE ALL THAT APPLY):

Frequent Urination	Can't Hold my Urine (wet myself)	Pain or burning on urination
Blood in urine	Awaken at night to urinate (how often?)	My urinary stream is restricted
I must wait to start urinating	My stream stops, after waiting I urinate more	Hernia
Problem with genitals	Unsatisfactory sexual function	Incomplete emptying

WHAT OTHER SYMPTOMS DO YOU HAVE TODAY (CIRCLE ALL THAT APPLY)

General/Constitutional	Fever	Weight Loss	Weight Gain	Night Sweats	Loss of Energy
Eyes	Blurry Vision	Cataracts	Blind		
Ear, Nose, Mouth, Throat	Hearing Loss	Nasal Stuffiness	Dry Mouth	Sore Throat	
Cardiovascular	Swelling	Chest Pain	Irregular Heartbeat		
Respiratory	Shortness of Breath	Wheezing	Cough		
Gastrointestinal	Abdominal Pain	Nausea/Vomiting	Change in Bowels	Constipation	
Musculoskeletal	Sore Muscles	Back Pain	Arthritis		
Integumentary/Skin	Rash	Dry Skin	Bruising	Lesions/Ulcers	
Neurological	Dizziness	Forgetfulness	Loss of Balance	Depression	
Hematologic/ Lymphatic	Swollen Glands	Bleeds Easily	Blood Clots		

FEMALE PATIENTS

☐ REGULAR PERIODS
☐ MENOPAUSE DATE OF LAST PERIOD _____

Patient's Signature

_____
The above is true and correct to the best of my belief.