Florida Urology Center
673-5100
www.floridaurology.com
Board Certified Urologists

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Ken Roberts, P.A.-C

Port Orange Med.Ctr.	Daytona Office	Ormond Office	Palm Coast Office	NSB Office
790 Dunlawton Ave	1620 Mason Ave	300 Clyde Morris Blvd	84 Pinnacles Dr	843 State Rd 44
Suite H	Suite E	Suite C	Suite 500	New Smyrna Bch
Port Orange,FL 32127	Daytona Bch,FL 32117	Ormond Bch,FL 32174	Palm Coast, FL 32164	Fl, 32168
386-322-8880	386-673-5100	386-673-5100	386-445-8533	386-957-3825

Practice Rules & Policies

Welcome to our practice. We are pleased you have decided to let us attend to your Urological health.
If you have received paperwork in the mail, please complete it; bring it with you to your appointment and arrive twenty minutes early to sign some required forms.

Your primary care physician has either agreed to send us records or given records to you. If you have the records, please mail them or drop them by so we can make sure they include the tests our doctors require.

If you have seen a Urologist before, it is important that we have those records also. Please obtain them and send us a copy. We need reports (and films if possible) of any x-rays, KUB(s), IVP(s), PSA(s), urinalysis, pathology, cytology or any surgeries you may have had.

PLEASE BRING YOUR INSURANCE CARDS AS WELL AS AN ACCURATE LIST OF ALL MEDICINES YOU ARE CURRENTLY TAKING and dosage (include vitamins, aspirin and other over the counter medications).

If your insurance company is an HMO, please do not forget to check with your primary care physician's office to make sure that your visit has been pre-authorized.

ABOUT OUR OFFICE: We are open from 8:00 am. – 4:30 pm. Mon. – Fri. We do close early the day before holidays and some Friday afternoons.

One of our physicians is always on call and available for emergencies or post-operative questions. Please do not call with routine questions (i.e. prescription requests) when the office is closed.

Prescriptions: Please contact your pharmacy and have them fax (not call) a request for refills. Please do your best to contact your pharmacy at least 2 weeks or more prior to running out of your medications. Most insurance companies are requiring a preauthorization which can be an exceptionally difficult and time consuming process. Please do not expect to call our office during the day and have the prescriptions available the same day. In most cases, even if no preauthorization is required, we are too busy caring for patients and attending to emergencies to handle refills that quickly. Also, due to time restraints, the potential for error, etc. we do not call prescriptions in to pharmacies such as Merck-Medco.

Communication: We try to get back to patients who call as soon as possible. We do, however, see patients in the hospital and office and to avoid running chronically behind with our appointments, non-emergent calls must be saved and returned within 48 hours. We will call with test results as soon as we have the report and it has been reviewed by your doctor. This may take up to 2 weeks. If you have an office visit scheduled within a week (or so) of the test, the doctor will discuss the results with you in person at that time. We do not discuss pathology results over the phone.

Cancellations: If you need to cancel an appointment, please give us as much notice as possible.
There are always people who have new symptoms or problems and need to be seen. Since we are a surgical practice, our physicians are frequently called away for emergency surgery. If this causes us to reschedule your appointment, we will do our best to contact you as quickly as possible.

Payment: If we do not participate with your insurance company, payment will be requested prior to seeing the doctor. If we do participate with your insurance company, your co-pay and/or deductible will be collected at the time of your visit.

HIPAA: Our practice is fully compliant with all HIPAA privacy guidelines. If you would like a copy of our HIPAA Privacy Notice, please don't hesitate to ask.

Cell Phones: Please silence or turn off your cell phone or other electronic device while at the office.

We try our very best to be warm and understanding of your needs, emotion, concerns, etc. Please afford us the same consideration. Our physicians and staff are good, caring people. We are like family here and do not like it if someone is rude or unduly difficult. In fact, we consider rudeness to our staff to be the same as rudeness to our physicians and should it occur we would undoubtedly feel that it would be in everyone's best interest for that individual to seek his/her urological care elsewhere. By the same token we also want to be made aware if one of us was less than polite to you.

If you have any questions, please let us know. We look forward to meeting and caring for you.

The FLORIDA UROLOGY CENTER

Patient Name:_____ Date of Birth ____-____-_____ Age _____ Gender: M F

Local Address: _____ SS#_____-_____-_____

Primary Phone: ☐ Home ☐ Cell

City: _____ State: ____ Zip: _____ _____-_____-_____

Secondary Phone: ☐ Home ☐ Cell

Permanent Address: _____ _____-_____-_____

Alternate Phone:

- -

Patient must initial

I authorize messages with medical information to be left at the above number(s)? _____

People the office can speak to about your Health Care

Emergency Contact: _____ Relationship To Patient: _____ Phone: - -

Other Contact: _____ Relationship To Patient: _____ Phone: _____-_____-_____

Other Contact: _____ Relationship To Patient: _____ Phone: _____-_____-_____

Employer/Position: _____ Phone: _____-_____-_____

Family Physician: _____ When was your last well visit/annual physical ? Phone: - -

Have you seen another urologist? _____ (Name) _____ Phone: _____-_____-_____

What **Pharmacy** do you use? _____ Phone: - -

What **Lab** do you use? _____ Phone: _____-_____-_____

Who referred you to our office? (Physician, yellow pages, ect…)

Primary Insurance: _____ Secondary Insurance: _____

** If either of the above insurances are offered through a retirement plan, please state the name of the company you worked for prior to retiring. _____.

** Do either of your insurance companies require pre-authorization to see a physician? Yes No

** If authorization is required did you bring it with you? Yes ___ No ___

If you receive insurance through someone else such as a parent, spouse, etc., put his/her information below:

Name of Insured: Employer: Relationship To Patient:

Address: _____ SS#_____-_____-_____

City: State: Zip: Insured's D.O.B.: - -

Office Use Only: Copy of insurance card? Y N Copy of D.L. or ID? Y N

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PRESCRIPTION REFILL POLICY

Effective January 1, 2013

Please strive to go to your pharmacy and refill your prescriptions at least 2 weeks or more prior to running out of your medication(s).

Most insurance companies are now requiring a pre-authorization for all drugs that are not on their "preferred" lists. Unfortunately, we have no way of knowing what the preferred drugs are for your insurance plan. There are hundreds of insurance plans and they all change their preferred lists or formularies regularly. They are also making the pre-authorization process much more difficult than it used to be. It usually requires one of our staff to sit on hold for 10-15 minutes per call. However, at times it can be much longer (30-45 min). We simply do not have the staff to do that on a regular basis. As a result, it can take up to 2 weeks for us to obtain your pre-authorization.

In some circumstances a different drug (that is on your insurance company's current formulary) may be necessary, which will require us to speak with your urologist and obtain his/her approval. If a side effect or drug interaction profile of the alternative drug is substantially different, an office visit to go over them may also be necessary.

You can help with this process by always refilling your prescription(s) at least 2 weeks early, or calling your insurance company (you may also be able go onto their website as well) and finding out if they prefer a similar drug and letting us know prior to filling your prescription. As noted above, we will consult your doctor and we will give you a new prescription if he feels it is appropriate.

Thank you very much!

Financial Policy

We are committed to providing you with the best possible care, and we would be happy to discuss our fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or Financial Policy.

Our office requires payment in full due at the time of service, unless we participate with your insurance company, or arrangements have been made prior to the appointment. Co-payments and deductibles are always expected at the time of the service. If it should become necessary to bill you, it is our policy to add a late payment charge of 1.5% per month on all unpaid balances starting at 30 days from the date of your first bill.

Also, *please remember that your insurance policy is a contract between you and your insurance company*. You are ultimately responsible for knowing what diagnosis (es) and/or procedure(s) may or may not be considered for payment or require deductible, co-payment, etc.

MISSED APPOINTMENTS: You may be subject to a $50 charge for missed appointments if the appointments are not canceled at least 24 hours in advance.

INSURANCE CHANGES: Please don't forget you must notify us prior to your next visit if your insurance changes or you may be responsible for payment yourself. I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered. I certify that the information I have provided is true and correct to the best of my knowledge. I will notify you of any changes in the information that I have provided.

PATIENT WITH MEDICARE COVERAGE
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician and authorize such physician to submit a claim to Medicare.

NON-MEDICARE PATIENTS
I authorize the release of all medical information to my insurance company (ies) and request that payment of my insurance benefits be sent directly to The Florida Urology Center (unless payment in full has been made at the time of service).

TREATMENT
By signing below, I authorize treatment by The Florida Urology Center's physicians and their staff.

CONTACT
By signing below, I authorize all of the phone numbers I have provided (including my mobile number) to be used to communicate with me regarding my treatment, billing or services rendered.

_____ _____
Signature of Patient/Guardian Date

Please bring your insurance cards
and picture identification to the appointment.

The Florida Urology Center 2020 Patient Questionnaire

Name: _____ Date: _____

What is your reason for seeing the doctor? _____

What questions would you like to ask the doctor? _____

Have you ever been treated for alcoholism: ___YES ___NO
Have you ever been treated for drug abuse: ___YES ___NO
Have you ever had a blood transfusion? ___YES ___NO

PERSONAL HISTORY	YES	SURGICAL HISTORY	YES	Date	ALLERGY HISTORY	YES
Arthritis		Appendix			Aspirin	
COPD						
Corinary Artery Dz						
Diabetes		Gall Bladder			Codeine	
Gonorrhea/Syphilis		Hemorrhoid			Morphine	
Hayfever/Asthma		Hernia			Mycins	
Heart Disease/Stroke		Prostate			Penicillin	
Hernia		Ovary(ies)			Sulfa	
High/Low Blood Pressure		Uterus			Tetracycline	
Neuritis		Other			Cipro	
Paralysis		Explain:			Latex	
Cancer					Iodine	
Explain:					Other:	

Date of last visit with primary care physician:

LIST ALL MEDICATIONS: PRESCRIPTION AND OVER THE COUNTER , Or provide written list

Medication name	Dosage/Strength	Frequency:how often	Taken orally?

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2020

The FLORIDA UROLOGY Center 2020

CHECK ALL THAT APPLY

CONSTITUTIONAL	YES
Weight Loss	☐
Fatigue	☐
Fever	☐
EYES	
Glasses/Contacts	☐
Eye Pain	☐
Double Vision	☐
Glaucoma	☐
Cataracts	☐
EAR, NOSE, THROAT	
Difficulty Hearing	☐
Ringing in Ears	☐
Vertigo	☐
Sinus Trouble	☐
Nasal Stuffiness	☐
Frequent Sore Throat	☐
CARDIOVASCULAR	
Murmur	☐
Chest Pain	☐
Palpitations	☐
Dizziness	☐
Fainting Spells	☐
Shortness of Breath	☐
Difficulty Lying Flat	☐
Swelling Ankles/Other	☐
OTHER	☐
Cancer:_____	
Diabetes: _NonInuslin _Insulin	☐
Hypertension	☐

RESPIRATORY	YES
Cough	☐
Coughing Blood	☐
Wheezing	☐
Chills	☐
GASTROINTESTINAL	
Heartburn	☐
Nausea/Vomiting	☐
Constipation	☐
Change in B.M.'s	☐
Diarrhea	☐
Difficulty Swallowing	☐
Jaundice	☐
Abdominal Pain	☐
Black Stools	☐
GENITOURINARY	
Pain Urinating	☐
Burning	☐
Frequency	☐
Nighttime	☐
Blood in Urine	☐
Difficulty Urinating	☐
History of Kidney Stones	☐
History of Sexually Transmitted Disease	☐
Abnormal Discharge	☐
ENDOCRINE	
Loss of Hair	☐
Heat/Cold Intolerance	☐
Change in Nails	☐

HEMATOLOGIC/LYMPH	YES
Easy Bruising	☐
Gums Bleed Easily	☐
Enlarged Glands	☐
Prolonged Bleeding	☐
MUSCULOSKELETAL	
Joint Pain/Swelling	☐
Stiffness	☐
Muscle Pain	☐
Back Pain	☐
SKIN	
Rash/Sores	☐
Lesions	☐
Itching/Burning	☐
NEUROLOGICAL	
Seizures	☐
Weakness/Paralysis	☐
Numbness	☐
Tremors	☐
Memory Loss	☐
ALLERGIC/IMMUNOLOGIC	
Hay Fever/Asthma	☐
Hives/Eczema	☐
PSYCHIATRIC	
Anxiety/Depression	☐
Mood Swings/Difficult Sleep	☐
FEMALE ONLY:	
Age of Onset of Periods	_____
Age of Onset Menopause	_____
Are Periods Regular?	Y / N

HABITS	**YES**
Exercise Adequately	
Sleep Well	
Sex-Entirely Satisfactory	
Coffee ( ) cups per day	
Alcoholic Beverages ( )per day	
Cigarettes/Cigars ( )packs per day	

FAMILY HISTORY / PT.RELATIONSHIP	**YES**
Cancer	
Diabetes	
Heart Trouble	
High Blood Pressure	
Stroke	
Kidney Stones	

What is your weight now: _____

What is your height? _____ft. _____inches

X-RAY HISTORY / DATE	**YES**
Chest	
CT Scan	
Bone Scan	
IVP	
KUB	
MRI	
OTHER	

The Florida Urology Center
Standard Authorization of use and disclosure of protected Health Information

Information to be Used or Disclosed: _____

_____

_____

Purpose of disclosure:_____ Treatment _____Other

Person authorized to use or disclose the above information:

	Name of Dr / Facility	Telephone #
1	_____	_____
2	_____	_____
3	_____	_____

Person / Organization to Whom Information may be Disclosed:

The Florida Urology Center
300 Clyde Morris Blvd Suite C
Ormond Beach, FL 32174

Phone: 386-673-5100
Fax: 386-673-6014

Expiration of Date Authorization
This authorization is effective through _____/_____/_____ or NO EXPIRATION (CIRCLE ONE) unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization:
You may revoke or terminate this authorization by submitting a written revocation to the Florida Urology Center HIPPA Privacy Officer.

Potential for Re-disclosure:
Information that is disclosed under this authorization may be disclosed again by the organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature _____ DOB/SS# _____

_____ _____
Name of Patient (Print or Type) Date

_____
Signature of Patient Representative

International Prostate Symptom Score (IPSS)

MALE PATIENTS ONLY

Patient Name: Date of Birth: Today's Date:

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

Total International Prostate Symptom Score = _____

1 -- 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)

1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No

MALE PATIENTS ONLY

Acct# _____NAME:_____DOB:_____ DATE:_____ M P H G

1. Have you been discharged from any inpatient facility in the last 30 days? Yes__ No__
   If YES , please list all of your discharge medications: Use back if needed. 1111F

2. Do you currently smoke or use tobacco products? Yes__ No__
   4004F, G9902 ,G9906 1036F,G9903

3. Do you have an advanced directive, living will etc.? Yes__ No__
   1123F 1124F

4. Are you currently in pain? Yes__ No__
   G8730 G8731

Please circle the appropriate figure below.

5. Please list all prescription & non prescription medications belowor provide a written list. Use back of form if needed.

Name	Dosage	Frequency	How taken?	G8427 Provided	G8430 Pt in pain

6. Were the office/medical staff professional and courteous? Yes__ No__
7. Were you satisfied with our automated confirmation system? Yes__ No__
8. Would you refer your family or friends to our office? Yes__ No__

07/10/19