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

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2023 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.

2023

2023

The FLORIDA UROLOGY CENTER

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

Local Address: _____ SS#_____-_____-_____

Primary Phone: ☐ Home ☐

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

Secondary Phone: ☐ Home ☐

Permanent Address: _____ _____-_____-_____

Email address

Preferred method of contact to confirm appointments: ___Voice ___ Text ___ Both

Please initial here.

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

People the office can speak to about your Health Care

	Relationship		Phone:
Emergency Contact:	To Patient:		_____-_____-_____
	Relationship		Phone:
Other Contact:	To Patient:		_____-_____-_____
			Phone:
Employer/Position:			_____-_____-_____
	When was your last well		Phone:
Family Physician:	visit/annual physical ?		_____-_____-_____
			Phone:
Have you seen another urologist? _____	(Name) _____		_____-_____-_____
			Phone:
What **Pharmacy** do you use?			_____-_____-_____
		Email	
What **Lab** do you use?		Address:	_____

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:

		Relationship
Name of Insured: _____	Employer: _____	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

Continued on back

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-2023

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.

HIPPA
By signing below, I acknowledge, I have received a copy of the Notice of Health Information Practices**.**

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*** *and* ***medication list*** *to the appointment.*

The Florida Urology Center 2023 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						
Coronary 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?

The FLORIDA UROLOGY Center 2023

CHECK ALL THAT APPLY

CONSTITUTIONAL	YES	RESPIRATORY	YES	HEMATOLOGIC/LYMPH	YES
Weight Loss	☐	Cough	☐	Easy Bruising	☐
Fatigue	☐	Coughing Blood	☐	Gums Bleed Easily	☐
Fever	☐	Wheezing	☐	Enlarged Glands	☐
EYES		Chills	☐	Prolonged Bleeding	☐
Glasses/Contacts	☐	**GASTROINTESTINAL**		**MUSCULOSKELETAL**	
Eye Pain	☐	Heartburn	☐	Joint Pain/Swelling	☐
Double Vision	☐	Nausea/Vomiting	☐	Stiffness	☐
Glaucoma	☐	Constipation	☐	Muscle Pain	☐
Cataracts	☐	Change in B.M.'s	☐	Back Pain	☐
EAR, NOSE, THROAT		Diarrhea	☐	**SKIN**	
Difficulty Hearing	☐	Difficulty Swallowing	☐	Rash/Sores	☐
Ringing in Ears	☐	Jaundice	☐	Lesions	☐
Vertigo	☐	Abdominal Pain	☐	Itching/Burning	☐
Sinus Trouble	☐	Black Stools	☐	**NEUROLOGICAL**	
Nasal Stuffiness	☐	**GENITOURINARY**		Seizures	☐
Frequent Sore Throat	☐	Pain Urinating	☐	Weakness/Paralysis	☐
CARDIOVASCULAR		Burning	☐	Numbness	☐
Murmur	☐	Frequency	☐	Tremors	☐
Chest Pain	☐	Nighttime	☐	Memory Loss	☐
Palpitations	☐	Blood in Urine	☐	**ALLERGIC/IMMUNOLOGIC**	
Dizziness	☐	Difficulty Urinating	☐	Hay Fever/Asthma	☐
Fainting Spells	☐	History of Kidney Stones	☐	Hives/Eczema	☐
Shortness of Breath	☐	History of Sexually Transmitted Disease	☐	**PSYCHIATRIC**	
Difficulty Lying Flat	☐	Abnormal Discharge	☐	Anxiety/Depression	☐
Swelling Ankles/Other	☐			Mood Swings/Difficult Sleep	☐
OTHER	☐	**ENDOCRINE**		**FEMALE ONLY:**	
Cancer:_____		Loss of Hair	☐	Age of Onset of Periods	_____
Diabetes:_NonInuslin _Insulin	☐	Heat/Cold Intolerance	☐	Age of Onset Menopause	_____
Hypertension	☐	Change in Nails	☐	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	

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