UROLOGY HEALTH SOLUTIONS
Celebration, Florida, USA

Richard R. Lotenfoe, MD

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Fellow of the American College of Surgeons

Phone: 407-566-1105
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Patient History – FEMALE

Patient Name: _____ Date of Visit: _____

Please state the reason for your visit today: _____

Current Voiding Symptoms:

- ☐ Slow stream
- ☐ Hesitancy
- ☐ Interrupted stream
- ☐ Urinary frequency
- ☐ Urgency of urination
- ☐ Pain/Burning on urination
- ☐ Blood in urine
- ☐ Not emptying the bladder
- ☐ Dribbling after urination
- ☐ Awakening at night to urinate
  - ☐ How many times?
- ☐ Inability to control urine
  - ☐ with urgency
  - ☐ with cough/sneeze/laugh
- ☐ Urethral discharge
- ☐ Vaginal discharge
- ☐ Abnormal menstrual periods
  - ☐ First day of last period_____
- ☐ Pelvic pain
  - ☐ with a full bladder
  - ☐ after emptying bladder
  - ☐ with sexual relations
  - ☐ other

UROLOGY HISTORY: Have you had?

- ☐ Kidney infections
- ☐ Urinary Tract Infections (UTI)
- ☐ Venereal disease
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Kidney failure
- ☐ Surgery to the kidney/bladder/ Uterus/ovaries/tubes/vagina

Previous Medical History

- ☐ Angina
- ☐ Anxiety disorder
- ☐ Aortic Aneurysm
- ☐ Aortic Stenosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Back ache
- ☐ Easy bleeding
- ☐ CAD/heart vessel disease
- ☐ Cancer- What kind?
- ☐ Cataract
- ☐ Chronic bronchitis
- ☐ Congestive Heart Failure
- ☐ Constipation
- ☐ CVA (large stroke)
- ☐ Diabetes I or II **(Please Circle)**
- ☐ Diarrhea
- ☐ DVT
  - ☐ Upper extremities
  - ☐ Lower extremities
- ☐ Ear problems
- ☐ Emphysema
- ☐ GERD/gastric reflux
- ☐ Glaucoma
- ☐ Heart attack/MI
- ☐ Heart valve disorder
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ Indigestion/dyspepsia
- ☐ Irritable bowel syndrome
- ☐ Macular degeneration
- ☐ Peptic ulcer
- ☐ Peripheral vascular disease
- ☐ Psychiatric problem(s)
- ☐ Thyroid problem(s)
- ☐ TIA (mini stroke)
- ☐ Tuberculosis
- ☐ Other medical problems

Previous Surgeries (Please list)

_____

_____

410 Celebration Place, Suite 203, Celebration, FL 34747
www.OrlandoUrologistMD.com

Family Medical History

Mother's age: _____ ☐ alive ☐ deceased Father's age: _____ ☐ alive ☐ deceased

Illnesses in your parent and siblings (excluding yourself)

Please Indicate M=Mother F=Father B=Brother S=Sister

☐ CAD/heart disease **F M B S**
☐ Cancer, **What kind**? **F M B S**
☐ Congestive Heart Failure **F M B S**
☐ COPD-Lung problem **F M B S**
☐ CVA- large stroke **F M B S**
☐ Diabetes **F M B S**
☐ Heart attack **F M B S**
☐ High blood pressure **F M B S**
☐ Kidney stone(s) **F M B S**
☐ Kidney disease **F M B S**
☐ Prostate cancer **F B**
☐ Bleeding Disorder **F M B S**
☐ Asthma **F M B S**
☐ Cystic Fibrosis **F M B S**
☐ Other: _____ **F M B S**

Social History

Do/did you use tobacco products?

☐ Never
☐ Quit
☐ Smoke cigarettes: _____packs/day
☐ Smoke pipe/cigars
☐ Chew tobacco

Do/did you consume alcohol?

☐ Never
☐ Quit _____ ago
☐ Yes ____ glasses/day
☐ Yes, occasionally

Do/did you use illegal drugs?

☐ Never
☐ Quit _____ age
☐ Yes
What kind? _____

Current or previous occupation:

☐ Employed
☐ Unemployed
☐ Retired
☐ Disabled

Marital status:

☐ single/never married
☐ married
☐ divorced
☐ widowed

Children:

☐ yes How many? _____
☐ no

Allergies and reactions: _____

_____

List of medications and dosage:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Weakness
- ☐ Fatigue
- ☐ Fevers

Eyes
- ☐ Redness
- ☐ Tearing
- ☐ Dryness
- ☐ Double vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Wear glasses

Ears
- ☐ Itching
- ☐ Dizziness
- ☐ Abnormal hearing
- ☐ Ringing
- ☐ Ear ache
- ☐ Discharge

Nose
- ☐ Frequent colds
- ☐ Nose bleeds
- ☐ Sinus problem

Mouth/Throat
- ☐ Bleeding gums
- ☐ Sore throat
- ☐ Tongue sores
- ☐ Hoarseness

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Swelling
- ☐ Rheumatic fever
- ☐ Heart problems
- ☐ Claudication

Respiratory
- ☐ Cough
- ☐ Blood cough
- ☐ Short of breath
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Pleurisy
- ☐ TB
- ☐ Sleep apnea
- ☐ Snoring

Gastro-intestinal
- ☐ Constipation
- ☐ Indigestion
- ☐ Appetite loss
- ☐ Nausea
- ☐ Heartburn
- ☐ Pale stool
- ☐ Hemorrhoids
- ☐ Black stool
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Swallowing problem
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Hepatitis
- ☐ BM habit change

Intugementary
- ☐ Skin rash
- ☐ Sores
- ☐ Dry skin
- ☐ Hair loss
- ☐ Itching
- ☐ Skin cancer

Breast
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Discomfort

Neurological
- ☐ Migraine
- ☐ Headache
- ☐ Muscle weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremors
- ☐ Fainting
- ☐ Seizures

Psychiatric
- ☐ Anxiety
- ☐ Depressed mood
- ☐ Nervousness
- ☐ Memory loss
- ☐ Bipolar
- ☐ Schizophrenia

Hematology/Lymph
- ☐ Anemia
- ☐ Easy bruising
- ☐ Clotting disorder
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Transfusions
- ☐ Enlarged nodes
- ☐ HIV positive

Muscularskeletal
- ☐ Joint pains
- ☐ Joint stiffness
- ☐ Arthritis
- ☐ Backache
- ☐ Limited joint movement
- ☐ Joint swelling
- ☐ Gout

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Thyroid problem
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Thirst
- ☐ Excessive urine output
- ☐ Diabetes
- ☐ Sweating

Patient Demographics

Patient Information	Insurance Information
Name:	Primary Insurance:
Address:	Policy Holder Name:
City:	☐ Self ☐ Spouse ☐ Other:
State Zip:	Policy Holder Date of Birth: _____/_____/_____
Date of birth: _____/_____/_____	Employer:
SSN#:	
	Secondary Insurance:
Occupation	Policy Holder Name:
Employer:	☐ Self ☐ Spouse ☐ Other:
Employer Address:	Policy Holder Date of Birth: _____/_____/_____
City:	
State: Zip:	**Pharmacy Information**
	Pharmacy Name:
Check Preferred Method	Phone: Fax:
☐ Home Phone:	Address:
☐ Cell Phone:	City: State: Zip:
☐ Work Phone:	
Email:	**Emergency Contact (If other than spouse)**
	Name:
Primary Physician:	Relationship:
Phone:	Phone:
Referring Physician:	
Phone:	**Guarantor information: Complete if different from patient**
	Name:
☐ Male ☐ Female	Address:
☐ Single ☐ Married ☐ Widowed ☐ Divorced	City: State: Zip:
	Phone: DOB: _____/_____/_____
☐ American Indian/Alaska Native ☐ Asian	Employer:
☐ White ☐ Black/African American	Address:
☐ Native Hawaiian ☐ Hispanic Latino	Work Phone: Ext:
☐ Veteran ☐ Other	
Spouse Information (If applicable)	
Name:	
Home/Cell Phone:	
Work Phone:	

Patient Demographics

Marketing

Whom may we thank for sending you to our office?

☐ Doctor: _____ ☐ Insurance Provider

☐ Patient: _____ ☐ Hospital: _____

☐ Internet ☐ Phone Book: _____

☐ Newspaper/Magazine: _____ ☐ Other: _____

Medical Release to File Insurance Claim:

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature: _____ Date: _____

Medicare Patient's Only

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Urology Health Solutions, Inc. for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to be released to the health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (Please print): _____

Patient's Signature: _____ Date: _____

Provider: Urology Health Solutions, Inc.
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410 Celebration Place, Suite 203
Celebration, FL 34747
Phone: 407-566-1105

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Financial Policy & Consent

1. It is your responsibility to provide Urology Health Solutions with accurate demographic and insurance coverage information. Urology Health Solutions will be unable to accept your insurance if sufficient proof of insurance and/or identity cannot be verified. If Urology Health Solutions is unable to obtain accurate and complete information and therefore unable to bill your insurance company, Urology Health Solutions will bill you for payment in full.
2. Some insurance companies require a written referral or prior authorization before our physicians can see a patient. If this information is not obtained prior to the appointment Urology Health Solutions may need to delay or reschedule your appointment. It is the patient's responsibility to make sure our office has referrals and authorizations for every visit.
3. For your convenience, and at our discretion, Urology Health Solutions will submit a claim to your insurance company on your behalf. You agree to assign and authorize Urology Health Solutions to bill, collect and/or negotiate payment by the insurance plan on behalf of your insurance benefits in place at the time services are rendered.
4. Payments for "out of pocket" obligations (i.e. copayments, deductibles, coinsurances, and outstanding balances) must be paid prior to being seen. Urology Health Solutions accepts the following types of payment: cash, debit/credit card. Urology Health Solutions reserves the right to refuse your credit card.
5. **There are circumstances where the information provided to us by you, your insurance company, or other third parties causes us to collect less than the actual amount due from you at the time of your visit. In those situations, you will be notified of the additional amount due afterwards and are expected to submit payment immediately.**
6. If you are having a surgical procedure performed, applicable deductibles, co-pays, or coinsurance for these surgical procedures shall be collected prior to surgery. Estimates of the amounts will be provided, but the final amount due may be different (see item #2 above).
7. Your insurance plan may not cover all services and/or supplies provided to you during your treatment with Urology Health Solutions. In the event your health plan determines a service to be "non-covered", you will be responsible for total charges at time of visit or upon receipt of a statement from Urology Health Solutions (see item #5 above).
8. If your insurance plan denies or delays payment to Urology Health Solutions within a reasonable period according to the State of Florida Prompt Payment Rules, you will be responsible for payment in full. Should it be necessary to refer the account to a collection agency for collection, you will pay reasonable collection expenses including but not limited to attorney costs and fees and court costs and fees.
9. Procedures such as surgery often result in charges other than those from Urology Health Solutions. These include: surgery center or hospital fees, anesthesia, pathology, laboratory, radiologists, etc.
10. **A NO SHOW Fee of $50 will be charged for patients who DO NOT call our office to cancel and/or reschedule their appointments less than one (1) business day before their scheduled appointment, except for medical emergencies. (We do not accept emails or voicemails as a form of cancellation). A NO SHOW of $250 will be charged for in or out of office surgeries and procedures cancelled less than three (3) business days before the scheduled procedure, except for medical emergencies.**
11. There will be a $35 returned check fee (or the maximum allowed by law) assessed for insufficient funds when paying by check.
12. There will be a prepaid fee of $10 to $100 for completing individual medical forms, disability, work restriction, employer forms, school forms, etc., depending on the complexity of the form, and the amount of information requested. A minimum of 5 to 7 working days is required to process all form requests.

Your signature certifies that you have read the foregoing and accept its terms. It further acknowledges your acceptance of responsibility for charges related to your care.

_____ _____

Patient or Patient's Representative or Responsible Party Date

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Patient Consent to the Use and Disclosure of Health Information for Purposes of Treatment, Payment and Healthcare Operations

I consent to medical examination and treatment for myself or for the patient for whom I am the parent or legally authorized representative. (If a patient is a minor, the parent having legal custody, a legal guardian, or a person authorized by them in writing must sign. If a patient is incompetent, a legal guardian or conservator must sign.)

I consent to the use or disclosure of my protected health information by Urology Health Solutions for the purpose of diagnosing and/or providing treatment to me, a means of communication among the health professionals who contribute to my care, as a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals, obtaining payment for my health care bills, or to conduct health care operations for Urology Health Solutions. I understand that diagnosis and/or treatment of me by Urology Health Solutions may be conditional upon my consent, as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physicians, another health care provider, a health plan and my employer or health care clearinghouse. This protected health information relates to my past, present, and/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 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. Urology Health Solutions is not required to agree to the restrictions that I may request; however, if Urology Health Solutions agrees to a restriction that I request then the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Urology Health Solutions has taken action in reliance on this consent.

I understand I have the right to review Urology Health Solution's Notice of Privacy Practices, which has been made available to me, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information this will occur in my treatment, payment of my bills, and in the performance of health care operations of Urology Health Solutions. The Notice of Privacy Practices for Urology Health Solutions is also posted in the office. This Notice of Privacy Practices also describes my rights and Urology Health Solutions duties with respect to my protected health information.

Urology Health Solutions 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 asking for one at the time of my next appointment or visiting the office.

I authorize Urology Health Solutions to use an automated telephone system and/or email to use my name, address and phone number; the name of my scheduled treating physician; and the time of scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare-related communication. I also authorize Urology Health Solutions to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voicemail system or answering machine.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____ _____
Description of Personal Representative's Authority Date

I hereby authorize the release of my Protected Health Information to the following individuals (Please print):

_____
_____
_____

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CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to send an accurate, error free, and understandable electronic prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** – Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Medication history transactions** – Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimes; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

Consent

By signing this consent form, you are agreeing that your provider may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health care services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent Urology Health Solutions to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my sastisfaction.

_____ _____

Printed Name of Patient or Personal Representative Date

_____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority