Florida Urology Partners, LLP

Date of First Office Visit_____

Physician You Are Here to See _____

Prefix Last First Middle Suffix

Maiden Gender SSN Marital Status Date of Birth

Race Ethnicity Primary Language

Address Line 1

Address Line 2

United States

Zip City State Country

Home Phone Cell Phone Work Phone

Please circle preferred contact phone

Email

Who referred you?

Primary Care Physician Phone

Preferred Pharmacy City Phone Intersection

Preferred contact not living with you (must be filled out) Phone

May we leave test results on voice mail at above contact numbers?

Primary Insurance ID # Group #

Secondary Insurance ID # Group #

Other Health Insurance ID # Group #

Primary Policyholder (if not patient) Phone Number Relationship

Medical History

Name _____

Vitals _____

Medications, Dosage, and Frequency (i.e. Warfarin 4mg by mouth daily)

Allergies (reaction)

Reason for Visit

Are you currently experiencing the following symptoms?

Fevers	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No
Chills	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No	Disorientation	☐ Yes ☐ No
Blurred Vision	☐ Yes ☐ No	Constipation	☐ Yes ☐ No	Increased Thirst	☐ Yes ☐ No
Double Vision	☐ Yes ☐ No	Joint Pain	☐ Yes ☐ No	Increased Appetite	☐ Yes ☐ No
Sinus Infections	☐ Yes ☐ No	Back Pain	☐ Yes ☐ No	Seasonal Allergies	☐ Yes ☐ No
Ear Pain	☐ Yes ☐ No	Acne	☐ Yes ☐ No	Animal Allergies	☐ Yes ☐ No
Leg Swelling	☐ Yes ☐ No	Boils	☐ Yes ☐ No		

Past Medical History

Diabetes	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Low Thyroid	☐ Yes ☐ No	Recurrent UTIs	☐ Yes ☐ No
Elevated PSA	☐ Yes ☐ No	Enlarged Prostate	☐ Yes ☐ No	Prostate Cancer	☐ Yes ☐ No

Medical History

Other Medical Problems

Past Surgical History

Kidney Stone Surgery	☐ Yes	☐ No	Prostate Surgery	☐ Yes	☐ No	Kidney Surgery	☐ Yes	☐ No
Bladder Surgery	☐ Yes	☐ No	Penile Implant	☐ Yes	☐ No	Hysterectomy	☐ Yes	☐ No
Gall Bladder Removal	☐ Yes	☐ No	Appendix Removal	☐ Yes	☐ No	Joint Replacement	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Heart Stent	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No

Other Surgeries

Family History

Kidney Stones	☐ Yes	☐ No	Prostate Cancer	☐ Yes	☐ No	Kidney Cancer	☐ Yes	☐ No
Bladder Cancer	☐ Yes	☐ No	Bleeding Disorder	☐ Yes	☐ No			

Other Family History

Social History

Do you smoke?	☐ Yes	☐ No	In the past?	☐ Yes	☐ No	Years _____	Packs/Day _____
Illegal drugs?	☐ Yes	☐ No	In the past?	☐ Yes	☐ No	Type _____	

Alcoholic Drinks per Day _____

Occupation _____

Florida Urology Partners, LLP

Cancellation – Patient no shows create gaps in the physician schedules that could be otherwise used to accommodate patients with urgent problems. Therefore we require a 24 hour notice of cancellation for office visits and 72 hours notice of cancellations prior to hospital or office surgeries or procedures. If we are not notified we will charge $50 for a missed appointment and $150 for a missed surgery or office procedure.

Forms – The completion of forms in addition to the usual and customary insurance claim forms or prescription authorization forms represents an administrative service above and beyond the provision of medical care. The volume of these requests have increased tremendously resulting in the need for additional staff costs. There will be a $25 fee collected for each form presented for completion. This includes but is not limited to FMLA forms, private disability or cancer policy forms, school or work disability or limitation forms, or financial deferment forms.

Records Request – Patients are entitled to a copy of their own office visit encounters and they will be furnished upon request. However, if multiple copies are requested or if a comprehensive request for records including all associated reports and documents is requested we will charge $1 per page not to exceed $10.

Assignment of Benefits – I hereby authorize my insurance benefits to be paid directly to Florida Urology Partners, LLP. I understand that I am responsible for non-covered services and I authorize the release of medical information to my insurance company.

Co-pays – Co-pays and deductibles are due at the time of services. We will make every effort to make an accurate determination of patient responsibility based on your insurance plan and use of the online insurance verification service Availity.

Referrals – If you have a HMO requiring a referral or prior authorization from your Primary Care Physician please understand that this is the insurance plan you selected and you are responsible for obtaining the referral prior to the office visit. Failure to do so will result in inconvenience to you and the Physician and your appointment being rescheduled.

Lifetime Signature – I authorize the release of medical information to my insurance company to process claims. I authorize this to be used as a lifetime signature to avoid the inconvenience of having to sign individual insurance claim forms at every office visit.

_____

Signature of Patient

Florida Urology Partners, LLP

Notice of Privacy for Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office uses and discloses your protected health information for the following reasons:
To share with other treating health care providers regarding your health care.
To submit to insurance companies claims or other payers to verify that treatment has been rendered.
To verify patient's benefits in a health care insurance plan.
Release of information required by State or Federal Public Health Law.
To assist in overcoming a language barrier when caring for a patient.
Business associates providing written assurances that your privacy have been attained.
Situations deemed emergent or medically urgent by the Physician.
Abuse, neglect, or domestic violence in accordance with State and Federal Law.
Appointment reminders to household members or on answering machines.
Sign-in logs may be disclosed to verify office visits.
Occasional photographs and other letters and cards of appreciation from patients that are displayed.

Any other disclosures will only be made with your specific written prior authorization.

You have the right to:
Revoke authorization in writing at any time by specifying who you want restricted.
Speak to our privacy officer who can be reached at 813-256-0196.
Inspect copy and amend your protected health information as allowed by law.
To render a complaint to our privacy officer or to the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Name of Patient_____

Signature _____

Date _____

Florida Urology Partners, LLP

Authorization for Release of Medical Records:

Name_____ Date of Birth _____

Last 4 digits of social security number_____

I authorize and request Florida Urology Partners, LLP to receive copies of medical records from any physician's office, laboratory, and hospital that has any health information on me. The information that is being requested is needed as soon as possible in order to get the proper medical treatment I need at the time the services are rendered.

Specific records or results requested

Physician or facility from where the records are being requested

Please send the records to the following address or fax number (circle):

Rudolph Acosta, MD
12408 North 56th Street Unit 1
Tampa, FL 33617
Fax 813-980-3106

William Assad, MD
601 South Armenia Avenue
Tampa, FL 33609
Fax 813-XXX-XXXX

Chandler Dora, MD
2815 West Virginia Ave Suite A
Tampa, FL 33607
Fax 813-870-1428

Tod Fusia, MD
Mark Swierzewski, MD
2822 West Virginia Avenue
Tampa, FL 33607
Fax 813-871-6139

Howard Heidenberg, DO
Malcolm Root, MD
1209 West Swann Avenue
Tampa, FL 33606
Fax 813-253-2098

Mohamed Helal, MD
Raviender Bukkapatnam, MD
1 Davis Blvd. Suite 604
Tampa, FL 33606
Fax 813-258-3535

David Hochberg, MD
Timothy Weber, MD
2708 West St. Isabel Street
Tampa, FL 33607
Fax 813-879-2015

Frank Mastandrea, MD
4710 North Habana Avenue
Suite 400
Tampa, FL 33614
Fax 813-872-7356

Osvaldo Padron, MD
Alonso Alvarez, MD
5913 Webb Road
Tampa, FL 33615
Fax 813-875-0188

Patient Name Signature _____ Date

Reset Form