



A Unique Healthcare IT Company

CONFIDENTIAL

UROLOGY CONSULTANTS OF SOUTH PALM

REGISTRATION INFORMATION

PLEASE PRINT

- New Patient
Existing Patient

Existing Patient: Revise all information that has changed since your last visit

DATE / / EMAIL ADDRESS

HOME PHONE: () -

CELL PHONE: () -

PATIENT'S NAME: LAST FIRST MI

STREET ADDRESS:

CITY: STATE: ZIP:

SSN: SEX: M F BIRTH-DATE: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

Referring Physician :

Patient Employed By :

Business Address:

Occupation: Business Phone: () -

Name of Spouse/Responsible Party (If Patient is minor): LAST FIRST MI

Spouse/Responsible Party Employed by:

Business Address:

Occupation: Business Phone: () -

RESPONSIBLE PARTY/SPOUSE SSN :

DO YOU HAVE MEDICAL INSURANCE ? NO YES If Yes:

NAME OF PRI. INS. : ID #: GRP #:

*SUBSCRIBER'S NAME: *BIRTH DATE: / /

ADDRESS OF PRI. INS. :

NAME OF SEC. INS. : ID #: GRP #:

*SUBSCRIBER'S NAME: *BIRTH DATE: / /

ADDRESS OF SEC. INS. :

*Required by HIPAA

Payment is due at the time of service.

In case of emergency, who should be notified? Relationship

Person authorized to receive PIH Relationship

PHONE: () -

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, (NAME OF INSURED) hereby authorize (NAME OF INSURANCE COMPANY)

to pay and hereby assign directly to (PROVIDER'S NAME) all benefits, if any, otherwise payable to

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to (PROVIDER'S NAME)

will be credited to my account, in accordance with the above said assignment.

(AUTHORIZED SIGNATURE OF SUBSCRIBER)

(DATE)

**UROLOGY ASSOCIATES OF WEST BROWARD
UROLOGY CONSULTANTS OF SOUTH PALM**

**RONALD L. COHEN, M.D., F.A.C.S.
MARSHALL M. KAPLAN, M.D., F.A.C.S.**

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

**FULL PAYMENT IS DUE AT TIME OF SERVICE
We accept: CASH, CHECKS AND VISA/MASTERCARD**

Regarding Insurance:

We will need copies of your insurance cards. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to you. Please be aware some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If a patient has no insurance they are responsible for full payment at time of service.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Date

Signature of patient or responsible party

**UROLOGY ASSOCIATES OF WEST BROWARD
UROLOGY CONSULTANTS OF SOUTH PALM
MARSHALL M. KAPLAN, M.D., F.A.C.S.
RONALD L. COHEN, M.D., F.A.C.S.**

Consent For Use and Disclosure of Health Information

Section A: Patient Giving Consent _____ **Social Security** _____

Section B: To the Patient: Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sheila K. Gilberry
Address: 7710 NW 71 Court, #303, Tamarac, FL 33321 Phone: 954-726-6868 Fax: 954-726-8818
13590 S. Jog Road, #2, Delray Beach, FL 33446 Phone: 561-381-7773 Fax: 561-381-7774

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Confidential Communications Request

I hereby request that Urology Associates of West Broward/Urology Consultants of South Palm may also communicate my protected healthcare information to my spouse or designated family member. I understand that this request for confidential communications will apply to all future communications, unless I request a change in writing.

Date of Request _____ **Patient:** _____

Alternate Address (Northern) _____ **Phone:** _____

Can personal health information be left on your home answering machine: YES NO

Alternate Person or Spouse: _____ **Phone:** _____

Designated Family Member's Name _____ **Phone:** _____

Can personal health information be faxed to your number: YES NO Fax Number: _____

Can we E-Mail: YES NO E-Mail Address _____

Signature _____ **Date** _____

UROLOGY CONSULTANTS OF SOUTH PALM

Patient History Form

Today's date _____ Date of birth _____ Age _____

Name Last, First & Middle _____ Sex _____

Referred by Doctor _____ Referred by Friend _____

Family doctor and address _____

CHIEF COMPLAINT:

What is the main reason for your visit? _____

When did you notice the problem? _____

How long does the problem last? _____

Where is the problem located? _____

What makes it better or worse? _____

How severe is the problem on a 0 to 10 scale? (Least severe) 0 1 2 3 4 5 6 7 8 9 10 (Most severe)

Does it interfere with normal function? _____

Past Medical History and Social History: Please circle answers

Marital Status:	Single	Married	Divorced	Widow
Race:	Caucasian	African-American	Asian	Other _____
Education:	High School/GED	College	Graduate Degree	_____
Occupation:	_____	_____	Full-time	Part-time Retired
Use of tobacco:	YES NO	Former	If yes, how many packs per day/week	_____
Use of alcohol:	YES NO	Former	If yes, how many drinks per day/week	_____

Are you taking any blood thinners? e.g. aspirin, coumadin, plavix. YES NO
If yes, please list: _____

Do you need any special antibiotics for dental work or procedures? YES NO
If yes, why? Metal Heart Murmur Other _____

List any surgeries, past illnesses, radiation or chemotherapy and dates: e.g. heart attack, diabetes, appendectomy.....

Family History:

Father:	Alive	Deceased at age _____	Medical problems _____
Mother:	Alive	Deceased at age _____	Medical problems _____
Siblings/ Children		Medical problems _____	_____

OVER PLEASE

UROLOGY ASSOCIATES OF WEST BROWARD

UROLOGY CONSULTANTS OF SOUTH PALM

We will be filling your prescriptions electronically and will need the following information.

Date: _____ Patient Phone # _____

Patient: _____ DOB: _____

Allergies: _____

Local pharmacy

Name: _____

Address: _____

Phone number: _____

Publix pharmacy

Address: _____

Phone number: _____

Mail away drug plan

Name of drug plan: _____

Address of drug plan: _____

Phone number of drug plan: _____

ID#: _____

Subscriber: _____

(Over for copy of drug plan card)