Patient name:_____Account#:_____Staff Initials: _____ 11.5.19

Patient Registration Form

Patient Information

Last Name:_____ First Name:_____ MI:____ Suffix:_____

SS#_____ Sex: ☐ Male ☐ Female Date of Birth: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated Language:_____

Race: ☐ Caucasian/ White ☐ Black/African American ☐ Asian Native American ☐ Other:_____

Ethnicity: ❑ Hispanic ❑ Latino ❑ Spaniard ❑ Mexican ❑ Central American ❑ South American ❑ Latin American ❑ Puerto Rican ❑ Cuban Dominican ❑ Not Hispanic/ Latino ❑ Prefer not to answer

Patient Mailing Address:_____ City:_____ St:_____ Zip:_____

Physical/Alternate Address:_____ City:_____ _____St:_____ Zip:_____

Email: _____ Phone #: _____ Work #: _____ Cell #:_____

Referring Physician:_____ Phone #:_____

Family Physician:_____ Phone #: _____

Pharmacy: _____ Location:_____ Phone #: _____

Emergency Contact:_____ Relationship: _____ Emergency Phone:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student (Full Time) ☐ Student (Part Time)

Employer/School: _____ May we contact you at work: ☐ YES ☐ NO

Spouse/Guarantor/Parent Information

Last Name:_____First Name:_____ MI:_____ Relationship:_____

Date of Birth:_____ Employer:_____ Work Phone #: _____

Insurance Information

Primary Insurance:_____ Policy Holder Name:_____

Policy Holder is: ☐Self ☐Spouse ☐Parent ☐Other: _____ Policy Holder Date of Birth_____

Policy #:_____ Group #:_____

Secondary Insurance:_____ Policy Holder Name:_____

Policy Holder is: ☐Self ☐Spouse ☐Parent ☐Other: _____ Date of Birth _____

Policy #:_____ Group #:_____

Authorization for release of information and to pay insurance benefits: Atlantic Urology Clinics, LLC is hereby authorized to release information to healthcare providers that have referred me to this physician or who may benefit from this information in the future. I authorize release of medical information to my insurance carrier, their utilization management agency, my employer, or any other agency that may be assisting in payment for my care. In the event of hopitalization, I hereby assign payment to Atlantic Urology Clinics, LLC for surgical and/or medical benefits otherwise payable to me.

_____ _____

Signature/Patient/Parent/Guardian Date AUC Staff Signature Date

Patient name:_____Account#:_____Staff Initials: _____ 10.14.19

ATLANTIC UROLOGY CLINICS LLC

Select any of the following medical conditions that you currently have:

Past Medical History: Select any of the following medical conditions you currently have:

- ❑ None
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation (Irregular Heartbeat)
- ❑ Bone Marrow Transplantation
- ❑ BPH/Enlarged Prostate
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD/Reflux
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV / AIDS
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke

❑ Other_____

_____

_____

_____

_____

_____

_____

Past Surgeries: Have you had any surgeries on the following organs?

- ❑ None
- ❑ Appendix (Appendectomy)
- ❑ Bladder Removal (Cystectomy)
- ❑ Breast : Breast Biopsy
- ❑ Breast : Lumpectomy (Left Breast)
- ❑ Breast : Lumpectomy (Right Breast)
- ❑ Breast : Mastectomy (Both Breasts)
- ❑ Breast : Mastectomy (Left Breast)
- ❑ Breast : Mastectomy (Right Breast)
- ❑ Colon (Colectomy) : Colon Cancer Resection
- ❑ Colon (Colectomy) : Diverticulitis
- ❑ Colon (Colectomy) : Inflammatory Bowel Disease
- ❑ Colon: Colostomy
- ❑ Gallbladder (Cholecystectomy)
- ❑ Heart : Biological Valve Replacement
- ❑ Heart : Coronary Artery Bypass Surgery
- ❑ Heart : Heart Transplant
- ❑ Heart : Mechanical Valve Replacement
- ❑ Heart : Stents
- ❑ Hernia
- ❑ Joint Replacement : Hip (Both)
- ❑ Joint Replacement : Hip (Left)
- ❑ Joint Replacement : Hip (Right)
- ❑ Joint Replacement : Knee (Left)
- ❑ Joint Replacement : Knee (Right)
- ❑ Kidney : Kidney Biopsy
- ❑ Kidney : Kidney Stone Removal
- ❑ Kidney : Kidney Transplant
- ❑ Kidney : Nephrectomy
- ❑ Kidney : Partial Nephrectomy
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries (Oophorectomy) : Endometriosis
- ❑ Ovaries (Oophorectomy) : Ovarian Cancer
- ❑ Ovaries (Oophorectomy) : Ovarian Cyst
- ❑ Ovaries: Tubal Ligation

Patient name:_____Account#:_____Staff Initials: _____ 10.14.19

ATLANTIC UROLOGY CLINICS LLC

Select any of the following medical conditions that you currently have: Past Surgeries:

Past Surgeries cont.'d

- ❑ Pancreas: Laser PVP
- ❑ Pancreas: Pancreatectomy
- ❑ Prostate : Prostate Biopsy
- ❑ Prostate : Prostatectomy
- ❑ Prostate : TURP
- ❑ Rectum: Abdominoperineal Resection
- ❑ Rectum: Low Anterior Resection
- ❑ Skin : Basal Cell Carcinoma
- ❑ Skin : Melanoma
- ❑ Skin : Skin Biopsy
- ❑ Skin : Squamous Cell Carcinoma
- ❑ Spleen (Splenectomy)
- ❑ Testicles (Orchiectomy)
- ❑ Uterus (Hysterectomy) : Fibroids
- ❑ Uterus (Hysterectomy) : Uterine Cancer
- ❑ Uterus (Hysterectomy): Cervical Cancer
- ❑ Other_____

_____

_____

_____

_____

_____

Gynecologic History

- ❑ Last Menstrual Period
- ❑ Last Pelvic Exam
- ❑ Last Mammogram
- ❑ Last Pap Smear

Pediatric Patients Only:

- ❑ Gestational Age at Birth (in weeks)
- ❑ Birth Weight _____ lbs ___oz
- ❑ Maternal illness during pregnancy
- ❑ Forceps delivery
- ❑ Past Urological History
- ❑ None

Past Urological History:

- ❑ Prostate Nodule
- ❑ Cancer (Bladder)
- ❑ Cancer (Kidney)
- ❑ Cancer (Penile)
- ❑ Cancer (Prostate)
- ❑ Cancer (Testicular)
- ❑ Cystinuria
- ❑ Elevated PSA
- ❑ Hematuria
- ❑ Hereditary Leiomyomatous Renal Cell Carcinoma
- ❑ Hydronephrosis
- ❑ Infertility
- ❑ Neurogenic Bladder
- ❑ Polycystic kidney disease
- ❑ Priapism
- ❑ Prostatitis
- ❑ Renal Insufficiency
- ❑ Renal Tubular Acidosis
- ❑ Sexual dysfunction
- ❑ Sexually transmitted disease
- ❑ Genitourinary trauma
- ❑ Tuberculosis
- ❑ Tuberous Sclerosis
- ❑ Undescended testis
- ❑ Urethral stricture
- ❑ Urinary incontinence
- ❑ Urinary retention
- ❑ Urinary tract infection
- ❑ Urolithiasis
- ❑ Vesicoureteral Reflux (VUR)
- ❑ Benign Prostatic Hyperplasia (BPH)
- ❑ Hematuria (gross)
- ❑ Hematuria (microscopic)
- ❑ Renal cyst(s)

- ❑ Other_____

_____

_____

_____

_____

Patient name:_____Account#:_____Staff Initials: _____ 11.12.19

ATLANTIC UROLOGY CLINICS LLC

Select any of the following medical conditions that you currently have:

Urological Surgical History

- ❑ None
- ❑ Burch Colposuspension
- ❑ Cryoablation
- ❑ Cystectomy
- ❑ Extracorporeal Shock Wave Lithotripsy
- ❑ Hysterectomy
- ❑ Insertion of artificial urinary sphincter
- ❑ Insertion of penile prosthesis
- ❑ Marshall-Marchetti-Krantz urethropexy
- ❑ Midurethral sling
- ❑ Nephrectomy
- ❑ Orchiectomy
- ❑ Orchiopexy
- ❑ Percutaneous Nephrostolithotripsy
- ❑ Partial Nephrectomy
- ❑ Pelvic Irradiation
- ❑ Penile reconstruction
- ❑ Prostate biopsy
- ❑ Prostate nodule
- ❑ Prostate radiation therapy
- ❑ Prostatectomy
- ❑ Pubovaginal Sling
- ❑ Renal ablation
- ❑ Rezum
- ❑ Transobturator Tape
- ❑ Transurethral Resection of Bladder Tumor
- ❑ Transurethral Resection of Prostate
- ❑ Transvaginal Tape
- ❑ Ureteral stent placement
- ❑ Ureteroscopy
- ❑ Urethroplasty
- ❑ Urolift
- ❑ Other_____

_____

_____

_____

Family History

- ❑ None
- ❑ Cancer Bladder
- ❑ Cancer Kidney
- ❑ Cancer Prostate
- ❑ Cancer Testicular
- ❑ Cystinuria
- ❑ Hereditary Leiomyomatous Renal Cell Carcinoma
- ❑ Polycystic Kidney Disease
- ❑ Renal Insufficiency
- ❑ Renal Tubular Acidosis
- ❑ Kidney Stones (Urolithiasis)
- ❑ Other_____

_____

_____

_____

Current MEDICATIONS: **List ALL MEDS you're currently taking INCLUDING over the counter** (Attach if necessary)

Drug Name:	Strength:	Directions/How you take it:

Pharmacy Name: _____ **Phone:** _____

Allergies- List ALL types (drug, seasonal, pets, environmental foods):_____

_____

_____

Patient name:_____Account#:_____Staff Initials: _____ 10.14.19

ATLANTIC UROLOGY CLINICS LLC

Smoking Status (QM402, QM226)

Last Screened Date: _____

Start Smoking:_____

Quit Smoking: _____

Number of packs per day: _____

Total years smoking: _____

Additional Details :_____

Social History Details

❑ None
❑ Not sexually active
❑ Sexually active with one partner
❑ Sexually active with more than one partner
❑ Same sex partner
❑ Drug use
❑ IV Drug Use (QM387)
❑ IV Drug Use Within Past 12 Months (QM387)
❑ Alcohol none
❑ Alcohol less than 1 drink per day
❑ Alcohol 1-2 drinks per day
❑ Alcohol 3 or more drinks per day
❑ Patient feels safe at home
❑ Patient feels unsafe at home
❑ Other

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? (QM431):_____

Driving Status

❑ Drive Daytime ❑ Drive Night

How often do you exercise? _____

What is your caffeine use? _____

Occupation and Workplace _____

Place of Residence _____

Vaccination Status (QM111)

For patients 65 and older: Have you received a pneumonia vaccination? Yes ❑ No ❑

Advance Care (QM47)

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes ❑ No ❑

Name: _____
Do you have a living will? Yes ❑ No ❑

Which statement(s) best reflects your wishes on advanced care recommendations?

❑Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

❑ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.

❑ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Do you have any implantable devices?Yes ❑ No ❑

If yes, please list it here:_____

_____

Family history of cancer (situation)

❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son ❑ Uncle
❑ Aunt ❑ Nephew ❑ Niece ❑ Grandmother ❑ Grandfather ❑ Grandson ❑ Granddaughter

Family history of diabetes mellitus type 2

❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son ❑ Uncle
❑ Aunt ❑ Nephew ❑ Niece ❑ Grandmother ❑ Grandfather ❑ Grandson ❑ Granddaughter

Other family histories: _____

_____

_____

_____

Patient name:_____Account#:_____Staff Initials: _____ 10.14.19

ATLANTIC UROLOGY CLINICS LLC

Medical Information Form

REVIEW OF SYSTEMS:

Genitourinary (G.U.)
Bedwetting
Blood in Urine
Dribbling
Burning with Urination
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Nocturia
Nocturnal Enuresis
Not Emptying
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine Retention
Weak Stream

Constitutional/Symptom
Fever or chills
Fatigue
Generalized Weakness
Insomnia
night sweats
Sleep Apnea

Eyes
Blurry vision
Glaucoma
Worsening Eyesight

Allergic/Immunologic
Drug Allergies
Environmental Allergies

Neurological
Balance Problems
Dizzy Spells
headaches
Leg or Arm Weakness
Memory Loss
Stroke

Endocrine
Diabetes
Excessive Thirst
Thyroid Disease
Tired/Sluggish

Gastrointestinal (G.I.)
Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Diarrhea
Nausea/Vomiting
Rectal Bleeding
Tarry Stool

Cardiovascular
Chest Pain/Angina
Edema
Heart Attack
Heart Failure
High Blood Pressure
Irregular Heart Beat
Swelling

Musculoskeletal
Arthritis
Back Pain
Gout
Joint Pain
Muscle weakness

ENT/Mouth
Sinus Problem
Sore throat

Respiratory
Frequent Cough
Shortness of breath

Hematologic/Lymphatic
Blood Clotting Problem
Bleeding Problem
Hepatitis
HIV (AIDS)

Psychiatric
Anxiety
Depression

Other:

_____

_____

_____

_____

_____

_____

_____

_____

ATLANTIC UROLOGY CLINICS LLC

Patient Permission To Communicate Information With Designated Individual

Our physicians and staff know that communicating with you about your healthcare is important. By completing this form, you give us permission to provide messages, and/or discuss information about your healthcare with the individuals designated below. I understand that I may cancel or update this information at any time by notifying a representative of the physician office.

1. **I give permission** to allow physicians and staff to discuss relevant medical, billing, and insurance information with the individuals listed below (examples, spouse, relatives, friend, etc.). I understand that my healthcare provider will use professional judgment to determine what information about my healthcare may be discussed with the designated individuals below*:

Involved Individual	Relationship to Patient	Phone Number

_____Date:_____Time:_____
Patient/Authorized Representative Signature**

Printed Name of Authorized Representative: _____

Relationship to Patient:_____

***If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.*

**Atlantic Urology Clinics expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment or healthcare operations.*

AUC Patient Policies Acknowledgment

I understand and acknowledge that all forms are available to me in my preferred format, upon request.

_____Initials

I hereby acknowledge the following statements: Atlantic Urology Clinics will submit claims to your primary carrier on your behalf. We will file a single claim to your secondary insurance as a courtesy. The insurance contract is between the patient and their insurance carrier. After 70 days of non-payment from the secondary carrier the balance will become the patient's responsibility. Eligibility is verified prior to your visit. Deductibles, co-pay and coinsurance are due at the time services are rendered.

Assignment of Benefits

_____Initials I hereby authorize payment of benefits be made directly to Atlantic Urology Clinics. I understand some services may not be covered by my insurance. Therefore, I will be responsible for payment of any non-covered services as well as any balance not covered by my insurance.

_____Initials I understand that if my account is turned over to a collection agency a 30% fee will be charged to my account.

_____Initials A copy of AUC's **Financial Policy** has been provided to me.

_____Initials A copy of the **Notice of Privacy Practices** has been provided to me

_____Initials If I came in for healthcare services in an emergency treatment situation, I was given the **Notice of Privacy Practices** as soon as reasonably practical after the emergency treatment situation.

_____Initials A copy of the **Telephone Consumer Protection Act [TCPA]** form is provided to me. I expressly consent for AUC and its contracted agents (collectively, "Practice") to contact me through the use of any dialing equipment at any telephone number associated with my account.

_____Initials A copy of the **Appointment Policy** form is provided to me. I understand that a late arrival to my appointment (15 mins or more) may result in a rescheduled appointment

_____Initials A copy of the **Patient Protection & Affordable Care Act of 2010 Patient Disclosure for Diagnostic PET/CT Services.** I am aware that I have the freedom to choose the supplier for my diagnostic services.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

Printed Name:_____

Signature: _____ Date: _____

Telephone Consumer Protection Act [TCPA]

Active communication with our patients is a key element in providing high quality health care services. To that end, GenesisCare desires to communicate timely information regarding health care services and functions to you in the most effective means possible, including via automated telephone and text messaging. Federal law requires that we obtain your consent prior to communicating with you via these means. Please read and sign below so that we can communicate with you for these important purposes. We apologize for the formality of this consent, but it is required under law.

I, [insert patient name], authorize the use of my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I consent to receiving multiple messages per day from my healthcare provider, when necessary, and I consent to allowing messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

I also authorize any of [insert practice name] independent contractors agents and/or affiliates (“collectively, “Practice”) to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice or other messaging system, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods even if I am charged for the call, as well as through any email address or other personal contact information supplied by me. I expressly consent to receive any such automated calls. I understand that, depending on my plan, charges may apply to certain calls or text messages.

Appointment Policy

Atlantic Urology Physicians and staff are dedicated to providing the highest quality healthcare in a professional and timely manner. In order to provide this level of care it is important that our patients are informed of our office policies regarding appointments and assignment of benefits.

APPOINTMENT POLICY

- Patients should make financial arrangements prior to the appointment to pay co-pays, deductibles and any out of pocket expenses.
- Payment is due prior to services being rendered for deductible, co-pay and out of pocket expenses.
- Patients should arrive at least 15 minutes prior to their scheduled appointment.
- Our physicians are on call at the local emergency rooms. Your Physician may be delayed for a medical emergency. The office staff will give the patient the option to reschedule their appointment or wait for the Physician to return to the office.
- Minors must be accompanied by a parent or legal guardian.

Compliance with these policies will help assure that all patients are seen in a timely fashion.

Patient Protection & Affordable Care Act of 2010 Patient Disclosure for Diagnostic PET/CT Services (Horry, Georgetown & Marion County, South Carolina Market)

Dear Patient,

If your physician determines that a referral for diagnostic PET/CT services is appropriate as a part or your medical evaluation and treatment; we may have these services available at one of our locations. We will provide you information about those options.

You, however, have the freedom to choose the supplier for this service. To the best of our knowledge, the following providers furnish these services in the area where you reside:

Georgetown County:

Tidelands Health
4070 Highway 17, Murrells Inlet, SC 29576
606 Black River Rd., Georgetown, SC 29440

Lowcountry Medical Associates
180 Wingo Way Ste 105, Mount Pleasant, SC 29464

Horry County:

Palmetto Imaging Inc.
900 21st Ave N, Myrtle Beach, SC 29577

Inmed Diagnostic Services of South Carolina
4701 Oleander Drive, Myrtle Beach, SC 29577

McLeod Seacoast Hospital
4000 Hwy 9 E Little River, SC 29566

Grand Strand Regional Medical Center
809 82od Parkway, Myrtle Beach, SC 29572

Marion County:

MUSC of South Carolina
2829 Hwy. 76 E., Mullins, SC 29574