Patient name:_____Account#:_____Staff Initials: _____ 8/2024

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: AUC Urologists, 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 AUC Urologists, LLC for surgical and/or medical benefits otherwise payable to me.

_____ _____

Signature Patient/Parent/Guardian Date Signature Atlantic Urology Specialists Staff Date

Patient name:_____Account#:_____Staff Initials: _____ 8/2024

Atlantic UROLOGY SPECIALISTS

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: _____ 8/2024

Atlantic UROLOGY SPECIALISTS

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: _____ 8/2024

Atlantic UROLOGY SPECIALISTS

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: _____ 8/2024

Atlantic UROLOGY SPECIALISTS

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: _____ 8/2024

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:

_____

_____

_____

_____

_____

_____

_____

_____

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.*

**AUC Urologists 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.*

Atlantic Urology Specialists 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: AUC Urologists, LLC 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 AUC Urologists, LLC. 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 Urologists's **Financial Policy is posted in the office and will be** provided to me upon request.

_____Initials A copy of the **Notice of Privacy Practices,** dated August 2024**,** 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 Urologists's 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: _____

AUC UROLOGISTS LLC

Georgetown County, South Carolina Market

Horry County, South Carolina Market

Patient Protection and Affordable Care Act of 2010

Patient Disclosure for Diagnostic CT Services

Dear Patient,

If your physician determines that a referral for diagnostic 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 with 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

Name: Tidelands Health

Address: 4070 Highway, Murrells Inlet, SC 29576

Address: 606 Black River Rd., Georgetown, SC 29440

Name: Lowcountry Medical Associates

Address: 180 Wingo Way Ste 105, Mount Pleasant, SC 29464

Horry County:

Name: Palmetto Imaging Inc.

Address: 900 21st Ave N, Myrtle Beach, SC 29577

Name: Inmed Diagnostic Services of South Carolina

Address: 4701 Oleander Drive, Myrtle Beach, SC 29577

Name: McLeod Seacoast Hospital

Address: 4000 Hwy 9 E Little River, SC 29566

Name: Grand Strand Regional Medical Center

Address: 809 82nd Parkway, Myrtle Beach, SC 29572

_____ _____

Patient Signature **Date**

Revision Date 8/2024

AUC UROLOGISTS LLC

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

All sections of this authorization form MUST be completed to be considered valid

Patient Name: _____ Date of Birth: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____

I request that my protected health information (PHI) from AUC Urologists, LLC be disclosed to:
Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

I request the following PHI to be released from my medical record(s):
Name of Physician: _____
Specific Treatment Dates: _____ to _____
☐ Consultation Reports ☐ Diagnostic Films ☐ Dosimetry Records ☐ Laboratory Results
☐ Physician Notes ☐ Portal Films/Simulation Films ☐ Progress Notes ☐ Radiology or Imaging Reports
☐ Surgery/Pathology ☐ Complete Medical Record ☐ Billing Records ☐ Genetic Records
☐ Other (please specify): _____

Purpose for requesting information:
☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

Disclosure Format: ☐ US Mail – paper format ☐ Fax (*healthcare provider only*) ☐ Secure E-mail
☐ CD/Flash drive – secure format or ☐ Other *(please specify):* _____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- The information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. I authorize the release of these records.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the _____ at the following address: _____. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire *one year* from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient/Authorized Representative
Signature* _____ **Date** _____ **Time** _____

Printed Name of Authorized Representative: _____

Relationship to Patient: _____
*If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.

Driver's License or Photo ID (*required when records are picked up*)
Driver's License State: _____ Number: _____
Witness Signature _____ **Date** _____ **Time** _____

INSTRUCTIONS FOR COMPLETING THE PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. Complete the first section with patient name, date of birth, address, e-mail address and day time telephone number.

2. **I request my records to be sent to:** Complete the name of the individual/company where you would like us to send the copies to. If the copies are for you, state "Self" in the name field. Also, complete the contact information including phone, address and fax number if the copies are to be sent to another health care provider. If the records are going to be picked up, the name of the individual picking up the records should be listed.

3. **I request the following Protected Health Information (PHI) to be released from my medical record(s):** Mark the documents that you are requesting. Test results when marked individually are generally for specific dates of service as indicated in the next section.

4. **Specific treatment dates:** If you do not remember the specific dates please indicate at least a time frame such as last month, last six months, etc.

5. **Purpose for requesting information**: Please mark if the records are for continuing care, personal, insurance, legal, or other.

6. **How information is to be received (if not marked, mail is the default):** Paper records or CDs will be mailed to the address provided. Records can be sent via secure e-mail if requested. Records will be faxed only to another health care provider. Records can be picked up between the hours of _____ Monday through Friday at _____. Please call _____ at _____ in advance of picking up records. When picking up records in person, a photo ID will be required as well as a copy of any legal papers (power of attorney, executor of estate, proof of custody, etc.).

7. **Patient/Authorized Representative Signature:** This form should be signed by the patient. If the patient is unable to sign and the request is being made by an authorized representative of the patient (parent of a minor, person named on Power of Attorney, executor of estate etc.) sign and date the form. Please provide printed name and relationship to the patient. Supporting legal documentation must accompany this authorization form when signed by an authorized representative.

8. **Driver's License or Photo ID:** This will be required when picking up records at either of our locations as listed above.

9. **Witness Signature:** A witness must sign and date the form in the event that the patient can only make an X or is unable to sign.

Please call _____ at _____ if you have any further questions.