



Dr. Bruce Armstrong
Dr. Ricky Bare, F.A.C.S.
Dr. J.G. Cargill III
Dr. James Brien
Dr. Michael Burris

PATIENT INFORMATION SHEET

DATE: _____

PATIENT NAME: _____
FIRST MI LAST

SOCIAL SECURITY NUMBER: _____ - _____ - _____ SEX: ☐ MALE ☐ FEMALE

ADDRESS: _____
STREET

_____ CITY STATE ZIP

DATE OF BIRTH: ____ / ____ / ____ AGE: _____

MARITAL STATUS (CHECK ONE): ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐ DOMESTIC PARTNER

RACE: _____ ETHNICITY: ☐ HISPANIC/LATINO ☐ NON-HISPANIC

HOME PHONE#: (____) _____ CELL PHONE#: (____) _____

EMPLOYMENT STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ UNEMPLOYED ☐ RETIRED ☐ STUDENT

EMPLOYER: _____ WORK PHONE: (____) _____

EMAIL ADDRESS: _____ PATIENT PORTAL: ☐ YES ☐ NO

FAMILY PHYSICIAN: _____ PHONE#: (____) _____

WHO REFERRED YOU TO US? REFERRING PHYSICIAN: _____

☐ ADVERTISEMENT ☐ FAMILY MEMBER/FRIEND ☐ HEALTH FAIR ☐ HOSPITAL ☐ INTERNET

☐ INSURANCE REFERRAL ☐ YELLOW PAGES ☐ OTHER: _____

EMERGENCY CONTACT: _____ PHONE#: (____) _____

IF PATIENT IS A MINOR, PLEASE PROVIDE NAME OF PARENT(S) OR LEGAL GUARDIANS: _____

RELATIONSHIP TO PATIENT: _____ PHONE#: (____) _____

A Division of RTA of WNC

Address: 1 Doctors Park – Asheville, NC 28801 Phone: (828) 253-5314 Fax: (828) 253-0434 Web: www.ashevilleurological.com



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AUA Admin.
MRN # _____

Patient Questionnaire

Date: ____/____/____ Patient Name: _____ Date of Birth: ____/____/____ Age: ____

1. What is the main reason you are seeing the doctor today? _____

2. Was this consultation requested by a Physician? ☐ Yes ☐ No

If so, by whom? _____

3. Have you seen a Urologist before? ☐ Yes ☐ No

If so, which Urologist have you seen? _____

4. What pharmacy do you prefer to use? Name _____

Address _____ Phone _____

5. Please list any medications that you are ALLERGIC to: ☐ **No Known Drug Allergies**

6. List the Names (and Dose, if known) of any prescription or over the counter medications you take

If you have a medication list, please give it to the medical staff

☐ **No Medications**

Medications	Strength	Times taken per day

7. Do you take any of the following blood thinners? (Check those that apply)

☐ **No Blood Thinners**

☐ Aspirin

☐ Coumadin/Warfarin

☐ NSAIDS

☐ Plavix

☐ Xarelto

☐ Pradaxa

☐ Other _____

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Patient Questionnaire Continued

AUA Admin.
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8. Please list all operations you have ever had (if known, list the date).

☐ **No Operations**

9. Please list ALL medical problems (check all that apply)

☐ **No Medical Problems**

- ☐ Blood Pressure – High or Low (circle one) ☐ High Cholesterol ☐ Diabetes – Type I or Type II (circle one)
☐ Thyroid - High or Low (circle one) ☐ COPD ☐ Heart Disease

Please list any additional medical problems

10. Do you leak urine? ☐ **Yes** ☐ **No**

11. Do you have a family history of any of the following? Place a ☒ in all boxes that apply.

	Father	Mother	Brother	Sister	Children
Bladder Cancer					
Kidney Stones					
Prostate Cancer					
Colon Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Kidney Cancer					
Kidney Dialysis					
Lung Cancer					

☐ **Family History Unknown**

12. What is your occupation? _____

13. Do you smoke? ☐ Current Every day Smoker ☐ Current Some Day Smoker ☐ Former Smoker

☐ Never Smoked Packs smoked per day _____

Smoking Duration: ☐ 1-5 years ☐ 6-10 years ☐ 11-20 years ☐ over 20 years

Smokeless Tobacco ☐ Yes ☐ No

14. How many caffeinated drinks do you have each day? _____

15. Do you drink alcohol? ☐ Yes ☐ No ☐ Former How much? _____

16. How much do you weigh? _____ How tall are you? _____ ft _____ inches

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Patient Questionnaire Continued

AUA Admin.
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17. Have you ever had a serious problem or been treated for any of the following?

(Please check *Yes* or *No* for each symptom)

Constitutional Symptoms

	Yes	No
Change in appetite		
Weight Change		
Chills		
Fever		

Eyes

Glaucoma		
Cataracts		

ENT

Nose Bleed		
Difficulty Swallowing		
Hoarseness		
Hearing Loss		

Respiratory

Shortness of Breath		
Cough		
Coughing up Blood		

Cardiac

Chest Pain		
Heart Attack		
Palpitations		
High Blood Pressure		

GI

Abdominal Pain		
Nausea		
Vomiting		
Diarrhea		
Constipation		

Musculoskeletal

Arthritis		
Joint Pain		
Joint Replacement		
Back Pain		

Neurological

	Yes	No
Dizziness		
Seizure		
Headache		
Loss of Consciousness		

Skin

Rashes		
Non-Healing Lesions		

Psychiatric

Nervousness		
Mood Changes		
Depression		

Endocrine

Thyroid Trouble		
Diabetes		

Hematology

Anemia		
Easy Bruising		
Swollen Glands		

Genito-Urinary

Kidney Disease		
Kidney Stones		
Bladder Trouble		
Blood in Urine		
Urinary Infection		
Prostate Gland		
Urinary Incontinence		
Urinary Frequency		

WHAT IS YOUR Enlarged Prostate (EP) Symptom Score?

Use this scorecard of symptoms. Circle one number in each line. Add the 7 circled numbers to get a total score, then talk to your doctor.

Over the past month, how often have you...	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
stopped and started again several times when you urinated?	0	1	2	3	4	5
found it difficult to postpone urination?	0	1	2	3	4	5
had a weak urinary stream?	0	1	2	3	4	5
had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 or more times
Over the past month, how many times did you typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Your score:

Symptom Score: ☐ 1-7 Mild ☐ 8-19 Moderate ☐ 20-35 Severe

Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Medical Record Number
Address (Street, City, State, ZIP Code)		Telephone Number

I request that my health information or medical billing record be disclosed or restricted, as follows:

I authorize the names listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

Authorized Name	Relationship to Patient
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***DO NOT** discuss or provide information to the following individuals or entities:

Restricted Name/Entity	Relationship to Patient
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*I request the use of **ONLY** the following address and/or phone number(s) to contact me regarding my health or billing information:

Patient Rights: Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	Date
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If Signed by Legal Representative, Relationship to Patient

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THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY

DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:

*Granted _____ Denied _____

*If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s).

Reason(s) for Denial, if Applicable _____

Physician Office Representative:

Date:



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FINANCIAL POLICY

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, your insurance coverage, and your financial responsibilities.

Professional Fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's education/training, and support costs associated with providing and coordinating your care. We will be happy to provide you with detailed fee information at any time.

Patient Payments: Co-pays, deductibles, services not covered by your insurance plan, and outstanding balances are due at the time of your appointment. Payments may be made with cash, check or credit card. Returned checks will be subject to the fee allowed by state regulations. Please let us know if you are having a particular financial problem and we will try our best to be understanding. Please feel free to discuss mutually acceptable payment arrangements with our in house Financial Coordinator or our Central Billing Office.

Insurance Payments: We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays. If your insurance company has not responded to us within 60 days of a filed insurance claim, the charges will be sent to you directly and you will be responsible for their payment as well as for payment of any other charges incurred consistent with this financial policy.

Restricted Service: While we always see patients for emergency care, routine care will only be given to the patients whose accounts are current or who have made financial arrangements with us and are maintaining the conditions thereof.

Medical Forms: The completion of disability forms, FMLA forms, and other supplemental insurance forms all require physician and staff time to complete. Accordingly, a fee of \$25.00 will be charged to complete these forms. The fee must be paid by cash or check prior to the completion of the forms.

Nurse Visit: Please note that if a patient comes in with an appointment or has a walk in appointment on the clinical staff schedule, charges will be filed with your insurance for services provided during your visit. As a result of charges being filed with your insurance, it is possible that your insurance may apply a co-payment or coinsurance for the visit.

Acknowledged, agreed, and accepted:

AUA Admin.
MRN # _____

Patient Name (Please Print)

Patient Date of Birth

Patient Signature or Authorized Person

Date

Witness

Relationship to Patient

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**Radiation Therapy Associates of Western North Carolina, PA
Asheville Urological Associates**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge: A copy of the Notice of Privacy Practices was given to me.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

Signature of Patient or Representative

Date

Print Name

Patient Date of Birth

FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgment was not obtained:

- ☐ Patient/family member received notice but refused to sign acknowledgment
- ☐ Emergency treatment situation
- ☐ Patient was incapacitated and no family member was present
- ☐ Unable to communicate due to language barriers
- ☐ Other (please describe below)

Signature of Employee

Date

**Assignment of Benefits/Right to Payment, Patient Responsibility
and Release of Information Form**

AUA Admin.
MRN # _____

**Radiation Therapy Associates of Western North Carolina, PA
Asheville Urological Associates
PO BOX 60914 CHARLOTTE, NC 28260-0914**

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

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.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature of Patient/Person Legally Responsible

Date: _____

Print Name of Patient/Person Legally Responsible

Relationship to Patient
(If signed by Person Legally Responsible)

Patient Date of Birth