Dr. Ricky Bare, F.A.C.S.
Dr J.G. Cargill III
Dr. James Brien
Dr. Michael Burris
Dr. H. Brooks Hooper
Dr. Andrew Franklin
Kimberly Bullock, FNP
C. Sydney Pilgrim, PA-C

PATIENT INFORMATION SHEET

DATE: _____

PATIENT NAME: _____
FIRST *MI* *LAST*

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

MAILING 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#: (_____) _____

DO YOU LIVE IN A SKILLED NURSING FACILITY? ☐ YES ☐ NO NAME OF FACILITY: _____

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

EMPLOYER: _____ WORK PHONE: (_____) _____

EMAIL ADDRESS: _____ PATIENT PORTAL: ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN: _____ PHONE#: (_____) _____

WHO REFERRED YOU TO US? REFERRING PHYSICIAN: _____

☐ *ADVERTISMENT* ☐ *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#: (_____) _____

WE ARE DEDICATED TO PROVIDING THE BEST CARE POSSIBLE TO OUR PATIENTS. WE CAN BETTER ACCOMPLISH THIS GOAL BY OBTAINING YOUR OPINION ON HOW WE ARE DOING. MAY WE CONTACT YOU BY MAIL, E-MAIL, TEXT, OR TELEPHONE FOR OUR SURVEY? ☐ YES ☐ NO

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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? _____

   Who is your Primary Care Physician? _____

3. Have you seen an 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 _____

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

Patient Questionnaire Continued

AUA Admin.
MRN #_____

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					
Colon Cancer					
Kidney Stones					
Diabetes					
Heart Disease					
High Blood Pressure					
Kidney Cancer					
Kidney Dialysis					
Lung Cancer					

	Father	Mother	Brother	Sister	Children	Aunts/Uncles	Grandparents	First Cousins	Nieces/Nephews
Prostate Cancer									
Breast Cancer									
Ovarian Cancer									
Pancreatic 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

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

Patient Questionnaire Continued

AUA Admin.
MRN #_____

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		

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**

*__DO NOT__ discuss or provide information to the following individuals or entities:

Restricted Name/Entity	**Relationship to Patient**

*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

If Signed by Legal Representative, Relationship to Patient

_____

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.

Clinical 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

AUA Admin.
MRN #_____

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.

_____ Date:_____
Signature of Patient/Person Legally Responsible

_____
Print Name of Patient/Person Legally Responsible

_____
Relationship to Patient
(If signed by Person Legally Responsible)

_____
Patient Date of Birth