Asheville Urological Associates, Inc.
1 Doctor's Park, Asheville, NC 28801
A Division of RTA of WNC

Phone (828) 253-5314 Fax (828) 253-0434
www.ashevilleurological.com

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: _______________________________________

☐ *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#: (______) ________________________

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Account #____________

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 ___________________

Patient Name: ________________________________ Date of Birth: ___/___/___ Age: ______

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Patient Questionnaire Continued

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

Patient Name: ______________________________ Date of Birth: ___/___/___ Age: ______

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Patient Questionnaire Continued

18. 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	Yes	No
Glaucoma		
Cataracts		

ENT	Yes	No
Nose Bleed		
Difficulty Swallowing		
Hoarseness		
Hearing Loss		

Respiratory	Yes	No
Shortness of Breath		
Cough		
Coughing up Blood		

Cardiac	Yes	No
Chest Pain		
Heart Attack		
Palpitations		
High Blood Pressure		

GI	Yes	No
Abdominal Pain		
Nausea		
Vomiting		
Diarrhea		
Constipation		

Musculoskeletal	Yes	No
Arthritis		
Joint Pain		
Joint Replacement		
Back Pain		

Neurological	Yes	No
Dizziness		
Seizure		
Headache		
Loss of Consciousness		

Skin	Yes	No
Rashes		
Non-Healing Lesions		

Psychiatric	Yes	No
Nervousness		
Mood Changes		
Depression		

Endocrine	Yes	No
Thyroid Trouble		
Diabetes		

Hematology	Yes	No
Anemia		
Easy Bruising		
Swollen Glands		

Genito-Urinary	Yes	No
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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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

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Account #____________

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

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FINANCIAL POLICY

Payment - All charges are due and payable in full at the time of service. If an emergency arises or if you are unable you pay in full at the time you are seen, we may be able to work out a payment schedule. Please let us know in advance if you have a problem that we can help you with.

Insurance Claims - We will file insurance for you under most circumstances as long as you provide us with current information on your insurance plan. While our staff is familiar with the regulations and restrictions of many insurance companies, you are ultimately responsible for understanding the details of any particular coverage you may have as well as the payment of all charges you incur.

Unpaid Insurance Claims - 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.

Minor Children of divorced parents - Charges for services rendered to minor children whose parents are divorced are the responsibility of the parent who seeks treatment for the child and are due at the time of service irrespective of any court ordered responsibility for medical costs. However, this shall not modify the duty of both parents to provide for the welfare of their minor children and we expressly reserve the right to hold either or both parents responsible for any and all reasonable and necessary medical expenses.

Returned checks - You will be charged $25.00 for any returned checks and such checks will not be redeposited.

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.

Missed appointment- If you fail to keep a scheduled appointment and you do not give our office at least a twenty-four (24) hours notice of cancellation, you will be charged a missed appointment fee. The charge will be the greater of $30.00 or 50% of the anticipated charges for your booked time slot. These charges are made because we must pay our staff to care for you whether or not you keep your appointment. Without timely notice, we cannot schedule other patients into your time slot. Cancellations can be made 24 hours a day by calling (828) 253-5314.

Charge for medical record copies- You will be charged a minimum $10.00 fee payable in advance when medical records are requested to be sent to a new doctor. Fees may be higher depending on the size of the medical records.

Collection costs, court costs, and attorney fees - Should your account become delinquent and be referred to a third party for collection, you will be responsible for payment of all collection costs, court costs, and reasonable attorney fees as defined by N.C. Gen Sta. 621.2

Acknowledged, agreed, and accepted:

AUA Admin.
Account #______________

___________________________________ ___________________________________
Patient Name (Please Print) *Patient Date of Birth*

___________________________________ _________________ _________________________
Patient Signature or Authorized Person *Date* *Witness*

____
Relationship to Patient