JUA JACKSON UROLOGICAL ASSOCIATES, PC

Donald T. McKnight, M.D.
Raymond C. Howard, M.D.
Peter G. Lawrence, M.D.
Brent J. Morris, M.D.
Brittany A. Proudfit, FNP-C
Taylor M. Smith, PA-C
Whitney S. Tucker, MBA
Administrator

Dear Patient,

Thank you for selecting Jackson Urological Associates, P.C. as your urological healthcare provider.

We wish to make your visit to our clinic a pleasant experience. To reduce your wait time, **please complete ALL information on the enclosed paperwork prior to your arrival.** Failure to complete any of this information may result in a delay or could result in the unfortunate rescheduling of your appointment.

If you have had x-rays or CT scans, **it is your responsibility to make sure we have the films and/or discs and the written report.** The written report may be faxed by the referring doctor to (731) 427-9973.

Please bring your current insurance card(s) and be prepared to pay any co-payments at check-in. Patients are responsible for knowing whether their insurance requires a written referral from their primary care physician. If a referral is required, it is the patient's responsibility to obtain this referral and have the referral available on the date of the appointment. **Jackson Urological Associates will not be responsible for obtaining these referrals.**

Some insurance plans require that only certain hospitals be used in case hospitalization is required during your treatment. Also, some plans require that certain outside reference labs be used if we must perform any lab tests. It is the patient's responsibility to know this information and to inform the receptionist, nurse, or insurance departments of these specific requirements before the services are performed.

If you have any questions prior to your appointment, please feel free to call. If you are unable to keep your appointment, please call our office to cancel or reschedule.

Thank you,

Jackson Urological Associates, P.C.

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Preferred Pharmacy

Pharmacy name _____ Phone number _____ Fax number _____

Address _____ City _____ State_____ Zip _____

Primary Care Provider _____ **Referring Provider** _____

Patient Information

First Name _____ Middle _____ Last Name _____

Preferred Name _____ **Prefix:** ___Dr. ___ Miss ___ Mrs. ___ Ms. ___ Mr **Suffix**: ___Jr. ___ Sr. ___ I ___ II ___III

Date of Birth _____-_____-_____ Sex _____ Race _____ Social Security Number _____-_____-_____

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed Drivers License Number _____

Mailing address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Work phone _____

Email _____ Preferred Method of Contact ___Mail ___Home Phone ___ Cell Phone

Employer _____ Occupation _____

Emergency Contact

Name _____ Phone Number _____ Relationship _____

Name _____ Phone Number _____ Relationship _____

Name _____ Phone Number _____ Relationship _____

Insurance Information

Primary _____ Subscriber/ID_____ Group _____

Policy Holder name if not patient _____ Date of Birth _____

SSN _____ Relationship to patient _____

Secondary _____ Subscriber/ID_____ Group _____

Policy Holder name if not patient _____ Date of Birth _____

SSN _____ Relationship to patient _____

COMPLETE ONLY IF PATIENT IS A MINOR

Responsible Party Information

Name _____ DOB _____ SSN _____

Relationship to patient ___ Father ___ Mother ___Other; please specify _____

Mailing address if different from patient

Address _____ City _____ State _____ Zip_____

Contact number _____ Employer _____

JUA JACKSON UROLOGICAL ASSOCIATES, PC

I. Insurance information

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to process my claim. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collection I will be responsible for all fees including, but not limited to, collection costs, attorney fees and court costs involved with my account.

II. Financial Policy

Our office is committed to providing quality and cost-effective healthcare to our patients. We stress that it is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorization or referral prior to your appointment. Your doctor may recommend services he/she feels are beneficial but may not be covered by insurance. It is your responsibility to understand the limit and restrictions affecting coverage for these services. If your insurance company requires you to use a specific lab or hospital, it is your responsibility to notify us of this. Insurance reimbursement is a contact between you and your insurance company. As a courtesy to you, we file all claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of all changes in insurance status. You will be responsible for all co-pays, deductibles, co-insurance amounts along with the entire amount of any non-covered services. Payment for services are expected at the time they are rendered unless other arrangements have been made with our business office. For your convenience, we accept cash. money order, personal checks, and all major credit cards. We also realize that healthcare is sometimes an unplanned event so we will attempt to accommodate your personal needs as circumstances require. In order to best meet your needs, please call our business office at (731) 427-9971 with any questions you may have regarding our financial policy and procedures. Patient who do not have insurance coverage (or proof of coverage) or who choose to pay for non-covered services are expected to pay in full at the time of the service. If you cannot pay the full amount, then you must make satisfactory payment arrangements with our business office prior to receiving services.

III. Preventative Care Services

Your health plan may not provide benefits for preventative services. It is important you determine if your plan offers benefits for this service and their guidelines for it. We use industry standard codes and guidelines to submit insurance claims based on the encounter and documentation in the medical records. Current laws regarding fraud/abuse with billing procedures prohibit us from changing the procedure and/or diagnosis codes in order to get the claim paid by the insurance company.

IV. Notice of Privacy Practices - Acknowledgment

You have the right to obtain and read our Notice of Privacy Practice before you decide whether to sign this consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

____ I **ELECT** to receive a copy of the Notice of Privacy Practices (Given by _____ Title _____)

____ I **DO NOT ELECT** to receive a copy of the Notice of Privacy Practices

V. AUTHORIZATION TO SHARE HEALTHCARE INFORMATION

This clinic will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.
This authorization ends only upon my written request. I permit you to share my healthcare information with:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Please check all that apply:

____ Share information only with MYSELF

____ All healthcare information

____ Only information regarding _____

____ Insurance and billing information

____ Other _____

I understand and agree to all of the above:

SIGNATURE _____ **DATE** _____

(For patients 17 years of age or younger, a parent or guardian MUST sign)

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PATIENT HISTORY FORM

If you run out of room, you may continue on the back side of this sheet.

Today's Date _____-_____-_____

First Name _____ **Middle** _____ **Last Name** _____

Social Security Number _____-_____-_____ **Date of birth** _____-_____-_____

Reason for visit _____

_____

_____

Pain Scale

1 2 3 4 5

6 7 8 9 10

1 being the lowest, 10 being the highest

Current Medications (Include dosage and any nonprescription drugs, herbs and vitamins)_____

_____

_____

_____

_____

Past operations, surgeries, and procedures	**Date**	*	**Allergies (Medications, food, etc.)**	**Adverse reactions**
_____	_____	*	_____	_____
_____	_____	*	_____	_____
_____	_____	*	_____	_____
_____	_____	*	_____	_____
		*		

Smoking: Packs per day, Number of years _____ Alcohol use _____ Recreational Drugs _____

Past Medical History

___Cancer; if yes, what kind? _____ ___Hernia; if yes, what kind? _____

___Prostate issues; if yes, what kind? _____ ___Mental illness; if yes, what kind? _____

___ Arthritis	___ Gallstones	___ Heart Attack	___ Kidney Disease	___ Sexually Transmitted Disease
___ Asthma	___ Glaucoma	___ Heart Disease	___ Kidney Stones	___ Stroke
___Cirrhosis	___Gout	___ Hepatitis	___ Pneumonia	___ Thyroid Disease
___ Clotting Disorder	___HIV/AIDS	___ High Blood Pressure	___Seizures	___Tuberculosis
___ Congestive Heart Failure		___ Diabetes	___Emphysema/COPD	___ Urinary Tract Infections

Family Medical History

Disease	**Family Member (Mother, Father, Sister,Brother, etc)**
Breast Cancer	_____
Diabetes	_____
High Blood Pressure	_____
Prostate Cancer	_____
Kidney Cancer	_____
Kidney Stones or Surgeries	_____

Physician Use Only (Comments/Notes)_____

_____

_____

_____

_____

_____

_____

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REVIEW OF SYSTEMS

Name _____ Date of Birth _____-_____-_____

Do you now or have you experienced any of these symptoms while experiencing the problem you are being seen for today?
Please circle YES or NO

Constitutional Symptoms

Fever Yes - No
Chills Yes - No
Headache Yes - No
Other _____

Gastrointestinal

Abdominal Pain Yes - No
Nausea/Vomiting Yes - No
Indigestion/Heartburn Yes - No
Other _____

Ear/Nose/Throat/Mouth

Ear Infection Yes - No
Sore Throat Yes - No
Sinus Problems Yes - No
Other _____

Eyes

Blurred Vision Yes - No
Double Vision Yes - No
Pain Yes - No
Other _____

Cardiovascular

Chest Pain Yes - No
Varicose Veins Yes - No
High Blood Pressure Yes - No
Other _____

Genitourinary

Urine Retention Yes - No
Painful Urination Yes - No
Urinary Frequency Yes - No
Other _____

Neurological

Tremors Yes - No
Dizzy Spells Yes - No
Numbness/Tingling Yes - No
Other _____

Integumentary

Skin Rash Yes - No
Boils Yes - No
Persistent Itch Yes - No
Other _____

Respiratory

Wheezing Yes - No
Frequent Cough Yes - No
Shortness of Breath Yes - No
Other _____

Endocrine

Excessive Thirst Yes - No
Too Hot or Cold Yes - No
Tired Sluggish Yes - No
Other _____

Musculoskeletal

Joint Pain Yes - No
Neck Pain Yes - No
Back Pain Yes - No
Other _____

Hematological/Lymphatic

Swollen Glands Yes - No
Blood Clotting Problem Yes - No
Other _____

Psychological

Are you generally satisfied with your life? Yes - No
Do you feel severely depressed/anxious? Yes - No
Have you considered suicide? Yes - No
Other _____

Physician _____
Date _____