JUA JACKSON UROLOGICAL ASSOCIATES, PC

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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.

28 Medical Center Drive - Jackson, TN 38301 - (731) 427-9971 - Fax (731) 427-9973

JUA
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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? ________________

___Prostate issues; if yes, what kind? ________________

___Hernia; if yes, what kind? ________________

___Mental illness; if yes, what kind? ________________

___ Arthritis

___ Asthma

___Cirrhosis

___ Clotting Disorder

___ Congestive Heart Failure

___ Gallstones

___ Glaucoma

___Gout

___HIV/AIDS

___ Heart Attack

___ Heart Disease

___ Hepatitis

___ High Blood Pressure

___ Diabetes

___ Kidney Disease

___ Kidney Stones

___ Pneumonia

___Seizures

___Emphysema/COPD

___ Sexually Transmitted Disease

___ Stroke

___ Thyroid Disease

___Tuberculosis

___ 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 ____________________