UACC
Urology Associates
Of Cape Cod, P.C.

PLEASE READ AS YOU WILL BE REQUIRED TO SIGN STATEMENT UPON CHECK-IN.

Urology Associates of Cape Cod is legally required to maintain the privacy of your protected information. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Information shared in treatment or obtained through tests is confidential and will not be disclosed to any party outside Urology Associates of Cape Cod, without your written consent. The sharing of medical information is for the purpose of medical treatment, medical quality assurance and peer review. Your written authorization may be revoked by you at any time, except to the extent that action has been taken in reliance on it. The exceptions to this policy are:

- When authorized and/or allowed by Federal Law or State authorities and when Insurance Carriers are allowed by law to re view information for evaluation, audit, or other purposes.
- If disclosure is necessary to protect you or someone else from serious physical harm.
- When there appears to be child, elderly, and/or handicapped abuse/neglect.
- If a court subpoenas your record.
- When required for treatment, payment, or health care operations*.

*Information you share with your doctor may be discussed with others if it is considered useful for your treatment. Treatment is defined as the provision, coordination and management of health care and related services by one or more health care providers, including management or coordination of providers' provision of care by a third party, as well as, consultations between providers and referrals between providers. To receive payment, information is released to third party payers such as insurance companies, workers' compensation, and federal and state agencies, etc. As part of our operations, we may use the services provided by business associates, such as billing or transcription service. To protect your information, we may require the business associate to appropriately safeguard your information. Using our best judgment and unless you object, we may disclose to a family member, other relative, close personal friend, or other person you identify, health information directly relevant to the person's involvement of your care or payment related to your care.

I understand that my treatment record is the property of Urology Associates of Cape Cod but that at any time, I may submit a request in writing to allow me to review my record under supervision and have clarifying statements entered into it. I may also receive a copy of my records and an accounting of disclosures, except psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administra tive action or proceeding, protected health information maintained by a covered entity such as CLIA or other acceptable, reasonable denials stated in the Privacy Rule. The fee for copies may be determined by the rate of copying expenses. I may request restrictions on the use or disclosure of protected information. Urology Associates of Cape Cod has the option to refuse such requests. Urology Associates of Cape Cod reserves the right to make amendments which will apply to all patients. Updated notices are posted in the office reception area. You have the right to file a complaint either verbally or in writing to the Privacy Officer or the Department of Health and Human Services. Our office will not retaliate against you if you file a complaint.

Please feel free to discuss any issues regarding confidentiality with your doctor or Privacy Officer. I have read and understand the above principles concerning the confidentiality of information shared with the clinical staff of Urology Associates of Cape Cod , the exceptions to the confidentiality policy, and my rights regarding my treatment record.

Billing Disclosure

I authorize Urology Associates of Cape Cod to release medical information to my insurance carrier relating to my condition if requested.

I understand that I am responsible for any collection or legal fees incurred for payment on my account. All balances over 60 days old are subject to court action. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I understand that Urology Associates of Cape Cod will bill all plans that Urology Associates of Cape Cod is affiliated with for payment on my behalf. I understand that I will pay for any balance or co-pays at time of visit, unless otherwise agreed to in writing by both parties, and it is my responsibility to submit to my private insurance to get reimbursed directly.

I further understand that if I receive specialty care services without the approval of my primary care physician and/or insurance provider, I will assume financial responsibility for such services.

RX and Procedure Consent

I further consent Urology Associates of Cape Cod to view my prescription history from external sources to assist in my healthcare.

I give my permission for procedures performed in the office (i.e. - prostate biopsy, cystoscopy, urodynamic studies, catheritizations, etc.).

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Comprehensive Urologic Care in a Local Setting

PATIENT INFORMATION

DATE: _____

NAME: _____ , _____ ___ **AGE:** _____ **D.O.B.** ___ /___ /___
Last First M.I.

HOME ADDRESS: _____ , _____ , _____ , _____
Street Address City / Town State Zip Code

MAILING ADDRESS: _____ , _____ , _____ , _____
(If Different From Home Address)

E-MAIL ADDRESS _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL PHONE** _____

EMERGENCY CONTACT: _____ **CONTACT PHONE NUMBER:** _____

MARITAL STATUS (Circle One): **Single** **Married** **Divorced** **Widowed**

SOCIAL SECURITY NUMBER: _____

PHARMACY NAME: _____ **ADDRESS:** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE #** _____

RACE:
American Indian or Alaskan Native ❑
Asian ❑
Native Hawaiian or other Pacific ❑
Black or African American ❑
White ❑
Other ❑
Unreported / refused to report ❑

ETHNICITY:
Hispanic or Latin ❑
Not Hispanic or Latin ❑
Refused to report ❑

LANGUAGE
English ❑
Spanish ❑
Portugese ❑
Other ❑

PLEASE BRING ALL INSURANCE CARDS AND A PHOTO IDENTIFICATION TO EVERY APPOINTMENT. ALL CO-PAYMENTS ARE EXPECTED AT TIME OF VISIT

110 Main Street, Hyannis MA 02601 • 68A Rt. 6A, Sandwich, MA 02563
Tel: 508-771-9550 • Fax: 508-862-6358

PATIENT HISTORY

Reason for your visit: _____

Medications: **List *all* your current medications and dosages or bring a list with you:**

Start Date	Drug Name & Strength	Dose (pills, units, puffs, drops)	When to Take	Purpose / Reason

Medical:

List *all* serious illnesses in your *personal* lifetime. (Example: diabetes, stroke, hypertension, breathing, heart problems, angina, prostate cancer, bladder cancer etc..): _____

_____

_____

List *all* allergies to medications (or other substances): _____

_____

_____

Surgical:

List *all* surgeries in your *personal* lifetime with appropriate dates: _____

_____

_____

Family History

List *all* serious illnesses in your immediate family: (Example: diabetes, stroke, hypertension, emphysema, heart attack, angina, cancer, prostate cancer, bladder cancer etc...): _____

_____

_____

Social History:

Do you drink alcohol? How much?

_____

Are you sexually active?

_____

Smoking: **Are you a:**

❑ **Current smoker** ❑ **Former smoker** ❑ **Non-smoker**

❑ ***If currently smoking,*** **would you like information on quitting?** ❑ **yes** ❑ **no**

REVIEW OF SYSTEMS

Do you *now* or have you *had* any problems related to the following systems?

Please circle Y = yes, N = no. Please explain all YES answers in space provided.

CONSTITUTIONAL SYSTEMS

FEVER	Y	N
CHILLS	Y	N
HEADACHE	Y	N
OTHER _____		

EYES

BLURRED VISION	Y	N
DOUBLE VISION	Y	N
GLASSES	Y	N
OTHER _____		

ALLERGIC / IMMUNOLOGIC

HAY FEVER	Y	N
SHELLFISH	Y	N
IODINE / DYES	Y	N
OTHER _____		

NEUROLOGICAL

TREMORS	Y	N
DIZZY SPELLS	Y	N
NUMBNESS	Y	N
SEIZURES	Y	N
PARALYSIS	Y	N
OTHER _____		

GENITOURINARY

PAINFUL URINATION	Y	N
HESITANCY	Y	N
FREQUENCY	Y	N
URGENCY	Y	N
INCONTINENCE	Y	N
BLOOD IN URINE	Y	N
TESTICLE PAIN / LUMP	Y	N
OTHER _____		

GASTROINTESTINAL

ABDOMINAL PAIN	Y	N
NAUSEA / VOMITTING	Y	N
INDIGESTION / HEARTBURN	Y	N
OTHER _____		

PSYCHOLOGICAL

HAVE YOU BEEN TREATED FOR:		
DEPRESSION?	Y	N
SUICIDE?	Y	N
SCHIZOPHRENIA?	Y	N
OTHER _____		

INTEGUMENTARY

SKIN RASH	Y	N
BOILS	Y	N
PERSISTENT ITCH	Y	N
OTHER _____		

MUSCULOSKELETAL

JOINT PAIN	Y	N
NECK PAIN	Y	N
BACK PAIN	Y	N
OTHER _____		

EARS / NOSE / THROAT

EAR INFECTION	Y	N
SORE THROAT	Y	N
SINUS PROBLEMS	Y	N
OTHER _____		

ENDOCRINE

EXCESSIVE THIRST	Y	N
TOO HOT / COLD	Y	N
FATIGUE	Y	N
WEIGHT LOSS	Y	N
WEIGHT GAIN	Y	N
OTHER _____		

HEMATOLOGICAL / LYMPHATIC

SWOLLEN GLANDS	Y	N
BLOOD CLOTTING PROBLEM	Y	N
LEUKEMIA	Y	N
ANEMIA	Y	N
OTHER _____		

RESPIRATORY

WHEEZING	Y	N
FREQUENT COUGH	Y	N
SHORT OF BREATH	Y	N
SPUTUM / PHLEGM	Y	N
OTHER _____		

CARDIOVASCULAR

CHEST PAIN / ANGINA	Y	N
HIGH BLOOD PRESSURE	Y	N
VARICOSE VEINS	Y	N
HISTORY OF:		
HEART ATTACK?	Y	N
ANGIOPLASTY / BYPASS?	Y	N
OTHER _____		