UROLOGY

Michael P. Zahalsky, MD - Mini Varghese, MD - Christopher P. Hollowell, MD
Michael Tyler, MD - Laurel Sofer, MD
Melissa Marchand, PA-C - Monika Kulik, PA-C - Linda Calderon, PA-C
954-714-8200 Phone 954-840-2626 Fax
www.zurology.com

## PERSONAL INFORMATION

PATIENT NAME:_____ DOB _____ SS# _____-_____-_____
HOW DID YOU HEAR ABOUT US? *(please circle one and provide the referral source so we may thank them):*
Friend / Doctor / Internet Search / Social Media / Website / Media / Other:_____
ADDRESS:_____
HOME PHONE: _____CELL PHONE_____WORK PHONE _____
EMAIL: _____ PRIMARY LANGUAGE: _____
RACE: _____ETHNICITY: _____ PHARMACY NAME /PHONE: _____
SEX: MALE _____ FEMALE _____ MARITAL STATUS_____
PRIMARY CARE PHYSICIAN: _____ PHONE: _____
REFERRING PHYSICIAN: _____ PHONE: _____
EMERGENCY CONTACT: _____
RELATIONSHIP:_____
ADDRESS:_____
HOME PHONE: _____CELL PHONE _____WORK PHONE _____
OCCUPATION: _____EMPLOYER NAME: _____
EMPLOYER ADDRESS:_____

## HEALTH INSURANCE

*PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD AND PHOTO IDENTIFICATION*

PRIMARY COMPANY: _____ SECONDARY COMPANY: _____
ID # _____GROUP # _____ ID # _____GROUP # _____
GUARANTOR NAME (PERSON TO BILL IF OTHER THAN PATIENT)_____
ADDRESS:_____
HOME PHONE: _____CELL PHONE_____WORK PHONE _____

## EXTENDED AUTHORIZATION AND CONSENT

I request that payment under the medical insurance program be made directly to the above named provider on any unpaid bills for services on or after the date indicated below. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers of insurance companies, any information needed for this or related Medicare or Insurance claim. I understand that I am financially responsible for services rendered regardless of my insurance status. I also understand that I am financially responsible for all and /or referring physicians when required. I permit a copy of this authorization to be used in place of the original. Should this account go to collections I will be responsible for all costs of collection and/or attorneys fees. I FURTHER ACKNOWLEDGE THE OFFICE "NO SHOW" POLICY. IF I FAIL TO NOTIFY THE OFFICE WITHIN 24 HOURS BEFORE MY SCHEDULED APPOINTMENT I WILL BE CHARGED $75.00. THIS IS AN UNCOVERED INSURANCE ITEM I WILL BE RESPONSIBLE FOR PAYMENT.

SIGNATURE OF PATIENT: _____ DATE: _____
or Signature of Guardian

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NAME: _____ DATE OF BIRTH: _____

List of Reasons for today's visit: _____

MEDICAL HISTORY
Prior Illnesses and Serious Injuries: _____

_____

Prior Surgeries: _____ Date _____

Prior Surgeries: _____ Date _____

Prior Hospitalizations: _____ Date _____

Prior Hospitalizations: _____ Date _____

Please list all the medications you are currently taking: _____

_____

Allergies and Reactions (Drug, Food, Or Other) : _____

_____

Sexually Transmitted Diseases: _____

FAMILY MEDICAL HISTORY
Urology Disease (i.e. Kidney stones, incontinence) ___mother ____father____other: ____

Please Specify :_____

Cancer_____mother _____father _____other: _____

Please Specify :_____

Social History

Marital Status: ____Single ____Married ____Divorced ____Widowed ____Cohabitating

Living Situation ____Living at Home ____Nursing Home ____Homeless ____Other

Occupation: _____

Tobacco Use: ___Non Smoker ___ Smoker: Packs Per Day: _____

Alcohol Use: ___Non Drinker ___Yes, I Drink _____Ounces Per day

Drug Use: ___Non User ___User Type: _____

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# HIPAA Authorization

PATIENT'S FULL NAME_____

SOC SEC #_____ BIRTHDATE_____ PHONE _____E-MAIL_____

STREET _____STATE ____ ZIP _____

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Z UROLOGY will not release confidential health information, either in person or by telephone, email, or fax to any unauthorized people. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Also, information will not be given to an unauthorized person who may answer your telephone (either at home or at work).

If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please complete the following:

I authorize Z UROLOGY to release confidential medical information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify Z Urology if this authorization information changes.

It is ok to leave confidential medical information for me on my: It is okay to give confidential medical information to my:

[] Home telephone/message _____
[] Work telephone _____
[] Mobile telephone _____
[] Home Facsimile _____
[] Work Facsimile _____
[] Other (name required) _____

(List specific names)
[] Spouse _____
[] Parent(s) _____
[] Son/daughter _____
[] Brother/Sister _____

I authorize this information to be disclosed in the following ways:

[] Written/photocopy/paper _____
[] Verbal _____
[] Facsimile _____

Dates of treatment: From _____ to:_____

Specific description of the protected health information that I authorize for disclosure (Authorization to disclose psychotherapy notes must be separate):

[] Progress notes
[] X-ray films or other images
[] Radiology reports
[] Operative reports
[] Discharge summary
[] Laboratory reports
[] Photographs/videotapes
[] Records from other facilities

[] Entire health records, (including, but not limited to information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities).

[] Other

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Please indicate/describe each authorized purpose of the use or disclosure:

[] At the request of the individual (patient) [] Other

_____

I understand that this authorization will automatically expire in 6 months unless otherwise specified:_____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____Date: _____Print Name: _____
*When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.*

Relationship or Authority of Personal Representative (if applicable)_____

Patient's Signature: _____Date: _____Print Name: _____

## HIPAA CONSENT

Patient Consent for use and Disclosure of Protected Health Information

With my consent, Z Urology May use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Z Urology Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

I understand that Z Urology reserves the right to revise its Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Z Urology, 5850 Coral Ridge Drive, Suite 106, Coral Springs, FL 33076.

With my consent, Z Urology may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Z Urology may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Z Urology may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Z Urology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form I am consenting to Z Urology use and disclosure of my PHI to carry out TPO.

At any time, I may revoke my consent in writing, by sending a signed and dated written statement to Privacy Officer, Z Urology, 5850 Coral Ridge Drive, Suite 106, Coral Springs, FL 33076, saying that I am revoking my authorization to disclose health records, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent Z Urology may decline to provide treatment to me.

Patient's Name (Printed) _____Signature (of Parent or Legal Guardian for Minors)_____

Parent or Legal Guardian Name (Printed) _____

Relationship or Authority of Personal Representative (if applicable)_____ Date_____
*If patient is less than 18 years of age, or can't legally sign for himself/herself, his/her parent's or legal guardian's signature is required.*

UROLOGY

**NAME:** _____ **DOB:** _____

**PLEASE COMPLETE BUBBLE SHEET THOROUGHLY**

## Urology

| | |
|---|---|
| Frequent urination | O Yes O No |
| Urgent need to urinate | O Yes O No |
| Pain with urination | O Yes O No |
| Nighttime urination | O Yes O No |
| Difficulty starting urinary stream | O Yes O No |
| Leakage or dribbling | O Yes O No |
| Reduced flow | O Yes O No |
| Blood in urine | O Yes O No |
| Straining to urinate | O Yes O No |
| Pelvic pain | O Yes O No |
| Sexual difficulty | O Yes O No |
| Female-infertility | O Yes O No |
| Female-irregular periods | O Yes O No |
| Female- vaginal discharge | O Yes O No |

Other: _____

## Male Reproductive

| | |
|---|---|
| Difficulty with erection | O Yes O No |
| Difficulty with ejaculation | O Yes O No |
| Diminished sexual drive | O Yes O No |

Other: _____

## Cardiology

| | |
|---|---|
| swelling of feet, ankles, or hands | O Yes O No |
| shortness of breath | O Yes O No |
| chest pain at rest | O Yes O No |
| Chest pain with exertion | O Yes O No |
| Dizziness | O Yes O No |
| Irregular heartbeat | O Yes O No |
| Palpitations | O Yes O No |

Other: _____

## Dermatology

| | |
|---|---|
| Scars | O Yes O No |
| Rash | O Yes O No |
| Dry or Sensitive Skin | O Yes O No |
| Hives | O Yes O No |
| Acne | O Yes O No |
| Skin cancer | O Yes O No |

Other: _____

## Endocrinology

| | |
|---|---|
| Fatigue | O Yes O No |
| Excessive Thirst | O Yes O No |
| Excessive Urination | O Yes O No |
| Cold Intolerance | O Yes O No |
| Hot flashes | O Yes O No |
| Weight Loss | O Yes O No |

Other: _____

## ENT

| | |
|---|---|
| difficulty swallowing | O Yes O No |
| Sore throat | O Yes O No |
| Cough | O Yes O No |
| Sinus Problems | O Yes O No |
| hearing loss/hard of hearing | O Yes O No |
| nose bleeds | O Yes O No |
| Tinnitis (ringing in ear) | O Yes O No |

Other: _____

## Gastroenterology

| | |
|---|---|
| black/tarry stools | O Yes O No |
| diarrhea | O Yes O No |
| abdominal pain | O Yes O No |
| nausea/vomiting | O Yes O No |
| Heartburn / indigestion | O Yes O No |
| blood in stool | O Yes O No |
| Constipation | O Yes O No |

Other: _____

## General

| | |
|---|---|
| fever | O Yes O No |
| Chills | O Yes O No |
| fatigue | O Yes O No |
| weakness | O Yes O No |
| weight loss | O Yes O No |
| weight gain | O Yes O No |

Other: _____

## Hematologic/Lymphatic

| | |
|---|---|
| excessive bleeding w/dental work | O Yes O No |
| easy bruising | O Yes O No |
| swollen glands | O Yes O No |
| loss of appetite | O Yes O No |

Other: _____

## Musculoskeletal

| | |
|---|---|
| fracture | O Yes O No |
| back pain | O Yes O No |
| Bone pain | O Yes O No |
| Muscle weakness | O Yes O No |
| Joint swelling, stiffness, pain | O Yes O No |

Other: _____

## Neurology

| | |
|---|---|
| Insomnia | O Yes O No |
| Dizziness | O Yes O No |
| Weakness | O Yes O No |
| Headache | O Yes O No |
| Numbness | O Yes O No |
| Seizures/Convulsions | O Yes O No |
| Leg weakness | O Yes O No |

Other: _____

## Ophthalmology

| | |
|---|---|
| blurring of vision | O Yes O No |
| eye drainage | O Yes O No |
| eye irritation, pain | O Yes O No |
| loss of vision | O Yes O No |
| Spots in vision | O Yes O No |

Other: _____

## Respiratory

| | |
|---|---|
| Shortness of breath | O Yes O No |
| Need for home oxygen | O Yes O No |
| Chest pain | O Yes O No |
| Cough | O Yes O No |
| Chronic/Frequent cough | O Yes O No |
| Difficulty breathing at rest | O Yes O No |
| Difficulty breath on exertion | O Yes O No |

Other: _____

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# Urologic Male and Female Consent for the Pelvic Exam

A pelvic exam is a part of the physical evaluation of the patient presenting with many medical conditions. A pelvic exam can be performed in the office awake or under anesthesia.

A female pelvic exam can involve an assessment of the external genitalia, vagina, bimanual palpation of the bladder, uterus, adnexa and rectum.

A male pelvic exam can involve an assessment of the penis, scrotum, testicles, inguinal canal, rectum and the prostate and seminal vesicles.

The potential benefit of a urologic pelvic exam includes the detection of many types of cancers, inflammatory conditions, prolapse, hernias or incontinence. It also may help the urologist explain normal anatomy and answer your specific questions.

Some patients may have fear, anxiety or embarrassment from a pelvic exam. If you have any concerns, you should discuss then with your health care provider. There are generally no significant risks with a pelvic exam.

These are few alternatives to a pelvic exam. The alternatives may not be as effective for providing diagnostic information or therapeutic improvement, and may carry their own set of potential risks.

I understand that this patient consent form is required by law, and by signing this form I am making an informed decision to have a pelvic examination, and that I have read and understand the information above. I understand that this form does not list every possible risk. I was not given any guarantee about the final result of this procedure

_____

**Print Name** **Date**

_____

**Signature** **Date**

Z Urology

# HIPAA Waiver

PATIENT'S FULL NAME_____

SOC SEC #_____ BIRTHDATE_____ PHONE _____ E-MAIL_____

STREET _____STATE ____ ZIP _____

| |
|---|
| **For more information, see** 45 CFR Parts 160 and 164 **or "**Protecting Personal Health Information in Research: Understanding the HIPAA Privacy Rule**."** |
| |

I hereby authorize ***Dr. Michael Zahalsky*** and the team at ZUROLOGY and such assistant personnel as he may select to use any and all of my testimonial, medical data, photographs, videos and all medical information collected during my procedure for purposes of this study, marketing and education. I understand that although all my personal health information, data, photographs and video shall be used, there shall be no personal identifying information such as my name, date of birth or social security number.

I, _____and/or my caregiver waive my HIPPA right in order to have a Telemedicine visit via any electronic platform (i.e. FaceTime, WhatsApp, Skype, etc)

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____Date: _____

Print Name: _____

_____

**Witness Full Name and Signature**

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# Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting **Z Urology at 954-714-8200**.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Florida and will be in Florida during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name | Patient/Parent/Guardian Signature

_____ _____

Witness Signature | Date

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# Patient Responsibility Policy

## Effective 1/1/2020

To Our Patients:

We have implemented a new Patient Responsibility Policy requiring a credit card on file effective 1/1/2020. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share, then you will receive a receipt.

This card can be charged for the following reasons:

- Co-payments not collected from you at the beginning of your visit
- Missed or canceled appointments without 24 hour notice ($75)
- Patient responsibility balances identified by your insurance company

Check out will be easier, faster, and more efficient. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

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# Patient Responsibility Policy

## Effective 1/1/2020

Thank you for choosing Michael P Zahalsky MD PA (Z Urology) for your urological health needs. We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to our patients, you, the insured. This is driving many practices to adopt new financial policies to enable more efficient operational processes. Some insurance plans require deductibles and co-payments in amounts not known to you or us at the time of your visit.

To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills, effective January 1, 2020, we will require all patients keep an active credit card on file with us. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card after we are notified of your patient responsibility. Circumstances when your card would be charged include but are not limited to:

- missed or canceled appointments without 24 hour notice, ($75)
- co-payments,
- patient responsibility balances as identified by your insurance plan

Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing the amount of your total patient responsibility. You will typically receive the EOB before we do, so if you disagree with the patient responsibility balance owed, it is your responsibility to contact your insurance carrier immediately.

When we receive the EOB, we will enter all pertinent payment information into our system. Any remaining balance owed by you will be charged to your credit card and a copy of the receipt will be sent to you.
If the credit card we have on file for you changes, please notify our office staff IMMEDIATELY by phone or email. It is not uncommon for people to change or cancel their credit cards for various reasons, including when a credit card expires. That is quite understandable. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days. We will contact you by email or leave you a phone message on the phone number you provided for us, asking you to give us a call with the new number right away. We will enter the new credit card number into your file, and that will become your new card on-file, subject to the same financial policy as the card you gave us in-person when you were in our office.

If there is a problem with your bill/claim and it is brought to our attention after your credit card payment processes, we will investigate it and if we owe you the money, we will refund it to the same card in a timely manner.

We understand that there are legitimate reasons that you may not have a credit card. If this is the case, you are welcome to leave an HSA (Health Savings Account) or Flex Plan Card on File or advance payment on account. You may also pay for the visit with cash or a personal check.

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**Card on File Authorization form**

By signing below, I agree to all of Michael P Zahalsky MD PA (Z Urology) Credit Card on File Policy and I authorize themto keep my signature and a valid credit/debit card number securely on-file with my account. I allow Z Urology to automatically charge my credit card for any outstanding balances. These may include:

- insurance denials for ANY reason (including no referral on file);
- Co-Pays, Deductibles, Co-insurances; as determined by our insurance plan
- No Show charges for missed or cancelled appointments without 24-hour notice will be charged $75 at the time ofthe appointment.

If the credit card that I give today changes, expires, or is denied for any reason, then I agree to immediately give Z Urologya new, valid credit card which I will allow them to key-in over the phone. Even though we are not swiping this card in person, I agree that the new card will still be subject to the financial policy listed here and may be used with the same authorization as the original card which I presented in person.

I understand that I am responsible for payment for all medical services provided to me by Z Urology. I understand that myinsurance may deny or delay payment for these services or only partially pay them, and I agree to allow Z Urology to immediately charge my credit card on file for the balance if that happens. I understand that this form is valid until I cancelthis authorization through written notice to Z Urology.

Date : _____

Name on Card_____
EMAIL (Mandatory): _____
Card Type: _____
Card Number: _____
Expiration Date: _____ CCV: _____
Billing Address: _____ Zip Code _____

_____
Signature of Patient / Credit Card Holder (or Legal Guardian)

**About the I-PSS**

The International Prostate Symptom Score (I-PSS) is based on the answers to seven questions concerning urinary symptoms and one question concerning quality of life. Each question concerning urinary symptoms allows the patient to choose one out of six answers indicating increasing severity of the particular symptom. The answers are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

The questions refer to the following urinary symptoms:

| Questions | Symptom |
|---|---|
| 1 | Incomplete emptying |
| 2 | Frequency |
| 3 | Intermittency |
| 4 | Urgency |
| 5 | Weak Stream |
| 6 | Straining |
| 7 | Nocturia |

Question eight refers to the patient's perceived quality of life.

The first seven questions of the I-PSS are identical to the questions appearing on the American Urological Association (AUA) Symptom Index which currently categorizes symptoms as follows:

Mild (symptom score less than of equal to 7)
Moderate (symptom score range 8-19)
Severe (symptom score range 20-35)

The International Scientific Committee (SCI), under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), recommends the use of only a single question to assess the quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of benign prostatic hyperplasia (BPH) Symptoms or quality of life, it may serve as a valuable starting point for a doctor-patient conversation.

The SCI has agreed to use the symptom index for BPH, which has been developed by the AUA Measurement Committee, as the official worldwide symptoms assessment tool for patients suffering from prostatism.

The SCI recommends that physicians consider the following components for a basic diagnostic workup: history; physical exam; appropriate labs, such as U/A, creatine, etc.; and DRE or other evaluation to rule out prostate cancer.

# ZUROLOGY

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## CONSENT FOR RELEASE OR OBTAIN MEDICAL RECORDS

*Pleases send all records to 5850 Coral Ridge Drive, Suite 106, Coral Springs, FL 33076*
*ATTN: Medical Records Department*

*Phone 954-714-8200 • Fax 954-840-2626 • Email: medicalrecords@zurology.com*

_____ _____ _____

NAME OF PATIENT DATE OF BIRTH SIGNATURE OF PATIENT OR LEGAL GUARDIAN

[ ] Call patient to pick up records [ ] Mail records to patient [ ] Please fax records to _____

I authorize and request the disclosure of all protected health information. I expressly request that the designated record custodian of all covered entities under HIPPA identified above, disclose full and complete protected medical records.

I request my records to go to the following Person/Provider (if records are going to yourself, write "Self"):

Name: _____

Address: _____

Phone #: _____

Fax #: _____

I request that you get my records from the following Provider:

Name: _____

Address: _____

Phone #: _____

Fax #: _____

Please check **all that apply** to which medical records to be released/requested:

[ ] Notes [ ] Surgical Procedures/Imaging [ ] Lab Report(s) [ ] Ultrasound Reports/Imaging [ ] Complete Medical Record

For Dates of Service from: _____ to: _____