MAUA Patient Registration Form

Patient Information

LAST NAME _____ FIRST NAME _____ MIDDLE NAME (if applicable) _____

MRN _____ SOCIAL SECURITY NUMBER (SSN #) ___-___-___ BIRTHDATE (MM/DD/YYYY) ___/___/___ PRIMARY LANGUAGE _____

SEX (M/F) _____ MARITAL STATUS _____ STUDENT STATUS (FULL/PART-TIME) _____ SMOKER? (Y/N) _____ VETERAN? (Y/N) _____

PRIMARY ADDRESS _____ CITY, STATE, ZIP CODE _____

HOME PHONE (___) _____ DAY PHONE (___) _____ EMAIL ADDRESS _____

SECONDARY/BILLING ADDRESS (if applicable) _____ SECONDARY CITY, STATE, ZIP CODE _____

PRIMARY CARE PROVIDER _____ REFERRING PHYSICIAN _____

EMERGENCY CONTACT NAME _____ EMERGENCY CONTACT HOME PHONE (___) _____ EMERGENCY CONTACT ALTERNATE PHONE (___) _____

Work Information

PRIMARY EMPLOYER _____ PRIMARY WORK PHONE (___) _____

PRIMARY EMPLOYER ADDRESS _____ CITY, STATE, ZIP CODE _____

SECONDARY EMPLOYER (if applicable) _____ SECONDARY WORK PHONE (___) _____

SECONDARY EMPLOYER ADDRESS _____ CITY, STATE, ZIP CODE _____

Responsible Party Information *(Only if different than above; If not applicable, check here: ____)*

LAST NAME _____ FIRST NAME _____ MIDDLE NAME (if applicable) _____

SOCIAL SECURITY NUMBER (SSN #) ___-___-___ BIRTHDATE (MM/DD/YYYY) ___/___/___ PRIMARY LANGUAGE _____ SEX (M/F) _____

MARITAL STATUS _____ STUDENT STATUS (FULL/PART-TIME) _____ SMOKER? (Y/N) _____ VETERAN? (Y/N) _____

PRIMARY ADDRESS _____ CITY, STATE, ZIP CODE _____

HOME PHONE (___) _____ DAY PHONE (___) _____ EMAIL ADDRESS _____

SECONDARY/BILLING ADDRESS (if applicable) _____ SECONDARY CITY, STATE, ZIP CODE _____

SECONDARY HOME PHONE (___) _____ RELATIONSHIP TO PATIENT _____ PRIMARY CARE PROVIDER _____

Primary Insurance

NAME OF INSURANCE COMPANY _____ NAME OF INSURED _____

POLICY # _____ GROUP # _____

COPAY AMOUNT _____ DEDUCTIBLE AMOUNT _____ EFFECTIVE DATE (MM/DD/YYYY) ____/____/____ EXPIRATION DATE (MM/DD/YYYY) ____/____/____

INSURANCE COMPANY ADDRESS _____ CITY, STATE, ZIP CODE _____

(_____) _____ NAME OF INSURED RELATIONSHIP TO PATIENT _____
INSURANCE COMPANY PHONE

Secondary Insurance *(if applicable)*

NAME OF INSURANCE COMPANY _____ NAME OF INSURED _____

POLICY # _____ GROUP # _____

COPAY AMOUNT _____ DEDUCTIBLE AMOUNT _____ EFFECTIVE DATE (MM/DD/YYYY) ____/____/____ EXPIRATION DATE (MM/DD/YYYY) ____/____/____

INSURANCE COMPANY ADDRESS _____ CITY, STATE, ZIP CODE _____

(_____) _____ NAME OF INSURED RELATIONSHIP TO PATIENT _____
INSURANCE COMPANY PHONE

PLEASE READ THE FOLLOWING CAREFULLY

I certify that the information above is correct. I agree that insurance benefits for MidAtlantic Urology Associates, LLC provider charges payable to the insured are to be made payable to MidAtlantic Urology Associates, LLC and that physician benefits otherwise payable to the insured are to be made payable to MidAtlantic Urology Associates, LLC. Any payments received for services rendered to me by MidAtlantic Urology Associates, LLC may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. I acknowledge that I am fully responsible for all non-covered services, deductibles and co-payments. I further agree, in the event of default due to non-payment, to be responsible for collection fees, court costs and/or legal fees, and there will be a $35.00 fee for all returned checks.

_____ ____/____/____
SIGNATURE OF PATIENT/GUARDIAN DATE (MM/DD/YYYY)

Patient Name: _____ DOB: _____

DEMOGRAPHIC DATA

Federal regulations now require our practice to collect new demographic data to aid health agencies understand disparities, improve quality of care, and strengthen research and outreach. We appreciate your assistance in meeting these new national standards. MidAtlantic Urology Associates, LLC is dedicated to being your partner in improving patient care.

Please check the appropriate statement:

RACE:

____ Alaskan Native
____ American Indian
____ Asian
____ African American or Black
____ Greek
____ Hawaiian
____ Hispanic or Latino
____ Indian
____ More than one race
____ Multiracial
____ North American Indian
____ White/Caucasian
____ Refused/Declined

ETHNICITY:

____ Hispanic or Latino
____ Not Hispanic or Latino
____ Refused/Declined

SMOKER:

____ Current every day smoker
____ Current some day smoker
____ Smoker, current status unknown
____ Never Smoker
____ Former Smoker (Year Quit:_____)
____ Unknown if ever smoked

PREFERRED LANGUAGE:

____ English
____ Spanish
____ Other _____

IF SMOKER, PLEASE INDICATE:

Type: _____
Units/Day: _____
Years Used: _____
Packs/Year: _____
Ever tried to quit? ____Yes ____No
Passive smoke exposure: ____Yes ____No

_____ _____
Patient Signature Date

Medicine Pharmacy Dentistry

The new HIPAA health care privacy regulations take effect on April 14, 2003. These regulations require every physician, dentist, pharmacy, medical imaging center, HMO, health insurance company and others with whom you have a direct treatment relationship, to inform you about the policies and procedures they are using to protect your medical data. HHS calls this information a "Notice".

Our Notice is available to you at our offices. Since the new law requires us to tell you about every possible contingency relative to the privacy and security of the data in your medical records, this Notice contains a very large amount of material. Many people simply glance at these types of documents, then throw them in the trash. However, this material could be important to you. In this light, we have tried hard to make this material straightforward and readable for you. If we work together in implementing these new regulations, both patient and provider will benefit.

MidAtlantic Urology Associates, LLC.
7500 Greenway Center Drive
8th Floor
Greenbelt, Maryland 20770-3520
Ofc: 301.477.2000
Fax: 301.474.2389
Website: mauamd.com

Available Forms

To copy and amend your medical, dental, or pharmaceutical records, ask for **Forms 66008** and **66009**

To file a complaint with your health care provider or the Secretary of the Department Of Health And Human Resources Ask for **Form 66005**

MidAtlantic Urology Associates, LLC.
7500 Greenway Center Drive
8th Floor
Greenbelt, Maryland 20770-3520
Ofc: 301.477.2000
Fax: 301.474.2389
Website: mauamd.com

Form 66103

Your Rights Under HIPAA

The New Health Care Regulations

Protecting people from exploitation through their medical records that detail some of the most sensitive moments of their lives

The Orlando Sentinel, November 30, 1997, reported that a few weeks after an Orlando woman had her doctor perform some routine tests, she received a letter from a drug company promoting a treatment drug for her illness.

The New York Times, August 14, 1991, reported that a speculator bid $4000 for the patient records of a family practice in South Carolina for the purpose, among other uses, of selling them back to the former patients.

The Boston Globe reported in 1993 that Johnson and Johnson marketed a list containing 5 million names and addresses of elderly incontinent women. (ACLU Legislative Update, April 1998).

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The Health Insurance Portability And Accountability Act Of 1996 (HIPAA)

continuing . . .

USA Today, October 10, 1996, reported that an employee of the Tampa, Florida, Department Of Health took a computer disk containing the names of 4,000 people who had tested positive for HIV, the virus that causes AIDS.

The Ann Arbor News, February 10, 1999, reported that a Michigan-based health system, accidentally posted the medical records of thousands of patients on the Internet.

Kiplingers, in February 2000, reported that a Utah-based prescription drug benefits management firm used patient data to solicit business for its owner, a drug store.

The Boston Globe, August 1, 2000, reported that a patient in a Boston-area hospital discovered that her medical record had been read by more than 200 of the hospital's employees.

The Department Of Health And Human Resources (HHS) published the above to illustrate why America needs a law to protect medical records from being used to the detriment of patients. In response, Congress passed the Health Insurance Portability And Accountability Act Of 1996 (HIPAA) which authorized HHS to create and implement standards governing the use and disclosure of data in medical records (medical data). HIPAA virtually establishes in law the fundamental principle that an individual's medical records belong to that individual and, with very few exceptions, cannot be used without the explicit permission of that individual.

Accordingly, HHS issued Privacy Rule 164 that becomes effective on April 14, 2003. This rule is enforced by the Office Of Civil Rights (OCR) of the Dept. Of Health And Human Resources (HHS).

The Use Of Your Patient Data — In order to function efficiently, physicians, dentists, pharmacists, hospital, insurance companies and other health care organizations do not need your prior approval when your medical data is used for treatment, payment, certain administrative tasks, disclosure to next-of-kin, urgent care and law enforcement. For virtually everything else, HIPAA requires providers to obtain authorization from you before using or disclosing your medical data. Examples include the marketing of health and non-health related products and services, fund raising and disclosure to an employer. HIPAA also forces health care providers to fully protect your patient data and prevent it from being accessed by unauthorized parties. Failure to do so involves fines and, in cases of malice, prison time.

The Right To Access Your Patient Data — After April 14, 2003, you will have the right to see and copy your medical data — except for notes that your provider may use to make decisions about your treatment and situations where the provider deems that release of the subject records would endanger your life or well-being. You will also have the right to amend your medical data and the right to an accounting for certain disclosures. If your health care provider does not agree with the changes or corrections you request, you must be allowed to insert a statement of disagreement into the record.

Disclosures — Your physician, dentist, pharmacist and other health care providers must provide you with full details of certain disclosures they make of your medical data. A pharmacy that sells the names of patients and the prescription drugs they use to drug companies — so that they can send literature on competing drugs that they manufacture — is an example of this requirement. The disclosure must include the date of each disclosure, name and address and identity of a contact person, a brief description of the data released and the purpose of the disclosure. This also applies to medical data released by the health care provider's business partners.

Complaints — Every health care provider must provide a process for patients to make complaints concerning their policies and procedures, their compliance with such policies and procedures, or other requirements of HIPAA. If you find a serious reason to file a complaint, a form entitled "Filing A Complaint" is available at your health care provider's offices. All complaints must be in writing. You can also send complaints directly to the Secretary of the Department Of Health And Human Resources. By law, your health care provider may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against you, for filing of a complaint provided you have a good faith belief that the practice opposed is unlawful or in violation of your provider's policies and procedures "Notice".

Forbidden To Require You To Waive Rights
Your health care provider or organization may not require you to waive your rights under Privacy Rule 164 as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.

PERMISSION TO RELEASE / OBTAIN MEDICAL INFORMATION

REQUIRED BY FEDERAL LAW

PATIENT (and/or GUARDIAN FOR DEPENDANT)

I, _____ hereby give permission to MidAtlantic Urology Associates, LLC., its employees, and sub-contractors to release current, past and future information about my medical condition, diagnoses, treatments and recommendations to:

(Cross out any that do not apply, other than the top six, that are required for us to care for you)

- My present and future health insurers.
- My referring or primary health care provider.
- Other health care providers caring for me.
- Health care providers/laboratories I am referred to.
- Health care facilities I am referred or admitted to.
- Authorized reviewers for regulatory compliance quality assurance and/or peer review.
- View / Obtain Medication History with past, present and future Pharmacies.
- My spouse or significant other _____.
- My parents _____.
- My employer (required for compensation cases) _____.
- Others _____.

This permission will remain in effect until I revoke all or part of it in writing. I understand MidAtlantic Urology Associates, LLC., will make reasonable efforts to insure my privacy, but cannot guarantee the conduct of others who receive this information as allowed above.

Signed: _____ Date: _____ Witness: _____

HIPAA CARE REGULATIONS BROCHURE RECEIVED!

_____

SIGNATURE DATE

I, _____ hereby am notified that my Physician, Dr. _____ has ownership interest in the following entities: *Metropolitan Ambulatory Urologic Institute, LLC. (MAUI) /* _____ */* _____, *and* _____. I may now or in the near future receive additional treatment at one of these facilities. I hereby acknowledge that I have the right to request or may choose to obtain the referred services from a different health care entity.

Signed: _____ Name Printed: _____ Date: _____

Insurance Information

Please give our receptionist your insurance card(s) and driver's license, which he/she will photocopy/scan into your computer chart and return to you. If you do not have your insurance card(s) with you, fill in all information (primary and secondary) in the appropriate section of the second page, until you provide a copy. Please write **NONE** in the secondary insurance block if you are covered by only one insurance policy.

If you tell us you have only one insurance policy and, at a later date, ask us to file claims for another insurance, you will be required to pay:

1. $50.00 for each additional insurance claim we must file (or re-file) for coordination of benefits.
2. The balance in full for all claims your insurance carriers refuse to pay because you withheld information that caused claims to be filed after their deadline date.

Patient Account Information

All patients that do not have HMO insurance or Medicare with secondary coverage are required to pay 20% of their office visit at the time of service. For these patients we will also require a $100.00 pre-payment for any diagnostic/surgical procedure.

Any account over 30 days is subject to a re-bill (finance) charge of 1.5% per month. If a payment plan has been setup and adhered to, this charge will not apply.

Any account that has been sent to the collection agency is required to be paid in full (in cash) prior to your next office visit. We also require a collection patient to pay the fee for his/her collection balance that we have been charged by the agency to collect your balance.

Office Appointments

PLEASE BE ADVISED THAT THERE WILL BE A $25.00 FEE CHARGED TO YOUR ACCOUNT, NOT YOUR INSURANCE COMPANY, FOR ANY AND ALL NO-SHOW APPOINTMENTS OR CANCELLED APPOINTMENTS IF NOTICE IS LESS THAN 24 HOURS.

By signing below I acknowledge that I have read and understand all of the information stated above.

_____ _____/_____/_____

SIGNATURE OF PATIENT/GUARDIAN DATE (MM/DD/YYYY)

PROCEDURE/SURGERY CANCELLATION POLICY

If it is determined and decided upon by you and your physician that you will need to have a procedure and/or surgery to resolve the issues you are experiencing, the following Procedure/Surgery Cancellation Policy applies:

1. If you choose to cancel your Procedure/Surgery, it may be up to 30-45 days until the next surgery date is available.
2. If you do not cancel the Procedure/Surgery within 4 days of the scheduled date, you will be charged a $100.00 cancellation fee (This is not charged to your insurance).
3. Before the Procedure/Surgery is rescheduled, you must have paid the above-mentioned cancellation fee.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____ DOB: _____

Note: Should you not elect to sign this cancellation policy prior to being seen and/or leaving this office today, then to be scheduled for your procedure/surgery you will have to appear in person to sign this document.

Name: _____

Date of Birth: _____

Referring Physician: _____

Primary Care Physician: _____

MIDATLANTIC UROLOGY ASSOCIATES, LLC.

Patient History Form

Person #: _____

Chief Complaint *Check the reason(s) for your visit below. Describe:*

__ Abdominal pain
__ Bladder cancer
__ Blood in the urine
__ Difficulty with urination
__ Elevated PSA
__ Erectile dysfunction
__ Incontinence
__ Infertility
__ Kidney cancer
__ Kidney stones
__ Prostate cancer
__ Prostate check
__ Urinary tract infection
__ Vasectomy
Other: _____

HISTORY OF PRESENT ILLNESS

Location of the problem: _____
When did you first notice it: _____
How long does it last: _____
Is it constant or variable: _____
Is there any other related problem: _____
What helps the problem: _____
What makes it worse: _____
Rate how severe the problem is (10 is most severe):
(circle) 1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY

Have you ever been treated for any of the following medical problems?
*Circle **Y** or **N**, Also List Treating Doctor*

Adrenal Problems	Y	N
Asthma/Emphysema	Y	N
Blood Clots	Y	N
Cancer: _____	Y	N
Cataracts	Y	N
Diabetes	Y	N
Gastrointestinal Bleed	Y	N
Glaucoma	Y	N
Gout	Y	N
Hepatitis	Y	N
Heart Attack/Stent/Bypass	Y	N
Heart Disease/Failure	Y	N
Irregular Heart Beat	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
HIV/AIDS	Y	N
Kidney Failure	Y	N
Kidney Stones	Y	N
Reflux/GERD/Irritable Bowel	Y	N
Sleep Apnea	Y	N
Stroke/Neurologic Disease	Y	N
Thyroid Disease	Y	N
Urinary Infection	Y	N

Other:_____

PAST SURGICAL HISTORY ___ *None*

Have you ever had any type of surgery or procedure?

Surgery/Procedure	Date & Doctor
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS ___ *None* (You may attach a list)

List all prescription & over-the-counter medications you are taking now or have taken in the past month.

Medication	Dose & Prescribing Doctor
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES ___ *No Allergies*

Check below if allergic to any of the following

___Penicillin ___ Sulfa ___ Latex

___ Contrast Dye ___Iodine ___Seafood

Other: _____

Physician Signature & Date

Patient Name: _____

Person #:

MIDATLANTIC UROLOGY ASSOCIATES, LLC.

Patient History Form

SOCIAL HISTORY *Circle **Y** or **N***

Do you currently smoke?	Y	N
Have you ever been a smoker?	Y	N
For how many years?	_____	
Packs per day	_____	
Do you drink alcohol?	Y	N
How many drinks per week?	_____	
Do you take any illegal drugs?	Y	N
Intravenous drugs?	Y	N

Occupation: _____

Employer: _____

___ Married ___ Divorced ___ Single ___ Widow

Number of Children___ Number of Pregnancies___

FAMILY HISTORY *Circle **Y** or **N***

Do you have any parents or siblings with any of the following conditions?

Prostate Cancer	Y	N
Kidney Cancer	Y	N
Other Cancers: _____		
Kidney Stones	Y	N
Diabetes	Y	N
Heart Disease	Y	N
High Blood Pressure	Y	N
Other: _____		

REVIEW OF SYSTEMS Do you now have or have you recently had any problems related to the following? *Circle **Y** or **N***

GENERAL SYMPTOMS		
Fatigue	Y	N
Fever	Y	N
Night Sweats	Y	N
EYE/EAR/NOSE/THROAT		
Eyes, Discharge	Y	N
Eyes, Visual Loss	Y	N
Ears, Discharge	Y	N
Ears, Hearing Loss	Y	N
Nasal Discharge	Y	N
RESPIRATORY		
Cough	Y	N
Shortness of Breath	Y	N
Wheezing	Y	N
HEART/VASCULAR		
Chest Pain	Y	N
Palpitations	Y	N
Swollen Feet/Legs	Y	N
ENDOCRINE		
Cold Intolerance	Y	N
Heat Intolerance	Y	N
Marked Thirst	Y	N
Chronic Hunger	Y	N

GENITOURINARY		
Blood in Urine	Y	N
Frequent Urination	Y	N
Painful Urination	Y	N
Less Sexual Interest	Y	N
Penile Discharge	Y	N
GYNECOLOGY		
Painful Periods	Y	N
Heavy Periods	Y	N
Vaginal Discharge	Y	N
GASTROINTESTINAL		
Abdominal Pain	Y	N
Constipation	Y	N
Diarrhea	Y	N
Vomiting	Y	N
Heartburn	Y	N
Reflux	Y	N
Poor Appetite	Y	N

NEUROLOGY		
Unstable Gait	Y	N
Tremors	Y	N
Numbness/Tingling	Y	N
Depression	Y	N
SKIN		
Persistent Itching	Y	N
Rash	Y	N
MUSCULOSKELETAL		
Back Pain	Y	N
Joint Pain	Y	N
Neck Pain	Y	N
BLOOD/LYMPH		
Easy Bleeding	Y	N
Easy Bruising	Y	N
Blood Clots	Y	N
IMMUNOLOGY		
Environmental Allergy	Y	N
Food Allergy	Y	N

VITAL SIGNS Height: _____ Weight: _____

I certify that, to the best of my knowledge, the information on this form is complete and correct.

Patient Signature: _____

Date: _____

For Office Use:

Reviewed by	Date	Reviewed by	Date
_____	_____	_____	_____
_____	_____	_____	_____

Physician Signature & Date: _____