



Providence Medical Park / 3841 Piper Street, Suite T300 / Anchorage, AK 99508  
Alaska Regional Campus / 2925 DeBarr Road, Suite 250 / Anchorage, AK 99508  
Ph: (907)-563-3103 F: (907)-561-1862

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Mat-Su Regional Medical Plaza / 2490 S. Woodworth Loop, Suite 401 / Palmer, AK 99645  
Ph: (907)-745-9300 Fax: (907)-745-9301  
[www.alaskaurology.com](http://www.alaskaurology.com)

### **NEW PATIENT INFORMATION AND INSTRUCTIONS**

1. Please complete all paperwork prior to your appointment. If you received a self addressed stamped envelope, please mail back the paperwork prior to your appointment.
2. Please bring your insurance card(s) with you to your appointment. If you do not have your insurance card, you may be asked to reschedule your appointment or pay in full at the time of service. You will then be responsible for submitting a claim to your insurance company.
3. Please bring a picture ID with you to your appointment.
4. **If you have had any prior consultations with another provider, please obtain your medical files from that provider's office prior to your visit to our office. From experience, it is more reliable to pick up your records than to rely on the mail delivery or another office to fax them to us. They will need a signed release from you to obtain these files. *If you have had any X-rays, Cat scans, Ultrasounds, or Biopsies pertaining to your urological problem, you should obtain these studies and the reports prior to your visit and bring them with you. Without these, it may be necessary to reschedule your appointment.***
5. The majority of patients will need to provide a urine specimen at the time of their visit.

### **BILLING AND PAYMENT**

**Medicare Patients:** Our office **does** accept Medicare assignment, which means that Medicare reimbursement will be sent directly to the Physician. Billing to your supplemental insurance will be taken care of from this office if you provide us with the appropriate insurance information, including copies of insurance card(s).

**Insurance Billing:** If you have given us the appropriate information, we will submit your charges to your insurance company. At the time of service, you will be responsible for the amount your insurance does not cover to include co-pays and any part of your deductible that has not been met.

**Medicaid Patients:** You **must** have your current month's sticker with you for your visits, and your co-pay is due at the time of service.

**Some insurance companies require referrals from your Primary Care Physician. If you have this type of insurance, be sure to bring us a completed referral form.** With the referral form, we will bill the insurance company. Without the referral, we will bill the patient in full.

**REMEMBER-You are responsible for any charges that are NOT covered by your insurance.**



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**PATIENT INFORMATION RECORD**

**Title:** (please circle) **Mr. Mrs. Ms. Dr.** other: \_\_\_\_\_ **Suffix:** **I II III IV Jr. Sr.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Referred by: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Location: \_\_\_\_\_

SEX: Male \_\_\_\_\_ Female \_\_\_\_\_ Other: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: **M W D S**

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \* Is it ok to call you at this number? **Y N** Leave a message? **Y N**

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \* Is it ok to call you at this number? **Y N** Leave a message? **Y N**

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \* Is it ok to call you at this number? **Y N** Leave a message? **Y N**

Preferred Method of Communication: **Home Work Cell Other:** \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

**In case of Emergency, contact:** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Emer. Contact Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship: \_\_\_\_\_

**INSURANCE INFORMATION**

Is this related to a Work Comp claim? **Yes** \_\_\_\_ **No** \_\_\_\_ -or- Motor Vehicle Accident? **Yes** \_\_\_\_ **No** \_\_\_\_

**Primary** Insurance Carrier: \_\_\_\_\_ Policy Holder: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_

Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

**Secondary** Insurance Carrier: \_\_\_\_\_ Policy Holder: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_

Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

----- Please see reverse side -----

**PRESCRIPTION HISTORY CONSENT**

For safe, effective medication prescribing, Electronic Health Records enables us to identify all of your current medications electronically. Alaska Urology automatically utilizes electronic prescriptions to and from pharmacies. Your consent is automatically authorized unless you sign below to OPT out.

\_\_\_\_\_  
Signature *Opting out* of Electronic Prescriptions

\_\_\_\_\_  
Date

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize Alaska Urology and its employees, agents or associated healthcare practitioners to disclose my protected health information to the following individuals:

Name \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Relationship \_\_\_\_\_

**PATIENT CONSENT/ASSIGNMENT:** I hereby authorize Alaska Urology to release any information acquired in the course of my treatment to/from my insurance company, physician’s office, hospital or any other treatment facility. I agree to be fully responsible for all expenses incurred for medical treatment. I assign to Alaska Urology any and all insurance benefits due to me, the full financial obligations for medical treatment that I have not paid for.

**Printed Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**IF the above patient is a CHILD, has a SPOUSE, has a LEGAL GUARDIAN, or is NOT RESPONSIBLE FOR THE BILL, PLEASE COMPLETE the information requested in the section below:**

**Please check one:**

- Parent of Child       Spouse       Legal Representative       Party responsible for the bill

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SEX: Male \_\_\_\_\_ Female \_\_\_\_\_ Other: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: **M W D S**

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_



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### FINANCIAL POLICY

Thank you for choosing Alaska Urology. We are committed to providing you the best urological healthcare available. You are required to read and sign our financial policy prior to any treatment. Please feel free to ask any questions and a copy of this policy will be provided to you upon request. As a courtesy to our patients, we bill all insurance types.

**INSURANCE...** We are participating providers for Medicare, Medicaid, Blue Cross/Blue Shield, Aetna, MultiPlan/BeechStreet and Cigna. It is **your responsibility** to know your insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions. All patients with insurance coverage of any type must show their insurance card for us to bill your insurance. If you do not provide proof of insurance, you will be expected to **pay in full** at the time of service and will be considered a self-pay patient until the appropriate billing information is provided to our office. If you are not insured, **payment in full** is expected at the time service is rendered.

**COPAYMENTS/COINSURANCE/DEDUCTIBLES...** All patient responsibility for services must be paid at the time of service. This is part of your contractual obligation with your insurance company.

**NON-COVERED SERVICES...** Please be aware that some or all of the services provided may not be covered or not considered reasonable or necessary by some insurers. It is your responsibility to pay in full for these services at the time of your visit.

**USUAL & CUSTOMARY...** Our prices are representative of the usual and customary charges for our geographic area. You are expected to pay in full for any balance after insurance. At our discretion, Alaska Urology may assist you in appealing your insurance determination and/or appeal benefits on your behalf.

**PROOF OF INSURANCE...** All patients must complete our patient information forms and sign where indicated before being seen. We must obtain a copy of your insurance card(s) and a copy of a photo ID for billing. Failure to provide us with correct information will result in you being responsible for the balance of your claim.

**CLAIMS SUBMISSION...** As a courtesy to our patients, we will submit claims and assist you in a reasonable way to get your claims paid. Your insurance company may need you to supply certain information directly to them. It is **your responsibility** to comply with their request. Please understand and be aware that the balance of your unpaid claim(s) is your responsibility.

**SURGERIES...** All patient responsibility for surgeries must be paid in advance.

**COVERAGE CHANGES...** If your insurance changes, please notify us as soon as possible, so we can make the appropriate changes to help you receive your maximum benefits. **If your insurance does not pay your claim**, the balance may be billed to you.

**NON-PAYMENT...** If your account is thirty (30) days past due, you may be contacted by our billing department asking for payment in full. If your balance is unpaid after six (6) months, we may refer your account to our collection agency and you may be discharged from this practice.

**PAYMENT OPTIONS...** We accept Cash, Check, Money Order, Visa, MasterCard, and Discover. Please note there will be a \$30 charge for checks returned for non-sufficient funds.

**MISSED APPOINTMENTS...** It is our policy to reserve the right to charge for missed appointments not cancelled with at minimum one (1) business day's notice of your scheduled appointment. Please assist us by keeping your appointment or cancelling with a minimum of one (1) business days notice. Appointments cancelled with less than one (1) business days notice will be considered a no-show. After one no-show, you will be required to pay a \$25 deposit to schedule another appointment. If cancellation is not given in a minimum of (1) business day for the appointment, your \$25 deposit will be forfeited and if you wish to reschedule, you will be asked for another \$25 deposit. We reserve the right to discharge patients from our practice for chronic missed appointments.

**PATIENT CONSENT/ASSIGNMENT...** I hereby authorize Alaska Urology to release any information acquired in the course of my treatment to/from my insurance company, physician's office, hospital or any other treatment facility. I agree to be fully responsible for all expenses incurred for medical treatment. I assign to Alaska Urology any and all insurance benefits due to me, the full financial obligations for medical treatment that I have not paid for.

Our practice is committed to providing the best urological care to our patients. Thank you again for choosing Alaska Urology. Please let us know if you have any questions or concerns.

**I have read and understand the Alaska Urology payment policy and agree to adhere to its guidelines.**

**I also hereby acknowledge that I have received Alaska Urology's Notice of Privacy Practices.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: (if different than patient) \_\_\_\_\_ DOB: \_\_\_\_\_

## Medical History Sheet

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**General Physician:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**Reason for Today's Visit:** \_\_\_\_\_

**Medical History: (please mark all you have ever been treated for or are currently being treated)**

- No Medical History

*General*

- Bleeding Disorder
- Glaucoma
- HIV/AIDS
- MRSA
- Rheumatic Fever
- Systemic Lupus Erythematosus
- Transplant Recipient, Organ: \_\_\_\_\_

*Cardiovascular*

- Aortic Abnormality: \_\_\_\_\_
- Atrial Fibrillation
- Blood Transfusion, Date: \_\_\_\_\_
- Congestive Heart Failure
- Coronary Artery Disease
- Clot in Leg or Lung
- Heart Attack
- Heart Murmur
- Heart Valve Disorder, Type: \_\_\_\_\_
- High Blood Pressure

*Endocrine/Metabolic*

- Diabetes
- Hyperthyroidism
- Hypothyroidism
- Low Testosterone

*Respiratory*

- Asthma
- COPD
- Emphysema
- Sleep Apnea
  - Use CPAP

*Gastrointestinal*

- Acid Reflux/GERD
- Crohn's Disease
- Hepatitis
- Stomach Ulcer
- Ulcerative Colitis

*Genitourinary*

- Chronic Kidney Disease
- Genital Herpes
- Genital Warts
- Interstitial Cystitis
- Kidney Stones
- Renal Failure
- STD: \_\_\_\_\_
- Urinary Tract Infections

*Men's Health*

- BPH
- Hydrocele/Spermatocele
- Prostatitis

*Women's Health*

- Endometriosis
- Uterine Fibroids

*Musculoskeletal*

- Arthritis
- Artificial Joints
- Chronic Back Pain
- Fibromyalgia
- Gout

*Neuro/Psych*

- Alzheimer's Disease
- Anxiety
- Parkinson's Disease
- Multiple Sclerosis
- Psychiatric Diagnosis: \_\_\_\_\_
- Spinal Cord Injury, Level: \_\_\_\_\_
- Stroke/TIA

*Cancer*

- Bladder
- Colon/Rectal
- Female, Type: \_\_\_\_\_
- Kidney
- Penile
- Prostate
- Testicular
- Other: \_\_\_\_\_

Other Medical History: \_\_\_\_\_

**Immunizations:**

Is the patient up to date on immunizations? Yes No

**Female Health History:**

Date of Last Menstrual Period: \_\_\_\_\_ Post-Menopausal: Yes No  
Pregnancies# \_\_\_\_\_ Live Births# \_\_\_\_\_ Abortions (elective or spontaneous)# \_\_\_\_\_

**Male Health History:**

Date of Last PSA: \_\_\_\_\_  
Date of Last Prostate Exam: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

**Recent Studies or Labs:**

What: \_\_\_\_\_ Where: \_\_\_\_\_ Date: \_\_\_\_\_  
What: \_\_\_\_\_ Where: \_\_\_\_\_ Date: \_\_\_\_\_

**Surgical History: (please list ALL surgeries you have ever had) \*if additional space needed, please ask.**

Vasectomy Date: \_\_\_\_\_ Hysterectomy Date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History: (please list type of cancer) \*if additional space needed, please ask**

Condition	Relative(s)	Age of Diagnosis	Living/Passed
Cancer:			
Cancer:			
Diabetes			
Heart Attack			
Heart Disease			
High Blood Pressure			
Kidney Stones			
Kidney Failure			
Other:			

**Social History: (circle or fill in appropriate response)**

Marital Status:  
\_\_\_ Single \_\_\_ Divorced # of Children: \_\_\_\_\_  
\_\_\_ Married \_\_\_ Widowed

Current Alcohol Consumption: No Yes \_\_\_\_\_ drink per day  
History of Alcohol Abuse: No Yes \_\_\_\_\_ days/months/years sober

Current Tobacco Use: No Yes cigarettes/cigars/chew \_\_\_\_\_ packs per day  
History of Tobacco Use: No Yes Age start? \_\_\_\_\_ Age stop? \_\_\_\_\_

Recreational Drug Use:  
\_\_\_ None \_\_\_ Current, name substance(s) \_\_\_\_\_  
\_\_\_ Former, name substance(s) \_\_\_\_\_ days/mos/yrs sober

Daily Fluid Intake:  
\_\_\_\_\_ 8 oz. cups of coffee per day \_\_\_\_\_ 8 oz. glasses of milk per day  
\_\_\_\_\_ 8 oz. glasses of tea per day \_\_\_\_\_ 8 oz glasses of water per day

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse/MA Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**Patient Medication List**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Local Preferred Pharmacy: \_\_\_\_\_

(Please include Prescription, Vitamins, and Over-the-counter Medications)

Medication	Dose	Time of Day (morning, noon, night)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

**Allergies**

(Please list all known allergies, reactions and cause)

\_\_\_\_\_ No Known Drug Allergies (X or initials)

1.
2.
3.
4.
5.





Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

REVIEW OF SYSTEMS

- 1. Constitutional Symptoms
2. Cardiovascular
3. Respiratory
4. Gastrointestinal
5. Genitourinary
6. Skin
7. Neurological
8. Musculoskeletal
9. Endocrine
10. Psychiatric
11. Hematologic/Lymphatic
12. Allergic-Immunologic
Female:

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_