REGISTRATION
(Please print)

MICHAEL F. SAROSDY, M.D.
South Texas Urology & Urologic Oncology, P.A.
9102 Floyd Curl Dr.
San Antonio, TX 78240
(210) 615-3899 telephone, (210) 615-3803 fax
www.DrSarosdy.com

Acct #:_____

Lab:_____

Date _____ Home Phone _____

Cell Phone _____

Patient _____ Sex [ ] M [ ] F
Last Name First Name Initial

Street Address _____

City _____ State _____ Zip _____ [ ] Single [ ] Married

Age _____ Date of Birth _____ SS # _____ Drivers Lic. # _____

Employer _____ [ ] Full time [ ] Part time [ ] Retired, date _____

Business Address _____ Business Phone _____

Occupation _____ Home/Business Fax _____

Spouse/Parent _____ Date of Birth _____ SS # _____

Employer Name/Address _____

Occupation _____ Business Phone _____

Person responsible for account _____ Relationship to patient _____

Address if different _____ Phone _____

Primary Insurance _____ HMO/PPO

Insured _____ Grp # _____ ID # _____

Secondary Insurance _____ HMO/PPO

Insured _____ Grp # _____ ID # _____

In case of emergency, who should be notified? _____ Phone _____

What is your email address? _____

Primary Care/Family Doctor _____ Phone _____ Fax _____

Whom may we thank for referring you? _____ Fax if M.D. _____

If you are from out of town, please let us know where you stay while in San Antonio and a phone number where we may reach you:

_____

Pharmacy Info: _____ **Cross-streets** _____

ASSIGNMENT AND RELEASE OF INFORMATION

I attest with my signature below that I have disclosed above all health care insurance under which I am covered. I hereby assign directly to **South Texas Urology & Urologic Oncology, P.A.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **South Texas Urology & Urologic Oncology, P.A.** to release any and all medical and personal information (which may include drug, alcohol, psychiatric, HIV or AIDS information) to my insurance carrier(s) necessary to process my claims. I authorized the use of this signature on all my insurance submissions.

_____ _____
Signature of patient/guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **South Texas Urology & Urologic Oncology, P.A.** for any services furnished me by them. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I have disclosed above all other health insurance under which I am covered. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier. This authorization will remain in effect until specifically revoked by me.

_____ _____
Signature of Beneficiary Date

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HISTORY (FEMALE)

PRINTED NAME_____ **AGE**_____**DATE**_____

REFERRED BY_____

*****PLEASE ANSWER ALL QUESTIONS THAT YOU CAN BY CIRCLING YES OR NO**

[YES] [NO] HAVE YOU BEEN SEEN PREVIOUSLY IN THIS OFFICE?

[YES] [NO] LOWER ABDOMINAL PAIN OR BURNING WITH URINATION

[YES] [NO] BLOOD IN URINE AT ANY TIME

[YES] [NO] SLOW URINARY STREAM

[YES] [NO] DIFFICULTY STARTING URINATION

[YES] [NO] INABILITY TO HOLD URINE (WET PANTS)

[YES] [NO] URINATING TOO FREQUENTLY (MORE THAN 6 TIMES A DAY)

[YES] [NO] AWAKENING AT NIGHT TO URINATE MORE THAN ONCE

[YES] [NO] BEDWETTING

[YES] [NO] KIDNEY INFECTIONS

[YES] [NO] BLADDER INFECTIONS

[YES] [NO] KIDNEY STONE

[YES] [NO] TUBERCULOSIS

[YES] [NO] RECENT FEVERS OR CHILLS

[YES] [NO] HAVE YOU BEEN TO A UROLOGIST BEFORE?

[YES] [NO] HAVE YOU HAD KIDNEY OR BLADDER X-RAYS BEFORE?

[YES] [NO] HAVE YOU HAD PRIOR SURGERY ON YOUR BLADDER OR KIDNEYS?

[YES] [NO] ARE YOUR PERIODS NORMAL? IF NOT, DESCRIBE_____

[YES] [NO] RECENT VAGINAL DISCHARGE?

[YES] [NO] HAVE YOU BEEN ON BIRTH CONTROL PILLS? [NOW] [PAST]

[YES] [NO] HAVE YOU HAD PRIOR SURGERY ON YOUR UTERUS, OVARIES OR VAGINA?

IF APPLICABLE, WHEN WAS YOUR LAST PERIOD?_____

IF APPLICABLE, WHAT TYPE OF CONTRACEPTION ARE YOU USING?_____

PLEASE CONTINUE TO THE NEXT PAGE

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NAME_____

DO YOU TAKE ASPIRIN OR ANY ASPIRIN-CONTAINING DRUGS [YES] [NO]

LIST ALL MEDICATIONS YOU HAVE TAKEN IN THE LAST TEN (10) DAYS

_____

LIST ALL MEDICINES YOU ARE ALLERGIC TO OR CANNOT TAKE

_____

LIST ALL PREVIOUS OPERATIONS OR SURGERIES

LIST PREVIOUS SERIOUS ILLNESSES OR INJURIES

HAS ANYBODY IN YOUR FAMILY HAD?... (CIRCLE): CANCER TUBERCULOSIS DIABETES

KIDNEY FAILURE KIDNEY STONE HIGH BLOOD PRESSURE HEART DISEASE

DO YOU SMOKE CIGARETTES? [YES] [NO] HOW MANY PACKS PER DAY?_____
IF YOU STOPPED SMOKING, WHEN _____HOW MANY YEARS DID YOU SMOKE?_____PACKS/DAY_____

DO YOU DRINK ALCOHOLIC BEVERAGES?

NEVER OCCASIONAL MODERATE HEAVY

WHAT KIND OF WORK DO YOU DO?_____

DO YOU GET REGULAR EXERCISE?_____WHAT?_____TIMES/WEEK?_____

HOW MANY PREGNANCIES? _____ HOW MANY CHILDREN BORN ALIVE?_____

WHEN WAS YOUR LAST PAP SMEAR?_____ HAVE YOU HAD PROBLEMS OR LUMPS IN YOUR BREASTS? [YES] [NO]

PLEASE CIRCLE ANY RECENT PROBLEMS YOU HAVE NOTED:

WEIGHT LOSS (_____POUNDS IN _____MONTHS), FEVER, CHILLS, OR NIGHT SWEATS?

VISUAL CHANGES, CATARACTS, HISTORY OF GLAUCOMA?

VERTIGO; CHANGES IN HEARING OR RINGING IN THE EARS; SINUS PROBLEMS; DIFFICULTY SWALLOWING; GUM SWELLING; BLEEDING OR PAIN?

CHEST PAIN, FLOPPING OF YOUR HEART, SHORTNESS OF BREATH AT REST OR WITH EXERTION? SWELLING OF ANKLES, NEEDING TO PROP UP ON PILLOWS TO SLEEP?

COUGHING OR WHEEZING?

NAUSEA, VOMITING, CONSTIPATION OR DIARHEA REQUIRING MEDICINES, BLOATING OR JAUNDICE?

JOINT OR MUSCLE PAIN, SWELLING OR WEAKNESS REQUIRING MEDICAL ATTENTION?

SKIN RASHES OR SORES OR LUMPS?

HEADACHES, SEIZURES, TREMORS, DOUBLE-VISION, DIZZINESS OR FAINTING?

ARE THERE ANY OTHER PROBLEMS THAT HAVE NOT BEEN MENTIONED?

SIGNATURE_____ DATE_____ v08/06

Michael F. Sarosdy, MD
South Texas Urology & Urologic Oncology, PA

Financial Policy

It is the policy of this office to extend to our patients the courtesy of allowing you to assign your insurance benefits directly to us and to bill them for your care. While this policy reduces your out-of pocket expenses, certain requirements remain your responsibility.

Insurance benefits vary from company to company and policy to policy. Although we will file your claim on your behalf, you will remain personally responsible for payment of all services rendered.

Cash Patients

All payments are expected at the time of service unless PRIOR arrangements have been made.

Insurance Patients

The privilege of insurance assignment begins when your insurance information is received and verified by our office and the Assignment of Benefits statement has been signed.

All deductible amounts must be paid prior to insurance submittal, a requirement of your insurance company or Medicare/Medicaid (spenddown).

Our office will verify your insurance benefits in an effort to determine exactly what coverage is available to you under your particular policy. You are responsible for monitoring any limits your policy may have, such as the number of visits, pre-certification requirements, noncovered services or maximum dollar amount that is covered.

All co-insurance and co-payments are payable at the time of service. A coinsurance is any part of our service that is not paid by your insurance.

Texas law requires insurance companies to respond to claims within 45 days. If your insurance company has not responded to a claim within 45 days of submission, you are responsible to take an active part in the recovery of your claim. After 60 days, you will be responsible for payment in full for any unpaid balance.

From time to time, we experience difficulty in collecting from insurance companies. If this occurs on a regular basis, contractual insurance assignment with that company may be terminated. We will give you ample notice and ask that you act on your own behalf with your insurance company under such a circumstance.

This office does not promise that an insurance company will pay the usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement limits set by that company. You will be responsible for payment of any amount which your insurance has determined to exceed their usual and customary benefit, unless we have a contractual agreement to accept that amount.

Should you discontinue care for any reason other than discharge by the doctor, any and all balances will be due and payable within 30 days.

All Patients

A returned check charge of $25.00 will be assessed for each check returned by your bank for any reason.

A finance charge of 1.0% monthly (corresponding to a 12% APR) may be added to all patient balances remaining after 30 days of patient responsibility. No fee is charged if the balance is paid in full within 30 days.

A Billing Fee of $5.00 may be added to all patient balances for each monthly statement generated after 30 days of patient obligation.

Accounts more than 90 days past-due are considered delinquent and may be forwarded for collection and credit reporting. As a result, you will be liable for all collection and/or attorney's fees and court costs.

Understanding and Agreement

I have read and understand this policy and agree to the terms set forth. I authorize and assign direct payment of medical benefits from insurance, attorney, or third party payer to South Texas Urology and Urologic Oncology, PA. I authorize the release of any medical or financial information necessary to secure payment for services rendered. I understand that I am personally responsible for ALL charges whether or not paid by insurance, attorney, or other third party payer.

_____ _____
Signature of Patient or Guardian Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of South Texas Urology & Urologic Oncology, P.A.'s Notice of Privacy Practices.

_____ _____
Signature of Patient or Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR SOUTH TEXAS UROLOGY & UROLOGIC ONCOLOGY, PA

Patient Name: _____

Date of Birth:_____

I acknowledge that South Texas Urology & Urologic Oncology has provided me with a written copy of their Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

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Name_____ **Date**_____

Race:
[ ] American Indian/Alaska Native
[ ] Asian
[ ] Black/African American
[ ] Native Hawaiian/Pacific Islander
[ ] White
[ ] Refuse to report

Ethnicity:
[ ] Hispanic/Latino
[ ] Non Hispanic/Latino
[ ] Refuse to report

Language:
[ ] English
[ ] Spanish
[ ] Other _____

For patient reminders/recalls, preferred method of contact ___phone ____email* ____US mail

I hereby give my consent for South Texas Urology & Urologic Oncology, PA to perform medication confirmation with my other physician(s) and/or pharmacy in order to determine the most accurate listing of my medications.

_____
Patient signature

I understand that South Texas Urology & Urologic Oncology provides a patient web portal for timely access to my health information.

[ ] I would like patient portal access*

[ ] I do not want patient portal access at this time. I understand I can request access in the future.

_____
Patient signature

*_____
Email address for contact and/or portal

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We are excited to offer you our NEW bidirectional patient portal. This portal is available to you 24/7 from any computer, tablet or smart phone! There you can find the following information from your Electronic Health Record with us:

*Demographic information
*Insurance Payers
*Problem List
*Family History
*Procedures
*Allergies
*Medication List
*Encounters
*Lab Results
*Educational Materials

This information can be viewed, printed, downloaded or securely transmitted to another provider if you choose to do so.

You can also contact us securely through this portal to:
*Ask a question
*Request a refill of medication
*Request an appointment

To request access please complete the following so that we can send you an invitation email:
(The email will come from "Follow My Health")

Name:_____ Date of Birth:_____

Email: _____

Last 4 digits of your Social Security # _____