MICHAEL F. SAROSDY, M.D.

REGISTRATION
(Please print)

South Texas Urology & Urologic Oncology, P.A.
4499 Medical Drive, Suite 218
San Antonio, TX 78229
(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?

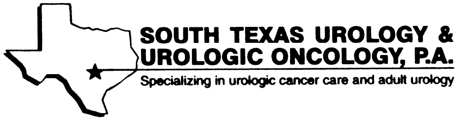
JOINT OR MUSCLE PAIN, SWELLING OR WEAKNESS REQUIRING MEDICAL ATTENTION?

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



Notice of Privacy Practices

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accounting Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **South Texas Urology & Urologic Oncology, P.A.**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.
Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state=s public health department.
Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders. Your health information will be used by our staff to send you appointment reminders.
Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include the right to:

- request restrictions on the use and disclosure of your protected health information
- receive confidential communications concerning your medical condition and treatment by alternative means or location
- inspect and copy your protected health information
- amend or submit corrections to your protected health information
- receive an accounting of how and to whom your protected health information has been disclosed
- receive a printed copy of this notice

South Texas Urology & Urologic Oncology, P.A.'s Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Privacy Officer, South Texas Urology & Urologic Oncology, P.A., 4499 Medical Drive, Suite 218, San Antonio, TX 78229. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the contact person listed below. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
South Texas Urology & Urologic Oncology, P.A.
4499 Medical Drive, Suite 218
San Antonio, Texas 78229

This Notice is effective on or after April 14, 2003

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) mayl 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 mayl 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 mayl 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