central ohio UROLOGY group

Central Ohio Urology Group

PATIENT INFORMATION

PATIENT INFORMATION SHEET					
Last:		First:		MI:	
Social Security #:		Birthdate:		Sex:	
Address:			Apartment #:		
City:		State:		Zip:	
Race:	Language:	Ethnicity:		Marital Status:	
Primary Care/Family Physician:			Referring Physician:		
Home Phone: ( ) -			Cell Phone: ( ) -		
Work Phone: ( ) -			Email:		
Employer:			Occupation:		

SPOUSE AND/OR RESPONSIBLE PARTY INFORMATION					
Last:		First:		MI:	
SSN #:	Birth Date:	Sex:	Relationship:		
Address:			Apartment #:		
City:		State:		Zip:	
Phone: ( ) -			Work Phone: ( ) -		
Employer:			Occupation:		

BUREAU OF WORKERS COMPENSATION (BWC)	
Is this a BWC claim?:	Who is your MCO (Careworks, Sheakley, etc):
Claim #:	If applicable please provide a copy of your C9

INSURANCE INFORMATION (PLEASE GIVE YOUR CARD TO THE FRONT DESK STAFF)	
Primary Insurance	**Secondary Insurance** (If applicable)
Plan Name:	Plan Name:
Policyholder's Name:	Policyholder's Name:
Policyholder's DOB:	Policyholder's DOB:
Policy/ID #:	Policy/ID #:
Group #:	Group #:

CENTRAL OHIO UROLOGY GROUP PATIENT HISTORY FORM

PATIENT INFORMATION				
First:	MI:	Last:		
Birthdate:	Age:	Sex:	Weight:	Height:

HISTORY OF PRESENT ILLNESS

COMPLAINT – What is the reason for your visit today?

_____

When did you first notice the problem?_____

Does the problem interfere with your normal functions? Yes No

Does anything make the problem worse?_____

Do you have any of the following symptoms: (Check all that apply)

☐ Blood in urine ☐Burning with urination ☐Urine leakage ☐Decreased urine stream ☐Straining to urinate

☐Waking up to urinate, how many times a night?_____ ☐Urinary frequency, how many times a day?_____

SOCIAL HISTORY			
Do you use tobacco? Yes No Former	Type:	Packs/Day:	Years:
Ever tried to quit? Yes No	Year Quit:		
Do you drink alcohol? Yes No	Type:	Amount:	Frequency:
Caffeine? Yes No	Type: Coffee Soda Tea Other	Amount:	Frequency:
History of illegal drug use? Yes No	Type:		

ALLERGIES

Please list name and reaction (example: penicillin-hives). Also list anesthesia problems:

1.	Reaction:
2.	Reaction:
3.	Reaction:
4.	Reaction:
5.	Reaction:

MEDICATIONS

Current medications (please include dosages and over the counter medications, continue on back if needed)

1.	Reason:	9.	Reason:
2.	Reason:	10.	Reason:
3.	Reason:	11.	Reason:
4.	Reason:	12.	Reason:
5.	Reason:	13.	Reason:
6.	Reason:	14.	Reason:
7.	Reason:	15.	Reason:
8.	Reason:	16.	Reason:
Do you take aspirin regularly?		If yes, how much?	

PHARMACY INFORMATION			
Pharmacy Name:	Pharmacy Phone #: ( ) -		
Address:	City:	State:	Zip:

_____ _____

Patient/Guardian Signature Date

Central Ohio Urology Group

FAMILY HISTORY

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Date: _____

Print Patient Name: _____ DOB: _____

Please check if applicable. Please state your family members' relation to you.

Condition	Family Member(s)
☐ Blood Disease	☐Paternal ☐Maternal Relation:
☐ BPH (Enlarged Prostate)	☐Paternal ☐Maternal Relation:
☐ Cancer: Type: _____	☐Paternal ☐Maternal Relation:
☐ Crohn's Disease	☐Paternal ☐Maternal Relation:
☐ Diabetes	☐Paternal ☐Maternal Relation:
☐ Eczema (Skin disorder)	☐Paternal ☐Maternal Relation:
☐ Gout	☐Paternal ☐Maternal Relation:
☐ Hearing Impairment	☐Paternal ☐Maternal Relation:
☐ Heart Disease Type: _____	☐Paternal ☐Maternal Relation:
☐ High Blood Pressure	☐Paternal ☐Maternal Relation:
☐ High Cholesterol	☐Paternal ☐Maternal Relation:
☐ Kidney Failure	☐Paternal ☐Maternal Relation:
☐ Kidney Stones	☐Paternal ☐Maternal Relation:
☐ Migraines	☐Paternal ☐Maternal Relation:
☐ Seizure Disorder	☐Paternal ☐Maternal Relation:
☐ Stroke	☐Paternal ☐Maternal Relation:
☐ Urinary Tract Infections	☐Paternal ☐Maternal Relation:
☐ Other: _____	☐Paternal ☐Maternal Relation:

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FEMALE PAST MEDICAL/SURGICAL HISTORY

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Print Patient Name: _____ DOB: _____

	Female Medical History	Year		Female Surgical History	Year
☐	Anemia		☐	Adrenalectomy	
☐	Arthritis		☐	Appendectomy	
☐	Cancer		☐	Back Surgery	
☐	Chest Pain		☐	Bladder Augmentation	
☐	Chronic UTIs		☐	Bladder Removal	
☐	Chronic Obstructive Pulmonary Disease (COPD)		☐	Bladder Suspension	
☐	Congestive Heart Failure		☐	Breast Biopsy	
☐	Depression		☐	Cesarean Section	
☐	Diabetes		☐	Colectomy	
☐	Diverticular Disease		☐	Colon Surgery	
☐	GERD (Acid Reflux)		☐	Coronary Artery Bypass Grafting (CABG)	
☐	Gout		☐	Coronary Stent	
☐	Heart Attack		☐	Cystoscopy	
☐	Heart Disease		☐	Gall Bladder	
☐	Hepatitis C		☐	Gastric Bypass	
☐	High Blood Pressure		☐	Hernia Repair	
☐	High Cholesterol		☐	Hip Replacement	
☐	Inflammatory Bowel Disease		☐	Hydrocelectomy	
☐	Kidney Disease		☐	Knee Replacement	
☐	Kidney Stones		☐	Laparoscopy	
☐	Liver Disease		☐	Lithotripsy	
☐	Lupus		☐	Liver Biopsy	
☐	Migraine Headaches		☐	Mastectomy	
☐	Neurologic Disease		☐	Nephrectomy	
☐	Osteoarthritis		☐	Nephrostomy Tube	
☐	Osteoporosis		☐	Pacemaker	
☐	Peptic Ulcer Disease		☐	Pubovaginal Sling	
☐	Peripheral Vascular Disease		☐	Shockwave Lithotripsy	
☐	Rheumatoid Arthritis		☐	Total Hyserectomy	
☐	Seizure Disorder		☐	Tubal Ligation	
☐	Stroke		☐	Ureteroscopy-Extraction	
☐	Thyroid Disease		☐	Ureteroscopy-Stent	
☐	Valvular Heart Disease		☐	Other	
☐	Other				

CENTRAL OHIO UROLOGY GROUP REVIEW OF SYSTEMS

Patient Name:_____ **Patient Date of Birth:**_____

Do you now or have you had any problems related to the following systems?

Constitutional Symptoms			**Metabolic/Endocrine**		
Chills	Yes	No	Cold Intolerance	Yes	No
Fever	Yes	No	Excessive Thirst	Yes	No
Weight Loss	Yes	No	Fatigue	Yes	No
Other:			Breast Pain	Yes	No
			Heat Intolerance	Yes	No
			Hot Flashes	Yes	No
			Other:		
Ears/Nose/Throat/Mouth			**Neurological**		
Blurred Vision	Yes	No	Difficulty Walking	Yes	No
Double Vision	Yes	No	Headache	Yes	No
Ear Infection	Yes	No	Memory Loss	Yes	No
Eye Pain	Yes	No	Seizures	Yes	No
Hearing Loss	Yes	No	Tremors	Yes	No
Sinus Infection	Yes	No	Other:		
Sore Throat	Yes	No			
Other:					
Respiratory			**Psychiatric**		
Chronic Cough	Yes	No	Anxiety	Yes	No
Shortness of breath	Yes	No	Depression	Yes	No
Known TB Exposure	Yes	No	Insomnia	Yes	No
Wheezing	Yes	No	Other:		
Other:					
Cardiovascular			**Integumentary**		
Chest Pain	Yes	No	Contact Allergy	Yes	No
Heart Murmur	Yes	No	Hives	Yes	No
Palpitations	Yes	No	Itching Skin	Yes	No
Varicose Veins	Yes	No	Rash	Yes	No
Other:			Other:		
Gastrointestinal			**Musculoskeletal**		
Abdominal Pain	Yes	No	Arthritis	Yes	No
Blood in stool	Yes	No	Back Pain	Yes	No
Constipation	Yes	No	Joint Pain	Yes	No
Diarrhea	Yes	No	Neck Pain	Yes	No
Heartburn	Yes	No	Other:		
Loss of Appetite	Yes	No			
Nausea	Yes	No			
Vomiting	Yes	No			
Other:					
Genitourinary			**Hematologic/Lymphatic**		
Dysuria (painful urination)	Yes	No	Easy Bleeding	Yes	No
Erectile Dysfunction	Yes	No	Swollen Glands	Yes	No
Hematuria (blood in urine)	Yes	No	Other:		
Urinary Frequency	Yes	No			
Urinary Incontinence	Yes	No			
Urinary Retention	Yes	No			
Other:					

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PATIENT HIPAA AND NOTICE OF PRIVACY PRACTICES FORM

PATIENT INFORMATION

Last Name_____First_____Middle Initial _____

DOB ____/____/_____

NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy

_____ _____

Patient/Guardian signature Date

HIPAA AND MEDICAL RECORDS CONSENT

I hereby give permission to COUG to disclose my name, contact information, social security number, progress notes, laboratory test results, radiology reports, Individually Identifiable Health Information and Protected Health Information to other physicians, health care practitioners, providers, and laboratories that work with your physicians with respect to my treatment, and to health plans with respect to payment for my treatment. I give permission to COUG to use my PHI for its Health Care Operations. I also give permission to release my medical and billing records to myself or to my guardian.

_____ _____

Patient/Guardian signature Date

Is there something you do not want us to disclose? _____

Is it okay to leave a Voicemail Message about your care? ☐ Yes ☐ No

Cell:_____Home:_____Work:_____

Please list any additional people that we are allowed to discuss your medical information with:

☐ Spouse Name_____ Phone_____

☐ Child Name_____ Phone_____

☐ Other Name_____ Phone_____

☐ Other Name_____ Phone_____

Central Ohio Urology Group

FINANCIAL POLICY

We are committed to providing you with the best possible medical care. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our practice participates with a variety of insurance plans. It is your responsibility to:
   - **Bring your current insurance card at every visit.** We consider an insurance card similar to a credit card because you are asking us to bill another party for charges for the services you have been provided. If you do not bring your insurance card, you should be prepared to pay for your services in full on that date.
   - **Be prepared to pay your copay at each visit.** We are required by your insurance plan to collect copays on the date of service. If you do not bring proper payment to your visit, you will need to reschedule your appointment, except in the case of a medical emergency.
   - **Deductibles, co-insurance and medical care <u>not covered</u> by your insurance are expected to be paid in full at the time of service. Patients that do not have insurance are considered self-pay and payment is expected at time of service.**
   - **In network** - you are responsible for verifying that we are an in-network provider for your insurance at our facilities. If we are **NOT AN IN-NETWORK PROVIDER** and you receive treatment, you **WILL be held liable for any charges.** Please note that insurance participation may vary per physician. If you have any questions concerning your coverage please contact your insurance carrier.
2. If you have insurance that we do not participate in, upon request our billing office will provide you with the itemized charges that you can file for reimbursement. However, payment in full is expected on the date of service. If you do not want us to bill your insurance, you must notify us prior to being seen. In this instance, you are considered self-pay and payment in full is required at time of service.
3. If you have secondary insurance coverage, you must provide that information on the date of service. You will be expected to pay any copay required by your primary insurance on the date of service. If you do not provide us with your secondary insurance information in order to file a timely claim, you will be responsible for any balance due after your primary insurance pays.
4. If you are unable to pay for necessary medical care, it is your responsibility to inform us prior to your visit.
5. Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the required referral, and are seen as a patient, you will be financially responsible.
6. If the patient is a minor (under 18 years of age), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at time of service.
7. A "Facility Fee" may be charged with certain commercial and government plans. You will be responsible for any portion of the "Facility Fee" that is not paid by those plans, according to your benefits.
8. If you have any questions about insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company customer service department (the number is on your insurance card).
9. If you fail to show up for an appointment more than once, without canceling at least one business day in advance, you will be charged a $25 no-show fee.
10. If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collections agency. You will be responsible for the fees assessed by the collections agency.

Our practice believes that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the office where you regularly receive services. Please sign that you have read and agree to the Financial Policy.

_____ / / _____

Name of Patient (Please Print) Date of Birth of Patient

_____ / / _____

Signature of Patient or Responsible Party Date of Signature

Central Ohio Urology Group

NOTICE OF PRIVACY PRACTICES

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.

I. Who We Are

This Notice describes the privacy practices of Central Ohio Urology Group, Inc. ("COUG"), Columbus Prostate Cancer Center, LLC (CPCC), their physicians, nurses, laboratory and radiology technologists, and other personnel. It applies to services furnished to you at any of our locations.

II. Our Privacy Obligations

We are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of our legal duties and privacy practices with respect to your Protected Health Information. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures without Your Written Authorization

In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures for Treatment, Payment and Health Care Operations. We may use and disclose PHI, but not your "Highly Confidential Information" (defined in Section IV.C below), in order to treat you, obtain payment for services provided to you and conduct our "health care operations" as detailed below:

- Treatment. We use and disclose your PHI to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.
- Payment. We may use and disclose your PHI to obtain payment for services that we provide to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care to verify that your payor will pay for health care.
- Health Care Operations. We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may disclose PHI to our Management staff in order to resolve any complaints you may have and ensure that you have a comfortable visit with us.
- We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Use or Disclosure for Directory of Individuals in COUG. We may include your name, location in COUG, general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name or members of the clergy; provided, however, that religious affiliation will only be disclosed to members of the clergy.

C. Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

D. Fundraising Communications. We may contact you to request a tax-deductible contribution to support important activities of COUG. In connection with any fundraising, we may disclose to our fundraising staff demographic information about you (e.g., your name, address and phone number) and dates on which we provided health care to you, without your written authorization. If do not want to receive any fundraising requests in the future, you may contact our Privacy Officer at 614-396-2544 or by email at privacyofficer@centralohiourology.com

E. Public Health Activities. We may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

F. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

G. Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

H. Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

I. Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

J. Decedents. We may disclose your PHI to a coroner or medical examiner as authorized by law.

K. Organ and Tissue Procurement. We may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

L. Research. We may use or disclose your PHI without your consent or authorization if our Privacy/Compliance Committee approves a waiver of authorization for disclosure.

M. Health or Safety. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

N. Specialized Government Functions. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

O. Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

P. As required by law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Uses and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described above in Section III, we only may use or disclose your PHI when you grant us your written authorization on our authorization form. For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

B. Marketing. We must also obtain your written authorization prior to using your PHI to send you any marketing materials. (We can, however, provide you with marketing materials in a face-to-face encounter without obtaining your authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining your authorization.) In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without your authorization.

C. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain highly confidential information about you, including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment and referral; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (7) is about domestic abuse of an adult with a disability; or (8) is about sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Privacy Office and submit the completed form to the Privacy Office. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

D. Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your Highly Confidential Information, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below. A form of Written Revocation is available upon request from the Privacy Office.

E. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the office where you receive services and submit the completed form to that office. If you request copies, we will charge you a fee consistent with Ohio law. We will also charge you for our postage costs, if you request that we mail the copies to you.

F. Right to Amend Your Records. You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Office and submit the completed form to the Privacy Office. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

G. Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you $0.75 per page of the accounting statement.

H. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on **Jan 1, 2013**.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas around COUG at www.centralohiourology.com. You also may obtain any new notice by contacting the Privacy Office.

VII. Privacy Office

You may contact the Privacy Office at:

Central Ohio Urology Group, Attn: Privacy Office
701 Tech Center Drive, Suite 250
Gahanna, Ohio 43230
Phone: (614) 396-2544
Email: privacyofficer@centralohiourology.com