PATIENT REGISTRATION

DATE: _____

Patient's Last Name	First Name	Middle Name	Nickname	Maiden/Previous Name
Address	City		State	Zip
Date of Birth	Sex: Male ☐ Female ☐	Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐	Social Security #	
Home Phone	Cell Phone		E-Mail Address	
Employer's Name	Occupation		Business Phone	
Employer's Address	City		State	Zip
Spouse's Last Name	First Name		Phone	
Emergency Contact Name (other than spouse)	Phone Number		Relationship	
Who is your primary care physician (PCP)?	Were you referred to by a physician other than you PCP, if so who?			
What Pharmacy do you use? (Name, Phone Number, and Location)				

Primary Insurance Co Name	Policy Number	Group Number	
Insured's Name	Insured's Social Security #	Insured's Date of Birth	Insured's Employer
Claims Address			
Secondary Insurance Co Name	Policy Number	Group Number	
Insured's Name	Insured's Social Security #	Insured's Date of Birth	Insured's Employer
Claims Address			
Tertiary Insurance Co Name	Policy Number	Group Number	
Insured's Name	Insured's Social Security #	Insured's Date of Birth	Insured's Employer
Claims Address			

RESPONSIBILITY & RELEASE OF INFORMATION: I authorize payment of medical benefits for services rendered to USCO. I understand that I am responsible to pay all medical services not covered by an authorization/agreement between my physician and insurance company employer. I authorize the release of all or part of the patient medical record for this period of care to any person or corporation liable for any part of the Physician charges. Oklahoma state law (63 O.S. 1-502.2 and 1-202.3) requires that we advise: "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficient Syndrome (AIDS)."
A PHOTOCOPY OF THE AUTHORIZATION AND ASSIGNMENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

PATIENT OR AUTHORIZED SIGNATURE	RELATIONSHIP	DATE

DO NOT WRITE BELOW THIS LINE

ACCOUNT NUMBER	TREATING PHYSICIAN	By:

UROLOGY SPECIALISTS OF
CENTRAL OKLAHOMA, LLC

E.N. Scott Samara, M.D., F.A.C.S.
E.N. Shea Samara, M.D.
Michael S. Holzer, M.D.
William J. Miller, M.D.
Jared P. Higley, M.D.

3366 N.W. Expressway, Suite 500
Oklahoma City, Oklahoma 73112
Phone (405) 943-1137 | Fax (405) 947-0731

Sharing Of Medical Information

Patient Name:_____

This will serve as authorization to release all medical records contained in the medical chart that relates to any physical condition or treatment given by any physician employed by Urology Specialists of Central Oklahoma, LLC to the above named patient. This will also serve as authorization for release of information to referring physicians and the patient's insurance company for insurance claim purposes only.

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS). Oklahoma Statute: 63 OS 1.502.2

I also authorize you to accept a photo copy of this release and it shall have the same force and effect as if it were the original.

I acknowledge that I understand all of the above information. My signature indicates that I have read this Medical Release and grant the request for Authorization.

Signature:_____ **Date:**____/____/____

Medicare Patients Only

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any information needed for this or a payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my medical treatment.

Signature:_____ **Date:**____/____/____

Acknowledgement of Receipt of Notice of Privacy Practices

This acknowledges I have received the Notice of Privacy Practices from my provider at Urology Specialists of Central Oklahoma, LLC.

Signature:_____ **Date:**____/____/____

UROLOGY SPECIALISTS OF
CENTRAL OKLAHOMA, LLC

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Financial Policy

Thank you for choosing us as your health care provider. The physicians and staff are committed to your treatment being successful. Please understand that payment of your bills is considered part of your treatment. This statement of Financial Policy must be read and signed by you prior to any treatment. Furthermore, all patients must complete the Patient Information form before seeing the physician.

All co-pays, deductibles and co-insurance are due at the time services are rendered.

Insurance Coverage:
The balance on your account is still your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 90 days from the date services are rendered, the balance will automatically be transferred to your responsibility. Please be aware that some, and perhaps all, of the services provided by the physician, a P.A. (Physician's Assistant), or other licensed professional may be non-covered services and not considered reasonable and necessary under your medical insurance.

Due to recent problems with insurance coverages, you must inform us if your insurance or your PCP (Primary Care Provider) changes. If you fail to notify us about any changes, you will be responsible for all charges incurred.

No Insurance Coverage:
If you do not have insurance coverage, you are expected to pay to your account in full before any medical procedures are performed. We accept cash, checks, Visa or MasterCard. If you are unable to pay your account in full at the time services are rendered, we will accept a payment schedule as follows: 50% in advance, 25% due in 30 days from the date of the procedure, and the remaining balance due in 60 days. (If your bill is $100.00 or less, the balance is due in full.)

I, _____ , have read the above information and agree with the
Print your name here
terms of the Financial Policy.

SIGNATURE _____ **DATE** _____

UROLOGY SPECIALISTS OF CENTRAL OKLAHOMA, LLC

HIPAA Questionnaire

Date: _____ Account #: _____

Patient Name: _____ Date of Birth: _____

***How do you prefer we contact you regarding appointments?**

Home_____Work_____Other Number_____

May we leave a message on this phone? Yes_____ No_____

***How do you prefer we contact you regarding test results?**

Home_____Work_____Other Number_____

May we leave a message on this phone? Yes _____ No _____

***Who do you authorize to receive your information?**

May we share information about your care with anyone such as a family member, caretaker or close friend?"

Name, Address, and Phone Relationship

_____ _____

_____ _____

_____ _____

Please specify what to share:

_____ Entire Medical Record _____ Appointment Information

_____ Test Results _____ Other: _____

***This Authorization will Expire (must choose one):**

_____ 12 months from date signed _____Until Revoked

Right to Revoke

I understand this authorization is voluntary. I may change this authorization at any time by writing to the address listed at the top of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

_____ _____

Signature (Patient or Legal Representative) Date

_____

Printed Name (Patient or Legal Representative)

(06/2016)

UROLOGY SPECIALISTS OF CENTRAL OKLAHOMA, LLC

Patient Name:_____ Date of Birth:_____

Employer: _____ Referred by:_____

Spouse Name:_____ Spouse Occupation:_____

A. Have You Had

1. Heart Trouble	Yes	No
2. High Blood Pressure	Yes	No
3. Asthma	Yes	No
4. Bronchitis, Emphysema or Other Lung Disease	Yes	No
5. Epilepsy or Seizure	Yes	No
6. Jaundice	Yes	No
7. Hepatitis	Yes	No
8. Mononucleosis	Yes	No
9. Back Trouble	Yes	No
10. Abnormal Chest X-Ray	Yes	No
11. Abnormal Electrogardiogram	Yes	No
12. Glaucoma	Yes	No
13. Abnormal Bleeding Tendencies	Yes	No
14. Anticoagulant Therapy (Blood Thinners)	Yes	No
15. Blood Diseases (anemia, etc.)	Yes	No
16. Kidney Disease	Yes	No
17. Fracture of Neck or Back	Yes	No
18. Paralysis	Yes	No
19. Blood Transfusion	Yes	No
20. Stroke	Yes	No
21. Blood Vessel Disease (Phlebitis, etc.)	Yes	No
22. Diabetes	Yes	No
23. Other Medical Illness	Yes	No

B. Do You

1. Smoke?	Yes	No
How many Pkg/day?_____		
2. Object to Blood Transfusion?	Yes	No
3. Use Alcoholic Beverages	Yes	No

C. Are You Pregnant? Yes No

D. Age_____ Weight_____ Ht_____

E. List Medication You Are Presently Taking:

1._____
2._____
3._____
4._____
5._____

F. List Allergies (drug, other)

1._____
2._____
3._____
4._____

G. List Previous Surgeries (type and approx. date)

1._____
2._____
3._____
4._____

H. Previous Anesthetic History:

1. Any Abnormal Reaction? Yes No
2. Date of Last Anesthetic_____
3. Relatives with any Abnormal Reactions? Yes No
4. Comments:_____

_____

PLEASE FILL OUT FRONT AND BACK OF THIS FORM. THANK YOU.

REVIEW OF SYSTEMS

Do you now, or have you had problems with any of the following?

	Y	N	Please explain any YES answers
GENERAL: Recent weight changes, fever, weakness, fatigue, headaches			
INTEGUMENTARY: Rashes, eruptions, dryness, jaundice, changes in skin, hair or nails, discoloration of skin			
EYES: Blurred vision, double vision			
EARS, NOSE, MOUTH & THROAT: Soreness and/or redness of gums, hoarseness, difficulty in swallowing, head colds, discharges, obstruction, postnasal drip, sinus pain, ear aches			
MUSCULOSKELETAL: Joint pain, neck pain, back pain			
RESPIRATORY: Chest pain, wheezing, cough, difficulty breathing, asthma, bronchitis, pneumonia, tuberculosis, shortness of breath, emphysema			
NEUROLOGIC: Fainting, blackouts, seizures, paralysis, tingling, tremors, memory loss, dizzy spells, stroke			
CARDIOVASCULAR: Chest pain, rheumatic fever, rapid heart beat, high blood pressure, swelling, dizziness, faintness, varicose veins, heart valve problems			
ENDOCRINE: Thyroid trouble, fatigue, heat or cold intolerance, excessive sweating, thirst or hunger			
GASTROINTESTINAL: Appetite, nausea, vomiting, diarrhea, constipation, indigestion, food intolerance, hemorrhoids, jaundice, heartburn, diabetes, hepatitis			
GENITOURINARY: Male - Hernias, testicular problems, penile problems impotency, infertility Female - Discharge, pain, discomfort Urinary - Frequent			
HEMATOLOGIC/LYMPHATIC: Anemia, easy bruising or bleeding, past transfusions, swollen glands, blood clotting problems			
PSYCHOLOGIC: Nervousness, mood swings, insomnia, headache, nightmares, depression			
ALLERGY/IMMUNOLOGIC: Food Allergies, plant allergies, environmental allergies			
OTHER: AIDS, HIV			