Richard D. Levin, MD, FACS

Center for Minimally Invasive Surgery

Urologic Oncology, Endo-Urology, Reconstructive Urology, Infertility

Today's Date:___/___/___

Patient Name: ____________________________________ Sex: M or F

Date of Birth: __/__/__ Age: __ SS# ___/___/___ Marital Status: S or M or D or W

Address: ____State_______Zip______

Home Phone ________________Cell Phone_______________Work Phone___________

Emergency Contact Name and Phone Number: _________________________________

Email Address: ____

Primary Doctor Name and Phone Number: _____________________________________

Medication Allergies: _____________________________ Reaction? ________________

Pharmacy Name and Phone Number: ____

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Have you seen a Urologist Before? Yes or NO If so, Name: ________________________

Primary Medical Insurance: _______________________ Policy #: __________________

Secondary Medical Insurance: _______________________ Policy#: ________________

Disclaimer: I fully understand that I am directly and fully responsible for all medical bills and payments to Richard D. Levin, M.D. for services rendered. This agreement is solely made for Dr. Levin's protection. I understand that payment is not contingent upon any settlement or judgement nor insurance payment by which I may eventually recover said fee. I agree to an interest of 2% to charges over 60 days late. I agree to pay for all professional fees associated with collecting my outstanding balances.

Authorization to pay benefits to Physician: I hereby authorize payment directly to the undersigned Physician of the medical/surgical benefits, if any, otherwise payable to me for his services as described, but not to exceed reasonable and customary charges for said services. I understand that I am fully financially responsible for charges not covered by this authorization. I understand that payment is not contingent upon any settlement or judgement nor insurance payment by which I may eventually recover said fee. I understand that information may need to be released to other parties, such as insurance agencies and/or Medicare, to facilitate payment. I understand that records may be also sent to my other physicians and family members, unless I instruct Dr. Levin otherwise.

Policy: We strive to see all patients on time. When patients show up late or do not call ahead to reschedule it has effect to all our other patients. Therefore, please be advised, IF YOU DO NOT CANCEL OR RESCHEDULE YOUR APPOINTMENT AT LEAST 2 WORKING DAYS PRIOR TO YOUR SCHEDULED TIME, YOU WILL BE CHARGED A $75.00 NO SHOW FEE. Certainly we will make every effort to accommodate your needs. We also must address emergencies as they are presented and will give you or any patient extra time when needed. Your understanding is appreciated in these circumstances.

By signing this page I attest that all information I am providing to the office of Dr. Levin is true and accurate.

Name: ______________________Signature: _______________________Date: _______

21355 East Dixie Highway, Suite 102, Aventura, Fl 33180

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AUTHORIZATION AND CONSENT TO TREAT: I request, consent and authorize Dr. Levin and staff to evaluate and treat me as indicated. I understand that certain circumstances may prelude a written consent and will be asked to give verbal consent for those treatments and in office procedures as deemed necessary. My verbal consent to treat will be considered as equal to a written informed consent. I also agree that under certain circumstances Dr. Levin and/or staff may be required to perform emergency services on my behalf and I agree, including the calling of 911 to provide emergency ambulance services to the local hospital. I understand that Dr. Levin is providing me with care to the best of his ability and will be explaining the risks benefits indications and options, as well as morbidity and mortality as indicated. I agree to ask for clarification if at any time any of this is unclear.

Patient Initials: _______________

CONSENT TO OBTAIN RECORDS: Recognizing the importance of accurate follow up in maintaining quality care, I hereby authorize Dr. Richard D. Levin to obtain medical information pertinent to my medical condition including, but not limited to, the diagnosis, treatment and care offered or rendered to me, as well as my records. This information will be treated as part of the medical record of Richard D. Levin, MD, FACS. This consent remains in effect until revoked by me.

Patient Initials: ______________

NOTICE TO PATIENTS: "Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. Your doctor meets these requirements and has decided not to carry medical malpractice insurance. This notice is provided pursuant to Florida Law."

Patient Initials: ______________

BINDING ARBITRATION: In the event a dispute shall arise between the parties and this medical practice (Urodocs, Dr. Richard Levin and/or Staff) it is hereby agreed that the dispute shall be referred for arbitration in accordance with the applicable United States Arbitration and Mediation Rules of Arbitration. The arbitrator's decision shall be final and legally binding and judgement may be entered thereon. Eah party shall be responsible for its share of the arbitration fees in accordance with the applicable Rules of Arbitration. In the event a party fails to proceed with arbitration, unsuccessfully challenges the arbitrator's award or fails to comply with the arbitrator's award, the other party is entitled to costs of suit, including reasonable attorney's fee for having to compel arbitration or defend or enforce the award.

Patient Initials: ______________

PRIVACY PRACTICES/OFFICE PRACTICES ACKNOWLEDGEMENT/AUTHORIZATION FOR RELEASE OF INFORMATION: I understand this information will only be furnished: (1) to my insurer(s) to which my medical bills have been assigned for payment; (2) as required by law; (3) upon my written authorization on a form acceptable to Dr. Richard D. Levin's office. Unless otherwise stated, I understand that Dr. Levin and staff may need to communicate my health information with other physicians and member of my medical team to facilitate my care. I understand that my medical information will not be released to any than my medical team and those named without my express written or verbal permission. I also understand that with my written permission, my entire record including my HIV status can be released to the healthcare provider as specified on my written request. Any revocation of this release must be submitted in writing to Dr. Richard D. Levin. I also authorize Dr. Levin to release my medical information to other healthcare providers as deemed necessary for my care.

For the purpose of this release, "medical information" shall mean copies of all medical records, tests, x-rays, reports and/or other material in the possession of Dr. Richard D. Levin's office relating to my medical condition and proposed or actual treatment. I UNDERSTAND THAT BY SIGNING THIS CONSENT, I AM ALSO AUTHORIZING RELEASE OF ANY INFORMATION CONTAINED WITHIN THE MEDICAL RECORD WHICH MAY BE RELATED TO AIDS AND/OR HIV ANTIBODY OR ANTIGEN TESTING.

By signing this Consent to Release Medical Information, I agree not to hold liable Dr. Richard D. Levin, the office staff, agents or employees, (or any unfavorable outcomes as the result of releasing this information). I REALIZE THAT RELEASE OF MY MEDICAL INFORMATION MAY BE NECESSARY BEFORE MY INSURER WILL COVER THE COST OF MY MEDICAL TREATMENT AND THAT BY FAILING TO AUTHORIZE THE RELEASE OF INFORMATION, I MAY BE REQUIRED TO PAY THE ENTIRE BILL TO FACILITATE MY MEDICAL CARE.

Patient Initials: ______________

LANGUAGE: I understand that Dr. Levin and staff may speak English or other languages with me, however it is my own responsibility to be certain I understand my care. If I am unable to understand I will provide translation.

Patient Initials: ______________

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it and agree with the above and wish for Dr. Richard D. Levin and staff to provide for my care.
By signing this page I attest that all information I am providing to the office of Dr. Levin is true and accurate.

____ ____
Signature Date

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MEDICATION LIST

Patient Name: ____ Date: ___________________________

Please include all your medications that you are currently taking include anything Over the Counter.

Medication Dose Started/Changed

____

____

____

____

____

____

____

____

____

____

____

Pharmacy Name and Phone Number: ____

____/_____/___________
Richard D. Levin, MD, FACS **Date**

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NEW PATIENT MEDICAL HISTORY

Patient's Name: ____________________________________ Date: __________________________________

(Female) Are you pregnant? Yes or No Last Menstrual Period: ____________________________

(Male) Last PSA Result: ___________________________ Date of PSA: ___________________________

Allergic to any Medications/ What is the reaction?:

*_________________________________ ____________________________________

*_________________________________ ____________________________________

Entire Surgical History: **Year and Procedure**

*_________________________________ ____________________________________

*_________________________________ ____________________________________

Past Medical History: (Please circle and List Details)

- Diabetes (Type/Years): Yes or No____________ Other Endocrine Disease: Yes or No__________
- Kidney Disease/Dialysis: Yes or No____________ Hypertension: Yes or No____________________
- Cardiac Disease (CHF, Infarcts, etc): Yes or No___________ Skin Disease: Yes or No __________________
- Neurological Disease (Strokes, etc): Yes or No ____________ Orthopedic Problems: Yes or No __________
- Respiratory/Lung/Breathing Problems (COPD, Asthma, etc): Yes or No _____________________________
- Gastrointesinal Disease (GERD, Reflux, Sprue/Colitis/Ulcers, etc): Yes or No ________________________
- Bleeding Disorders (hemophilia, etc): Yes or No ______________
- Eye Disease (Glaucoma, Cataracts): Yes or No _____________
- Psychiatric Disease (Anxiety/Depression): Yes or No _____________________
- Any History of Cancer: Yes or No ____
- Any Other Medical Problems: ____

Family Medical History (Please circle)

- Prostate Cancer: Yes or No __________________ Bladder Cancer: Yes or No _______________________
- Kidney Cancer: Yes or No ___________________ Testis Cancer: Yes or No _________________________
- Diabetes, Cardiac Disease, Hyoertension, Bleeding Disorder: Yes or No _____________________________
- Congenital Disease/Birth Defects: ____

Social History:

- Cigarettes: Yes or No How much? _________ Alcohol: Yes or No How much? ___________

Current Review of Systems: (Please circle and list details):

- Constitutional: weight loss/gain; fever;chills;malaise Yes or No _______________________
- Eyes: sudden vision change;pain;dry eyes: Yes or No _______________________
- ENT: nose bleeds;severe hearing loss: Yes or No _______________________
- Respiratory: difficulty breathing, recent infections: Yes or No _______________________
- Cardiovascular: chest pain; palpitations: Yes or No _______________________
- GI: nausea;vomiting;constipation;diaherra;abdominal pain: Yes or No _______________________
- Psych: anxiety;depression: Yes or No _______________________
- Male Genital: erection issues;ejaculation problem: Yes or No _______________________
- Female Genital: discharge;painfull intercourse; misc: Yes or No _______________________
- Urological Irritative: frequency, urgency; burning Yes or No _______________________
- Incontinence: Yes or No _______________________
- Urological Obstructive: retention;weak/slow stream; hesitancy: Yes or No _______________________
- Blood in urine: (when? how much?) Yes or No _______________________
- Neurological: seizures;hallucinations;numbness/tingling: Yes or No _______________________
- Endocrine: hair loss;increased thirst;heat/cold intolerance: Yes or No _______________________
- Heme: easy bleeding; night sweats: Yes or No _______________________
- Skin Problems: Yes or No _______________________

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