Urodocs
Modern Compassionate Urology

Patients Name: **Today's Date:** / /

Date of Birth: ____/___/_____ Age: _____ Sex: M or F (decline)

Social Security #: _____/____/_____ Marital Status: Single or Married or Divorced

Permanent Address: _____

_____

EMAIL (for portal access and communications): _____

TEL: _____ _____ _____

(Home Phone) **(Cell Phone)** **(Other Phone)**

Emergency Contact: Name: _____ Phone #: _____

Health Care Surrogate : Name: _____ ***Phone #:*** _____

Employment Information:

Employer Name: _____ Phone Number: _____

Medical Provider Information:

Referring Physician: _____ Phone #: _____ Fax#: _____

Family Physician: _____ Phone #: _____ Fax#: _____

Preferred Pharmacy:_____

Address: _____ , City_____

Phone #: _____ Fax#: _____

****

Have you seen a Urologist before? , **if yes, name of your prior Urologist**: _____

MEDICAL / INSURANCE INFORMATION:

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Insured Member: _____ Insured Member: _____

Group Number: _____ Group Number: _____

Disclaimer: I fully understand that I am directly and fully responsible, and guarantee payment, for all medical bills and payment to Urodocs. for services rendered. This agreement is made solely for Urodocs and Dr. Levin's protection. I understand that payment is not contingent upon any settlement nor judgment 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. I agree to allow Urodocs to use a credit card I maintain on file for payments due.

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 nor judgment 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 also be 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 an affect an 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 may be charged **a $ 75.00 no show fee, at our discretion**. Certainly we will make every effort to accommodate your needs. We also must address emergencies as they present and will give you or any patient extra time when needed. Your understanding is appreciated in these circumstances.
I am aware and understand the policy of this practice.
By signing this page I attest that all the information I am providing to the office of Dr. Levin is true and accurate.

(Name) _____ (Date) : _____/_____ / _____

Responsible persons Signature): _____

21355 E Dixie HWY, ste 102, * Aventura, FL 33180 * 305-932-4444 * Fax: 305-932-4456

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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 preclude 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.

Responsibility to follow up: I/we understand it the patient's sole responsibility to make sure to follow up on any tests, biopsies, imaging, results, and/or recommendations. Dr Levin and Urodocs cannot be held liable for any failure to follow up on results, keep appointments, even if rescheduled or delayed, for any reason.

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. Dr. Levin will not be able to obtain any records from his prior practice.

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 may decide not to carry medical malpractice insurance. This notice is provided pursuant to Florida law."

BINDING ARBITRATION
In the event a dispute shall arise between the parties and this medical practice (Urodocs, Dr Levin and 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 judgment may be entered thereon.
Each 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 a reasonable attorney's fee for having to compel arbitration or defend or enforce the award

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 other 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 I my written request. Any revocation of this release must be submitted in writing to Richard D. Levin, MD, FACS. I also authorize Dr. Levin to release my medical information to other health care 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 Richard D. Levin, MD, FACS '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 THIS INFORMATION, I MAY BE REQUIRED TO PAY THE ENTIRE BILL, to facilitate my medical care.

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 unable to understand I will provide for my own family or other to help with translation.
Messaging Consent: I consent to automated massaging and being contacted by Cell Phone Text messaging and or EMAIL is deemed Necessary by Urodocs and Staff.
Audio/Video Consent: I consent to Use of Audio/Video recording of any part of my evaluation and management, in accordance with appropriate privacy practices.

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

NAME: _____ Date: _____/_____/_____

Signature: _____

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New Patient Medical History

Patients Name: _____ **Date:** _____/_____/_____

(*Female*) Are you pregnant? _____ Last Menstrual Period: _____/_____/_____

(*Male*) Last PSA Result: _____ DATE of PSA: _____/_____/_____

Allergic to any Medications/What happens:

- _____ _____
- _____ _____
- _____ _____

Entire Surgical History:

Year and Procedure

- _____ _____
- _____ _____

Past Medical History(Please circle and List Details)

- Diabetes (type/years): Yes/No_____ Other Endocrine Disease: Yes/No_____
- Kidney Disease/Dialysis: Yes/No_____ Hypertension: Yes/No_____
- Cardiac Disease (CHF, Infarcts, etc): Yes/No _____ Neurological Disease (Strokes, etc): Yes/No _____
- Respiratory/Lung/Breathing problems (COPD, Asthma, etc): Yes/No _____
- Gastrointestinal Disease (GERD/Reflux/Sprue/Colitis/Ulcers, etc): Yes/No _____
- Orthopedic Problems: Yes/No_____ Bleeding Disorders (hemophilia, etc): Yes/No _____
- Eye Disease (**Glaucoma**, Cataracts): Yes/No _____ Skin Disease (Psoriasis, etc): Yes/No _____
- Psychiatric Disease (Anxiety/Depression): Yes/No _____
- Any History of Cancer: Yes/No _____
- Any Other Medical Problems: _____

Family Medical History (Please circle and add as needed)

Prostate Cancer: Yes/No _____ Bladder Cancer: Yes/No_____
Kidney Cancer: Yes/No _____ Testis Cancer: Yes/No_____
Diabetes, Cardiac Disease, Hypertension, Bleeding Disorder: Yes/No_____
Congenital Disease/Birth Defects: _____

Social history: (Yes/No How much?)

Cigarettes_____ Alcohol_____

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

- **Constitutional**: wt loss/gain; Fever; Chills; Malaise: Yes/No_____
- **Eyes**: Sudden vision change; pain, Dry eyes: Yes/No_____
- **ENT**: Nose bleeds; Severe Hearing loss: Yes/No_____
- **Respiratory**: difficulty breathing, recent infections: Yes/No_____
- **Cardiovascular**: Chest pain; palpitations: Yes/No_____
- **GI**: Nausea; Vomiting; Constipation; Diarrhea; Abdominal Pain: Yes/No_____
- **Psych**: Anxiety; Depression: Yes/No_____
- *Male* **Genital**: Erection issues; Ejaculation problem: Yes/No_____
- *Female* **Genital**: Discharge; Painful intercourse; Misc. : Yes/No_____
- **Urological Irritative**: Frequency; urgency; burning: Yes/No_____
- **Incontinence** : Yes/No _____
- **Urological Obstructive**: retention; weak / slow stream; hesitancy: Yes/No_____
- **Blood in urine:** (when? How much?) Yes/No_____
- **Neurological**: seizures; hallucinations; numbness/tingling: Yes/No_____
- **Endocrine:** hair loss; increased thirst; Heat/Cold Intolerance: Yes/No_____
- **Heme**: Easy bleeding; night sweats: Yes/No_____
- **Skin Problems** : Yes/No_____

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Medication List

Patient Name: _____ Date: _____

Please include all of your Medications that you are currently taking.

Medication	Dose	Reason/Diagnosis

Preferred local Pharmacy: _____

Address: _____ City: _____ Zip_____

Phone # _____ Fax #: _____

Preferred Mail order pharmacy: _____

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Patient Acknowledgement of Office Privacy Practice

I have read and understand the Privacy Practice Policy.
(It is available on our website as well.)

___ I have received a copy

___ I declined to receive a copy

_____ _____/_____/_____
(Signature) **(Date)**

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Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.