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#: ______________________________

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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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