Affix Label Here

MINNESOTA UROLOGY

Patient Authorization and Consent Form

Consent for Treatment: I consent to and authorize my health care provider to examine and treat me. I understand this could include lab tests or other diagnostic procedures, education or images which may result in separate billable charges. I understand my provider is available to explain the purpose of the procedure(s) and treatment(s), and I have the right to refuse such procedure(s) or treatment(s).

- o I authorize Minnesota Urology (MNU) to verbally communicate regarding my personal health care or billing information with me by leaving voicemail messages on phone number: _____.

Privacy: I acknowledge I have received a copy or have been made aware of MNU's privacy practices. I understand I may request a copy of this notice. I authorize MNU to discuss and disclose health care/billing information to others as provided below:

- o I authorize MNU to verbally communicate regarding my personal health care or billing information with:
  Name: _____Relationship:_____

Assignment of Benefits and Release of Information: I request payment of authorized benefits directly to the provider for services rendered to me at this facility or other facility owned or operated by MNU, including physician services, any provider under contract with MNU or participating in a provider network in which MNU or its affiliates participates. I consent to MNU releasing my health records and other information related to my health care services for payment and healthcare operational purposes. I agree that MNU may release my health records and other information to my insurance company.

Release of Information by Payers and Networks: I authorize Medicare, my insurance company or HMO, other payers, payer network organizations including accountable care organizations, their contractors and 3rd party administrators to share my health records and information obtained by MNU or any other provider, with MNU, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and 3rd party administrators of these parties as needed for payment and health care operations.

Release of Information to Health Care Providers: I consent to the release of my health records created and received by MNU for my treatment to other health care providers who are involved in my treatment.

Lab Billing/Outside Lab Billing: I understand that if my provider decides to order lab work during my visit, some tests may require evaluation by an outside (third party) laboratory. In this case, I understand I may receive a separate bill from the outside lab.

Payment Agreement: I understand that I am financially responsible for and agree to promptly pay any charges for the care and treatment of non covered services rendered to me that are not covered by my insurance plan. If I do not have active insurance coverage, I understand: 1) my billing status will be listed as 'self-pay,' 2) I will be required to make a $100 down payment prior to receiving an evaluation and treatment, and 3) I will be billed for the remainder of all charges related to my evaluation and treatment. Regardless of insurance coverage, I understand my past due balances may be assessed a finance charge.

No Show/Late Cancellation Policy: I acknowledge that by not cancelling my appointment in at least 24 hours in advance or not showing up for your appointment prevent other patients from being scheduled. I understand I may be assessed a $100 fee for each missed appointment after my second *Office Visit* no-show Further, I understand that I will be assessed a $50 fee for any *Procedure* no show appointment or late cancel for any appointment.

When electronically signing this form, I acknowledge I have read and agree to all of the above.

You may withdraw this consent at any time by advising us in writing at: Minnesota Urology, 6025 Lake Road, Suite 200, Woodbury MN, 55125. I understand my revocation shall have no effect on releases that have already been completed.

_____

Signature of Patient/Personal Representative | Print Patient Name | Date of Birth | Today's Date

_____ _____

Relationship to Patient (if patient unable to sign) | Reason Patient Unable to Sign

Patient Label

METROUROLOGY

Patient Medical History – Adult Male

Height _____ Weight_____

Email Address:_____

Pharmacy name, address phone number _____

Telephone number to contact patient: (Home)_____(Cell)_____

Patient's Employer/Occupation:_____

Emergency Contact: Name_____Phone_____

Who referred you for this consultation? (Self? Doctor? If so, from what clinic?)_____

_____

Describe the location/symptom/problem that is the reason for your visit: _____

_____

When did this problem start?_____

Does anything make this problem better or worse? Please describe:_____

Are there other associated problems? ☐ No If yes, describe_____

Please mark on the line the severity of your problem: 0 ..... 1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 10

None Moderate Severe

ALLERGIES

ALLERGY	TYPE OF REACTION (RASH, NAUSEA, ETC)

MEDICATIONS

NAME	DOSE	HOW OFTEN TAKEN

PAST SURGICAL HISTORY

SURGERY		DATE / YEAR
Appendix	☐	
Back	☐	
Bladder	☐	
Breast	☐	
Colon	☐	
Gallbladder	☐	
Heart Bypass	☐	
Heart Valve	☐	
Hernia	☐	
Kidney	☐	
Lung	☐	
Pelvic Laparoscopy	☐	
Thyroid	☐	
Total Joint Replacement	☐	
Right: ☐ Hip ☐ Knee	☐	
Left: ☐ Hip ☐ Knee	☐	
Urethra	☐	
Other/Explain:	☐	

MEDICAL AND FAMILY HISTORY

	You	Family Member	If family member, relationship to you
Anemia	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Cancer	☐	☐	
Depression	☐	☐	
Diabetes	☐	☐	
GERD / Acid Reflux	☐	☐	
Gout (high uric acid)	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Kidney Stones	☐	☐	
Liver Disease	☐	☐	
Mitral Valve Prolapse	☐	☐	
MRSA	☐	☐	
Osteoporosis	☐	☐	
Positive Mantoux/PPD	☐	☐	
Rheumatic Fever	☐	☐	
Thyroid Problems	☐	☐	
Toxic Exposure	☐	☐	
Tuberculosis	☐	☐	
Other/Explain:	☐	☐	

SOCIAL HISTORY

Bolded questions in this section are Government required due to the Health Care Reform Act.

Marital Status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Annulled ☐ Life Partner

Smokeless Tobacco (chewing) ☐ Yes ☐ No

Smoking Status? ☐ Current Every day ☐ Current Some Days ☐ Former ☐ Never

How many years if current ? _____ When did you quit? _____

How many caffeinated drinks do you have each day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Do you ever drink alcohol? ☐ Yes ☐ Not Anymore ☐ Never Drank

Do you use Recreational Drugs ☐ Yes ☐ No

Race?_____

Have you had a blood transfusion? ☐ No ☐ Yes

Ethnicity? ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Preferred Language?**_____

Do you have children? ☐ No ☐ Yes

Have you ever had MRSA? ☐ No ☐ Yes

Positive Mantoux/PPD? ☐ No ☐ Yes

Are you on a special diet? ☐ No ☐ Yes If yes, explain _____

REVIEW OF SYSTEMS

Do you have any problems NOW related to the following systems? Please circle No or Yes.

Constitutional Symptoms

Fever	No	Yes
Chills	No	Yes
Fatigue	No	Yes
Weight Loss	No	Yes
Weight Gain	No	Yes
Other _____	No	Yes

Eyes

Blurred vision	No	Yes
Double vision	No	Yes
Pain	No	Yes
Other _____	No	Yes

Endocrine

Excessive thirst	No	Yes
Too hot/cold	No	Yes
Tired/sluggish	No	Yes
Other _____	No	Yes

Cardiovascular

Chest pain	No	Yes
Varicose veins	No	Yes
High blood pressure	No	Yes
Other _____	No	Yes

Integumentary

Skin rash	No	Yes
Boils	No	Yes
Other _____	No	Yes
Persistent itch	No	Yes

Respiratory

Wheezing	No	Yes
Frequent cough	No	Yes
Shortness of breath	No	Yes

Other_____

Gastrointestinal

Abdominal pain	No	Yes
Nausea/vomiting	No	Yes
Indigestion/Heartburn	No	Yes
Constipation	No	Yes
Irritable bowel	No	Yes

Other _____

Musculoskeletal

Joint pain	No	Yes
Neck pain	No	Yes
Back Pain	No	Yes

Other_____

Neurological

Tremors	No	Yes
Dizzy spells	No	Yes
Numbness/Tingling	No	Yes
Headache	No	Yes

Other _____

Genitourinary

Urine retention	No	Yes
Painful Urination	No	Yes
Urinary frequency	No	Yes

Urinary tract infections

If yes, # per year_____

Ear/Nose/Throat/Mouth

Ear infection	No	Yes
Sore throat	No	Yes
Sinus problems	No	Yes

Other_____

Allergic/Immunologic

Hay fever	No	Yes
Drug allergies	No	Yes
Other _____	No	Yes

Hematologic/Lymphatic

Swollen glands	No	Yes
Blood clotting	No	Yes
Pulmonary embolism	No	Yes

Sexual History

Sexually active?	No	Yes
Pain with intercourse?	No	Yes
Leaking urine with intercourse?	No	Yes

Psychologic

Are you generally satisfied with your life?	No	Yes
Are you depressed?	No	Yes
Have you ever considered suicide?	No	Yes

Please circle/check the response that most accurately relates to you.

Problem	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
Sensation of not emptying bladder.	0	1	2	3	4	5
Urinating less than 2 hours after urination	0	1	2	3	4	5
Stopping & starting during urination	0	1	2	3	4	5
Difficulty in postponing urination	0	1	2	3	4	5
Weak urinary stream	0	1	2	3	4	5
Pushing/straining during urination	0	1	2	3	4	5
How many times do you urinate from the time you go to bed at night until you get up?	0 times	1 time	2 times	3 times	4 times	5 times

Total of the 7 circled items above_____

Problem	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Do you experience any pain with urination? ☐ No ☐ Yes

Do you experience leaking urine? ☐ No ☐ Yes

Do you have blood in your urine? ☐ No ☐ Yes

Are you experiencing any impotence problems? ☐ No ☐ Yes

Have you ever had a kidney or bladder infection? ☐ No ☐ Yes

How many **times** a **day** are you using the restroom? _____

- How **frequently** do you use the restroom? Every _____ hours?
- How many **accidents** are you having per day? _____
- How many **pads** are you using per day? _____

***We will use these questions throughout your treatment to gauge your progress**

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? Circle the number that best reflects your feelings about your urinary problem.

0	1	2	3	4	5	6
Pleased			**Indifferent**			**Terrible**

Physician use only: (Comments/Note)

Physician Signature:_____ ***Date:***_____