

ADULT PEDIATRIC UROLOGY



Rev.Feb.05

PATIENT INFORMATION RECORD

Name _____ Social Security Number _____

Reason for visit _____

Referring Physician _____

Family Physician _____

Please list any major illnesses and/or any prior hospital stays you have had:

List any medication or pills taken regularly:

1.) _____

1.) _____

2.) _____

2.) _____

3.) _____

3.) _____

Recent bladder or kidney x-rays (when and where) _____

Please list medication to which you are allergic:

Please list any surgery you have had:

1.) _____

1.) _____

2.) _____

2.) _____

3.) _____

3.) _____

Have you ever had jaundice, hepatitis, or blood transfusions? _____ When? _____

Have you ever smoked? _____ If so, when? _____ How much? _____

Have you ever had heart trouble? _____ Have you ever had lung trouble? _____

Height _____ ft. _____ in. Weight _____ lb.

Family Medical History

	Heart Problems (please describe)	Cancer (please describe)	Other Major Problems
Mother			
Father			
Sister			
Brother			

Signature _____

Date: _____

ADULT PEDIATRIC UROLOGY

Review of Symptoms

Do you or have you had any problems related to the following symptoms? Circle Yes or No.
Please explain any Yes answers in space provided.

Current Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other	_____	

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other	_____	

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other	_____	

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other	_____	

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other	_____	

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other	_____	

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N
Other	_____	

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other	_____	

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other	_____	

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other	_____	

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other	_____	

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other	_____	

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other	_____	

Psychologic

Are you generally satisfied with your life? _____
Do you feel severely depressed? _____
Have you considered suicide? _____
Other _____

Physician: _____

Date: _____

Patient Assessment Questionnaire

For each question below, please circle the answer that best describes how you feel today.

The last 2 columns on the right are for your doctor to assess your answers. Please do not mark anything in these columns.

Patient's Name: _____

Today's date: _____

		0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1	How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2	a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
	b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3	Are you sexually active? YES ____ NO ____							
4	a. IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or symptoms during or after intercourse?	Never	Occasionally	Usually	Always			
	b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5	Do you have pain associated with your bladder or in your pelvis: (vagina, lower abdomen, urethra, perineum)?	Never	Occasionally	Usually	Always			
6	Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7	a. If you have pain, is it usually...		Mild	Moderate	Severe			
	b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8	a. If you have urgency, is it usually...		Mild	Moderate	Always			
	b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
SYMPTOMS SCORE (1, 2a, 4a, 5, 6, 7a, 8a) -SUBTOTAL								
BOTHER SCORE (2b, 4b, 7b, 8b) - SUBTOTAL								
TOTAL SCORE (Symptom Score + Bother Score)								

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

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.

The law requires us to keep your medical records confidential and to provide you with this Notice of Privacy Practices describing how we may use and disclose your health information, including your medical history, symptoms, examination and test results, diagnoses and treatment plans, to carry out treatment, payment and health care operations and for other purposes that are allowed or required by law. It also describes your rights to review and control the use and disclosure of your health information.

We are required to follow the privacy practices described in this Notice. We may change our privacy practices at any time. The revised privacy practices will be set forth in a revised Notice and will be effective for all health information that we maintain at that time. Upon your request, we will provide you with a copy of the most recent Notice. A current copy of our Notice of Privacy Practices will be posted in our office in a visible location at all times.

1. Uses and Disclosures

The law allows us to use and disclose your health information for treatment, payment and health care operations. The following are examples of such uses and disclosures:

- **Treatment.** We will use and disclose your health information to individuals within our office in order to provide, coordinate, and manage your medical care and any related services. This includes the use or disclosure of your health information to aid in the coordination or management of your medical care with a third party. For example, your health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
- **Payment.** Your health information will be used or disclosed, as needed, to allow us to obtain payment for health care services provided to you. This may include disclosure to your health insurance plan or carrier as they undertake certain activities before approving or paying for medical services. Such activities include making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.
- **Healthcare Operations.** We may use or disclose, as needed, your health information to operate our business. These activities include, but are not limited to, quality assessment and improvement activities, reviewing the quality of care provided by your health care providers, training of personnel and medical students, licensing, and conducting or arranging for other business activities.

- **Incidental Uses and Disclosures.** There may also be incidental uses or disclosures of your health information as a result of otherwise allowed uses and disclosures. Such uses and disclosures may occur because they cannot reasonably be prevented. For example, when your name is called in the waiting room, we cannot reasonably prevent others from overhearing your name.
- **Other.** We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your health information, as necessary, to contact you to schedule or remind you of an appointment, including leaving messages on your answering machine.

We will share your health information with other organizations that perform various activities on our behalf such as billing or transcription services. Whenever an arrangement between our office and another organization involves the use or disclosure of your health information, we will have a written contract that contains terms that will protect the privacy of your health information.

We may use or disclose your health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you: For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services we believe may be beneficial to you.

We may disclose your health information to another health care provider of yours for their health care operations relating to their quality assessment and improvement activities, reviewing the competence or qualifications of their health care professionals, or detecting or preventing health care fraud and abuse.

We may use or disclose demographic information about you and the dates we provided health care services to you for the purpose of raising funds for our organization.

We may use or disclose your health information for marketing purposes in meetings between our physicians and you or when we provide you with promotional gifts of nominal value.

2. Uses and Disclosures Allowed or Required by Law

We may use or disclose your health information in the following situations as allowed or required by law:

- **Required By Law.** We may use or disclose your health information if we are legally required to do so. We will limit the use or disclosure to that required by such law.
- **Public Health.** We may disclose your health information to a public health authority for purposes of controlling disease, injury or disability. We may also disclose your

health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases.** We may disclose your health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight.** We may disclose health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include, but are not limited to, government agencies that oversee the health care system, government benefit programs, other government regulatory programs and entities subject to civil rights laws.
- **Abuse or Neglect.** We may disclose your health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your health information to the governmental entity or agency authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Food and Drug Administration.** We may disclose your health information to a person or company as required by the Food and Drug Administration ("FDA") for purposes relating to the quality, safety or effectiveness of FDA regulated products or activities.
- **Legal Proceedings.** We may disclose health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions, in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose health information, so long as applicable legal requirements are met, to law enforcement officials, for law enforcement purposes.
- **Coroners, Funeral Directors and Organ Donation.** We may disclose health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. Health information may be used and disclosed for cadaveric, organ, eye or tissue donation purposes.
- **Research.** We may disclose your health information to researchers when their research has been approved by a privacy board or an institutional review board.

- **Criminal Activity.** Consistent with applicable federal and state laws, we may disclose your health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military Activity and National Security.** When the appropriate conditions apply, we may use or disclose health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your health information to authorized federal officials for conducting national security and intelligence activities, including providing protective services to the President of the United States or others.
- **Employers.** We may disclose to your employer health information obtained in providing medical services to you at the request of your employer for purposes of conducting an evaluation relating to medical surveillance of the workplace or determining whether you have a work-related illness or injury when such medical services are needed by the employer to comply with certain legal requirements.
- **Correctional Institutions.** If you are an inmate or in legal custody, we may disclose to the correctional institution or law enforcement official having legal custody of you, certain health information if necessary for health and safety purposes.
- **Workers' Compensation.** Your health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.
- **Compliance.** Under the law, we must make disclosures of health information to the Secretary of the Department of Health and Human Services to enable it to investigate or determine our compliance with the requirements of the privacy laws.

3. Written Authorization

Any uses and disclosures of your health information for purposes other than treatment, payment and health care operations, or as otherwise allowed or required by law as described above will be made only with your written authorization. Any authorization you provide to us is effective for the period specified in the authorization (which cannot exceed one year) unless you revoke the authorization in writing. Any written authorization may be revoked by you, at any time. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to your authorization prior to the time we received your written revocation.

4. Facility Directories.

Unless you notify us, we will use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your

religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation. If you do not want us to use or disclose such information or want some restrictions on what is placed in our facility directory or who the information is disclosed to,' your request must be in writing, addressed to our Privacy Officer and state the specific restrictions requested. If you are not present or able to express your objection or request a restriction to such use or disclosure, then your physician may, using the physician's professional judgment, determine whether the use or disclosure is in your best interest.

5. Others Involved in Your Healthcare.

We may disclose to a member of your family, a relative, a close friend or any other person you identify, your health information that directly relates to that person's involvement' in your health care or who has responsibility for payment of your health care. We may also use or disclose your health information to notify or assist in notifying a relative or any person responsible. for your care, of your location, general condition or death. In addition, we may use or disclose your health information to a public or private entity, authorized by law or by its charter to assist in disaster relief efforts, for the purposes of coordinating the above uses and disclosures to your family or other individuals involved in your health care.

6. Your Rights

Following is a statement of your legal rights with respect to your health information and a brief description of how you may exercise these rights.

- **Access.** You have the limited right, subject to certain grounds for denial, to look at all of your health information that we keep except for the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and certain laboratory information restricted by federal law. You also have the limited right, subject to certain grounds for denial, to obtain copies of that health information you have a right to look at. Our office may charge you a reasonable fee for copying, mailing, labor and supplies associated with your request. Any request for access to or copies of your health information must be in writing and provided to our Privacy Officer. If your request for access to or copies of your health information is denied, you may, depending on the circumstances, have a right to have a decision to deny access reviewed. We will provide you, in writing, with our reasons for denial of access and, if, by law, you are allowed to have such denial reviewed, we will provide you with instructions for having a denial of access reviewed.
- **Restrictions.** You may ask us to restrict the use or disclosure of any part of your health information to carry out treatment, payment or healthcare operations. You may also request that any part of your health information not be disclosed to family, relatives or friends who may be involved in your care or to notify them of your location, general condition or death. In addition, you may request that we restrict the use and disclosure of your health information for disaster relief efforts. Your request

must be in writing, addressed to our Privacy Officer and state the specific restriction requested and to whom you want the restriction to apply. If you are not present or able to express an objection or request a restriction to such use or disclosure, then your physician may, using the physician's professional judgment, determine whether the use or disclosure is in your best interest.

- We are not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your health information, your health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your health information in violation of that restriction unless there is an emergency. We may terminate our agreement to restrict uses and disclosures of your health information by providing you with written notice of such; provided, however, that our termination shall only be effective with respect to health information created or received after we have given you notice of termination of the restriction.
- **Confidential Communication.** You have the right to request that we send your health information to you by alternative means or to an alternative location. We will accommodate reasonable requests. We may condition this accommodation by having you sign an authorization, asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must be in writing, addressed to our Privacy Officer, and state the accommodations you are requesting.
- **Amendments.** You may request an amendment of your health information that we maintain. Such request must be in writing and provided to our Privacy Officer. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement that will become part of your health information. If you file a statement of disagreement, we reserve the right to respond to your statement. You will receive a copy of any response we make and any such response will become part of your health information.
- **Accounting of Disclosures.** You have the right to receive an accounting of certain disclosures we have made, if any, of your health information. This right applies to disclosures made on and after April 14, 2003 for purposes other than (i) treatment, payment or healthcare operations as described in this Notice; (ii) disclosures made to you; (iii) disclosures to a facility directory; (iv) disclosures to family members or friends involved in your care or for notification purposes; or (v) disclosures pursuant to an authorization. The right to receive this information is subject to certain exceptions, restrictions and limitations. Your request for an accounting must be in writing, addressed to our Privacy Officer.
- **Electronic Notice.** If you receive a copy of this Notice on our website or by e-mail, you have the right to obtain a paper copy from us upon request.

7. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. To complain to us, you may send our Privacy Officer a letter describing your concerns to the address found below. We respect your privacy and support any efforts to protect the privacy of your health information. We will not retaliate against you for filing a complaint.

8. Privacy Officer Contact Information

If you have any questions about this Notice, you may contact our Privacy Officer by telephone, e-mail, facsimile, or mail at the address set forth below. If, however, you want to exercise any of your rights pursuant to this Notice of Privacy Practices or have a complaint, such action must be in writing and faxed or mailed to our Privacy Officer at the address set forth below.

Adult and Pediatric Urology, P.C.

Attn: Michelle Fibich
7710 Mercy Road, Suite 406
Omaha, NE 68124
Phone: (402) 397-7989
Facsimile: (402) 397-8703

**RECEIPT OF NOTICE
OF PRIVACY PRACTICES**

I have received a copy of **Adult & Pediatric Urology, P.C.**'s Notice of Privacy Practices that became effective April 14, 2003.

Date

Printed Name

Signature

Note: If signed by someone other than the patient, we need written proof of your authority.

I, _____, give my permission to Adult & Pediatric Urology, P.C., to give any & all medical information regarding myself to the following person(s):

Signature

Date

For office use: A signature was not obtained because: _____

