ROGUE VALLEY UROLOGY

PHYSICIANS AND SURGEONS, PC

Patient Name: ______________________ **Date of Birth:** ______________

Please Circle: Male / Female **Marital Status:** Single Married Divorced Widowed Other

Race: ☐ Decline ☐ American Indian/Alaskan native ☐ Asian ☐ Black/African American ☐ White ☐ Unknown
Ethnicity: ☐ Decline ☐ Not Hispanic/Latino/Spanish Origin ☐ Hispanic or Latino
Languages: ☐ Decline ☐ English ☐ Spanish ☐ Chinese ☐ German ☐ Russian ☐ French

Family Physician: ______________ Referring Physician: ______________ Pharmacy: ______________

Patient Address: ______________________ Home Phone: ______________

City/State/Zip: ______________________ Cell Phone: ______________

Social Security #: ______________________ Work Phone: ______________

Emergency Contact: ______________ Relationship: ______________ Contact Phone: ______________

Detailed Messages (appointments, call back, labs, results, etc) may be left at ___Home___ Cell Phone ___ Work

Email Address: ______________________________________

Patient Portal RVU Web Communication communications consent Initial: (Yes) __________ **or (No)** __________

Employer: ______________________ Occupation/Dept.: ______________

If Minor, Responsible Party: Name: ______________________ **Date of Birth:** ______________

Social Security #: ______________ Contact Phone: ______________ Relation to patient: ______________

Address: ______________________________________

Employer/Address: ______________________ Employer Phone: ______________

Primary Insurance: ______________ ID#: ______________ Group#: ______________

Subscriber's Name: ______________ Subscribers Date of Birth: ______________

Secondary Insurance: ______________ID#: ______________ Group#: ______________

Subscriber's Name: ______________ Subscribers Date of Birth: ______________

X______________________________ X______________________

Patient or Guarantor Signature **Date**

I understand that Rogue Valley Urology will use and disclose health information about me.

PROVIDENCE PLAZA SUITE 280

1698 E. McAndrews Road, Medford, Oregon 97504 | Phone 541-774-5808 | Fax 541-732-3910 | www.RogueValleyUrology.com

ROGUE VALLEY UROLOGY

PHYSICIANS AND SURGEONS, PC

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.
I understand and agree that Rogue Valley Urology may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practice

Patient Name (please print): ______________________ Date of Birth: ______________

X ______________________ Date: ____________
(Patient Signature)

-OR-

By: ______________________ Date: ____________
(Patient Responsible Representative)

ROGUE VALLEY UROLOGY
PHYSICIANS AND SURGEONS, PC

(541) 774-5808
www.RogueValleyUrology.com

Financial Policy

Thank you for choosing Rogue Valley Urology for your health care needs. We are committed to providing you the best urological care available. You are required to read and sign our Financial Policy prior to any treatment. Please feel free to ask any questions and a copy of this policy will be provided to you upon request. As a courtesy to our patients, we bill most insurance types.

INSURANCE: We are participating providers with most insurance companies. It is **your responsibility** to know your insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions. All patients with insurance coverage of any type must show their insurance card for us to bill your insurance. If you do not provide proof of insurance, you will be expected to **pay in full** at the time of service and will be considered a self-pay patient until the appropriate billing information is provided to our office. If you are not insured or insured by a plan that we don't participate with, **payment in full** is expected at the time service is rendered.

CO-PAYMENTS/CO-INSURANCE/DEDUCTIBLES: All patient responsibility for services must be paid at the time of service. This is part of your contractual obligation with your insurance company.

NON-COVERED SERVICES: Please be aware that some or all of the services provided may not be covered or not considered reasonable or necessary by some insurers. It is your responsibility to pay in full for these services at the time of your visit.

REFERRALS: Some insurance plans require a referral from a primary care physician to obtain services by a specialist. These health plans will not pay for services rendered without a referral. If the necessary referral is not obtained, you may either re-schedule your appointment or if allowed by your insurance company, you may sign a waiver agreeing to pay for the service at the time it is rendered.

AUTHORIZATIONS: Obtaining a prior authorization for services is not a guarantee of payment or benefits. A prior authorization means that the information given at that time meets the medical necessity for the services, not a guarantee of payment. Your insurance plan will confirm to you that even though the services may be authorized, the services may not be covered under your plan and a decision for payment will not be rendered until a claim is submitted.

USUAL & CUSTOMARY: Our prices are representative of the usual and customary charges for our geographic area. You are expected to pay in full for any balance after insurance. At our discretion, Rogue Valley Urology may assist you in appealing your insurance determination and/or appeal benefits on your behalf.

PROOF OF INSURANCE: All patients must complete our patient information forms and sign where indicated before being seen. We must obtain a copy of your insurance card(s) and a copy of a photo ID for billing. Failure to provide us with correct information will result in you being responsible for the balance of your claim. Your photo ID is required at check-in; if you do not have it at the time of check-in then your appointment may be re-scheduled.

------------------PLEASE SEE REVERSE SIDE------------------

ROGUE VALLEY UROLOGY
PHYSICIANS AND SURGEONS, PC

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CLAIMS SUBMISSION: As a courtesy to our patients, we will submit claims and assist you in a reasonable way to get your claims paid. Your insurance company may need you to supply certain information directly to them. It is **your responsibility** to comply with their request in a timely manner. Your failure to reply to your insurance plans request may result in your claim being denied and if so, will result in our seeking full reimbursement from you for services rendered. Please understand and be aware that the balance of your unpaid claim(s) is your responsibility.

SURGERIES: All patient responsibility for surgeries must be paid in advance.

COVERAGE CHANGES: If your insurance changes, please notify us as soon as possible, so we can make the appropriate changes to help you receive your maximum benefits. **If your insurance does not pay your claim,** the balance will be billed to you.

NON-PAYMENT: If your account is sixty (60) days past due, you may be contacted by our billing department asking for payment in full. If your balance is unpaid after six (6) months, we may refer your account to our collection agency and you may be discharged from this practice.

PAYMENT OPTIONS: We accept cash, check, cashier's check, money order and all major credit cards. Please note there will be a $30 charge for checks returned for non-sufficient funds. After the second occurrence, checks will no longer be accepted and you will need to pay with a different form of payment.

MISSED APPOINTMENTS: Please assist us by keeping your appointment or cancelling with a minimum of one (1) business days notice. We reserve the right to discharge patients from our practice for chronic missed appointments.

PATIENT CONSENT/ASSIGNMENT: I hereby authorize Rogue Valley Urology to release any information acquired in the course of my treatment to/from my insurance company, physician's office, hospital or any other treatment facility. I agree to be fully responsible for all expenses incurred for medical treatment. I assign to Rogue Valley Urology any and all insurance benefits due to me, the full financial obligations for medical treatment that I have not paid for.

Our practice is committed to providing the best urological care to our patients. Thank you again for choosing Rogue Valley Urology. Please let us know if you have any questions or concerns.

I have read and understand the Rogue Valley Urology Financial Policy and agree to adhere to its guidelines.

Patient Name: ________________________________ DOB: __________

Date: ____________________

Signature: X____

Name: (if different than patient) ____________________ DOB: __________

Rogue Valley Urology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Rogue Valley Urology cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Rogue Valley Urology tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

ROGUE VALLEY
UROLOGY P.C.
At Providence Plaza

HEALTH HISTORY (ADULT)

Name: ______________________

Birthdate: ______________ Age: ________

Phone (H) ______________ (W) ________

Primary Doctor: ______________________

Date ______________________ Referring Physician ______________

Occupation **(past and present)** ______________________

Reason for coming ______________________

Marital Status ________ Emergency Contact ______________ Phone # ________

PAST MEDICAL HISTORY: Have you had any of the following problems?

Medical Illnesses

- ☐ Lung disease
- ☐ Asthma or Emphysema
- ☐ Tuberculosis or abnormal skin test
- ☐ Heart disease - Heart attack
- ☐ High blood pressure
- ☐ Cholesterol problem
- ☐ Ulcers
- ☐ Liver disease or hepatitis
- ☐ Acid reflux or hiatal hernia
- ☐ Sexually transmitted disease
- ☐ Brain or nerve disease (stroke)
- ☐ Migraine
- ☐ Depression/Anxiety
- ☐ Seizures
- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Anemia
- ☐ Blood clots or phlebitis
- ☐ Cancer ________

PAST UROLOGIC HISTORY

____
____
____
____
____
____
____
____

Operations/Hospitalization (include tonsillectomy and appendectomy)

Date	Operation/Hospitalization	Complications

Severe Accidents and Injuries and date

____

MEDICATIONS CURRENTLY TAKEN regularly or occasionally. Include vitamins, birth control pills, sleeping pills, pain pills, laxatives, aspirin - with dosage. Please bring these with you if you are are unsure.

ALLERGIES and Adverse Medication Reactions (please list reaction)

____

Recreational drugs? ☐ No ☐ Yes **IV drug user?** ☐ No ☐ Yes **Last HIV test?** ________

Tobacco Use? ☐ No ☐ Yes Pkgs/day ________ # of years ________ Quit? ________ Year quit ______

Alcohol Use? ☐ No ☐ Yes Drinks/day ________ Drinks/week ________ ☐ Beer ☐ Wine ☐ Hard Liquor

Female Patients

Last menstrual period ________ Last pap smear ________

Number of pregnancies ________ Number of births ________

SEE REVERSE SIDE

FAMILY HISTORY

General health; major health problems & illnesses, OR age and cause of death

	Age of death	Age if alive	Prostrate Cancer	Breast Cancer	Kidney / Stones	Other
Mother						
Father						
Brothers						
Sisters						

Significant illness in Grandparents, Cousins, Aunts, Uncles or Children?

____

____

REVIEW OF SYSTEMS: Do you have, or have you had in the past month, any of the following? (Place a check mark next to those you have experienced).

YES	NO	**General**
☐	☐	Recent fever
☐	☐	Weight Loss
☐	☐	Night Sweats
☐	☐	Fatigue
☐	☐	Change in lymph nodes
☐	☐	Chills

		Eyes
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Vision Loss

		Ears/Nose/Throat/Neck
☐	☐	Tinnitus
☐	☐	Decreased Hearing
☐	☐	Nosebleeds
☐	☐	Loose teeth
☐	☐	Sore Throat
☐	☐	Goiter
☐	☐	Difficulty swallowing

		Cardiovascular
☐	☐	Chest pain
☐	☐	Heart Attack
☐	☐	Irregular beats
☐	☐	Murmur
☐	☐	Leg swelling
☐	☐	Clots in legs

YES	NO	**Pulmonary/Respiratory**
☐	☐	Shortness of breath
☐	☐	Wheezing
☐	☐	Cough (productive)
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Tuberculosis

		Digestive/G.I.
☐	☐	Severe Heartburn
☐	☐	Vomiting
☐	☐	Ulcers
☐	☐	Abdominal pain
☐	☐	Jaundice/Hepatitis
☐	☐	Bloody bowel movements

		Genitourinary
☐	☐	Burning on urination
☐	☐	Bloody urine
☐	☐	Incontinence
☐	☐	Infections
☐	☐	Difficulty urination
☐	☐	Urination at night: # times
☐	☐	Difficulty with erections
☐	☐	Sexually transmitted diseases
☐	☐	Multiple sexual partners

		Skeletal
☐	☐	Fractures
☐	☐	Arthritis

YES	NO	**Skin/Breasts**
☐	☐	Rashes
☐	☐	Changes in mole
☐	☐	Discharge from nipples
☐	☐	Lumps

		Neurologic/Psychiatric
☐	☐	Convulsions
☐	☐	Stroke
☐	☐	Headaches
☐	☐	Depression, low motivation
☐	☐	Numbness/Change in vision
☐	☐	Anxiety, excessive worry

		Blood/Lymphatic
☐	☐	Easy Bruising
☐	☐	Excessive bleeding
☐	☐	Transfusions

Do you have an Advanced Directive for end-of-life? ______________

UPDATED/SIGNATURE