

WERNER-FRANCIS UROLOGY ASSOCIATES LLC

Mid Atlantic Urology Associates Llc

7500 HANOVER PKWY SUITE 206

GREENBELT, MD, 20770

OFFICE USE ONLY
DR# _____ OFFI# _____
SIG ON FILE _____
STATEMENT _____
INS FORM _____

PATIENT INFORMATION SHEET

I WAS REFERRED TO YOUR OFFICE BY: DR: _____

Friend/Patient _____ Internet _____ Yellow Pages _____ Ins Company _____ Other _____

PATIENT:

NAME	SS#	DOB	
ADDRESS / STREET	CITY	ST	ZIP CODE
() - HOME PHONE	() - WORK PHONE	S M D W P MARITAL STATUS	M F SEX

E-MAIL ADDRESS

ARE YOU A STUDENT? __Y N IF YES, WHERE? _____

IS THIS CONDITION WORK RELATED __Y N AUTO ACCIDENT RELATED? __Y N

IF YOU ARE RETIRED BUT ARE STILL COVERED BY YOUR FORMER EMPLOYER'S BENEFITS, PLEASE INDICATE NAME AND PHONE NUMBER OF THAT EMPLOYER

EMPLOYER NAME

() -
EMPLOYER PHONE

PERSON FINANCIALLY RESPONSIBLE FOR STATEMENTS

NAME	RELATIONSHIP TO PATIENT		
ADDRESS / STREET	CITY	ST	ZIP CODE
() - HOME PHONE	() - WORK PHONE	SS#	

IN CASE OF EMERGENCY CONTACT _____
 NAME
 () -
 PHONE

PRIMARY INSURANCE COMPANY

Ins Name _____

ADDRESS _____

CITY/STATE/ZIP _____

POLICY HOLDER NAME (LAST, FIRST) _____

RELATIONSHIP _____

CERTIFICATE # _____

GROUP # _____

MEMBER _____

SECONDARY INSURANCE COMPANY

Ins Name _____

ADDRESS _____

CITY/STATE/ZIP _____

POLICY HOLDER NAME (LAST, FIRST) _____

RELATIONSHIP _____

CERTIFICATE # _____

GROUP # _____

MEMBER # _____

INSURANCE AUTHORIZATION AND ASIGNMENT

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIMS AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO **Mid Atlantic Urology Assoc LLC** FOR MYSELF AND/OR DEPENDENTS. I UNDERSTAND I AM RESPONSIBLE FOR ANY DEDUCTIBLES, CO-INSURANCE OR AMOUNTS FOR SERVICES NOT COVERED BY THE INSURANCE CARRIER.

DATE _____

SIGNATURE _____

Ins Name _____

OTHER INSURANCE COMPANY

ADDRESS _____

CITY/STATE/ZIP _____

POLICY HOLDER NAME (LAST, FIRST) _____

RELATIONSHIP _____

CERTIFICATE # _____

GROUP # _____

MEMBER # _____

Werner-Francis Urology Associates LLC Mid Atlantic Urology Associates, LLC

Permission to Release Medical Information Required by Federal Law

Patient:

I, _____ hereby give permission to Werner-Francis Urology Associates LLC, Mid Atlantic Urology Associates LLC. Its employees, and sub-contractors to release current, past and future information about my medical condition, diagnoses, treatments and recommendations to:

(Cross out any that do not apply, other than the top six, (*in italics*), that are required for us to care for you)

- *My present and future health insurers*
- *My referring or primary health care provider*
- *Other health care providers caring for me*
- *Health care providers/laboratories I am referred to*
- *Health care facilities I am referred or admitted to*
- *Authorized reviewers for regulatory compliance quality assurance and/or peer review*
- My spouse or significant other _____
- My parents _____
- My employer (required for compensation cases)
- Others _____

This permission will remain in effect until I revoke all or part of it in writing. I understand that Werner-Francis Urology Associates LLC, Mid Atlantic Urology Associates LLC will make reasonable efforts to insure my privacy, but cannot guarantee the conduct of others who receive this information as allowed above.

Signed _____ Date _____

Witness _____

Guardian for Dependant:

I, _____ hereby give permission Werner-Francis Urology Associates LLC, Mid Atlantic Urology Associates LLC. Its employees, and sub-contractors to release current, past and future information about _____'s, diagnoses, treatments and recommendations to:

(Cross out any that do not apply, other than the top six, (*in italics*), that are required for us to care for you)

- *His/her present and future health insurers*
- *His/her referring or primary health care provider*
- *Other health care providers caring for him/her*
- *Health care providers/laboratories he/she is referred to*
- *Health care facilities he/she is referred or admitted to*
- *Authorized reviewers for regulatory compliance quality assurance and/or peer review*
- His/her spouse or significant other _____
- His/her parents _____
- His/her employer (required for compensation cases)
- Others _____

This permission will remain in effect until I revoke all or part of it in writing. I understand that Werner-Francis Urology Associates LLC, Mid Atlantic Urology Associates LLC will make reasonable efforts to insure his/her privacy, but cannot guarantee the conduct of others who receive this information as allowed above.

Signed _____ Date _____

Witness _____

Mid Atlantic Urology Associates LLC (MAUA)
Werner-Francis Urology Associates LLC
7500 Hanover Pkwy # 206 Greenbelt, MD 20770
4000 Mitchellville Road # 406 Bowie, MD
7350 Van Dusen Road #350 Laurel, MD
(301) 441 8900

Insurance Authorization and Assignment of Benefits

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to

FINANCIAL POLICY

GENERAL INFORMATION FOR ALL PATIENTS

1. Patients with NO INSURANCE are responsible for payment in full for all services at the time they are rendered.

7. Copies of medical records are made free of charge one time with the appropriate medical records release form. If you are sending your records to another doctor, you should make a copy for your own records.

8. Payment for medications, devices, and equipment dispensed from this office is expected at the time you pick them up. (There are some exceptions to this with Medicare patients).

9. As a courtesy to our patients, we do file secondary insurances. However, if we do not hear from your second insurance within 45 days of our filing a claim, the responsibility for payment reverts to the patient.

10. All insurances do not cover all medical problems. If we are notified by your insurance that we have filed a claim for a non-covered benefit, it becomes patient's responsibility
HMO/PPO INSURANCES. HMO patients without referrals can do the following:

1. Referrals, including for Out Patient surgery are patient's responsibility

- a) Pay for appointment. Checks will be held for 48 hrs. and returned to patient if valid referral is obtained.
- b) Reschedule appointment or surgical procedure.
- c) If referral is not obtained within 48 hrs., patient is responsible for paying charges for that date of service.

6. Co-pays are due prior to seeing the physician on the day of appointment. Cash or credit

MidAtlantic Urology Associates LLC, for myself and/or dependents. I understand

3. There are some benefits that require a special authorization from your primary care physician as well as an increased (up to 50%) co-payment. Example: infertility evaluation and treatment.
4. Mailhandler's does not pay benefits for sexual dysfunction.

I am responsible for any deductibles, co-insurance or amounts for services not

MEDICARE

1. There are some services that Medicare does not pay for. You will be asked to sign a release for such services indicating that you accept responsibility for payment for these services.
2. Our policy with regard to secondary insurance applies to Medigap insurances as well.

covered by the insurance carrier.

WORKER'S COMPENSATION

1. In order for us to accept Worker's Comp insurance, we must have the Case number and the name and phone number of the case worker or attorney.
2. In the event that our treatment is considered unrelated to the accident, the patient is responsible for the balance in full.

I have read and fully understand all of the above information,

Patient Name _____

Signed: PATIENT (GUARDIAN) _____ DATE _____

- _____
Relationship if Guardian

WITNESS (STAFF) _____ DATE _____

Pt. Name _____ Date Of Birth _____

Do you now or did you ever have any problems related to the following systems? Circle Yes or No

Constitutional Symptoms	Andrologic (Males only)
Fatigue	Y	N		Penile Discharge	Y	N
Fever	Y	N		<i>Sexual Dysfunction</i>	Y	N
Night Sweats	Y	N		Metabolic / Endocrine		
HEENT				Cold Intolerance	Y	N
Eyes, Discharge	Y	N		Heat Intolerance	Y	N
Eyes, Visual loss	Y	N		Marked Thirst	Y	N
Ears, Discharge	Y	N		Chronic Hunger	Y	N
Ears, Hearing loss	Y	N		Frequent urination	Y	N
Nose/Sinus, Nasal discharge	Y	N		Neuro / Psychiatric		
Throat/mouth	Y	N		Unstable Gait	Y	N
Respiratory				<i>Tremors</i>	Y	N
Cough	Y	N		<i>Numbness / tingling</i>	Y	N
Shortness of Breath	Y	N		<i>Other:</i>	Y	N
Wheezing	Y	N		Labile Emotions	Y	N
Heart				<i>Depression</i>	Y	N
Chest Pain	Y	N		Skin		
Shortness of breath	Y	N		Persistent Itching	Y	N
Palpitations /Irregular beat	Y	N		Rash	Y	N
Vascular				Musculoskeletal		
Claudication	Y	N		<i>Back Pain</i>	Y	N
Gastrointestinal				Joint Pain	Y	N
Abdominal Pain	Y	N		<i>Neck Pain</i>	Y	N
Constipation	Y	N		Blood / Lymph		
Diarrhea	Y	N		Easy Bleeding	Y	N
Vomiting	Y	N		Easy Bruising	Y	N
<i>Heartburn</i>	Y	N		<i>Blood Clots</i>	Y	N
<i>Reflux</i>	Y	N		Immunologic		
Genitourinary				Environmental Allergies	Y	N
Painful urination	Y	N		Food Allergies	Y	N
Blood in urine	Y	N		Other Symptoms		
Gynecologic (Females only)						
Painful Periods	Y	N				
Heavy Periods	Y	N				
Vaginal Discharge	Y	N				

Physician Initials _____ Date _____

Office Note: Items in italics have to be manually entered into EMR



Patient History Form (female)

Today's Date _____ LastName _____ FirstName _____ MI _____

Date of Birth ____/____/____ Referred by: _____

Primary Physician: _____

Please answer all Questions in the SHADED area

Why are you here today? (circle all appropriate answers)

My Doctor told me come I want to be checked for Another person sent me

I am here because of:

Blood in Urine Urinary Tract Infections Bladder Infections

Incontinence: Lose urine due to: Stress, cough, laugh, sneeze, etc Urge: Gotta go RIGHT NOW
Both Stress and Urge Incontinence

Frequent Urination Difficulty Urinating

Kidney Stones Back Pain Bladder Pain

Kidney Mass or Cyst

Other: _____

How long have you had the problem?

____ Years ____ Months ____ Weeks ____ Days

Are the symptoms: Constant Intermittent Worse Getting Better Gone

Have you had this problem before? Yes No

If "yes", what helped it? _____

FAMILY HISTORY: Cancer, Diabetes, Hypertension, Heart disease, etc: _____

PERSONAL HISTORY: Illnesses and Surgeries (Year) _____

MEDICATIONS: _____

ALLERGIES: _____

SOCIAL HISTORY: S M D W O (Optional: G) # of Children _____

OCCUPATION: _____

Alcohol N Y How often: _____ Amount _____ Stopped # _____ yrs ago

Smoke N Y Pks/Day _____ Yrs Smoked _____ Stopped # _____ yrs ago