Today's Date

Patient Name *(First, Middle, Last)* | Date of Birth | Gender | Marital Status

Patient Mailing Address | City | State | Zip code

Social Security Number | Email | Preferred Contact Phone Number

Alt Contact Phone Number | Employer | Work Number

Appointment Reminders: *(Please select the option you wish to receive appointment reminders.)*

[ ] I request to receive appointment reminders via Text Message
[ ] I request to receive appointment reminders via Email
[ ] I **DECLINE** to receive any appointment reminder.

Provider Information:

Primary Care Provider | Phone: | Cross Streets

Referring Provider: Who referred you here? | Phone: | Cross Streets

Policy Holder Information:

Primary Insurance | ID Number | Group Number | Address *(PO Box listed on back)*

Phone Number | Policy Holder Name | Relationship to Patient | Date of Birth

Secondary Insurance | ID Number | Group Number | Address *(PO Box listed on back)*

Phone Number | Policy Holder Name | Relationship to Patient | Date of Birth

Patient Contact List

Emergency Contact: Indicate any person who should be notified in case you experience a medical emergency while at our office.

Emergency Contact Name | Date of Birth | Phone | Relationship to

Non-Emergent Contact: Indicate persons who we may contact if we are having difficulty reaching you. Note: Unless you authorize the following individuals to access your protected health information (PHI), they may not receive test results or office visit information on your behalf.

Non-Emergency Contact #1 | Date of Birth | Phone | Relationship to patient

Non-Emergency Contact #1 | Date of Birth | Phone | Relationship to patient

Do you have an advance care plan? [ ] No [ ] Yes
Do you have a living will? [ ] No [ ] Yes
Do you have a surrogate/ decision maker? [ ] No [ ] Yes

If you wish to list individual(s) in your advance care plan and or your surrogate/decision maker, please write information below.

Surrogate/ Decision Maker Name	Date of Birth	Phone	Relationship to patient
Surrogate/ Decision Maker Name	Date of Birth	Phone	Relationship to patient

Patient Name: _____ Date of Birth: _____

Patient Signature/ Patient representative: _____ Date: _____

Social History:

Do you have any children? [ ] No [ ] Yes If yes, how many? _____

Do you currently smoke? [ ] No [ ] Yes If yes, how often? _____

Are you a former smoker? [ ] No [ ] Yes If yes, how many years? _____

Do you chew tobacco? [ ] No [ ] Yes If yes, how long? _____

Do you drink alcohol? [ ] None [ ] Socially [ ] 1-2 per day [ ] 3-4 per day [ ] over 4 per day

Have you ever used illegal drugs: [ ] No [ ] Yes If yes, what kinds? _____

Are you currently sexually active? [ ] No [ ] Yes

Have you ever had a sexually transmitted disease (STD)? [ ] No [ ] Yes
If yes, list what kind: _____ Date: _____
_____ Date: _____

Authorization to Disclose

Arizona State Urological Institute (ASUI) is committed to protecting your privacy and ensuring that your health information is used and disclosed properly.

List persons with who you authorize ASUI to discuss your healthcare and protected health information

First and Last Name:	Date of Birth: *(MM/DD/YYYY)*	Relationship to patient
_____	___/___/___	_____
_____	___/___/___	_____

Please select a security question below to verify with the individuals who are authorized to access and discuss your medical records with our office.

[ ] Security Pin Code: _____ [ ] Security Phrase: _____
[ ] Security Question: _____ _____
Answer to security question:

May we leave Protected Health Information & results on your voicemail?

[ ] No [ ] Yes If yes, what number(s) may we call? _____

Arizona State Urological Institute, LLC
The Center for Comprehensive Urological Care

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____ Contact Number _____

Patient Mailing Address: _____ City _____ State _____ Zip code _____

I hereby authorize: _____ _____
(Provider, Hospital, Urgent Care, etc.) Fax

Address _____ City, State & Zip Code _____ Phone _____

To release information to:

Arizona State Urological Institute, LLC
2730 S Val Vista Dr. Bld 13, Suite 177
Gilbert, AZ 85295
Phone**:** 480-394-0200 **| Fax: 480-394-0202**

☐ For the following purpose: _____

OR

☐ All Records

Medical Records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

☐ **I DO** authorize the release of this type of information.

☐ **I DO NOT** authorize the release of this type of information.

I understand that:

- I may revoke this authorization, except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization for my personal records.

Patients: This form allows our office to request medical records on your behalf from other physicians, hospitals, and care providers to better coordinate your care. Please fill out the form to the best of your ability. Please make sure to sign and date form.

Patient Signature or Personal Representative of Patient Signature _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Arizona State Urological Institute (ASUI) is committed to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our Practice and outlines your rights regarding your health information. Please sign this form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Arizona State Urological Institute, LLC.

Printed Name of Patient or Personal Representative	Date
Signature of Patient or Personal Representative	Date

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Imagine fully informed health

Notice of Health Information Practices

(Participant) participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information.

I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

Signature of Patient or Personal Representative	*Date:* __/__/__
Printed Name of Patient or Personal Representative	*Date:* __/__/__

Past Medical History: ◯ No Past Medical History

Anemia	◯ Yes ◯ No	Gout	◯ Yes ◯ No	Kidney Stones	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Heart Disease	◯ Yes ◯ No	Pancreatitis	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Panic Attacks	◯ Yes ◯ No
Bladder Infections	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rashes	◯ Yes ◯ No
Bleeding Problems	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Blood Transfusions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
COPD	◯ Yes ◯ No	Infections	◯ Yes ◯ No	TB	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	IBS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Obesity	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Other (please specify)					

Have you received a Pneumococcal Vaccine in the past? [ ] No [ ] Yes If Yes, when was the last injection date: _____

Have you received the Influenza Vaccine? [ ] No [ ] Yes If Yes, when was the last injection date:_____

Family Medical History: ◯ None ◯ Unknown

	Mother	Father	Siblings	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Cancer (specify type please)							
Diabetes							
Heart Disease							
High Blood Pressure							
Kidney Disease							
Lung Disease							
Stroke							
Other:							

Surgical History:

Surgical History: (Please list surgeries/ Hospitalizations ◯ None	**Dates**

Medications:

○ No, I do not take medications

○ Yes, I do take medications. (please list below your current medications including over the counter supplements)

Medication Name:	Dosage & How often taken	Reason for taking Medication

Allergies:

○ No known drug allergies

○ Yes, I do have allergies. (Medications and reactions listed below.)

Medication Name:	Reaction

Pharmacy Information:

Pharmacy- Local _____ Phone _____ Cross Streets _____

Pharmacy- Mail Order _____ Phone _____ Cross Streets _____

Review of Systems

Constitutional Symptoms

Appetite Change	◯	No	◯	Yes
Weight Gain	◯	No	◯	Yes
Weight Loss	◯	No	◯	Yes
Fatigue	◯	No	◯	Yes
Fever	◯	No	◯	Yes
Chills	◯	No	◯	Yes

Skin

Hives	◯	No	◯	Yes
Itching	◯	No	◯	Yes
Rash	◯	No	◯	Yes

Allergy/ Immune

Cancer	◯	No	◯	Yes
Seasonal Allergies	◯	No	◯	Yes

Ears/Nose/Mouth/Throat

Hearing Changes	◯	No	◯	Yes
Nose Bleeds	◯	No	◯	Yes
Tinnitus	◯	No	◯	Yes
Comments:				

Eyes/Head

Dizziness	◯	No	◯	Yes
Headaches	◯	No	◯	Yes
Vision Changes	◯	No	◯	Yes
Comments:				

Respiratory

Shortness of Breath	◯	No	◯	Yes
Cough	◯	No	◯	Yes
Wheezing	◯	No	◯	Yes
Other:	◯	No	◯	Yes
Comments:				

Cardiovascular

Edema	◯	No	◯	Yes
Chest Pain/Discomfort	◯	No	◯	Yes
Syncope/Loss of consciousness	◯	No	◯	Yes
Comments:				

Gastrointestinal

Bloody Stool	◯	No	◯	Yes
Bowel Changes	◯	No	◯	Yes
Abdominal Pain	◯	No	◯	Yes
Nausea	◯	No	◯	Yes
Heartburn	◯	No	◯	Yes
Diarrhea	◯	No	◯	Yes

Genitourinary

See HPI	◯	No	◯	Yes
Decreased flow/force	◯	No	◯	Yes
Vaginal Discharge	◯	No	◯	Yes
Penile Discharge	◯	No	◯	Yes
Pain with Urination	◯	No	◯	Yes

Endocrine

Diabetes	◯	No	◯	Yes
Comments:				

Musculoskeletal

Bursitis	◯	No	◯	Yes
Gout	◯	No	◯	Yes
Osteoporosis	◯	No	◯	Yes
Muscle/Joints Stiffness	◯	No	◯	Yes
Back Pain/Injuries	◯	No	◯	Yes
Arthralgias/Arthritis	◯	No	◯	Yes
Comments:				

Neurological

Epilepsy	◯	No	◯	Yes
Palsy	◯	No	◯	Yes
Speech	◯	No	◯	Yes
Stroke	◯	No	◯	Yes
Tingling	◯	No	◯	Yes

Hematologic/Lymphatic

Anemia	◯	No	◯	Yes
Easy Bruising	◯	No	◯	Yes
Comments:				

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ARIZONA STATE UROLOGICAL INSTITUTE

Health Information Request Form

Please complete and return this form to your healthcare provider who will return this form to Health Current.

Patients have the right to request a copy of their health information that is available through Health Current, Arizona's health information exchange (HIE). Patients also have a right to request a list of the persons who have accessed their health information through the HIE in the last three years.

If you want to request any of this information, please complete and return this form to your healthcare provider. You will receive a response to the request within 30 days. Please note, Health Current may only send data to an address within the United States of America or its territories. If you are filling out this form for another person, the references to "I" and "my" in this form refer to that other person.

Patient Name:_____ **Date of Birth**: _____

Street Address:_____

City:_____ **State**:_____ **Zip**:_____

Please check all boxes that apply:

- ☐ I request a copy of all of my health information that is available through Health Current.
- ☐ I request a list of all persons who have viewed my health information through Health Current in the past three years. I understand that this list will not include persons who viewed my health information in other ways, such as through a healthcare provider's electronic health record.

Signature of Patient or Patient's Parent/Guardian/Health Care Decision Maker:_____

Print Name:_____ **Date**:_____

If signed by a person other than the patient, please indicate your authority to sign for the patient (check one):

☐ Spouse ☐ Parent/Guardian ☐ Caregiver with authority to make healthcare decisions

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Provider Office Only: This section must be completed before sending via secure fax to Health Current.

Organization/Provider: _____

Print Name:_____ Date:_____

Signature:_____ Phone:_____

To: All Male Patients

From: Arizona State Urological Institute

Insurance Payment Guidelines for Erectile Dysfunction, Impotence and Infertility, Vasectomy Consults and Vasectomy

As you prepare for your visit with our Physicians, we must make you aware of a potential situation regarding insurance coverage for certain diagnoses and conditions which are commonly treated by Urologists.

Specifically, it is possible that treatment for erectile dysfunction, impotence, infertility, sterilization and related conditions may not be reimbursed by your insurance carrier. **BCBS of Arizona and Golden Rule** typically do not cover these services.

BCBS of Arizona typically does not cover TESTOPEL pellets or Testosterone Injections and considers those experimental. **United Health Care Community Plan** (formerly APIPA) does not cover TESTOPEL pellets. Please contact your insurance to find out your individual plans benefits. In this case, you will be responsible for payment for any treatment you receive related to these conditions.

While some insurance plans do cover such treatment, there is no way for us to know in advance whether your carrier will, in fact, cover you. You may wish to contact your carrier prior to your visit to determine what their policy is.

If you are a Medicare patient, you should know that these diagnoses are generally covered.

Also, many plans do not cover medications to treat Erectile Dysfunction. Samples are extremely limited and may only be distributed up to one time as deemed necessary by the Physician.

We ask you to sign the following statement so that there is no confusion regarding this issue:

"I understand that if I am ever treated for erectile dysfunction, impotence, infertility, sterilization or a related diagnosis, and that any of my insurance carriers refuse payment for this treatment, I am fully responsible for paying all charges incurred during the course of my treatment. I also understand ED samples (**Viagra, Cialis, Levitra**) are very limited and my insurance may not cover such medications."

_____ _____

Patient Signature DOB Date

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Arizona State Urological Institute (**ASUI/we/us**) as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, phone number, name, insurance information, etc.)

Because insurance coverage varies, it is important that you understand your individual health plan and what it covers, including deductibles, coinsurance and copays. We recommend that you call the customer service number on the back of your insurance card for any questions regarding your health insurance plan.

Patient Financial Responsibilities: We will bill your primary insurance company and any secondary insurance as a courtesy to you. In order to properly bill your insurance company, you must timely and accurately disclose all insurance information, including primary and secondary insurance plans, as well as any change of insurance information. Failure to provide timely, accurate and/or complete insurance information may result in you being responsible for the entire bill. We do our best to estimate your financial responsibility up front, but please understand this is only an estimate. Although we may **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits.

Copayments, Coinsurance, and Outstanding Balances: Copayments, coinsurance, deductibles and balances not covered by insurance are due prior or at the time services are rendered. Inability to pay at the time of service may result in having to reschedule your appointment. Payment can be made by check, cash, MasterCard, VISA, and Discover.

We cannot waive co-payment, deductibles, co-insurance or any service amounts defined as patient responsibility under the terms of our contractual agreement with your insurance plan. We are required to bill for services rendered. You will be asked to pay on any estimated out of pocket costs and past due balances at the time of check-in.

Account Balances: Our billing office will provide you with a monthly statement of all account activity including our charges, payments and contractual adjustments from your insurance carrier along with payments made by you. Please be aware that you will be charged a returned check fee for all payments, made by a personal check, that have been returned by your banking institution for any reason. Please note that failure to pay outstanding balances that are your responsibility may result in having to reschedule future appointments until the balances are paid in full. In addition, any unpaid delinquent balance may: (a) delay scheduling of future appointments; (b) result in your account being forwarded to a collection agency or collection attorney of our choice; (c) reporting you to one or more third-party credit reporting agencies; and/or (d) termination from ASUI.

Referrals: Certain insurance plans require referrals to see a Specialist. It is your responsibility to obtain a referral from your primary care physician. Referrals must be presented at the time services are rendered, if applicable. As a courtesy, we will make efforts to obtain referrals and prior authorizations on your behalf. If you need to have a referral faxed to us, our office will provide you with our fax number. If your insurance plan requires you to have a referral or other authorization, and you fail to provide that to us, your appointment will be rescheduled or your claim for that date of service will be processed via optout benefits, if applicable.

Surgical procedures: You will be required to pay estimated out-of-pocket costs associated with your surgical procedure prior to the procedure. The amount you will be required to pay will be determined based upon your individual insurance

plan and will include any deductibles, co-payments and co-insurance which your insurance carrier indicates that you will owe. We do our best to estimate your financial responsibility up front, but please understand this is only an estimate. In addition, you will be required to make arrangements to pay any other outstanding balances that you may owe to us at that time. Failure to do so may result in rescheduling your procedure. You may receive separate bills for services related to your surgical procedure provided by third-parties, which may include hospital fees, anesthesiology fees, surgical assist fees, laboratory fees, and/or radiology fees.

For self-pay patients, payment is due at check-in. The account balance is expected to be paid in full. We do our best to estimate your financial responsibility up front, but please understand this is only an estimate.

Diagnostic Testing: During the course of your medical treatment with ASUI, your urologist may request a tissue, blood or urine specimen be obtained for diagnostic testing. This testing is being performed in order to assist your urologist in the diagnosis and management of your urologic condition. Depending upon the requirements of your insurance coverage, these specimens may be processed at ASUI's in-house pathology laboratory or at a third-party laboratory, for example Quest or LabCorp. The costs of these laboratory tests vary depending upon the nature and complexity of each test. The cost for a diagnostic test, including the cost that you will be required to pay, if any, depends on your insurance carrier and the type of insurance coverage you have. Please note: 1) All charges for specimens processed at ASUI's laboratory will be included in the statement you receive 2) Charges for specimens processed at a third-party laboratory will be billed to you directly by that laboratory.

FMLA/Disability Form Completion: $25.00 charge

Patient Authorizations: By my signature below:

- I hereby authorize ASUI and the physicians, staff, labs and facilities associated with ASUI to release necessary medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- I hereby assign my financial benefits directly to ASUI for all items and services rendered by or on behalf of ASUI, to the maximum extent permitted by law. I understand that I am financially responsible for charges not covered by this assignment.
- I understand the physicians that treat me may have a financial interest in the facility they refer me to including, but not limited to, surgery centers, lithotripsy centers, pathology labs, and other medical and non-medical related entities.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Agreement:

X_____ X_____

Printed Name of Patient Date of Birth

X_____ X_____

Signature of Patient or Guardian Date

International Prostate Symptom Score (IPSS)

Patient Name: Date of Birth: Today's Date:

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

Total International Prostate Symptom Score = _____

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	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

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)									
1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

Would you like to discuss with your doctor about a minimally invasive option for your bothersome urinary symptoms?	Yes	No

The information provided in this form may be de-identified and aggregated and provided to a 3rd party for use.

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: _____ **TODAY'S DATE:** _____

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. **TOTAL:** _____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED **8-11 Moderate ED** **12-16 Mild to Moderate ED** **17-21 Mild ED**