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

Today's Date: _____

Patient Name: _____ Date of Birth: _____

So that ASUI can provide you the best care, please review and update your information since your last visit.

Address: [ ] Unchanged [ ] New: _____

Telephone: [ ] Unchanged [ ] New Home: _____ [ ] New Cell: _____

Email Address: [ ] Unchanged [ ] New: _____

Current Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed
Is it okay to leave a detailed message on your phone if you are not available? [ ] Yes [ ] No
On which phone number may we leave a message? [ ] Home [ ] Cell
Do we have permission to speak with someone if you are not available? [ ] Yes [ ] No

If yes, who? Name: _____ Date of Birth: _____

Phone number: _____ Relationship: _____ Same as Emergency contact? [ ] Yes [ ] No

To protect your privacy and ensure your health information is disclosed properly, please provide a Security Question/Answer that the authorized person knows.

Security Question, PIN or Phrase: _____
Security Answer: _____

Have you had any medication changes since the last visit? Dosage changes or new medication?

[ ] No [ ] Yes, please list: _____

Have you been diagnosed with any new conditions? [ ] No [ ] Yes, please list: _____

Have you had any additional surgeries? [ ] No [ ] Yes, please list: _____

I understand that I am responsible for charges not covered or reimbursed by the above agents (Insurance). I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

1. I authorize my insurance carrier to release information regarding my coverage to Arizona State Urological Institute.
2. My right to payment of all pharmaceuticals, procedures, tests, medical equipment rentals, supplies, and nursing/physician services including major medical benefits are hereby assigned to Arizona State Urological Institute. This agreement covers all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans.
3. I understand that I have a right to request and receive a Notice of Privacy Practices from Arizona State Urological Institute.

I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Arizona State Urological Institute.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have received a copy of the above statements and accept the terms. A duplicate of this statement is considered the same as the original.

Patient Signature/Responsible Party:_____ **Today's Date:** _____

healthcurrent

ASUI
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:_____

healthcurrent

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 Date

Aviso de Prácticas de Información de Salud

(Participant) participa en una organización sin ánimo de lucro, organización no gubernamental de intercambio de información sobre la salud (HIE-por sus siglas en ingles) llamada Health Current. Esto no le generará ningún costo y puede ayudar a su medico, proveedores de salud y planes de salud a coordinar mejor su cuidado compartiendo de forma segura su información médica. Este aviso explica cómo funciona el programa HIE y le ayudará a entender sus derechos con repesto al mismo bajo las leyes estatales y federales.

Yo reconosco que he recibido y leído el Aviso de Prácticas de Información de la Salud. Yo estoy consiente que mi proveedor participa en el HIE (Arizona's Health Information Exchange). Yo estoy consiente que mi información de la salud será compartida de manera segura atrávez del sistema HIE, al menos de que llene una forma de Optar Por No.

Firma Fecha

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*

Patient Assessment Questionnaire

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

The last 2 columns on the right are for you doctor to assess your score. 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+		
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
2b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3. Are you currently sexually active? YES _____ NO _____							
4a. IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or symptoms during or after sexual intercourse	Never	Occasionally	Usually	Always			
4b. 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, uretha, perineum, testes, scrotum)?	Never	Occasionally	Usually	Always			
6. Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7a. If you have pain, is it usually…		Mild	Moderate	Severe			
7b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8a. If you have urgency, is it usually…		Mild	Moderate	Severe			
8b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
	Symptom Score (1, 2a, 4a, 5, 6, 7a, 8a)- SUBTOTAL						
	Bother Score (2b, 4b, 7b, 8b)- SUBTOTAL						
	TOTAL SCORE (symptom Score + Bother Score) =						