PROUD PARTNER OF THE ARIZONA DIAMONDBACKS

Affiliated UROLOGISTS

Phone: 602-264-0608 Fax: 602-234-0417 www.affiliatedurologists.com

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Dear New Patient-

Thank you for choosing Affiliated Urologists, Ltd an affiliated of Arizona Oncology Associates and welcome to our practice. Our mission is to provide you the highest quality Urological care with compassion, efficiency and professionalism. Please take a moment to read the information below to answer frequently asked questions.

Parking-

Central & Camelback- 5133 N. Central Ave Suite 206 Phoenix, AZ 85012 There is parking in front of the building, as well as near the "Circle K." You may take the elevator up to the 2nd floor, or there are two sets of stairs on either side of the building.

Tatum- DESERT RIDGE- 20940 N. Tatum Blvd Suite 125 Phoenix, AZ 85050 Parking is located around the building. When you enter the building, make a right and we are down the hall on the right-hand side.

Scottsdale- 3501 N. Scottsdale Road Suite 246 Scottsdale, AZ 85251 Parking is located around the building. We are located on the second floor.

Sonoran - 33300 N. 32nd Ave Suite 201 Phoenix, AZ 85085 Parking is located around the building. We are located on the second floor in the HonorHealth office.

Biltmore- 2222 E. Highland Suite 400 Phoenix, AZ 85016 We are located in the "Arizona Oncology" suite on the 4th floor. Parking is available around the building as well as a parking garage behind the building. We are only at this location on Thursday afternoons & Friday mornings.

Arrowhead- 6320 W. Union Hills Drive Suite B1600 Glendale, AZ 85308 Parking is located around the building. We are located on the first floor.

Registration Packet-

We will email you the new patient paperwork prior to your visit or you can print it off of our website. Please fill out the packet and bring it in to your appointment. If you did not receive or are unable to fill out the paperwork, please come in 30 minutes prior to your appointment. You will need to have your updated insurance card, medication list, surgical and medical history

You can join the Patient Portal by providing us your email address. You will receive an email with your login information. You can obtain your results, request prescription refills and much more via the patient portal. The link to our portal is https://health.healow.com/affiliatedurologists There is also an app available for smart phones- healow by eClinicalWorks .

About Us-

Please visit our website at www.affiliatedurologists.com to find out more about our Practice. If you would like to schedule future appointments online, you can do so through Zoc Doc. A link is available on our website. We are affiliated with Arizona Oncology Associates. Billing statements will be sent via Arizona Oncology's Central Business Office.

Insurance-

Please bring your Insurance Card(s) to your appointment. It is important that you have your correct insurance information at the time of your appointment and to notify our staff if your insurance coverage changes. ***Co-pays, deductibles and co-insurances are due at the time of service***. If a referral is needed from your Primary Care Physician, please ensure they are informed of your upcoming visit. If a surgery is scheduled, we will contact your insurance to verify benefits and call you to arrange payments for out of pocket costs.

Office Hours-

Our phone hours for both locations are from 8:00 am- 5:00 pm Monday- Thursday with lunch taken between 12:00-1:00pm. We do close at 1:00pm on Friday's; however, we always have a Physician on call for emergent needs. We always have a doctor on call 24/7. If you need to speak with your physician urgently, please call our main line and you are able to page the on-call physician. Non urgent prescription refills will not be filled after hours.

Lab and Lab testing-

We have an on-site Sonora Quest phlebotomist at our Central location for your convenience. Sonora Quest is a separate entity and lab services will be billed separately through Sonora Quest. If your insurance is not contract with Sonora Quest, we will send your lab work to Lab Corp. Please be aware we do not have any access to Sonora Quest billing and are unable to adjust the bill on your behalf. You always have the option of taking the order to a Lab facility of your choice. Ask the Medical Assistant and they will be happy to give you a copy of your lab order.

Pathology-

If you have any Pathology services performed, we will send it out to a Pathologist for reading. The Pathologist will send us back a report with their findings. The Pathologist will bill for his services separately.

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NEW PATIENT REGISTRATION & HISTORY FORM

Date: ____/____/____Last Name: _____First Name: _____Date of Birth: ____/____/____

Phone Number(s) _____May we leave Protected Health Information & results on this voicemail? Yes ☐ No ☐

Phone Number(s) _____May we leave Protected Health Information & results on this voicemail? Yes ☐ No ☐

Social Security Number: _____ Email: _____Occupation: _____

Mailing Address: _____City/Zip _____

Race/Ethnicity: _____ Language: _____ Primary Care Doctor_____

Physician who referred you here:_____Cardiologist: _____

Pharmacy Name: _____Phone: _____Cross streets:_____

Primary Insurance:_____Ins ID #:_____Policy Holder Name/DOB: _____

Secondary Insurance: _____Ins ID #:_____Policy Holder Name/DOB:_____

How did you hear about our practice? _____

Height: _____ft_____in Weight: _____lbs Do you have a pacemaker or any implantable devices? ☐ Yes ☐ No

CHIEF COMPLAINT: What is the main reason for your visit today (please describe in as much detail as possible)

_____

_____

_____

HISTORY OF PRESENT ILLNESS:

When did this issue start? _____ Has it occurred before?_____ If yes, when?_____

Anything else you'd like to mention?_____

ILLNESS/MEDICAL CONDITIONS

Example: (diabetes, breast cancer, heart disease, etc.)

Check here if you do not have any medical illnesses/conditions ☐

Medical Condition	Year	Medical Condition	Year

MEDICATION- please list all medications or feel free to attach a list

Check here if you are NOT currently taking any medication ☐

Name of Medication &Dose	Date started	Name of Medication & Dose	Date started

ALLERGIES- please list allergies and year you encountered the allergy

Check here if you have No Known Drug Allergies ☐

Name of Medication/Food	Date	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREVIOUS SURGERIES:

Check here if you have not had any prior surgery ☐

Surgery:	Month/Year	Surgery:	Month/Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREVIOUS HOSPITILIZATIONS:

Check here if you have not had any prior hospitalizations ☐

Reason :	Month/Year	Reason:	Month/Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY MEDICAL HISTORY **List all serious illness in your immediate family: (i.e. Diabetes, Cancer, Heart Disease, etc.)**

Children (#):_____ ☐ **Healthy** **Medical Problems?** _____

Brothers (#):_____ ☐ **Healthy** **Medical Problems?** _____

Sisters (#):_____ ☐ **Healthy** **Medical Problems?** _____

Mother: Age_____ ☐ **Healthy** **Medical Problems?** _____

Father: Age_____ ☐ **Healthy** **Medical Problems?** _____

SOCIAL HISTORY: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Significant Other**

Do you or have you ever smoked or used tobacco? ☐ **Yes** ☐ **No**

If yes- What year did you start smoking _____ What year did you quit smoking? _____

How many packs of cigarettes do you smoke _____per ☐ day ☐ week

What type of tobacco? (circle all that apply) Chew Tobacco Smoke Cigarette Pipe Smoker

Did you have a drink containing alcohol in the past year? ☐ **Yes** ☐ **No** (0 point)

If yes, how often did you have a drink containing alcohol in the past year?

☐ Monthly or less (1 pt) ☐ 2-4 times per month(2pts) ☐ 2-3 times per week(3pts) ☐ 4 or more times a week(4 pts)

If Yes, how many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 drinks (0pts) ☐ 3 or 4 drinks (1 pt) ☐ 5 or 6 drinks (2pts) ☐ 7 to 0 drinks (3 pts) ☐ 10 or more drinks (4pts)

If Yes, how often did you have 6 or more drinks on one occasion in the past year?

☐ Never (0pts) ☐ Less than monthly (1 pt) ☐ Monthly (2pts) ☐ Weekly (3 pts) ☐ Daily or almost daily (4pts)

Have you been exposed to sexual transmitted diseases? ☐ **Yes** ☐ **No**

Type of Disease(s)	Year	Type of Disease(s)	Year
_____	_____	_____	_____

Have you previously received an **influenza immunization** (flu shot)? ☐ **Yes** ☐ **No** Date (most recent):_____

REVIEW OF SYSTEMS-PLEASE MARK A (X) IN THE SPACES PROVIDED IF YOU EXPERIENCE THE BELOW CONDITIONS

1) General	X	1) Neurological	X	9) Psychological	X
Fever		Dizziness		Anxiety	
Fatigue		Muscle Weakness		Depression	
Weight Loss		Numbness		Memory Loss	
2) Cardiovascular	**X**	**2) Endocrine**	**X**	**10) Hematologic**	**X**
Chest Pain		Cold Intolerance		Abnormal Bruising	
Heart Palpitations		Excessive Thirst		Abnormal Clotting	
Swelling of Feet		Heat Intolerance		Anemia	
3) Respiratory	**X**	**3) Musculoskeletal**	**X**	**11) Eyes**	**X**
Shortness of Breath		Back Pain		Blurred Vision	
Cough		Joint Pain		Double Vision	
Sleep Apnea		Muscle Cramps		Irritation	
4) Gastrointestinal	**X**	**4) Integumentary(Skin)**	**X**		
Abdominal Pain		Dryness			
Constipation		Itching			
Nausea		Skin Rash			

E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

Formulary and benefit transactions — Gives the prescriber information about which drugs are covered by the drug benefit plan.
Medication history transactions - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
Fill status notification - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Affiliated Urologists, Ltd an affiliated of Arizona Oncology Associates can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Affiliated Urologists, Ltd an affiliated of Arizona Oncology Associates to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient or Personal Representative Signature: _____Date: _____

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Affiliated UROLOGISTS

FINANCIAL POLICY:

Thank you for choosing Affiliated Urologists as your healthcare provider, an affiliate of Arizona Oncology Associates. 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, we require that you disclose all insurance information, including primary and secondary insurance plans, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility 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 Arizona Oncology Associates 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 backing institution uncashed due to insufficient funds or stopped payment. Please note that failure to pay outstanding balances that are your responsibility may result in having to reschedule future appointments until balances are resolved. 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 (d) termination from the practice.

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, Affiliated Urologists 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 make arrangements to pay estimated out-of-pocket costs associated with your surgical procedure prior to services being rendered. 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. You may receive separate bills for services related to your surgical procedure provided by non-Affiliated Urologists/outside providers and facilities. This includes 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 Affiliated Urologists, including your office visit and/or surgical procedure, your urologist may request that a tissue, blood or urine specimen be obtained for the purpose of 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 Affiliated Urologists 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 Affiliated Urologist's laboratory will be included in the statement you receive from Arizona Oncology Associates. 2) Charges for specimens processed at a third-party laboratory will be billed to you directly by that laboratory.

No Show / Same Day Cancellation Policy: A $25 missed appointment fee will be charged to you for any missed appointment where you fail to cancel a scheduled appointment at least 24 business hours prior to the time of that scheduled appointment. The fee will be your responsibility to pay and will not be billed to your insurance company.

Missed Surgeries/Same Day Cancellation Policy: A $250.00 missed surgery will be charged to you for any missed surgeries where you fail to cancel a scheduled procedure at least 24 business hours prior to the time of the surgery. The fee will be your responsibility to pay and will not be billed to your insurance company

FMLA/Disability Form Completion: $35.00 charge

Patient Authorizations

- By my signature below, I hereby authorize Affiliated Urologists, Arizona Oncology Associates and the physicians, staff, labs and hospitals associated with AU 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.
- By my signature below, I hereby authorize assignment of financial benefits directly to Affiliated Urologists, Arizona Oncology Associates and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, 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 oncology treatment facilities, radiation facilities that perform CT and PET scans and other medical and non-medical related entities.
    - The list below is designated purely as a resource to patients and does not necessarily include the names of all providers of imaging service in our community. Please keep in mind that your physician has made the medical decision to order these studies and considers it medically necessary regardless of where you choose to have it done. Other Radiology Providers: Scottsdale Medical Imaging, Ltd- 480-425-5030 Valley Radiology- 623-847-2000 Simon Med Imaging- 480-306-7900

If you do not want your insurance billed and would like to be self-pay, please initial here _____

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

X_____ X_____

Printed Name of Patient Date of Birth

X_____ X_____

Signature of Patient or Guardian Date

PROUD PARTNER OF THE ARIZONA DIAMONDBACKS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Affiliated Urologists and Arizona Oncology Associates, P.C. share in the same commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practice identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

CONTACT LIST:

The purpose of this form is to provide Affiliated Urologists and Arizona Oncology with the names of people to be contacted on your behalf.
Emergency: Indicate any person who should be notified in case you experience a medical emergency while at our office
Other contacts: Indicate persons who we may contact if we are having difficulty reaching you.
Authorization to disclose: Indicate persons who you give us permission to discuss your protected health information.

Emergency Contact Name:	Relationship:
Primary Phone Number:	Alternate Phone Number:
Do you authorize Affiliated Urologists/Arizona Oncology to disclose your protected health information to this contact?	☐ Yes ☐ No

Other Contact Name:	Relationship:
Primary Phone Number:	Alternate Phone Number:
Do you authorize Affiliated Urologists/Arizona Oncology to disclose your protected health information to this contact?	☐ Yes ☐ No

Other Contact Name:	Relationship:
Primary Phone Number:	Alternate Phone Number:
Do you authorize Affiliated Urologists/Arizona Oncology to disclose your protected health information to this contact?	☐ Yes ☐ No

I acknowledge that I have received a copy of the Notice of Privacy Practices of Arizona Oncology Associates, P.C./Affiliated Urologists, Ltd. I give my consent to Arizona Oncology Associates, P.C./Affiliated Urologists, Ltd. to contact the person(s) listed above for the purposes I designated. 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.

Patient or Personal Representative Signature: _____Date: _____

Patient or Personal Representative Name (Printed):_____

PROUD PARTNER OF THE ARIZONA DIAMONDBACKS

HIPAA AUTHORIZATION TO USE AND DISCLOSE MEDICAL INFORMATION

I, [**Patient Name**:]_____, [**Date of Birth**:]_____ authorize Dr._____- Fax: _____to **use and disclose** my medical information to:

Organization Name: **Affiliated Urologists, Ltd** Attention: **Medical Records**
Phone: **602-264-0608** Fax: **602-234-0417**

INFORMATION TO BE RELEASED:

☐ Provider Office Notes ☐ Surgical Reports ☐ Progress or Discharge Notes ☐ Immunizations
☐ Tests and Results ☐ Allergy Records ☐ Hospital Records Including Reports
☐ Prescriptions ☐ Radiology Reports ☐ Consultations ☐ Laboratory Reports (Including Pathology)
☐ **Entire Record** ☐ Other (Specify):_____

In addition, I specifically authorize the release of records pertaining to:

☐ Mental Health ☐ Alcohol and Drug Abuse ☐ HIV-related information ☐ Other Communicable Diseases ☐ Genetic information ☐ Developmental Disabilities ☐ Other (Specify):_____

For The Following Date(s): _____ to _____ ****OR**** ☐ all past, present and future periods

HOW THIS FORM MAY AFFECT ME AND MY RIGHTS:

Right to Revoke Authorization. I understand that I have the right to revoke this authorization, except to the extent that Affiliated Urologists has already used or disclosed my medical information in reliance of this authorization. I understand that my revocation is effective only if it is in writing. To revoke my authorization, I understand that I must send a written request for revocation to Arizona Oncology medical records staff.

My Medical Information May Be Re-Disclosed. I understand that if my medical information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives my medical information. I understand that this re-disclosure may not be protected by the applicable privacy laws.

Right to Inspect and Copy My Medical Information. I understand that I have the right to inspect and copy my medical information in Arizona Oncology records. I understand that to inspect and copy medical information, I must submit my request in writing to Affiliated Urologists medical records staff. If I request a copy of the information, I understand that Affiliated Urologists may charge a reasonable cost-based fee in accordance with applicable law to fulfill my request. I understand that Affiliated Urologist may deny my request to inspect and copy in certain very limited circumstances. If I am denied access to medical information, I may request that the denial be reviewed in certain circumstances.

I Am Not Required to Sign this Authorization. I understand that I may refuse to sign this authorization without affecting my ability to obtain treatment at Affiliated Urologists. However, I also acknowledge that I have agreed to sign this authorization.

Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

EXPIRATION DATE:

This authorization will remain in effect until the following date (or event): _____. If no date or event is specified, this authorization shall expire one year from the date this form is executed as listed below.

Signature of Patient:_____**Date:**_____

Signature of Legal Representative:_____**Date:**_____

If signed by a Legal Representative, **include documentation of legal authority** and complete the following:

1. The Individual is: ☐ a minor ☐ legally incompetent or incapacitated □ deceased
2. Legal authority: □ parent* □ legal guardian □ next of kin/executor of deceased □ activated POA for Health care

By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order

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Bladder Satisfaction Survey

Name:_____ DOB:_____ Date:_____

Which symptoms best describe you?

- ☐ Frequent Urination- Day, Night or Both
- ☐ Leaking with Sneezing, Coughing, Exercising
- ☐ Sudden or Strong Urge to urinate
- ☐ Leaking with Urge or No Warning
- ☐ Unable to Empty the Bladder
- ☐ Bladder or Pelvic Pain

How long have you had these symptoms: _____

Have you tried medications to help your symptoms? ☐ Yes ☐ No

If yes, check the medications you have tried:

- ☐ Detrol LA ® ☐ Ditropan XL®
- ☐ Flomax®
- ☐ Cardura®
- ☐ Oxytrol® Patch
- ☐ Enablex® ☐ Vesicare®
- ☐ DDAVP®
- ☐ Sanctura®
- ☐ Elavil®
- ☐ Elmiron® ☐ Mybetriq®
- Other:_____

Did these medications help your symptoms? _____ No Relief-0 1 2 3 4 5 6 7 8 9 10-Completely

Cured If you've stopped taking your meds explain why: ☐ Did not help ☐ Side Effects ☐ Too Expensive

Describe side effects:_____

Behavior Modifications Tried:_____
(i.e.: caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms?

Not Frustrated- 0 1 2 3 4 5 6 7 8 9 10 -Very Frustrated

Are you interested in learning more about treatment alternatives to medications?

☐ Yes ☐ No