Affiliated UROLOGISTS
PROUD PARTNER OF THE ARIZONA DIAMONDBACKS

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.

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.

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 readily available. We will update your medications at every visit for your safety.

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 8:30 am- 5:00 pm Monday- Friday with lunch taken between 12:00-1:00pm. We do close at noon on Friday's; however, our phone lines are open for an emergency. 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 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):_____

If over the age of 65, have you previously received a **pneumococcal vaccination**? ☐ **Yes** ☐ **No** Date:_____

If age 50-75, have you had an appropriate **colorectal cancer screening** (colonoscopy in the past 10 years, etc)?

☐ **Yes** ☐ **No** Date:_____ If no, is there a medical reason (ie:colorectal cancer/total colectomy)?_____

If female and age 50-69, have you had at least one breast cancer **screening mammogram** within the past 2 years?

☐ **Yes** ☐ **No** Date:_____ If no, is there a medical reason (ie: mastectomy)? _____

If female and over the age of 65, have you had a **DEXA (Bone Density)** ordered or performed in the last 12 months?

☐ **Yes** ☐ **No** Date:_____

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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Bladder Satisfaction Survey

Name:_____ DOB:_____ Date:_____

Which symptoms best describe you?

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

How long have you had these symptoms: _____

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

If yes, circle the medications you have tried:

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

Did these medications help your symptoms? Circle #: 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, kegels, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle #

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

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Affiliated Urologists, Ltd as your healthcare provider, an affiliate of Arizona Oncology Associates. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is responsible for full payment for his/her treatment and care. Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your claim. If your insurance or notifies us that the services are not covered under your insurance plan, you will pay us the outstanding balance for services. The patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for obtaining any necessary referrals from your primary care physician and prior approval before the start of treatment. As a courtesy, Affiliated Urologists will make efforts to obtain referrals and prior authorizations on your behalf.

Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients are responsible for contacting their insurance carrier for explanation of any service not covered. **Payment is due at the time of service**. This includes Deductible amounts, Co-pay, Coinsurance and any prior balances due on your account. For your convenience, we accept cash, check, and most major credit cards at our office.

Patients may incur, and are responsible for the payment of additional charges at the discretion of Affiliated Urologists & Arizona Oncology Associates. These charges may include but are not limited to: Charge for returned checks. $25.00, **Charge for missed appointments without 24 hours advance notice$25.00**, Charge for missed surgeries- $250.00, Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions. $100.00, Charge for copying and distribution of patient medical records (no cost when requested to be sent to another treating Provider). $50.00, Charge for forms completion, including but not limited to disability and FMLA forms. $35.00, Any costs associated with collection of patient balances, including 3rd party collection agency fees.

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 ALL 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- Multiple Valley locations- 480-425-5030
        - Valley Radiology- Multiple Valley locations- 623-847-2000
        - Simon Med Imaging- Multiple Valley locations- 480-306-7900
- By my signature below, I authorize AU, AO personnel to communicate by phone, mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

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

X_____ X_____

Printed Name of Patient Printed Name of Guardian (if applicable)

X_____ X_____

Signature of Patient or Guardian Date

Waiver of Patient Authorizations**(ONLY SIGN IF YOU DO NOT WISH TO HAVE YOUR INSURANCE BILLED AND WILL PAY OUT OF POCKET AT THE TIME OF SERVICES)** **** I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____

Signature of Patient or Guardian Date

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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