

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.

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 HOSPITALIZATIONS: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 OtherDo 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: _____

International prostate symptom score (IPSS)

Name: _____

DOB: _____

Date: _____

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your score
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	

	None	1 time	2 times	3 times	4 times	5 times or more	Your score
Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed, until the time you got up in the morning?	0	1	2	3	4	5	

Total IPSS score	
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Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed – about equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Total score: 0-7 Mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic.

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 at the time of service. We will provide an estimate based on your insurance benefits. Patients are responsible for contacting their insurance carrier for explanation of any service not covered. **Payment is due at the time of service**, and 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 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 _____

Printed Name of Patient

X _____

Printed Name of Guardian (if applicable)

X _____

Signature of Patient or Guardian

X _____

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

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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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): _____

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*

To: All Male Patients

From: Affiliated Urologists

Insurance Payment Guidelines for Erectile Dysfunction, Impotence and Infertility

As you prepare for our visit to the Physician, 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 and related conditions may not be reimbursed by your insurance carrier. **BCBS of Arizona and Golden Rule** typically does not cover these services. BCBS of Arizona typically does not cover TESTOPEL pellets or Testosterone Injections and considers experimental. UnitedHealthCare 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, 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.”

Signature

DOB

Date