

MISSISSIPPI UROLOGY CLINIC, PLLC

1421 N. State Street, Suite 403 • Jackson, MS 39202

Phone: 601-353-9900 • Fax: 601-353-3654

PLEASE PRINT

Patient's Social Security # _____ Age: _____ Title: Dr. ___ Mrs. ___ Mr. ___ Ms. ___

Patient's Last Name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone # (____) _____ Work phone# (____) _____ Cell Phone # (____) _____

Date of Birth: _____ Gender ___M___F Marital Status: _____ Race _____ Ethnicity _____

Email _____ Preferred Language _____

Name of Employer _____ Phone _____ Ext. _____

Spouse Employer _____ Phone _____ Ext. _____

Primary Physician _____ Referring Physician _____

Emergency Contact: _____ Phone _____

Relationship to contact _____

Name of Person/Guardian Responsible for this Bill

First Name _____ MI _____ Last Name _____

Social Security # _____ Date of Birth: _____

Address _____ City _____ State _____ Zip _____

Phone _____ Relationship to patient _____

Insurance #1 _____ ID# _____

Subscriber's Name _____ Subscriber's Social Security # _____

Subscriber's DOB _____ Relationship to patient _____

Insurance #2 _____ ID# _____

Subscriber's Name _____ Subscriber's Social Security # _____

Subscriber's DOB _____ Relationship to patient _____

Please allow the receptionist to copy all insurance cards and picture ID after completion of paperwork

Consent For Treatment

The undersigned authorizes the physician assigned to furnish medical and/or surgical treatment of those means he/she considers necessary and proper in the treatment of the patient identified below while a patient of Mississippi Urology Clinic, PLLC. This treatment may require diagnostic procedures including but not limited to, laboratory testing, blood drawing for those test(s), CT Scans, Ultrasound, Urodynamics, etc.

Patient and/or Guardian Signature

Date

(over)

Financial Agreement

For services rendered to the patient named below, I, the undersigned, agree to pay all professional and/or outpatient charges not covered by insurance. This includes any co-payments, co-insurance and deductibles that may be owed. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.

Patient or Guardian Signature

Date

Authorization To Release Medical Information and Payment of Insurance Benefits

I hereby authorize Mississippi Urology Clinic, PLLC or my attending physician to release or disclose to insurance companies and/or outpatient benefits programs information from my medical record pertaining to my treatment as needed to process insurance claims. Furthermore, I hereby assign payment directly to Mississippi Urology Clinic, PLLC benefits wherein specified and otherwise payable to me but not to exceed Mississippi Urology Clinic, PLLC regular charges for medical treatment. I understand that I am financially responsible for charges not covered by this authorization.

Patient or Guardian signature

Date

Statement To Permit Payment Of Medicare Benefits To Physician (Medicare Patients)

I certify that the information given by me in applying for payment under the Title XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services, and authorize such physician or organization to submit claims to Medicare for payment.

Patient or Guardian Signature

Date

Prescription Refills

Telephone prescription refills must be requested on Monday – Thursday between the hours of 8:30 am and 4:00 pm. Please allow 24-48 hours for your prescription to be called in. Telephone prescription refills may be delayed due to necessity for the physician to review your record and determine the appropriate medicine to prescribe. Also, please note that it is our belief that narcotic pain relievers are, in general, for short-term use only. Likewise, narcotic pain relievers will not be called in after hours and on weekends.

Patient or Guardian signature

Date

Return Phone Calls

The clinic staff at Mississippi Urology Clinic will return patient phone calls received before 4 pm Mon – Thurs or 11 am Fri before the clinic closes that day. Calls after this time will be returned the next day. If you believe your medical situation is urgent in nature, please proceed to a hospital emergency room for immediate treatment.

Patient or Guardian Signature

Date

MISSISSIPPI UROLOGY CLINIC, P.L.L.C

Doctors: Adams, Blalock, Daily, Myers, Ross, Secret

Urochart Intake Form

MRN # _____

Patient Name: _____

Date: _____

Who referred you to this office? _____ Medical Doctor/PCP: _____

Why are you seeing the physician today: _____

When did your problem start: _____ Pharmacy (Name & Number): _____

My Main Problems are:

- Blood in urine Bladder Cancer Bladder Infection Bladder Pain Dropped Bladder
 Kidney Stones Interstitial Cystitis Leak Urine Overactive Bladder
 Other _____

Allergies: (please list all allergies) _____

Medications: (please list all current medications) _____

Surgical History

- Appendectomy Back/Hip/Knee Bladder Tack C – Section # _____
 Cystoscopy Gallbladder Heart Bypass Hysterectomy Kidney Stone Surgery
 Lithotripsy Sling (TVT) Vaginal Deliveries # _____ Other _____
 No Changes

Medical History

- Diabetes Emphysema Heart Attack Heart Murmur
 Hepatitis Hernia Hypertension Last Period: _____ Menopause
 Parkinson's Pregnant # _____ Strokes Cancer: _____
 Other _____ No Changes

Family History

- Kidney Cancer Kidney Stones Heart Disease

Social History (Circle One)

Marital Status: *Single* *Married* *Divorced* *Widowed*

Drink Alcohol: *Yes* *Not Anymore* *Never* *Socially*

Blood Transfusion: *YES* *NO*

Smoke: *Yes* *Not Anymore* *Never*

Daily Caffeine Intake: *0* *1* *2* *3* *4+*

My Symptom(s) are:

- | | | | |
|---------------------------|--|---|--|
| General/Constitutional | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chills |
| Eyes | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Cataracts |
| Ears, Nose, Mouth, Throat | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Nasal Stuffiness | <input type="checkbox"/> Sore Throat |
| Cardiovascular | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Irregular Heartbeat |
| Respiratory | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chronic Cough |
| Gastrointestinal | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Change in Bowels |
| Genitourinary | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine |
| Musculoskeletal | <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Chronic Neck Pain | <input type="checkbox"/> Sore Muscles |
| Integumentary/Skin | <input type="checkbox"/> Rash | <input type="checkbox"/> Persistent Itching | <input type="checkbox"/> Skin Cancer History |
| Neurologic | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Dizziness |
| Hematologic/Lymphatic | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Transfusion History |

Urinary Symptom(s) are:

- Frequency Urgency Leakage Straining
 Abdominal Pain Bladder Pain Pain in Side R / L Not Emptying Bladder
 Urinating at Night # _____

MISSISSIPPI UROLOGY CLINIC, P.L.L.C

PF-3000 (b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Clinic Administrator.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

PRINT PATIENT'S NAME

PATIENT MRN NUMBER

Patient or Legally authorized individual signature

Date Time

Printed Name if signed on behalf of the patient

Relationship to Patient

(Notation, if any, by staff)

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

Print Name of person/organization

Relationship to Patient

Print name of person/organization

Relationship to Patient