



|             |               |             |                |      |
|-------------|---------------|-------------|----------------|------|
| MRN:        | Patient Name: |             | Date of Birth: |      |
| Address:    |               | City:       | State:         | Zip: |
| Home Phone: |               | Cell Phone: |                | Sex: |
| Race:       | Ethnicity:    |             | Language:      |      |

**PHYSICIAN:**     Adams     Blalock     Daily     Haraway     Ross     Runnels

**PATIENT INFORMATION**

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Last Name: \_\_\_\_\_      First Name: \_\_\_\_\_      MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_      State: \_\_\_\_\_      Zip: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Sex:    Male      Female      DOB: \_\_\_\_\_      Email: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_      PCP: \_\_\_\_\_

Marital Status:    Single      Married      Divorced      Widowed      Separated

**PRIMARY INSURANCE:** \_\_\_\_\_

Subscriber Name (Full Name): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_      Subscriber DOB: \_\_\_\_\_

Insurance ID # \_\_\_\_\_      Group Number #: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

Subscriber Name (Full Name): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_      Subscriber DOB: \_\_\_\_\_

Insurance ID # \_\_\_\_\_      Group Number #: \_\_\_\_\_

**MEANINGFUL USE DATA**

Race:    African American      Asian      Caucasian      Hispanic      Indian      Native American      Pacific Islander

Ethnicity:    Hispanic      Non-Hispanic      Preferred Language:    English      Spanish      Other: \_\_\_\_\_

**IN CASE OF EMERGENCY**

Relative/Friend: \_\_\_\_\_      Relationship: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mississippi Urology Clinic, PLLC or my insurance company to release any information required to process my claims.

**PATIENT SIGNATURE:** \_\_\_\_\_      **DATE:** \_\_\_\_\_



PATIENT NAME:

MRN:

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



PATIENT NAME:

MRN:

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)

\_\_\_\_\_  
**Telephone Message Authorization**

I    DO    DO NOT authorize Mississippi Urology Clinic to leave a message on my home and/or cell telephone.

Initials \_\_\_\_\_

**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**

**FEES CHARGED FOR ASSISTANCE AND COMPLETION OF FORMS.** Effective June 1, 2017 Mississippi Urology Clinic, PLLC will charge and collect a fee of \$25 per form for assistance in the completion of any required forms such as Family Medical Leave Act (FMLA), Cancer and Disability Forms, etc.

Initials \_\_\_\_\_



**Mississippi Urology Clinic, PLLC and Mississippi Urology Outpatient Surgery Center, LLC  
Clinic – Physician – Patient Arbitration Agreement**

\_\_\_\_\_ (“Patient”), engages Mississippi Urology Clinic, PLLC or Mississippi Urology Outpatient Surgery Center, LLC and any employees thereof individually or collectively referred to as (“Clinic”), and each Physician affiliated with the clinic (“Physician” or “Physicians”) that renders medical care and services to perform services in conjunction with Patient’s medical care. For and in partial consideration of the rendition of any and all present and future medical care and services, Patient agrees that in the event of any dispute, claim or controversy arising out of or relating to the performance of medical services, including but not limited to patient fees, informed consent, negligence or medical malpractice, between Patient (whether a minor or an adult) or the heirs-at-law or personal representative of Patient, as the case may be, and the Clinic and each Physician individually, where the claim or the amount in controversy exceeds \$5,000, such dispute or controversy shall be submitted to Judicial Arbitration & Mediation Services (JAMS), or its successor, on an arbitration form for final and binding arbitration. All claims for unliquidated damages shall be deemed claims for in excess of \$5,000.

Either party may initiate arbitration of any matter subject to arbitration by filing a written demand for arbitration at any time. Patient shall be entitled to an in person hearing in the county where the care at issue occurred, in accordance with the Federal Arbitration Act. The arbitration shall be administered by Judicial Arbitration & Mediation Services (JAMS) pursuant to its Comprehensive Arbitration Rules and Procedures and Minimum Standards of Procedural Fairness, and all parties are bound by the arbitrator’s decision. Any decision by the arbitrator(s) shall be accompanied by a reasoned opinion. Judgement may be entered on the arbitrator’s award, if any, by any court having jurisdiction of the subject matter.

All parties agree that their relationship affects interstate commerce and that this Agreement shall be governed by the Federal Arbitration Act, and, if not, by Mississippi law. The party requesting arbitration shall bear all costs of the arbitration, except the Patient is not required to pay any more than \$125.00, with the Clinic bearing the other arbitration costs. However, each party is solely responsible for their own attorney, expert, and other associated costs, expenses, and litigation fees on their behalf.

If you are not willing to submit to binding arbitration, the Clinic and/or Physicians may perform the services or refer you to another health care provider capable of rendering the medical care or services which you require (although Physician assumes no responsibility for the quality of care or service rendered by any other health care provider). Please inform a Clinic representative immediately if you do not agree to binding arbitration and desire such referral.

This Agreement may be rescinded by written notice by either party within fifteen (15) days of signature. However, any claim or dispute related to medical services rendered after execution of this Agreement and prior to the date of such written notice of rescission shall be subject to the terms of this Agreement. Written notice of such rescission may be given by a guardian or conservator of Patient if Patient is a minor or incapacitated. This agreement may be modified only by signed agreement by each party or its authorized representative. If any portion of this Agreement is found unenforceable, that portion shall be stricken and the remainder of this Agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where services are rendered.

**NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL.**

If a parent or guardian has signed on behalf of their minor child or ward, such parent or guardian hereby attests that he or she has full legal authority to execute this Arbitration Agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Clinic from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

A photo static or electronic copy of this authorization shall be considered as effective and as valid as the original.

**SIGNATURE OF PATIENT/GUARDIAN**

By: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only

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Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



|      |               |                |
|------|---------------|----------------|
| MRN: | Patient Name: | Date of Birth: |
|------|---------------|----------------|

PHYSICIAN:  Adams  Blalock  Daily  Haraway  Ross  Runnels

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:**

- |   |  |  |   |  |
|---|--|--|---|--|
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Bladder Cancer        | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Bladder Pain       | <input type="checkbox"/> Dropped Bladder |
| <input type="checkbox"/> Kidney Stones  | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Leak Urine        | <input type="checkbox"/> Overactive Bladder |  |
| <input type="checkbox"/> Other _____    |  |  |   |  |

**Allergies**  None Please list all allergies: \_\_\_\_\_

**Medications**  None Please list all medications: \_\_\_\_\_

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

- Medical History**  Diabetes  Emphysema  Heart Attack  Heart Murmur  Hepatitis  
 Hernia  Hypertension  Last Period: \_\_\_\_\_  Menopause  Parkinson's  
 Pregnant # \_\_\_\_\_  Strokes  No Changes  
 Cancer: \_\_\_\_\_ Other \_\_\_\_\_

**Family History**  Kidney Cancer  Kidney Stones  Heart Disease

**Social History (Circle One)**

**Marital Status:**  Single  Married  Divorced  Widowed **Smoke:**  Yes  Not Anymore  Never  
**Drink Alcohol:**  Yes  Not Anymore  Never  Socially **Daily Caffeine Intake:** 0 1 2 3 4+  
**Blood Transfusion:**  YES  NO

**Recent Immunizations:**  Yes  No If yes, list name & date: \_\_\_\_\_

**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 |

**My Urinary Symptom(s) are:**

- |  |   |   |                                    |   |                                       |
|--|---|---|------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Frequency                 | <input type="checkbox"/> Urgency              | <input type="checkbox"/> Leakage                    | <input type="checkbox"/> Straining | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Bladder Pain |
| <input type="checkbox"/> Pain in Side Right / Left | <input type="checkbox"/> Not Emptying Bladder | <input type="checkbox"/> Urinating at Night # _____ |                                    |   |                                       |