Urology Group of Western New England P.C.

Patient Information Sheet

PATIENT NAME: _____ SEX _____

ADDRESS: _____ D.O.B. _____

_____ MARITAL STATUS _____

_____ S.S.# _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PATIENT CONTACT INFORMATION

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

How would you like to receive appointment reminders?

☐ **Phone call** ☐ **Text message** ☐ **Email**

☐ **I would like to sign up for the Patient Portal**

PATIENT EMPLOYMENT INFORMATION

(Give Information For Person Responsible If Patient Is A Minor or Student)

EMPLOYER _____

ADDRESS _____

_____

IS YOUR CURRENT CONDITION RELATED TO

	YES	NO
Employment?	☐	☐
Auto Accident?	☐	☐
Other Accident?	☐	☐

BILLING RESPONSIBILITY (Only If Patient Is A Minor - Otherwise Patient Is Responsible Party)

SEND BILLS TO _____ PHONE _____

ADDRESS _____

EMERGENCY CONTACT

NAME _____ PHONE _____

INSURANCE INFORMATION

PRIMARY _____ INS ID# _____

INSURED _____ RELATION _____ D.O.B. _____

SECONDARY _____ INS ID# _____

INSURED _____ RELATION _____ D.O.B. _____

PHARMACY

NAME _____ PHONE _____

ADDRESS _____

Name: _____ Date of Birth: _____

PLEASE READ CAREFULLY AND THOROUGHLY. IF YOU HAVE ANY QUESTIONS, PLEASE ASK BEFORE SIGNING.

UROLOGY GROUP OF WESTERN NEW ENGLAND, PC

AUTHORIZATION

NAME OF PATIENT:

I, the undersigned, hereby authorize payment directly to Urology Group of Western New England P.C. of medical / surgical benefits, if any, otherwise payable to me under the terms of my health insurance policy.

I fully understand that I am primarily and financial responsible for fees incurred by the above patient; I further understand that payment to said Doctor is not contingent on any settlement, judgment or verdict by which the above patient may eventually recover said medical / surgical fees.

I hereby authorize medical / surgical treatment, care and/or services by Urology Group of Western New England P.C. to the above patient.

I hereby authorize Urology Group of Western New England P.C. to release information that may be needed to process my claim for payment to my third party insurance carrier.

I hereby authorize any physician, health care practitioner, hospital or medical care facility to provide all information on the above patient's medical history to Urology Group of Western New England P.C.

I hereby authorize Urology Group of Western New England to release the above patient's medical information to any physician that is involved in the above patient's medical care. Any other requested medical information, e.g. HIV, STD's and/or substance abuse, attorney requests, family members, spouse, etc., will require a secondary written authorization form.

I hereby authorize photocopies of this form to be valid as the original.

I certify that I have read and fully understand the above authorization.

DATE: _____ SIGNATURE: _____

Patient, Parent or Guardian
If patient is a minor, a parent or guardian must sign.

Name: _____ Date of Birth: _____

Urology Group of Western New England, P.C.
Acknowledgement of Receipt of *Notice of Health Information Practices*

I have been presented with a copy of Urology Group of Western New England's *Notice of Health Information Practices*, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

I authorize Urology Group of Western New England to leave me messages regarding appointments on my answering machine.

I further authorize Urology Group of Western New England to speak to the following individuals about my care:

Name: _____ Relation: _____

Name: _____ Relation: _____

Signed: _____ **Date**: _____

Printed Name: «PLFI» MRN#: «PNumber»

Date of Birth: «PDOB»

If not signed by patient, please indicate relationship to patient:

Relationship: _____ **Witness**: _____

****

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (date and time): _____
By: (name and title) : _____

Name: _____ Date of Birth: _____

Urology Group of Western New England PC
3640 Main Street, Suite 103
Springfield, MA 01107

Insurances we Do Not Participate With

Aetna Excel Plan
Ambetter
Anthem HMO Blue Care New England
Berkshire Fallon Health Collaborative
Celtic Care
Community Care Coopertive
Connecticare Medicare Replacement Plan
Connecticare – Individual Exchange Plan
Fallon Connector Plan
Fallon Direct Care
Fallon MassHealth
Fallon Summit Elder Care
Fallon Total Care
Harvard Pilgrim Focus Network
Harvard Pilgrim GIC Primary Choice Plan
Health New England Be Healthy
Health New England Care Plan
MassHealth Standard
MassHealth Health Safety Net
Neighborhood Health Plan
One Care Tufts Health Unify
Oxford (Unless have out-of-network benefits)
Partners Healthcare Choice ACO
RiverBend Pace Program
Senior Whole Health (Medicare Replacement Plan)
Tufts Spirit Plan
United Health Care Evercare Medicaid Only Community

I understand that this list may not be inclusive of all plans that UGWNE does not participate with. I understand it is my responsibility to ensure that my provider participates with my insurance carrier.

_____

Patient Signature Date

Name: _____ Date of Birth: _____

Urology Group of Western New England PC
3640 Main Street, Suite 103
Springfield, MA 01107

Cancellation Policies

No Show/Late Cancellations

In order to provide all of our patients with the best care, Urology Group of Western New England PC requires our patients to provide adequate notice for changing or cancelling an appointment. When a patient *No-Shows* or *Cancels Late* for their appointment, another patient loses the opportunity to receive the treatment that they require. If you are unable to make your scheduled appointment, we require that you provide ***at least 24 BUSINESS hours notice***. Failure to cancel or change an appointment within 24 business-hours will result in you being considered a *No-Show*.

> No-Show and Late Cancel appointments will incur a $25.00 Re-Booking Fee. You are directly responsible for payment of this fee prior to any new appointment being made. The Re-Booking Fee cannot be billed to your insurance company.

By signing below, I understand the policy above and agree to the billing of any charges described in this text.

Signature: _____ Date:_____

Surgery Cancellations

In order for us to maintain our efficiency in the Operating Room, as well as giving full consideration to the hospital and anesthesia staff, it is necessary for us to implement a cancellation policy. Scheduling, cancelling, or rescheduling your surgery/procedure requires coordination between us, the hospital or outpatient facility, insurance company, and patient. We understand that there are times when you must cancel an appointment due to emergencies, inclement weather, or obligations for work or family. However, when you do not call to cancel the surgery in a timely manner, you may be preventing another patient from getting much needed treatment.

> Cancellation of a surgical procedure 72 hours or less (3 days prior) to the scheduled date will be charged a $150 cancellation fee. This fee is not billable to insurance, nor is it reimbursable. This fee must be paid before we can schedule any further appointments or procedures. If you are requesting a refund of your surgical deposit, and are with in the 3 day period, you will receive your refund less the $150 cancellation fee.

I have read and understand the cancellation policy for surgical procedures for the Urology Group of Western New England, PC.

Signature: _____ Date:_____

Name: _____ Date of Birth: _____

PATIENT ASSESSMENT QUESTIONNAIRE

For each question below, please circle the answer that best describes how you feel.

The last 2 columns on the right are for you doctor to assess your score. Please do not mark anything in these columns.

	0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1. How many times do you go to the bathroom during the day?	3 to 6	7 to 10	11 to 14	15 to 19	20 +		
2.**a.** How many times do you go to the bathroom at night?	0	1	2	3	4+		
b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3. Are you currently sexually active? **YES____ NO____**							
4.**a. If you are sexually active,** do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, scrotum)?	Never	Occasionally	Usually	Always			
6. Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7.**a.** If you have pain, is it usually...		Mild	Moderate	Severe			
b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8.**a.** If you have urgency, is it usually...		Mild	Moderate	Severe			
b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
SYMPTOM SCORE (1, 2a, 4a, 6, 7a, 8a) - SUBTOTAL							
BOTHER SCORE (2B, 4B, 7B, 8B) - SUBTOTAL							
TOTAL SCORE (Symptom Score + Bother Score) =							

Name: _____ Date of Birth: _____

Prostate Symptom Score (PSS)	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	

Nocturia	None	1 time	2 times	3 times	4 times	5 time or more	Your Score
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 PSS Score	

Quality of life due to urinary symptoms	Delighted	Pleased	Most Satisfied	Mix- 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