Comprehensive Urology
www.urologist.org
Michigan's Leading Large Urology Group Committed to Excellence in Patient Care, Research and Education

**Name:** _____
**Date of Birth:** ____/____/____
**Home Phone:** _____
**Work Phone:** _____
**Cell Phone:** _____
**Pharmacy Name:** _____
**Pharmacy Phone:** _____

Date: _____

**Referred by:** Doctor _____ Family/Friend _____

**Family Physician (Internist):** _____

Employer:

Occupation: (Present) _____

Person to notify in case of emergency: _____

Phone # _____ Relationship to patient: _____

## List all your MEDICATIONS, DOSAGES and FREQUENCY (if known):

| MEDICATIONS | DOSAGES | FREQUENCY | MEDICATIONS | DOSAGES | FREQUENCY |
|---|---|---|---|---|---|
| | mg. | | | mg. | |
| | mg. | | | mg. | |
| | mg. | | | mg. | |
| | mg. | | | mg. | |

**Do you take BLOOD THINNERS, COUMADIN, PLAVIX or ASPIRIN products or other over the counter PAIN MEDICATIONS on a regular or daily basis? If so, please list below.**

| MEDICATIONS | DOSAGES | FREQUENCY | MEDICATIONS | DOSAGES | FREQUENCY |
|---|---|---|---|---|---|
| | mg. | | | mg. | |
| | mg. | | | mg. | |

## List all known ALLERGIES to medications / Iodine / X-ray dye / latex etc...

_____ _____ _____

_____ _____ _____

## PAST MEDICAL HISTORY

| Diagnosis / Condition | | | Diagnosis / Condition | | | Diagnosis / Condition | | |
|---|---|---|---|---|---|---|---|---|
| Heart Attack | Y | N | Breathing Problems | Y | N | Diabetes | Y | N |
| Angina | Y | N | Asthma | Y | N | Liver Disease | Y | N |
| Stroke | Y | N | Kidney Disease | Y | N | Hepatitis | Y | N |
| High Blood Pressure | Y | N | Kidney Stones | Y | N | Neurologic Disease | Y | N |
| Irregular/Rapid Heart Beat | Y | N | Thyroid Disease | Y | N | Cancer | Y | N |
| | | | | | | Type: | | |

## FAMILY HISTORY

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Prostate Cancer | Y N | Bladder Cancer | Y N | Kidney Cancer | Y N | Kidney Disease | Y N |
| Kidney Stones | Y N | Colon Cancer | Y N | Heart Disease/Attack | Y N | | |
| Other: | | | | | | | |

## SOCIAL HISTORY

Do you exercise? Y N Amount_____
Do you smoke? Y N Amount_____
Do you drink Alcohol? Y N Amount_____
Do you drink caffeine? Y N Amount _____

Is your problem ( ) work or ( ) accident related?
Contact name and number_____

Is there an attorney or case worker working with you?
Contact name and number_____

Are you currently in a nursing home? Y N



Please fill out the back side of this form.

**OVER**

## SURGICAL HISTORY List all surgical procedures that you have had and the approximate dates.

## REVIEW OF SYSTEMS

**Constitutional Symptoms**

| | | |
|---|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Headache | Y | N |
| Other _____ | | |

**Eyes**

| | | |
|---|---|---|
| Blurred vision | Y | N |
| Double vision | Y | N |
| Pain | Y | N |
| Other _____ | | |

**Allergic/Immunologic**

| | | |
|---|---|---|
| Hay Fever | Y | N |
| Drug Allergies | Y | N |
| Other _____ | | |

**Neurological**

| | | |
|---|---|---|
| Tremors | Y | N |
| Dizzy Spells | Y | N |
| Numbness/tingling | Y | N |
| Other _____ | | |

**Endocrine**

| | | |
|---|---|---|
| Excessive thirst | Y | N |
| Too hot/cold | Y | N |
| Tired/sluggish | Y | N |
| Other _____ | | |

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal pain | Y | N |
| Nausea/vomiting | Y | N |
| Indigestion/heartburn | Y | N |
| Other _____ | | |

**Cardiovascular**

| | | |
|---|---|---|
| Chest pain | Y | N |
| Varicose veins | Y | N |
| High blood pressure | Y | N |
| Other _____ | | |

**Integumentary**

| | | |
|---|---|---|
| Skin rash | Y | N |
| Boils | Y | N |
| Persistent itch | Y | N |
| Other _____ | | |

**Musculoskeletal**

| | | |
|---|---|---|
| Joint pain | Y | N |
| Neck pain | Y | N |
| Back pain | Y | N |
| Other _____ | | |

**Ear/Nose/Throat/Mouth**

| | | |
|---|---|---|
| Ear infection | Y | N |
| Sore throat | Y | N |
| Sinus problems | Y | N |
| Other _____ | | |

**Genitourinary**

| | | |
|---|---|---|
| Urine retention | Y | N |
| Painful urination | Y | N |
| Urinary frequency | Y | N |
| Other _____ | | |

**Respiratory**

| | | |
|---|---|---|
| Wheezing | Y | N |
| Frequent cough | Y | N |
| Shortness of breath | Y | N |
| Other _____ | | |

**Hematologic/Lymphatic**

| | | |
|---|---|---|
| Swollen glands | Y | N |
| Blood clotting problem | Y | N |
| Headache | Y | N |
| Other _____ | | |

**Psychologic**

| | | |
|---|---|---|
| Are you generally satisfied with your life? | Y | NDo |
| you feel severely depressed? | Y | N |
| Have you considered suicide? | Y | N |
| Other _____ | | |

**I certify that the above information is correct to the best of my knowledge.**

**It is my responsibility to call the office for all test results one week after the test is performed.**

NAME:_____DATE OF BIRTH:

Patient or Legal Guardian Signature: **X**_____ Date: _____

Reviewed by:_____ Date:_____/_____/_____



Form No. CU 5003
Rev. 02/21

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| PATIENT NAME: LAST | | FIRST | MIDDLE |
| DATE OF BIRTH: | SEX: ☐ MALE ☐ FEMALE | SOCIAL SECURITY NO. | |
| ADDRESS: | CITY: | STATE: | ZIP: |
| HOME PHONE NO.: | WORK PHONE NO. | CELL/OTHER PHONE NO.: | |
| EMERGENCY CONTACT NAME: | | PHONE NO.: | |
| WOULD YOU LIKE TO BE REMINDED BY CELL PHONE TEXT ABOUT YOUR UPCOMING APPOINTMENTS? ☐ YES ☐ NO | | | |
| EMAIL ADDRESS: **MANDATORY FOR YOUR PATIENT PORTAL TO OBTAIN YOUR HEALTH RECORD** | | | |

## INSURANCE

| | | |
|---|---|---|
| MEDICARE: ☐ YES ☐ NO | | |
| IDENTIFICATION NO.: | | EFFECTIVE DATE: |
| BLUE CROSS BLUE SHIELD OF MICHIGAN: ☐ YES ☐ NO | | |
| IDENTIFICATION NO.: | | GROUP: |
| SUBSCRIBER NAME: | | RELATION: |
| MEDICAID: ☐ YES ☐ NO | | |
| IDENTIFICATION NO.: | PRIMARY SPONSOR: | PHONE NO.: |
| OTHER INSURANCE NAME AND ADDRESS: | | |
| PHONE: | IDENTIFICATION NO.: | SUBSCRIBER: |
| Are you currently in a Nursing Facility / Rehab Center / Home? ☐ YES ☐ NO | | |
| EMPLOYMENT (Is subscriber employed? ☐ YES ☐ NO) | | |
| EMPLOYER NAME AND ADDRESS: | | PHONE NO.: |

## POLICY HOLDER / RESPONSIBLE PARTY INFORMATION (if different than patient)

| | | | |
|---|---|---|---|
| PATIENT NAME: LAST | | FIRST | MIDDLE |
| DATE OF BIRTH: | SEX: ☐ MALE ☐ FEMALE | SOCIAL SECURITY NO. | |
| ADDRESS: | CITY: | STATE: | ZIP: |
| HOME PHONE NO.: | WORK PHONE NO. | CELL/OTHER PHONE NO.: | |
| EMPLOYER NAME AND ADDRESS: | | PHONE NO.: | |

## ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I assign payment of authorized benefits to Comprehensive Urology on my behalf for services rendered. I understand that I am financially responsible for the charges not covered by my policy. In addition, I authorize release of any medical information required by my insurance company to process claims.

_____ _____

**SIGNATURE OF INSURED / GUARDIAN** **DATE**

## REFERRING PHYSICIAN

| | | |
|---|---|---|
| NAME: M.D. / D.O. | | |
| ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| PHONE NO.: | | |

## FAMILY DOCTOR / PEDIATRICIAN (IF NOT THE SAME AS REFERRING DOCTOR)

| | | |
|---|---|---|
| NAME: M.D. / D.O. | | |
| ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| PHONE NO.: | | |

## AUTHORIZED INDIVIDUALS WE CAN SPEAK WITH (i.e. Spouse, Parent, Child, etc.)

| | | |
|---|---|---|
| NAME: | RELATIONSHIP: | PHONE NO.: |
| NAME: | RELATIONSHIP: | PHONE NO.: |
| NAME: | RELATIONSHIP: | PHONE NO.: |
| NAME: | RELATIONSHIP: | PHONE NO.: |

**I AUTHORIZE COMPREHENSIVE UROLOGY TO RELEASE MEDICAL INFORMATION ABOUT ME TO ANY / ALL OF THE ABOVE DESIGNATED INDIVIDUALS.**

NAME:_____ DATE OF BIRTH: _____

PATIENT / GUARDIAN SIGNATURE:_____ DATE: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**MEDICARE PATIENTS ONLY**

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NAME: _____ DOB: _____ DATE: _____

**Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle the number to indicate your answer).**

| | | Not at all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|---|
| 1 | Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2 | Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3 | Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4 | Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5 | Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6 | Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7 | Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8 | Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9 | Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| 10 | If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all _____<br>Somewhat difficult _____<br>Very Difficult _____<br>Extremely difficult _____<br><br>TOTAL: _____ | | | |

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

REV. 2/21 IA

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# CONSENT TO BE CONTACTED ABOUT RESEARCH OPPORTUNITIES

Medical research is an integral part of our modern medical practice. Comprehensive Urology a division of Michigan Healthcare Professionals participates in many research protocols in all aspects of medicine and urology. If your medical condition is such that your doctor thinks that you may be eligible for participation in a research study, you may be referred to the Comprehensive Urology research department. By signing this consent form, you acknowledge that you are aware of this policy, and would welcome phone contact by the research department at the phone number you provided to the practice. This phone contact will only be to explain the research protocol that you may be eligible to participate in. This in only an informational phone call. By signing this form, you will not be obligated in any way to participate in the research. If you chose to participate, as with all research projects you will be able to withdraw from participation at any time. Thank You for your consideration in this matter.

**Patient Name**: _____ **DOB**:_____

**By signing this form, I consent to be contacted by the research department of Comprehensive Urology.**

**Patient Signature**: _____ **Date**: _____

☐ **Check this box and initial below if you DECLINE to be contacted by the research department with opportunities**

**Initials**_____

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**MICHIGAN HEALTHCARE PROFESSIONALS,**

**P.C. ACKNOWLEDGEMENT OF RECEIPT OF**

**NOTICE OF PRIVACY PRACTICES**

**Please refer to the Front Desk or our Website www.urologist.org to obtain a copy of "NOTICE OF PRIVACY PRACTICES"**

I acknowledge that I read and or received a copy of the Michigan Healthcare Professionals, P.C. Notice of Privacy Practices effective September 23, 2013

Date:_____

Print
Name:_____DOB:_____

Signature:_____

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# Patient Financial Policy

**Thank you for choosing Comprehensive Urology as your health care provider.** We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e., address, phone number, name, insurance information, etc.)

## METHODS OF PAYMENT

We accept the following methods of payment:

- Cash, Check, Money Order, Credit Cards (Visa, MasterCard, Amex, Discover)
- HSA and HRA debit cards

## CO-PAYMENTS / BALANCES

The patient is expected to present ID and current insurance card **at each visit.** All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with the office. We accept cash, check, money order or credit cards. Absolutely no-postdated checks will be accepted.

## INSURANCE CLAIMS

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company and any secondary insurance as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance plans, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowances. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

## REFERRALS / AUTHORIZATION

If your insurance company requires a referral, you are responsible for obtaining this document. Failure to obtain the referral may result in a lower payment or no payment from the insurance company and the balance will be your responsibility.

## LABORATORY SERVICES

Lab tests that may be ordered by the physician are primarily performed at our in-house laboratory. If you need testing to be sent out to a different lab, you are responsible to notify the staff each time a test is ordered. In the event you receive a bill that you feel should have been paid by your insurance, contact our office for assistance.

**SELF-PAY ACCOUNTS**

**All self-pay accounts will require a $150.00 deposit** to be paid at the time of check-in and/or prior to seeing the doctor. **This amount will be applied toward the charges for the services provided.**

After seeing the doctor and upon check-out, you will be required to pay for any additional amounts due for services rendered which could include but not limited to: *Lab Tests, X-rays, CT Scans, Office Procedures, Office Visit/Consult*

Please be prepared to make the required **$150.00 deposit** at the **point of check-in** and also ready to pay any balance due upon check-out.

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Extended payment arrangements are available if needed. Please ask to speak with the billing office to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

**NO SHOW POLICY**

Appointments must be cancelled within 24 hours of your scheduled appointment or you will be charged a $25.00 no show fee.

**WORKERS COMPENSATION AND AUTOMOBILE ACCIDENTS**

In the case of a worker's compensation injury or automobile accident, it is your responsibility to obtain the **claim number, phone number, contact person, and name and address of the insurance carrier** prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

**OUTSTANDING BALANCE POLICY**

It is our policy that all past due accounts must be paid prior to making an appointment. There will be a 3% charge on all balances past 30 days. If you are not able to pay your balance in full, we will work with you to arrange a reasonable payment plan. If no resolution can be made, your account may be sent to the collection agency and possible discharge from the practice.

***This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us at (248) 336-3188.***

Patient Name (Printed):_____D.O.B._____

Signature of Patient/Guardian X_____

Date: _____