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

ANNUAL ESTABLISHED PATIENT FORMS

Name: _____
Date of Birth: _____ /_____/ _____

Home Phone: _____
Cell Phone: _____
Street Address: _____
City, State, Zip: _____
Pharmacy Name: _____
Pharmacy Phone: _____

1) Reason for today's visit
☐ Follow Up ☐ New Complaint (Please list)_____

2) Any changes to your medical history since your last visit? Please list changes.

_____

_____

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

MEDICATIONS	DOSAGES	FREQUENCY	MEDICATIONS	DOSAGES	FREQUENCY
	mg.			mg.	
	mg.			mg.	
	mg.			mg.	
	mg.			mg.	

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

_____ _____ _____

_____ _____ _____

REFERRING PHYSICIAN

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

OTHER PHYSICIANS / AUTHORIZED INDIVIDUALS

NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
PHONE NO.:		

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.

Patient or Legal Guardian Signature: X_____ Date: _____

Reviewed by:_____ Date:_____/_____/_____

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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 _____ Somewhat difficult _____ Very Difficult _____ Extremely difficult _____ TOTAL: _____			

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

REV. 2/21 IA

International Prostate Symptom Score (IPSS) for Men 60 and UP

Patient Name | Date of Birth: | Today's Date:

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

Total International Prostate Symptom Score = _____

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)									
1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No

SEXUAL HEALTH INVENTORY FOR MEN 18 AND UP

NAME: _____DOB:_____DATE:_____

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence is one type of a very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one response for **each question.**

OVER THE PAST 6 MONTHS

1. How do you rate your confidence that you could get and keep an erection?

Very low	Low	Moderate	High	Very High
1	**2**	**3**	**4**	**5**

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

No Sexual Activity	Almost never or never	A few times (much less than Half the time)	Sometimes (about half the time)	Most times (much more than half The time)	Almost always or always
0	**1**	**2**	**3**	**4**	**5**

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Did not attempt Intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	**1**	**2**	**3**	**4**	**5**

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Did not attempt Intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
0	**1**	**2**	**3**	**4**	**5**

5. When you attempted sexual intercourse, how often was it satisfactory for you?

Did not attempt Intercourse	Almost never or never	A few times (much less than half the time	Sometimes (about half the time)	Most times (much more half the time)	Almost always or always
0	**1**	**2**	**3**	**4**	**5**

SCORE_____

Add the numbers corresponding to questions 1-5. If your score is 21 or less, you may want to speak with your doctor.

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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: _____