MISSISSIPPI UROLOGY CLINIC, PLLC

501 Marshall St, Suite 301 • Jackson, MS 39202

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

*****PLEASE PRINT*****

Medical Record #_____

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

Patient's Last Name_____First_____ MI _____

Email _____ Preferred Language _____

Address_____City_____State_____Zip_____

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

Date of Birth: _____ Marital Status: _____ Race _____ Male or Female Ethnicity _____

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

MRN #_____ Doctors: Adams, Blalock, Daily, Haraway, Myers, Ross, Urochart Intake Form

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 _____
☐ Colonoscopy ☐ **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* 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/date:* _____/_____

My Symptom(s) are:

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

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**