

WELCOME

Welcome to the office of Dr. Bechara G. Tabet, Dr. David G. Heiser, Dr. Steven E. Ochs, Amy Hughes, FNP-BC and Rebecca Thomas CNS. Please complete the enclosed patient information and clinical history form, bring the forms with you at the time of your appointment. Please **DO NOT** send them back in the mail. Completing this information ahead of time allows us to see you in a timely manner upon your arrival at our office, and ensures we have the information necessary to fully address your health care needs.

In addition, please bring the following items with you:

- A photo ID
- Your insurance card (s)
- A referral (if required by your insurance plan)
- Your copayment (if required by your plan)
- A list of any medications you are currently taking
- Copies of any recent imaging studies and labs
- The name and phone number of the physician referring you to our office

Our offices Locations are as follows:

Canton

1330 Mercy Drive NW #510
Canton, OH 44708

Akron

157 West Cedar St #203
Akron, OH 44307

Dover

420 James St
Dover, OH 44622

Barberton

103 5th Street #P
Barberton, OH 44203

Carrollton

125 Canton Road
Carrollton, OH 44615

Dennison

819 First St
Dennison, OH 44621

Massillon

7337 Caritas Circle #240
Massillon, OH 44646

Millersburg

1261 Wooster Road # 220
Millersburg, OH 44654

Should you need to reschedule or cancel your appointment, please call us at least twenty-four hours in advance to allow us the courtesy of offering your spot to another patient. Our phone number is (330) 456-6760.

Please feel free to call our office with any questions you may have regarding your upcoming appointment. We look forward to meeting you and taking care of your medical needs.

Appointment Date _____ Time _____

Office Location _____ Physician _____

Urology One, Inc.
Patient Information

Co-pay \$_____

Work Comp Yes No

Patient Name: _____ MI: _____ Date of Birth: _____

Address: _____ Referred By: _____

City, State, Zip _____ Family Dr.: _____

Sex: Male Female Social Security #: _____ Marital Status: S M D W

Home Phone: _____ Phone: _____

Employer: _____ Work Phone: _____

Emergency Contact Person: _____ Phone: _____

Contact Relationship: _____

Individuals able to have access to medical records: _____

Billing Information-Person Responsible for Paying This Bill

Name: _____ Relationship to Patient: _____

Address: _____

Primary Insurance Company: _____ **Policy Holder:** _____

Insurance Address: _____ City, State, Zip: _____

Relationship to Patient: _____ Date of Birth: _____

ID#: _____

Secondary Insurance Company: _____ **Policy Holder:** _____

Insurance Address: _____ City, State, Zip: _____

Relationship to Patient: _____ Date of Birth: _____

ID: _____

I hereby consent to treatment by Urology One, Inc. I hereby assign my insurance benefits to be paid directly to Urology One, Inc. I understand that I am financially responsible for all charges not covered by this assignment.

Signature: _____

Date: _____

Urology One, Inc.

New Patient History Form

Name: _____ Birth date: _____

Today's date _____ Primary Medical Doctor _____

Other specialists you see _____

Reason for visit _____

Allergies: _____

Current Medications:

_____	_____
_____	_____
_____	_____
_____	_____

Family History (Circle if Present)

Heart Disease	Diabetes	Prostate Cancer
Stroke	Bleeding disorder	Bladder Cancer
Kidney disease	Kidney stones	
Mental Illness	Kidney Cancer	

Current Medical Problems (Circle if Present)

High Blood Pressure	Sickle Cell Disease	Kidney disease
Congestive Heart Failure	Enlarged Prostate	Depression
Heart Disease	Diabetes	Irritable Bowel Syndrome
Stroke	Kidney Stones	High Cholesterol
Poor Circulation	Obesity	Dementia

Cancers: _____

Other: _____

Social History

Do you smoke? No Yes _____ packs/day for _____ years

Do you consume alcohol regularly? No Yes _____ per day

Occupation: _____ Caffeine intake _____ cups/day

Preferred Pharmacy _____ Height _____ Weight _____

Previous Surgeries or Major Hospitalizations (please include vasectomy)

Review of Systems: (Please circle if you are experiencing any of the following)

General: weight loss chills fever night sweats

Skin: bruising rashes chronic ulcers

HEENT: vision changes hearing loss dizziness seasonal allergies

Cardiovascular: fainting chest pain irregular heart beat palpitations

Respiratory: chronic cough shortness of breath wheezing bloody sputum

GI: chronic diarrhea abdominal pain bloody stools nausea vomiting

Neuro: numbness decreased memory seizures

Endocrine: heat or cold intolerance excessive thirst hot flashes

Hematology: excessive bleeding blood clots clotting disorders

Psych: anxiety depression suicidal thoughts

Musculoskeletal: leg cramps back pain joint pain weakness

Urination Pattern:

How often do you urinate in the day? Every hour 2 hours 3 hours 4 hours

How often do you get up at night to urinate? 0 1 2 3 4+

Do you leak urine if you cough or sneeze? Yes No

Does it burn when you urinate? Yes No

Do you see blood in your urine? Yes No

Do you have problems with erections? Yes No

Have you ever used medicines for erections? Yes No

Urology One, Inc.
Professional Service Agreement

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. It is our office understanding that the effectiveness of our urology practice depends on efforts of the patient, as well as, those of the physician.

Financial Responsibility

The patients' insurance will be billed as a courtesy to our patients, therefore, it is very important that our office maintain accurate information at all times. All patients must complete our information and insurance forms before seeing the doctor. We accept assignment of insurance benefits after verification of coverage is received.

All copays are due at the time of service. Urology One has the right to refuse treatment if the copay is not paid at the time of service. The balance is your responsibility whether the insurance pays or not. We can't bill your insurance if you don't provide us with an insurance card and all the correct information. If your insurance does not pay within 90 days, the balance could be transferred to your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance programs. We accept cash, credit cards, money orders, and post dated checks. We also offer Care Credit, an interest free program, for those who qualify. All copays are due at the time of service.

Prescription Refills—It will be our pleasure to call in refill medications at any time, but please allow our office a 48 hour notice so that request may be properly handled. When calling to request a refill, please have the following information available: medication name, dosage, pharmacy name and number. **No pain medication will be called in after hours or on the weekends. If you are in need of pain medication, please go to the emergency room.**

Medical Records: In accordance with state and federal copying fee schedule, you will be charged for your records. .

NSF Checks—*The office will be charging a \$35.00 fee for any returned checks. The patient will also no longer be allowed to make payments by check. Only Cash, Credit Card or Money Order.*

Missed Appointments/Cancellations—*It is the patient's responsibility to understand that regular follow-up will produce the maximum benefits. It is the patient's responsibility to give the office a 24-hour notice of any appointment cancellations. You will be charged a \$25.00 missed appointment fee for not cancelling your appointment 24 hours prior to your scheduled appointment. The amount may be more if you are scheduled for a procedure. Three no show and or same day cancellations without prior notification may result in being discharged from our practice.*

By signing below, you have read the professional agreement and agree to the terms. I also have viewed the HIPAA privacy notice information on the back of the page. I understand a copy of the HIPAA privacy notice is available upon request.

Patient Signature

Date

Witness

Date

UROLOGY ONE, INC.
SUMMARY OF NOTICE PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY!!

The Health Insurance Portability and Accountability Act (HIPAA) contains a new federal policies and procedures which mandates by law how Urology One, Inc. can use and disclose or release medical or health information about you to others: as well as, how you can gain access to your own health information. The purpose of this new law is to protect the privacy of your medical or health information and give you more control over it. These new privacy practices are effective as of April 14, 2003.

As always Urology One, Inc. must obtain your authorization prior to disclosing your protected health information (PHI) to anyone, except in the following situations:

- When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.
- In emergency treatment situations
- To Avoid harm to yourself or others

As in the past, we will be using your PHI in treatment (consultation with your healthcare providers), for billing (contracting your insurance company or other third party payers) and in agency operations government regulations and reports). In addition, unless you specifically object, we may contact you from time to time by mail or by telephone to confirm appointments, provide information about related services, and inquire about your satisfaction with services, or inform you about the status of your account. You also now have the following rights under the need federal rules:

- The right to request limits on uses and disclosures of your PHI, in allowable by law
- The right to choose how we send HI to you
- The right to view and obtain copies of your PHI
- The right to correct or update your PHI

A more detailed description of your rights under this law is available upon request. Special forms to request changes, corrections, or copies of your PHI (including any fees) are available from the Privacy Officer.

Urology One, Inc. has the right to change our privacy practices as the law or agency protocols are changed. You will be notified in writing at the time of your next appointment following any such changes. Please contact me if you think that your privacy rights may have been violated or if you disagree with a decision we made about access to your PHI. You may also send a written complaint to the Secretary of the Department of Health and Human Services. Urology One, Inc. wants to assure you are provided with the best possible care so please be aware that we will take no retaliatory action against you for filing a complaint about our privacy practices. We welcome questions and suggestions about these new rules and regulations.

Privacy Officer