MRN	Patient Name:		Date of Birth:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		Sex:
Race:	Ethnicity:		Language:

PHYSICIAN: ❑Adams ❑Blalock ❑Daily ❑Haraway ❑Ross ❑Runnels

PATIENT INFORMATION

Social Security #: ____________-____________-_____________

Last Name: __________________________ First Name: __________________________ MI: ________

Address: ____

City: ____________________________________ State: _______________ Zip: ______________

Home #: (______)______-________ Work #: (______)______-________ Cell #: (______)______-________

Sex: Male Female DOB: _______________ Email: ___________________________________

Referring Doctor: ____________________________________ PCP: ____________________________________

Marital Status: Single Married Divorced Widowed Separated

PRIMARY INSURANCE: ___________________________________ _______________________________________

Subscriber Name (Full Name): ______________________________________ Relationship to Patient: ___________

Subscriber SSN: _____________________________________ Subscriber DOB: ________________________

Insurance ID # _______________________________________ Group Number #: ________________________

SECONDARY INSURANCE: ____

Subscriber Name (Full Name): ______________________________________ Relationship to Patient: ___________

Subscriber SSN: _____________________________________ Subscriber DOB: ______________________

Insurance ID # _______________________________________ Group Number #: ______________________

MEANINGFUL USE DATA

Race: African American Asian Caucasian Hispanic Indian Native American Pacific Islander

Ethnicity: Hispanic Non-Hispanic Preferred Language: English Spanish Other: ______________

IN CASE OF EMERGENCY

Relative/Friend: ____ Relationship: __________________

Home #: (______)______-________ Work #: (______)______-________ Cell #: (______)______-________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mississippi Urology Clinic or my insurance company to release any information required to process my claims.

PATIENT SIGNATURE: ____________________________________ **DATE:** _____________________

PATIENT NAME: MRN:

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

PATIENT NAME: MRN:

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**

FEES CHARGED FOR ASSISTANCE AND COMPLETION OF FORMS. Effective June 1, 2017 Mississippi Urology Clinic, PLLC will charge and collect a fee of $25 per form for assistance in the completion of any required forms such as Family Medical Leave Act (FMLA), Cancer and Disability Forms, etc.

Initials_________

Mississippi Urology Clinic, PLLC and Mississippi Urology Outpatient Surgery Center, LLC
Clinic – Physician – Patient Arbitration Agreement

______________________________________ ("Patient"), engages Mississippi Urology Clinic, PLLC or Mississippi Urology Outpatient Surgery Center, LLC and any employees thereof individually or collectively referred to as ("Clinic"), and each Physician affiliated with the clinic ("Physician" or "Physicians") that renders medical care and services to perform services in conjunction with Patient's medical care. For and in partial consideration of the rendition of any and all present and future medical care and services, Patient agrees that in the event of any dispute, claim or controversy arising out of or relating to the performance of medical services, including but not limited to patient fees, informed consent, negligence or medical malpractice, between Patient (whether a minor or an adult) or the heirs-at-law or personal representative of Patient, as the case may be, and the Clinic and each Physician individually, where the claim or the amount in controversy exceeds $5,000, such dispute or controversy shall be submitted to Judicial Arbitration & Mediation Services (JAMS), or it successor, on an arbitration form for final and binding arbitration. All claims for unliquidated damages shall be deemed claims for in excess of $5,000.

Either party may initiate arbitration of any matter subject to arbitration by filing a written demand for arbitration at any time. Patient shall be entitled to an in person hearing in the county where the care at issue occurred, in accordance with the Federal Arbitration Act. The arbitration shall be administered by Judicial Arbitration & Mediation Services (JAMS) pursuant to its Comprehensive Arbitration Rules and Procedures and Minimum Standards of Procedural Fairness, and all parties are bound by the arbitrator's decision. Any decision by the arbitrator(s) shall be accompanied by a reasoned opinion. Judgement may be entered on the arbitrator's award, if any, by any court having jurisdiction of the subject matter.

All parties agree that their relationship affects interstate commerce and that this Agreement shall be governed by the Federal Arbitration Act, and, if not, by Mississippi law. The party requesting arbitration shall bear all costs of the arbitration, except the Patient is not required to pay any more than $125.00, with the Clinic bearing the other arbitration costs. However, each party is solely responsible for their own attorney, expert, and other associated costs, expenses, and litigation fees on their behalf.

If you are not willing to submit to binding arbitration, the Clinic and/or Physicians may perform the services or refer you to another health care provider capable of rendering the medical care or services which you require (although Physician assumes no responsibility for the quality of care or service rendered by any other health care provider). Please inform a Clinic representative immediately if you do not agree to binding arbitration and desire such referral.

This Agreement may be rescinded by written notice by either party within fifteen (15) days of signature. However, any claim or dispute related to medical services rendered after execution of this Agreement and prior to the date of such written notice of rescission shall be subject to the terms of this Agreement. Written notice of such rescission may be given by a guardian or conservator of Patient if Patient is a minor or incapacitated. This agreement may be modified only by signed agreement by each party or it's authorized representative. If any portion of this Agreement is found unenforceable, that portion shall be stricken and the remainder of this Agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where services are rendered.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL.

If a parent or guardian has signed on behalf of their minor child or ward, such parent or guardian hereby attests that he or she has full legal authority to execute this Arbitration Agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Clinic from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

A photo static or electronic copy of this authorization shall be considered as effective and as valid as the original.

SIGNATURE OF PATIENT/GUARDIAN

By: ____ Date: ________________________

For Office Use Only

Witness Signature: ____________________________________ Date: ________________________

MISSISSIPPI
UROLOGY CLINIC, PLLC

MRN	Patient Name:	Date of Birth:

PHYSICIAN: ❑Adams ❑Blalock ❑Daily ❑Haraway ❑Ross ❑Runnels

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:

❑ Enlarged Prostate ❑ Blood in urine ❑ High PSA ❑ Bladder Infection ❑ Kidney Stones
❑ Prostate Infection ❑ Urinary Incontinence ❑ Bladder Cancer ❑ Prostate Cancer ❑ Erectile Dysfunction
❑ Overactive Bladder ❑ Infertility ❑ Lump in Testicle ❑ Interstial Cystitis ❑ Leak Urine
❑ Curvature of Penis ❑ Urethral Stricture ❑ Other ____

Allergies ❑ None Please list all allergies: ____

Medications ❑ None Please list all medications: ____
____

Surgical History ❑ Appendectomy ❑ Back/Hip/Knee ❑ Cystoscopy ❑ Gallbladder ❑ Heart Bypass
❑ Kidney Stone Surgery ❑ Lithotripsy ❑ Prostate Biopsy ❑ Prostate Seed ❑ Prostate Surgery ❑ Colonoscopy
❑ Other ____ ❑ **No Changes**

Medical History ❑ Diabetes ❑ Emphysema ❑ Heart Attack ❑ Heart Murmur ❑ Hepatitis ❑ Hernia
❑ Hypertension ❑ Parkinson's ❑ Strokes
Cancer: ❑ Prostate ❑ Kidney ❑ Testis ❑ Other ________________________________ ❑ **No Changes**

Family History ❑ Prostate Cancer ❑ 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 name & 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

My Urinary Symptom(s) are:

❑ Incomplete Emptying ❑ Frequency ❑ Intermittency ❑ Weak Stream ❑ Straining
❑ Testicle Pain ❑ Pain in Side Right / Left ❑ Urinating at Night # _____________