FEMALE UROLOGY
OF NASHVILLE

Abel · Allen · Scarpero

PATIENT REGISTRATION

Patient Information

Last Name: ______________________________ First Name: ______________MI: ____

Current Address: ____

City: ____ State: ______ Zip: ______

Home Phone: ______________________ Cell Phone: __________________________

E-mail Address: ____________________________________ SSN# _______________

Date of Birth: _______________ Sex: ☐ M ☐ F

Referring Physician: ____

Primary Care Physician: ____

Emergency Contact Name: ____

Emergency Contact Phone Number: ____

Financial Party Responsible/Guarantor:

Last Name: ______________________________ First Name: ______________ MI: ____

Current Address: ____

City: ____ State: ______ Zip: ______

Home Phone: ______________________ Cell Phone: __________________________

SSN#: ______________________________ Date of Birth: _____________________

Relationship of Guarantor to Patient: ____

Insurance Information: Please present ID and Insurance cards to receptionist at the time of visit

Primary Insurance Name: ____

Secondary Insurance Name: ____

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GENERAL CONSENT FORM

Patient Name ______________________________ DOB ____________

Assignment of Benefits. I authorize Female Urology of Nashville, P.C. to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that Female Urology of Nashville, P.C. will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: ____________

Consent for Treatment. I consent for Female Urology of Nashville, P.C, to administer medical care and services, including, but not limited to, diagnostic tests, examinations, administration of medication, and other medical procedures which are, in the judgment of a practitioner, necessary for the diagnosis and treatment of my illness or condition. I understand that no one connected with Female Urology of Nashville, P.C. makes, or has made, any guarantees or representations of any kind or nature, express or implied, with respect to the conclusions, decisions, or outcomes of the medical procedures.

Patient Initials: ____________

Electronic Prescription. I understand Female Urology of Nashville utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Phone Calls. By providing contact information, I authorize Female Urology of Nashville, P.C., its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of others in Care. I authorize Female Urology of Nashville, P.C. to discuss my/the patient's care and medical needs with the following persons:

NAME	Date of Birth	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** ____________

May we contact you by phone and leave a message about your care?

Primary Phone: ______________________

☐ Leave message with contact number only
☐ Leave message with detailed information
☐ Do not leave message

Secondary Phone: ______________________

☐ Leave message with contact number only
☐ Leave message with detailed information
☐ Do not leave message

Patient Financial Policy.
I acknowledge receipt of the "Patient Financial Policy." **Patient Initials:** ____________

Notice of Privacy Practices.
I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** ____________

Witness: ______________________________ **Date:** ____________________

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REVIEW OF SYSTEMS

Patient Name ______________________________ DOB ____________

Check if you are currently experiencing any of the following symptoms. Please mark Yes or No for each selection.

CONSTITUTIONAL

Symptom	Yes	No
Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Weight gain over 10 lbs	☐ Yes	☐ No
Weight loss over 10 lbs	☐ Yes	☐ No

NEUROLOGICAL (nervous system)

Symptom	Yes	No
Seizures	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Numbness in extremity	☐ Yes	☐ No
Weakness in extremity	☐ Yes	☐ No
Loss of balance	☐ Yes	☐ No
Frequent falls	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

ENDOCRINE (internal glands)

Symptom	Yes	No
Excessive thirst	☐ Yes	☐ No
Cold or heat intolerance	☐ Yes	☐ No
Excessive fatigue	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No

GASTROINTESTINAL

Symptom	Yes	No
Abdominal pain	☐ Yes	☐ No
Nausea vomiting	☐ Yes	☐ No
Indigestion / Heartburn	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

CARDIOVASCULAR

Symptom	Yes	No
Chest pain, pressure	☐ Yes	☐ No
Palpitations / Arrhythmia	☐ Yes	☐ No
Wake up breathless	☐ Yes	☐ No
Swelling in legs / ankles	☐ Yes	☐ No
Uncontrolled Hypertension	☐ Yes	☐ No

MUSCULOSKELETAL

Symptom	Yes	No
Joint pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Joint Laxity	☐ Yes	☐ No

RESPIRATORY (lungs)

Symptom	Yes	No
Wheezing	☐ Yes	☐ No
Frequent coughing	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

HEMATOLOGIC / LYMPHATIC

Symptom	Yes	No
Swollen lymph glands	☐ Yes	☐ No
Bleeding tendency	☐ Yes	☐ No
History of Blood Clots	☐ Yes	☐ No

GENITOURINARY (urinary and genital)

Symptom	Yes	No
Painful urination	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Urgent urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Weak urine stream	☐ Yes	☐ No
Straining to urinate	☐ Yes	☐ No
Interrupted urine flow	☐ Yes	☐ No
Incontinence / Bladder leakage	☐ Yes	☐ No
Incomplete emptying	☐ Yes	☐ No
Nighttime Urination	☐ Yes	☐ No
Sexual dysfunction	☐ Yes	☐ No
Vaginal Pain	☐ Yes	☐ No
Vaginal Burning	☐ Yes	☐ No

EYES

Symptom	Yes	No
Dry eyes	☐ Yes	☐ No
History of glaucoma	☐ Yes	☐ No

EAR/NOSE/THROAT/MOUTH

Symptom	Yes	No
Dry Mouth	☐ Yes	☐ No

PSYCHOLOGICAL

Symptom	Yes	No
Depression	☐ Yes	☐ No
Substance abuse	☐ Yes	☐ No
Severe anxiety	☐ Yes	☐ No

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MEDICAL HISTORY

Patient Name ______________________________ DOB __________

CURRENT MEDICATIONS

List all medications you currently take including vitamins, herbal supplements and over-the-counter medications. If needed, attach an additional sheet.

Name of Medication	Dose (mg)	How often is the medication taken	Reason for taking medication	Physician prescribing
1				
2				
3				
4				
5				

PHARMACY

List pharmacy most frequently used for prescriptions.

Name ____________________ Phone ____________ Fax ____________

Address ______________________________

City/State/Zip ______________________________

Mail Order Pharmacy ______________________________

ALLERGIES

List any allergies and reactions you have. Attach extra sheet if necessary.

Name of Allergen	Name of Allergen
1	6
2	7
3	8
4	9
5	10

PAST SURGERIES

Include all surgery in your lifetime. Attach extra sheet if necessary.

Type of Surgery	Type of Surgery
1	6
2	7
3	8
4	9
5	10

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MEDICAL HISTORY

Patient Name ______________________________ DOB __________

CHECK ANY PAST MEDICAL PROBLEMS:

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer; Type ______________________
- ☐ Chronic UTIs
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Enlarged Prostate
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ IBS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Neurologic Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Valvular Heart Disease
- ☐ Other ______________________

CHECK ANY FAMILY HISTORY OF DISEASE:

Adopted? ☐ **Y** ☐ **N**

- ☐ Diabetes
- ☐ Enlarged Prostate
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Cancer
- ☐ Stroke
- ☐ Urinary Tract Infections
- ☐ Cancer, Other
- ☐ Other ______________________

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Current ☐ Former ☐ Never Type: ______________________ Year quit: __________

Caffeine: ☐ Y ☐ N Type: ______________________ Amount per day: ______________________

Alcohol: ☐ Y ☐ N ☐ Former

Type: ______________________ Frequency: ________________ Amount: __________ Last Drink: __________

Pregnancies: Number of Live Births: __________ Vaginal ________________ C-Section: ________________

Sexual Activity: Are You Sexually Active: ☐ Y ☐ N

Any issues or concerns you would like to discuss today: ☐ Y ☐ N ______________________

____

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www.femaleurologyofnashville.com

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FINANCIAL POLICY

Patient Name ____ DOB ____________

PLEASE READ PRIOR TO RECEIVING SERVICES

Female Urology of Nashville, P.C. recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

Before receiving services, you must verify that we are participating providers for your insurance company. In the event that we are not participating providers with your insurance company, we will file an initial claim as a courtesy. Payment, however, is due in full at the time of service.

Payment: Payment is expected at time of visit whether you have a copay or deductible plan. Every insurance policy is different please consult with your insurance company to determine if your diagnostic tests will be covered. There will be an additional $20 charge for co-payments and deductibles not received at time of service.

Insurance Plans: We will bill your insurance company for services received by you at our office. To properly bill your insurance company, we require that you provide all insurance information including primary and secondary insurance, as well as any change of insurance information. You are expected to present an insurance card at each visit. Copayments and past due balances are due at time of check-in unless previous arrangements have been made with our billing department.

Payment for known copays, co-insurance, and deductibles are your responsibility, and will be due at the time services are performed. Not all services provided by this office are covered by every plan. You are responsible for understanding your benefit plan and for knowing its requirements for referrals to specialists, preauthorization of procedures, etc. It is your responsibility to pay for non-covered services. After insurance claims are paid, remaining balances on your account are your responsibility to be paid in full, within the regularly scheduled billing cycle of 30 days.

Self Payment (Private, Cash Payment): If you have no insurance coverage, we ask that you coordinate your care with our office prior to your visit. We require payment in full for professional services.

Statements: We will send a statement (to the billing address you provide) notifying you of any balance you may owe. It is your responsibility to notify our office of any changes in your address, name, telephone, insurance information, etc. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business within 30 days after receipt of the initial statement. You can call 615-476-9018.

Missed Appointments: Female Urology of Nashville requires 24-hour notice of appointment cancellation. Appointments missed and are not previously canceled may be charged a fee of $25.00 for office visits and $50.00 for in-office procedures.

Failure to keep your account balance current may require us to cancel or reschedule your appointment. Financial needs are understood by this office, please ask to speak with our billing department to discuss a mutually agreeable payment plan, or information on additional resources that maybe available.

If you have any questions about our fees, our policies, or your responsibilities, our billing department is available at 615-476-9018 and happy to assist.