ST. PETE UROLOGY

830 Central Ave, Suite 100 St.
Petersburg, FL 33701727-822-9208
(ph) 727-822-9211 (fax)

REGISTRATION FORM

Patient's Last Name	First Name		Middle Initial
Street Address	**City**	**State**	**Zip Code**
Social Security Number	**Date of Birth**	**Age**	**Sex**
			□ Male □ Female
Home Phone Number	**Cell Phone Number**	**Email Address**	

Marital Status: ☐Married ☐Divorced☐Legally Separated ☐Widowed ☐Single

Contact Name (Emergency)	Contact Phone Number
Primary Care Physician	**PCP Phone Number**
Pharmacy Name	**Pharmacy Location**

Referred to Practice by:

□ Primary Care Physician □ Insurance □ Internet □Friend/Relative □ Coworker □ Yellow Pages

FINANCIAL ASSIGNMENT/AGREEMENT

The above information is true to the best of my knowledge. I authorize the release of information to my insurance company and any other appropriate agency as required for claims payment. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balances that are not reimbursed by my insurance company. I agree to inform the staff of St Pete Urology of any changes in my insurance coverage. I agree to pay any deductibles and/or copayments at the time service is provided. If I cancel an appointment within 48 hours of my scheduled appointment or do not show up for a scheduled appointment without any notification, a $25.00 fee will be billed to my account.

Patient Signature:	
Date:	

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Medical History Form

Patient Name:	Date:

Medication List:	

Are you on any blood thinners? □ No □ Yes (List)

Allergies (Medication or Other):

Surgery History:	

Medical History:	

Do you drink coffee daily? □ No □ Yes (□ Regular □ Decaf)

Do you drink tea daily? □ No □ Yes (□ Regular □ Decaf)

Do you smoke? □ No □ Yes	How much?	How long?
Do you drink alcohol? □ No □ Yes	How often?	

Mark an "X" on any condition in your immediate family:

□ Diabetes □ High Blood Pressure □ Stroke □ Kidney Stones □ Kidney Failure
□ Cancer (Type_____) □ Other_____

Mark an "X" if you currently have a significant and persisting problem or have had in the past:

General	Eyes	Neurology	Gastrointestinal
□ Fevers □ Weight Loss (> 10 pounds/in 6 months)	□ Cataracts □ Vision Loss □ Double Vision □ Glaucoma	□ Dizzy Spells □ Frequent Headaches □ Seizures □ Stroke □ TIA □ Tremors	□ Ulcers □ Abdominal Pain □ Nausea □ Heartburn □ Colon Cancer □ Blood in Stool
Cardiovascular	**Skin**	**Musculoskeletal**	**ENT**
□ Chest Pain □ Heart Attack □ Irregular Heart Beat □ High Blood Pressure □ Feel Heart Racing	□ Skin Cancer □ Melanoma □ Persistent Rash □ Yellow Jaundice □ Breast Cancer	□ Back Pain □ Neck Pain □ Arthritis □ Use Wheelchair	□ Hearing Loss □ Sore Throat □ Sinus Infection
Respiratory	**Blood/Lymphatic**	**Psychiatric**	**Gynecologic**
□ Shortness of Breath □ Asthma □ Lung Cancer □ Emphysema/COPD □ Require Oxygen	□ Anemic □ Swollen Glands □ Bleed/Bruise Easily □ Blood Transfusion	□ Depression Treatment	□ Hysterectomy □ Abnormal PAP □ Cervical Cancer □ Vaginal Bleeding □ Vaginal Discharge

NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about ouprivacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003, and will remain in effect until it is amended or replaces by us. It is our right to change our privacy practices provided law permits the changes. Before we make significant change, this Notice will be amended to reflect the changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Dr. Robert Spiegel. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff member' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves some of our office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our office staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page. If you want the copies mailed to you, postage and handling fees will also be charged. If you prefer a written summary or explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep record of routine disclosures therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.) Please be aware however, that it is the policy of this office not to disclose your health care information to anyone in a “non-routine” manner as defined by the federal privacy law. This section is included in this policy because it is required.

Restrictions: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. We may ask you to put your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. However, we hope you will give us the opportunity to address your grievance first.

HOW TO CONTACT US

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St. Petersburg, FL 33701
727-822-9208
727-822-9211

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Acknowledgement of Receipt of Notice of Privacy Practices
Authorization to Release Information

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. I acknowledge receipt of the Notice of Privacy Practices and I authorize the release of medical information for the typical uses and disclosures of health information. You may refuse to sign this acknowledgment, if you wish.

Print your name here: _____

Signature: _____

Date: _____

***Please list any family members, significant others, and/or friends that you authorize the release of information to:

_____

_____

For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient and the authorization to release medical information, as indicated in our Notice of Privacy Practices. It could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We were not able to communicate with the patient.
- Other (please provide specific details)

_____

_____

Employee Signature: _____Date: _____