NEW JERSEY
UROLOGY
Excellence In Care

I hereby give my permission for the results to be obtained on my behalf, as long as I am a patient of New Jersey Urology. Please send requested information to the following:

_____ Fax to 201-487-2602

_____ Send to:

New Jersey Urology
255 W. Spring Valley Avenue, Suite 101
Maywood, NJ 07607

_____ _____

Print Name Sign Name

_____

Date

NEW JERSEY UROLOGY
Excellence In Care

DATE _____ SOCIAL SECURITY _____ DATE OF BIRTH _____ AGE _____ S M W D

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____ HOME PHONE: _____

For Government mandated reporting, please answer the following: **PRIMARY PHONE:** _____

MALE ____ FEMALE ____ RACE: ASIAN ____ BLACK ____ HISPANIC ____ WHITE ____ OTHER ____ DECLINE ____

ADDRESS _____ EMAIL ADDRESS: _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____ WORK PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT: _____ RELATIONSHIP _____ PHONE # _____

INSURANCE NAME _____ ID# _____ GROUP# _____

ADDRESS _____ **IS COVERAGE IN YOUR NAME?** _____

IF NO, NAME OF INSURED _____ INSURED'S DATE OF BIRTH _____ RELATIONSIP TO PT. _____

EMPLOYER NAME _____ EMPLOYER PHONE NUMBER _____

SECOND INSURANCE NAME _____ ID# _____ GROUP# _____

ADDRESS _____ NAME OF INSURED _____

INSURED'S DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

EMPLOYER NAME _____ EMPLOYER PHONE NUMBER _____

NAME OF YOUR MEDICAL DOCTOR _____ **PHONE #** _____

ADDRESS _____

HOW WERE YOU REFERRED HERE? _____

AUTHORIZATION TO RELEASE INFORMATION TO YOUR MEDICAL / REFERRING DOCTOR: _____

Please Sign: X _____

NAME OF PERSON RESPONSIBLE FOR BILL _____ SOCIAL SECURITY # _____

ADDRESS _____ HOME# _____ WORK# _____

PHARMACY NAME _____ PHARMACY PHONE# _____

PHARMACY ADDRESS: _____

ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

I HAVE VIEWED AND READ A COPY OF NEW JERSEY UROLOGY NOTICE OF PRIVACY POLICIES DETAILING HOW MY INFORMATION MAY BE USED AND DISCLOSED AS PERMITTED UNDER FDERAL LAW. I UNDERSTAND THE CONTENTS OF THE NOTICE AND I REQUEST THE FOLLOWING RESTRICTIONS CONCERNING THE USE OF MY PERSONAL MEDICAL INFORMATION: _____

FURTHER, I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT. REGULATIONS PERTAINING TO MEDICAL ASSIGNMENT OF BENEFITS APPLY.

SIGNED: X _____ DATE: _____

IF NOT SIGNED BY PATIENT, PLEASE INDICATE RELATIONSHIP TO PATIENT.

RELATIONSHIP: _____ WITNESS: _____

INTERNAL USE ONLY: IF THE PATIENT'S REPRESENTATIVE REFUSES TO SIGN THE ABOVE, PLEASE DOCUMENT AND SIGN BELOW.

PRESENTED ON (DATE/TIME) _____ BY: (NAME/TITLE) _____

NEW JERSEY UROLOGY
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ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY FORM

Assignment of Benefits and Claims

I hereby assign and transfer to Gregory Lovallo MD, Christopher Wright MD, Michael Esposito MD, Vincent Lanteri MD, Mutahar Ahmed MD, Thomas Christiano MD, Andrew Siegel MD and Martin Goldstein MD (the practice doctors), all of my rights, titles and benefits payable by my insurance carrier for services performed by the doctors.

I hereby authorize the doctors to submit a claim to my insurance carrier or intermediary for all services rendered by the doctors and to exercise any appeals and other rights under my policy on my behalf.

I authorize and assign to the doctors the right to file suit and to obtain counsel and enter into legal or other actions on my behalf and/or in my name, including the arbitration/dispute resolution process, for any claims against my insurance carrier, PIP carrier, Workers' Compensation carrier, plan administrator, payor, or third party. This authorization includes the right to assignment to pursue declaratory relief or other legal remedies.

I authorize the doctors to appoint an attorney to represent me directly for the collection of PIP benefits, Workers' Compensation benefits, and all other insurance benefits through the carriers themselves plan administrator, payor or third party. I authorize the doctors to obtain any attorney to represent me directly in appealing a claim to the State Health Benefits Commission for all state plans. I authorize the doctors to represent me directly in appealing a claim to the appropriate Federal Agency for all federal plans.

I authorize the doctors to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities.

I direct my insurance carrier, or intermediaries, to issue a payment check directly to the doctors.

If my insurance company will not directly pay the doctors, I authorize and direct that the insurance company sends all checks and copies of Explanation of Benefit forms in connection with services of the doctors to the doctors at CL4480 P.O. Box 95000, Philadelphia, PA 19195-4480 as my agent for delivery of said items and use.

Financial Responsibility

I understand and agree that I am responsible for all charges incurred in connection with the receipt of services and care from the doctors and promise to pay promptly to the doctors the amount of charges for services rendered.

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ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY FORM-PAGE 2

I hereby authorize the doctors to release all information necessary regarding services rendered to my insurance company and referring physician.

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges of services rendered not covered by the insurance company. I understand that co-payments or deductibles are due in full at the time of service.

I agree to cooperate , aid and assist the doctors in procuring all possible insurance benefits.

Patient Receipt of Checks

In the event that I receive direct payment of any amount due for services rendered, I agree that I will hold such payment in trust for the doctors and I also agree to send such payment to the doctors one week after receipt of same. I also agree to pay attorney's fees equal to 33 1/3% of the outstanding balance, plus court costs, in the event the account is turned over to an attorney for collection.

Consent to Disclose

I authorize the doctors and their agents and attorneys to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to the doctors about me, including medical reports, X-Ray reports, narrative reports, and any other report or information regarding my physical condition.

Failure to Comply

I understand that failure to comply with my responsibilities under this form will result in my account remaining active. I guarantee payment of all said charges incurred. In the further event that the account must be placed with an attorney, I will also be responsible for collection agency fees and costs incurred in collection.

The undersigned has read and understands the above terms.

_____ _____

Patient Signature Date

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HEALTH HISTORY

NAME _____ DOB ___/___/_____ AGE _____

PHARMACY NAME AND PHONE # _____

To help us meet all your healthcare needs, please fill out this form completely. This is confidential record of medical history.

CHIEF COMPLAINT: What is the **MAIN REASON** for your visit? **WHEN** did you first notice the problem, the **LOCATION** of the problem, **HOW LONG** the symptoms last, is it **CONSTANT** or **VARIABLE**, does anything make **BETTER OR WORSE**, and a **NUMBER SCORE** (between 1-10, 1 being least and 10 being most severe) that best describes the severity of the problem.

_____

_____

_____

_____

_____

HEIGHT: _____FT _____IN WEIGHT: _____LBS

PAST MEDICAL HISTORY - Have you ever had a diagnosis of the following (describe): _____ NONE

☐ Cancer_____	☐ Irritable Bowel Syndrome_____	☐ Lung _____
☐ Heart _____	☐ Elevated Cholesterol_____	☐ Fibroids/ovarian cysts_____
☐ Stroke/TIA_____	☐ Bleeding Disorders _____	☐ High blood pressure_____
☐ Thyroid Disease _____	☐ Low testosterone _____	☐ Gout _____
☐ Glaucoma _____	☐ Diabetes Type I _____	☐ GERD/Reflux _____
☐ Tuberculosis _____	☐ Diabetes Type II _____	☐ Hepatitis (type) _____
☐ Kidney stone_____	☐ Enlarged Prostate _____	☐ HIV/AIDS _____
☐ Genital warts/STD's_____	☐ Urinary tract infections _____	☐ Elevated PSA _____
☐ Breast _____	☐ Other _____	☐ Other _____
☐ Other _____	☐ Other _____	☐ Other_____

PAST SURGICAL HISTORY - Have you ever had a diagnosis of the following (describe): _____ NONE

☐ Appendix _____	☐ Heart _____	☐ Hernia Repair _____
☐ Back Surgery_____	☐ C-Section _____	☐ Hysterectomy _____
☐ Breast _____	☐ Gastric Surgey_____	☐ Thyroidectomy _____
☐ Cataract _____	☐ Gallbladder _____	☐ Tonsil/Adnoids _____
☐ Colon _____	☐ Prostate _____	☐ Vasectomy _____
☐ Sling _____	☐ Cystocele/rectocele _____	☐ Kidney stone _____
☐ Other_____	☐ Other _____	☐ Other _____

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MEDICATIONS: Please list all medicines you are currently taking _____ NONE

CURRENT MEDICATIONS:	Dosage (mg)	how often per day?

ALLERGIES (food, drugs, and environment) _____ NONE KNOWN

FAMILY HISTORY: Has any blood relative (mother, father, sister, brother, aunt, uncle, maternal or paternal grandmother/grandfather) had any of the following: (check box, leave blank if uncertain)

	Relationship
☐ History of heart disease (heart attacks, heart failure)?	
☐ History of strokes/blood clots?	
☐ History of high blood pressure?	
☐ History of diabetes/high blood sugar?	
☐ History of high cholesterol?	
☐ History of Cancer? If so, site?	
☐ History of thyroid disease?	

SOCIAL HISTORY:

Tobacco: ☐ never ☐ minimal (social) ☐ yes (____packs/day x____yrs) ☐ quit____yrs ago

Alcohol: ☐ never ☐ rarely ☐ less than 10 per week ☐ more than 10 per week

Illicit drug ☐ No ☐ Yes what type: _____

Excercise: ☐ None ☐ Minimal ☐ Moderate ☐ Heavy ☐ Active but no formal excercise

MENSTRUAL HISTORY (females only)

Age at Menstruation _____ Age at menopause _____

Pregnancies _____ # Vaginal deliveries _____ # C-sections _____

Miscarriages _____ # Abortions _____

Are you sexually active? Yes____ No____

Are you on Hormone replacement therapy? Yes____ No____

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REVIEW OF SYSTEMS

Please circle any of the following symptoms that are relevant to you
If you do not have any of the symptoms, circle "no problems"

Constitutional:

no problems
poor appetite
weight loss
weakness
fatigue
malaise
fever
chills
sweats
pain

Neurological:

no problems
numbness
difficulty walking
headaches
tremors
balance problems
fainting
forgetfulness
paralysis

Heart/Blood Vessels:

no problems
palpitations
irregular heart beat
chest pain
buttock pain walking
leg swelling

Ear/Nose/Throat:

no problems
sinus problem
hearing loss
ringing in ear
nosebleeds

Gastrointestinal:

no problems
change in bowel habit
constipation
diarrhea
nausea/vomiting
blood in stool
black stools
exccesive gas
heartburn
jaundice
fecal incontinence

Skin:

no problems
moles/lesions
rashes
hair loss

Eyes:

no problems
visual impairment
blurry vision
double vision
eye pain

Musculoskeletal:

no problems
muscle weakness
muscle pain
neck/back ache
joint pain
bone pain

Endocrine:

no problems
excess thirst
excess urine
hyperactivity
sluggishness
excessive body hair
male-enlarged breast
nipple discharge
loss of facial/body hair
loss of muscle strength
increased body fat

Psychiatric

no problems
anxiety
depression
mania
alchoholism
insomnia
eating disorder
mood changes

Hematological:

no problems
easy bruising
clotting problems
bleeding tendency
swollen lymph glands

Respiratory:

no problems
cough
coughing blood
shortness of breath
tuberculosis exposure

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Urinary review of systems: (circle all that apply and fill in the blanks where indicated)

NO URINARY COMPLAINTS

Have you been diagnosed with or treated for:

Visible blood in urine (start of stream, end of stream, entire stream, no pain)
Microscopic blood in urine
Urinary infections
Urinary retention
Kidney cancer
Kidney infections
Kidney mass
Kidney obstruction
Kidney stones
Bladder cancer
Prostate cancer

Do you have:

Painful urination
burning with urination
difficult urination
frequent urination
urgent urination
night time urination
# of times _____

foul smelling urine
air in urine
stool in urine
cloudy urine
urethral discharge
incomplete emptying
flank pain
groin pain

hesitant stream
need to strain to pass urine
weak stream
spraying/split stream
stream starts/stops
long time to empty
dribbling after urination
burning after urination

difficulty urinating at night
but not during the day

need to urinate twice or more to empty

Leakage issues:

on the way to the toilet
with running water
getting out of the car
sitting quietly
running
laughing
lifting
playing sports

putting the key in the door
without realizing it
during intercourse
continuous leakage
sneezing
shouting
bending

in cold weather
while sleeping
with orgasm
walking
coughing
climbing stairs
standing
dribbling after urination

#_____ of pads per day

_____ of liners per day

_____ of diapers per day

Gynecological (for females only):

excessive menstrual bleeding
excessive menstrual cramping
sexually transmitted diseases

no problems
bulge coming out of vagina
lubrication problems
genital rash or lesions

lax vagina
painful intercourse
breast lumps

Males only: *no problems*

loss of sexual desire
difficulty achieving an erection
difficulty maintaing an erection
painful erections
prolonged erections
angulated erections
decreased sensation with orgasm
blood in semen

Are you sexually active: yes no

premature ejaculation
delayed ejaculation
inability to ejaculate
painful ejaculation
foreskin difficulties
abnormal penile opening
infertility
sexually transmitted disease

undescended testicle
lump on testicle
testes hang too low
painful testicle(s)
absent testicle(s)
shrinking penis
penile rash or skin abnormality

Any other unlisted problems:

_____

_____

_____

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PATIENT NOTICE REGARDING PATHOLOGY CHARGES

Please note that charges for laboratory testing services (e.g. specimen, tissue, blood or bodily fluids) are not included in your physician's fees and are separate from any payments made to your doctor during your office visit. NJ Urology (NJU) will submit a claim to your insurance carrier for any laboratory test performed at the request of your physician; you will receive a statement for any amount you required to pay after insurance has paid its portion of the bill or denied payment. By ensuring our office has your most current insurance information, you can help expedite this process.

You may receive a bill from a laboratory which may appear to be a duplicate for service performed. However, these charges are not included in any other statement. The doctor's charge relates to the professional services provided during your ofiice visit or surgical procedure and the pathology bill relates to the professional services associated with the interpretation or diagnosis of the specimen, tissue, blood or bodily fluids.

If you have questions regarding your pathology statement or outstanding balance, or would like to make a payment, please contact Patient Account Services at 877-366-5876.

PATIENT/RESPONSIBLE PARTY ACKNOWLEDGEMENT AND AGREEMENT:

I Acknowledge that I have read and fully understand the NOTICE REGARDING PATHOLOGY CHARGES. I understand that I am financially responsible for non-covered services not paid by the insurance carrier within the confines of my policy.

_____ _____

Signature, Patient Date

_____ _____

Signature, Financially Responsible Party (if not patient) Date

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PATIENT CONSENT FOR PROVIDER APPEAL

PROVIDER INFORMATION

Name: _____ NPI: _____

Group Name: _____ Phone: _____

Address: _____

Date of Service: _____

Description of Services to be appealed:

Member Information and Consent (This section only)

I agree to allow the provider listed above to file and appeal for me with _____ if there is a question about coverage for the services listed. I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand the information in the consent form and give my consent for this provider to file an appeal for me.

Patient name: _____ DOB: _____ ID# _____

Address: _____ Phone: _____

Patient signature: _____ Date: _____

Consent from a Designated Representative

The patient listed above is unable to sign this consent form because of the(se) reason(s) and I consent for the patient: _____

Representative name: _____ Relationship to patient: _____

Representative signature _____ Date _____

Witness name: _____ Signature: _____ Date: _____

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PERMISSION FORM

I ALLOW NEW JERSEY UROLOGY TO DISCUSS MY HEALTH INFORMATION WITH:

CIRCLE ALL THAT APPLY

WIFE/HUSBAND (NAME) _____

DAUGHTER/SON (NAME) _____

MOTHER/FATHER (NAME) _____

OTHER (SPECIFY NAME) _____

I ALLOW NJU TO LEAVE DETAILED MESSAGES ON MY VOICEMAIL YES NO

PATIENT NAME (PRINT) _____

SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HPPA"), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW UP AMOUNG MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY OR INDIRECTLY
- OBTAIN PAYMENT FROM THIRD PARTY PAYERS
- CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS

I HAVE REVIEWED, READ AND UNDERSTAND YOUR *NOTICE OF PRIVACY PRACTICES* CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS *NOTICE OF PRIVACY PRACTICES* FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME TO OBTAIN A CURRENT COPY OF THE *NOTICE OF PRIVACY PRACTICES.*

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE WITH MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.