Bladder Health and Reconstructive Urology Institute

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PATIENT INFORMATION

LAST NAME	FIRST NAME	M	SEX
			☐Male ☐Female
DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS	
		☐Single ☐Married ☐Divorced ☐Widowed	

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE

E-MAIL	PREFERRED METHOD OF CONTACT
	☐Call Home ☐Call Cell ☐Send E-mail ☐Send Text

EMPLOYER	OCCUPATION	EMPLOYER PHONE
RACE	ETHNICITY	PREFERRED LANGUAGE

PRIMARY CARE PHYSICIAN. (PCP)	WHO REFERRED YOU TO DR. GOUSSE
	☐PCP ☐Insurance ☐Family/Friend ☐Other:_____

EMERGENCY CONTACT	RELATIONSHIP TO PATIENT / PHONE NUMBER

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_____ (Please print your name), authorize(s) Dr. Angelo Gousse and his appointed staff, to release or discuss Information related to my medical condition (including Information related to my diagnosis, treatment plan, medication Information and/ or billing and Insurance Information) to the following named person(s):

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
_____	_____	_____

INSURANCE INFORMATION

GUARANTOR/PARTY RESPONSIBLE FOR BILL (please give your insurance card to check-in)

PRIMARY INSURANCE	POLICY#	GROUP#
SUBSCRIBER NAME	SOCIAL SECURITY #	DATE OF BIRTH
PATIENT RELATIONSHIP TO SUBSCRIBER	☐Self ☐Spouse ☐Child ☐Other	

SECONDARY INSURANCE	POLICY#	GROUP#
·SUBSCRIBER NAME	SOCIAL SECURITY #	DATE OF BIRTH
PATIENT RELATIONSHIP/TO SUBSCRIBER	☐Self ☐Spouse ☐Child ☐Other	

I, the undersigned, certify that 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, whether or not it is paid by insurance. I authorize Dr. Angelo E. Gousse, M.D., or his designated staff, to release all information necessary to secure the payment of benefits and to process my claims. I also authorize the use of this signature on all insurance submissions.

MEDICAL HISTORY

WHAT IS YOUR REASON FOR TODAY'S VISIT?

LIST CURRENT MEDICATIONS				
Name of Medication	/	Dose	/	Frequency

PAST OR CURRENT MEDICAL CONDITIONS? (Check those that are applicable)

□HIV □Diabetes □ High Blood Pressure □Heart Attack
□Stroke □Kidney Disease □Transplant
□Cancer _____□Hepatitis □Liver Failure □High Cholesterol_____

□Acid Reflux □OOPD □Asthma □Lung Infections □Irritable Bowel Disease

Please provide any details to further explain your past or current medical conditions:

_____

_____

PAST SURGICAL HISTORY	
Type of Surgery	Date

FAMILY HISTORY? (Check those that are applicable)

Has anyone in your family had:

□Cancer? -What Kind? _____

□Stroke? - if yes, who? _____ □Diabetes? - if yes, who?_____

□Heart Disease? -if yes, who? _____ □High Blood Pressure? -If yes, who? _____

□Kidney Failure? -if yes, who? _____ □Kidney Stones?-if yes, who?_____

□Other? -Please explain: _____

SOCIAL HISTORY? (Check those that are applicable)

What is your occupation? _____

With whom do you live? _____

ALCOHOL: Do you drink alcohol? □No □Occasionally □Often
If often, how much per day? _____

Tabacco: Do you smoke? □No □Yes
If yes, how many packs per day? _____ Since when? _____
If you were a former smoker, when did you quit? _____

REVIEW OF SYSTEMS

CONSTITUTIONAL Chills ☐Yes ☐ No Fevers ☐Yes ☐ No Fatigue ☐Yes ☐No Night Sweats ☐Yes ☐ No Other:	EYES Blurred Vision ☐Yes ☐ No Vision Loss ☐Yes ☐No Glaucoma ☐ Yes ☐ No Cataracts ☐Yes ☐ No Other:	EARS/NOSE/THROAT/MOU Ear Infection Yes ON Hearing Loss ☐Yes☐No Sore Throat ☐Yes ☐No Sinus Problem ☐Yes ☐No Other:
CARDIOVASCULAR Heart Trouble ☐Yes ☐No Chest Pain ☐Yes ☐No Ankle Swelling ☐Yes ☐ No Fainting ☐Yes ☐ No Other:	PULMONARY Wheezing ☐Yes ☐No Cough ☐Yes ☐ No Breath Shortness ☐Yes ☐ No Coughing up Blood ☐ Yes ☐ No Other:	GASTROINTESTINAL Abdominal Pain ☐Yes ☐ No Nausea/Vomiting ☐Yes ☐ No Indigestion/Heartburn ☐Yes ☐ No Rectal Bleeding ☐Yes ☐ No Other:
GENITQURINARY Urinary Retention ☐Yes ☐ No Painful Urination ☐Yes ☐ No Urinary Frequency ☐Yes ☐ No Other:	MUSCULOSKELETAL Joint Pain ☐Yes ☐No Neck Pain ☐Yes ☐ No Back Pain ☐Yes ☐ No Other:	INTEGUMENTARY Skin Rash Yes ☐ No Changes to Moles ☐ Yes ☐ No Itchy Skin/Hives ☐Yes ☐ No Other:
NEUROLOGICAL Severe Headaches ☐Yes ☐No Numbness ☐Yes ☐ No Nerve Tingling ☐Yes ☐ No Dizziness/Vertigo ☐Yes ☐ No Weakness ☐Yes ☐ No Other:	PSYCHOLOGICAL Are you Depressed ☐Yes ☐No Severe, Anxiety/Nervousness? ☐Yes ☐No Have you ever considered suicide? ☐Yes ☐No Other:	ENDOCRINE Too Cold ☐Yes ☐No Excessive Thirst Yes ☐ No Too Hot/Hot Flashes ☐ Yes ☐ No Too Thirsty ☐Yes ☐ No Steroid Use ☐Yes ☐ No Other:

HEMATOLOGIC/LYMPHATIC Bruising Easily ☐Yes ☐ No Bleeding Problems☐Yes ☐ No Blood Clotting ☐Yes ☐ No Swollen Glands☐Yes ☐No Other:	ALLERGIC/IMMUNOLOGIC Hay Fever ☐Yes ☐ No HIV Exposure ☐Yes ☐ No Seasonal Allergies ☐Yes ☐ No Drug/Food Allergies ☐Yes ☐ No Other:

Is there anything else that you would like to discuss today?_____

PELVIC EXAMINATION INFORMED CONSENT

I understand that by law, my healthcare practitioner requires written informed consent to perform a Pelvic Examination on me. I have been informed that I will be receiving a Pelvic Examination.

Description of the Examination:
A "Pelvic Examination" means an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but are not limited to, the healthcare provider's gloved hand or instrumentation.

I have been informed about the nature and process of the Pelvic Examination. All my questions have been answered to my satisfaction. I hereby GIVE MY INFORMED AND VOLUNTARY CONSENT to receive a pelvic examination.

DISCLOSURE AND USE OF HEALTH INFORMATION

Abuse or Neglect:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, domestic violence, or 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.

Appointment Reminders:
We may use or disclose your health information to provide you with appointment reminders via phone or mail.

Access:
Upon written or verbal 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). You must contact the office during office hours and have the disclosure of this information approved by the Office Manager. Copies, once requested, will be $1.00 per page. If you have any further questions, please ask the front desk or Office Manager.

Restrictions:
Be aware that you have the right to request that Dr. Angelo Gousse place additional restrictions on our use or disclosure of your health information. We do not have to agree to these in writing. You also have the right to receive an account of certain disclosures we have made, if any, of your protected health information.

Questions and Complaints:
You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. If you feel we have violated your privacy rights, or if you have any questions or concerns, please contact us in writing. We support your right to the privacy of 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.

PATIENT CONSENT FOR MEDICAL TREATMENT

I, the undersigned, hereby consent to any and all diagnostic procedures, tests, and/or medical treatment by the physician and/or his appointed medical staff. I am aware that practice is not an exact science, and I acknowledge that NO guarantees have been made or implied to me as a result of tests, examinations, treatments, procedures, or any other services rendered.

I understand that it is my sole responsibility to follow up with recommendations given by the doctor. I agree that Dr. Gousse and/or his medical staff will not be held liable for appointments not kept, rescheduled, cancelled, or delayed by the patient. It is my own responsibility to follow up on all test results, biopsy results, and adhere to strict treatment recommendations.

Please review this carefully and sign to acknowledge that you have read and understand this notice.

Signature of Patient/Legal Guardian: _____

Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I am aware that this office adheres to all HIPAA guidelines relating to patient privacy and confidentiality. I acknowledge that I have read and understood the contents of the Privacy Policies and consent to all provisions herein. If I had any questions or concerns, they were answered appropriately to my satisfaction.

Disclosure:
We may disclose and/or share healthcare information with other healthcare professionals who provide treatment and/or services to you. These professionals will have a privacy and confidentiality policy similar to ours. Health information about you may also be disclosed to your family, friends, and/or people you choose to involve in your care. We will only disclose this information with your written consent.

Payment:
We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business 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. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care.

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 medical staff, outside health or management reviews, 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, by court or administrative orders, subpoena, discovery request, or other legal purposes. We will use and disclose your information when requested by national security, intelligence, and other state or federal officials and/or if you are an inmate or otherwise under custody of law enforcement.

Signature of Patient/Legal Guardian: _____

Date: _____