Drs. Levine, Reigle & Schneider, Inc.

Practice Limited to Urology

440-753-0018 * Fax: 440-753-0035

FREDERIC J. LEVINE, M.D. MELISSA D. REIGLE, M.D. KURT W.SCHNEIDER M.D. ZURAB DAVILI, M.D.

Dear Patient,

Welcome to our practice! Please complete the enclosed paperwork, to the best of your knowledge, prior to your appointment and bring it with you to ensure a more effective and timely visit. Please arrive 15 minutes before your scheduled appointment.

When you come in, please bring with you:

- Insurance card (s)
- Drivers license (or picture ID)
- A list of **all** your current medications
- Co-payment (if insurance requires)

If you do not have your insurance card or co-payment, you will be asked to reschedule your appointment.

If you are self-pay, you are expected to pay the bill in full the day of the visit. There will be a 25% discount. You will be asked to provide your drivers license or picture ID when you arrive. It will be returned to you after payment is made at the end of your visit.

(over)

6803 Mayfield Rd Suite 418 Mayfield Hts., Ohio 44124

7580 Auburn Rd Suite 108 Concord, Ohio 44077

13221 Ravenna Rd Suite 2 Chardon, Ohio 44024

890 W. Main St Room 202 Geneva, Ohio 44041

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Please give us all the pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information for all carriers. If your coverage is contingent on a second opinion or pre-admission approval, it is your responsibility to inform us. If you insurance requires a referral, it is your responsibility to bring it in or have it sent to us.

I request that payment of authorized Medicare/Other Insurance benefits be made either to me or on my behalf to Drs. Levine, Reigle & Schneider, Inc. for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare /Other Insurance Company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare /Other Insurance Company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare /Other Insurance Company.

I have read and understand the procedures on contacting the office for test results.

Print Name:________________________________**Signature:**____________________________________**Date:**__________

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GENERAL INFORMATION: **Today's Date:** _____/_____/_____

Name: ____ **Social Security #:** ____________________________

LAST NAME FIRST NAME MI

Address:_______________________________________ **Apt#** ______ **City/St**. _____________________ **Zip:** _______________

Gender: **(Please Circle)** M / F **Date of Birth:** _____/______/_____ **Marital Status:** **(Please Circle)** Single / Married / Divorced / Widowed

Phone: Home: ( ) __________________ **Cell:** ( ) ___________________

If we need to contact you, what is the **preferred** number? **(Please Circle)** Home / Cell / Work

Can we leave a message? Y / N If "**yes**", with whom and what relationship is the person to you ______________________________

Spouse's Name: _______________________________________ **Date of Birth:** _____/_____/_____ **Age** ___________________

Employer: ____ **Employer Phone:** ___________________________________

Email:______________________________________ **Emergency Contact:**_____________________ Phone:__________________

Preferred Pharmacy: (Name & Address): ____

Billing: (Please complete ONLY if cardholder is OTHER than patient above)

Cardholder's Name: ____ Social Security #:_____________________________________

Date of Birth: _______________________ Relationship to cardholder: **(Please Circle)** Spouse / Child / Other

Referring Physician:

Did a doctor send you and do you want us to send the doctor a report about today's visit? **(Please Circle)** Yes / No

Name of Referring Doctor /Family Doctor _________________________________Phone #_______________________________

Main Reason for your visit: ____

Allergies to Medications	**Current Medications**		**Surgical History and Dates**
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________

Medical History: (Please check any boxes that apply to you")

☐ Arthritis	☐ COPD	☐ Hypertension	☐ Peptic Ulcer
☐ Cancer (Type) __________	☐ Diabetes	☐ Hyperthyroidism	☐ Stroke
☐ Chronic infection	☐ Elevated Cholesterol	☐ Hypothyroidism	☐ Seizures
☐ Colitis	☐ Heart Disease	☐ Liver Problems	☐ Other_______________

****** If between ages 50-75 Have you had a colonoscopy?** **(Please Circle)** **Yes / No** **If yes when? Date** _______________

****** If over 65 have you had a Pneumonia vaccine** **(Please Circle)** **Yes / No**

Family History: (Please check any boxes that apply to you)

☐ Prostate Cancer If yes, who? _______________________ ☐ Kidney Cancer If yes, who? _______________________

☐ Testicular Cancer If yes, who? _______________________ ☐ Bladder Cancer If yes, who? _______________________

☐ Kidney Stones If yes, who? _______________________

(over)

Patient Name: ____ **Date:** ______________________

Social History:

Are you: **(Please Circle)** Single / Married / Divorced / Widowed If Female, how many pregnancies? _________ Live Births ________

Do you **Smoke**? **(Please Circle)** Never / Yes / Not Anymore - Quit Date _____/_____/_____

If yes, when did you start approximately? _____/_____/_____ How much do you smoke? ___________________________

Do you **Drink alcohol?** **(Please Circle)** Never / Yes / Not Anymore - If yes, How many drinks? ________ week/month/year

Types of **Alcohol consumed**: **(Please Circle)** Beer / Liquor / Wine

Drink Habits: **(Please Circle)** Social / Light / Moderate / Excessive / How many **Caffeinated drinks** per day? (0-4+) ___________

Do you use **Recreational drugs?** **(Please Circle)** Yes / No Do you use **Smokeless tobacco?** **(Please Circle)** Yes / No

Have you ever had a **BLOOD TRANSFUSION?** **(Please Circle)** Yes / No

Government regulations require we ask for the following identifying information:

Language: **(Please Circle)** English / Spanish Other _______________________

_

Race: **(Please Circle)** Caucasian / African American / Hispanic / Russian Other ______________________

Ethnicity: **(Please Circle)** Hispanic or Latino / Not Hispanic or Latino

What is your CURRENT or FORMER occupation? ____

Review of Systems: (Please check all boxes that apply to you") * If none apply please initial here ______.**

General
- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Fever
- ☐ Chills
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain
- ☐ Change in Appetite

Eyes
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Cataracts

Ear, Nose & Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Difficulty Swallowing

Respiratory
- ☐ Shortness of Breath
- ☐ History of Pneumonia
- ☐ History of Bronchitis
- ☐ History of Blood in Sputum
- ☐ History of Asthma
- ☐ Chronic Cough
- ☐ Sleep Apnea
- ☐ Snoring

Cardiovascular
- ☐ Chest Pains
- ☐ History of Coronary Artery Disease
- ☐ Palpitations
- ☐ Irregular Heartbeat
- ☐ History of Stroke or TIA
- ☐ Fainting

Vascular
- ☐ History of Blood Clots/DVT
- ☐ Varicose Veins
- ☐ Leg Ulcers
- ☐ Leg Swelling/Edema

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Reflux
- ☐ Constipation
- ☐ History of Hepatitis
- ☐ Diarrhea
- ☐ Colitis, Crohn's,UC
- ☐ History of Ulcers
- ☐ Jaundice
- ☐ Blood in Stool
- ☐ C Diff. Infection

Neurological/Psychiatric
- ☐ Difficulty Speaking
- ☐ Stroke/TIA
- ☐ MS
- ☐ Difficulty Walking
- ☐ Memory Problem
- ☐ Seizures
- ☐ Chronic Pain
- ☐ Depression
- ☐ Anxiety

Integumentary
- ☐ Rash
- ☐ Persistent Itching
- ☐ Skin Cancer History

Musculoskeletal
- ☐ Arthritis
- ☐ Gout
- ☐ History of Fracture
- ☐ Muscle Weakness
- ☐ Back Pain

Hematologic/Lymphatic
- ☐ Swollen Glands
- ☐ Abnormal Bleeding
- ☐ Transfusion History

Genitourinary
- ☐ Incontinence
- ☐ Painful Urination
- ☐ Blood in Urine

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Lupus
- ☐ High Cholesterol

(Pediatric Patients only:)
- ☐ Was your child full term?
- ☐ Any problems w/ delivery?
- ☐ Is your child potty trained?
- ☐ Daytime – What age _____?
- ☐ Nighttime – What age____?

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Dear Patient:

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

Therefore, we urge you, as the patient, to please check with your insurance company prior to any testing or surgery being performed. <u>It is your responsibility to know your individual coverage.</u> *Failing to comply* with this suggestion could result in you, the patient, being responsible for all costs incurred.

I authorize and understand that an outside laboratory is used to process and interpret the specimens. I understand that this is a separate charge from today's services. If your insurance company requires you to use a specific Laboratory please notify our staff today prior to the procedure.

Please remember, your insurance policy is between you and your insurance company and <u>not with the insurance company and your doctor.</u>

Patient Signature:______________________________ **Date:**_______________

Witness:___________________________________ **Date:**_______________

Please complete this section only if you are a Male and over the age of 40.

PATIENT SELF-ASSESSMENT BPH* SYMPTOM SCORE

Name: Date:

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your score
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	☐
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	☐
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	☐
Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	☐
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	☐
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	☐

	None	1 time	2 times	3 times	4 times	5 times or more	Your score
Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	☐

TOTAL SYMPTOM SCORE ☐

Total score: 0-7 Mildly symptomatic 8-19 Moderately symptomatic 20-35 Severely symptomatic

	Delighted	Pleased	Mostly satisfied	Mixed (about equally satisfied and dissatisfied)	Mostly dissatisfied	Unhappy	Terrible
Bother Score If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6