STARKVILLE UROLOGY

W. JORDAN WINDHAM, MD
SARAH RENTROP, MD

PATIENT INFORMATION:

Patient's Name (First) _____(Middle)_____(Last)_____

Mailing Address _____ City _____ State _____ Zip _____

SSN _____ Cell Phone _____Home Phone _____

Email _____

Sex _____ Marital Status _____ Date of Birth _____ Age _____

Employer _____ Work Phone _____

Emergency Contact _____ Phone Number _____

Primary Physician _____ Phone Number _____

Pharmacy _____ City _____

SPOUSE/PARENT/GUARDIAN INFORMATION:

Name_____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

SSN _____ Cell Phone _____ Home Phone _____

Employer _____ Work Phone _____

INSURANCE INFORMATION:

Primary Insurance _____ Name of Insured _____

ID # _____ Relationship _____ Insured DOB _____

Secondary Insurance _____ Name of Insured _____

ID # _____ Relationship _____ Insured DOB _____

⚠ Please allow receptionist to copy all insurance cards and picture ID after completion of the paperwork. ⚠

Signature of Patient or Legal Representative _____ Date _____

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Date: _____

Name _____ Age _____ DOB _____

How did you hear about us? _____

Allergies (medication allergies, x-ray dye allergies, etc) _____

_____

_____

Surgeries _____

_____

_____

Do you have an implanted device? (Example: pacemaker, defibrillator, InterStim, etc)	YES	NO
Do you take Nitroglycerin for chest pain?	YES	NO
Do you have a medical condition that requires prophylactic antibiotic treatment prior to any procedures being performed (artificial joint, mitral valve prolapse or heart valve)?	YES	NO

If yes, please explain: _____

PAST MEDICAL HISTORY:

Autoimmune Disorder	Yes	No	Gastric reflux/ulcers	Yes	No
If yes, list the type: _____			Eye disorders/glaucoma	Yes	No
Arthritis	Yes	No	Liver disease	Yes	No
Artificial joint/joint replacement	Yes	No	Hepatitis C	Yes	No
Bleeding disorder/blood transfusion	Yes	No	High blood pressure	Yes	No
Personal cancer history	Yes	No	High cholesterol	Yes	No
If yes, list the type: _____			Kidney disease/kidney failure	Yes	No
Radiation Therapy	Yes	No	Dialysis	Yes	No
Lung disease	Oxygen	CPAP	HIV	Yes	No
Diabetes	Yes	No	Ear, nose, throat problems	Yes	No
Skin disorders	Yes	No	Seizures	Yes	No
Heart disease, heart attack, or stroke	Yes	No	Thyroid disease	Yes	No
Congestive heart failure	Yes	No	Psychiatric illness	Yes	No
			If yes, list the type: _____		

FAMILY HISTORY:

Diabetes	Yes	No	Bladder Cancer	Yes	No
Heart disease	Yes	No	Kidney Cancer	Yes	No
Lung disorders	Yes	No	Prostate Cancer	Yes	No
Renal disease/failure	Yes	No	Penile or Testicular Cancer	Yes	No
Kidney stones	Yes	No	Other Cancer	Yes	No

SOCIAL HISTORY:

Current Smoker	Yes	No	Prior Smoker	Yes	No
Packs per day	_____		Year Quit	_____	
How many years	_____				
Do you drink alcohol	Yes	No	How often	_____	
Illegal Drugs	Yes	No			

Occupation or former occupation: _____

Patient Signature _____ Date _____

Physician Signature _____ Date _____

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MEDICATION RECONCILIATION SHEET

Medication Name	Dose	Frequency	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial

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PATIENT CONSENT AND AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Consent for Treatment
The undersigned authorizes the physician assigned to furnish medical and/or surgical treatment of those means he/she considers necessary and proper treatment of the patient identified below while a patient of Starkville Urology. This consent includes examination and treatment by the physicians, nurses, and other health care professionals at Starkville Urology. I also consent to any medical procedures, CT scans, Urodynamics, Ultrasound, laboratory tests and/or other health care services ordered by Starkville Urology. I understand that I may refuse specific treatments or procedures by informing a health care professional of such refusal.

Confirmation of Appointments:
As a courtesy to you, we do call and text prior to your appointment to confirm the time and date of your appointment. This information cannot be left on your voicemail or answering machine or related to someone else without written permission. The undersigned authorizes Starkville Urology to leave appointment reminder information by voicemail, answering machine or with the person who may answer my phone number.

Medical Records:
Medical records cannot be sent to your primary care physician or referring provider without written permission from you. The undersigned authorizes Starkville Urology to disclose my patient information and medical record to the physician(s) or provider(s) listed on my patient registration form. I understand that I may revoke this authorization, except to the extent that action has already been taken, in writing at any time by sending written revocation of authorization to Starkville Urology.

Acknowledgement of Notice of Privacy Practices:
By my signature below, I verify that I have been given the HIPAA Notice of Privacy Practices, which provides me with the information of how my Protected Health Information (PHI) is used.

Test Results:
Test results cannot be left on your voicemail or answering machine or discussed with another family member, even your spouse, without your written permission. The undersigned authorizes that Starkville Urology may leave information regarding test results with the following individual(s):

Name of Person: _____ Phone Number: _____ Relationship to Patient: _____

Name of Person: _____ Phone Number: _____ Relationship to Patient: _____

Patient (or Guardian) Signature: _____ Date: _____

Printed Name of Patient (or Guardian): _____

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FINANCIAL AND INSURANCE POLICIES

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

You must pay your copay and any coinsurance at each visit. You must pay any deductible or coinsurance BEFORE any office procedure or surgery is performed. Starkville Urology participates in the Medicare and Mississippi Medicaid programs as well as other commercial insurance products. We do not participate in most HMO plans.

If the clinic participates in your insurance plan, you will be responsible for all copays, deductibles, and coinsurance amounts at the time of service. You will also be responsible for any services not covered by your insurance plan. **You must bring your insurance card(s) to every visit.**

If the clinic does not participate in your insurance plan, you will be considered Self Pay. You will be required to pay $295.00 deposit on your first visit which will be applied to your charges. If you have any questions regarding the networks we participate in, please ask prior to being seen.

If you do not have any insurance, you will be required to pay a $295.00 on your first visit. This must be paid before you are seen. All future charges should be paid at time of service unless you work out other payment arrangements with our billing staff.

You understand that you are financially responsible for all clinic charges unless covered and paid by your third-party insurance as explained above. If you should default on your financial responsibility, you understand that your account may be turned over to a collection agency. If this occurs, you may be charged for all reasonable collection fees incurred by the clinic. You consent to receive communications regarding your account from the clinic or its collectors by any phone number(s) you provide including cell, employer, and home landline numbers.

The clinic reserves the right to charge patients a no-show fee of $100.00 who continually do not show up for appointments.

The clinic reserves the right to charge patients a fee of $25.00 for returned checks.

Assignment of Benefits

Medicare and Medicaid: You hereby request that the payment of authorized Medicare/Medicaid benefits for services rendered by the clinic on your behalf, shall be made to the clinic, and you specifically assign such benefits to the clinic. You hereby certify that all information given by you in connection with applying for such benefits is correct and complete in all respects. You understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid Programs to pay all copays, coinsurance, and deductibles upon demand by the clinic, including at the time of service.

Commercial Insurance: You hereby assign to the clinic all rights, benefits, and interest under any insurance policy, health plan, or workers compensation plan in consideration for services rendered by the clinic. You hereby authorize payment of such benefits directly to the clinic for treatment you receive by the clinic. You understand that you are required to pay all copays, coinsurance, and deductibles upon demand by the clinic, including at the time of service.

I agree that in the event of non-payment for services provided, I accept full and complete responsibility for the balance due, collection costs, court costs, as well as any attorney fees should legal action become necessary. I authorize the use of my signature on all insurance submissions.

Discussion of Your Account/Payment Responsibility:

We cannot discuss your bill with anyone without written permission, including your spouse or any other family member, unless they have a power of attorney on file. By my signature below, I give Starkville Urology permission to discuss billing information with the following individual(s):

Name of Person: _____ Phone Number: _____ Relationship to Patient: _____

Name of Person: _____ Phone Number: _____ Relationship to Patient: _____

Consent to Release Health Information for Billing and Payment Purposes:

You hereby consent to the release of your health information by the clinic for the purpose of obtaining authorization and payment of services rendered to you by the clinic. Your consent does NOT waive your privacy rights under federal law (known as the Health Insurance Portability and Accountability Act, or HIPAA).

Patient (or Guardian) Signature: _____ Date: _____

Printed Name of Patient (or Guardian): _____

HIPAA Privacy Policy
Confidentiality Statement

Protecting the Privacy of Patients' Health Information

INFORMATION REQUIRED TO BE PROTECTED

1. The privacy of all medical records and other individually identifiable health information must be always protected. Information relating to a patient's health care history, diagnosis, condition, treatment, or evaluation shall be considered individually identifiable health information. Confidentiality of this health information must be always maintained and may only be disclosed with the express written consent of the patient.
2. Non-individually identifiable health information, (e.g. health information that cannot be linked to a specific patient) is not included within the definition of protected health information.

BOUNDARIES ON HEALTH INFORMATION USE AND RELEASE

1. An individual's health information can be used for health purposes only.
2. Protect individually identifiable health information. Starkville Urology shall not publish or otherwise make generally available any information or data that identifies a patient for purposes other than treatment, payment or other health care operations, without his or her express written consent. This does not restrict the internal use of such information or data that is required in the performance of the scope of work that Starkville Urology has been engaged to perform for a client. Starkville Urology also maintains physical, electronic, and procedural safeguards to protect individually identifiable health information. Starkville Urology is always assessing those safeguards and shall make ongoing improvements to maintain and enhance our level of security for individually identifiable health information.
3. Ensure that health information is not used for non-health purposes. Patient information can be used or disclosed only for purposes of health care treatment, payment, and operations. Health information cannot be used for purposes not related to health care without explicit authorization from the patient. For example, Starkville Urology may not access the personal health information obtained by a Starkville Urology affiliate for any purpose other than to perform the services, for which we were engaged, unless Starkville Urology first obtains the explicit authorization of the patient.
4. Maintain health information in a manner to protect confidentiality. All individually identifiable health information shall be maintained by Starkville Urology in a confidential manner that prevents unauthorized or inadvertent disclosure to third parties. For example, Starkville Urology may share confidential information with a third party under contract or affiliated with Starkville Urology for the same purpose of performing the services for which we were engaged, provided that the information shall always remain confidential and shall be shared with only those persons that have authority to receive such information.

PENALTIES FOR MISUSE OF PERSONAL HEALTH INFORMATION

There are serious penalties for violation of the confidentiality of health information. Please be advised of the following:

1. State Penalties. Various state laws impose criminal and civil penalties on individuals who misuse or disclose individually identifiable health information without explicit consent by the patient.
2. Federal Penalties. HIPAA (Health Insurance Portability and Accountability Act) is a piece of federal legislation that directly addresses the protection of confidential health information. HIPAA provides for civil money penalties up to $25,000 per person, per year for violations of patient confidentiality. HIPAA also provides for federal criminal penalties.
3. Starkville Urology Penalties. Any employee who violates the privacy and confidentiality of patient health information, through disclosure or otherwise, may be subject to disciplinary action, including termination of his or her employment with Starkville Urology.