PROGRESSIVE UROLOGY

NAME: _____ Chart#: _____

STREET: _____ Sex: _____ Marital Status: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

DATE OF BIRTH: _____ AGE: _____ SSN: _____

RACE: _____ ETHNICITY: _____ PREFERRED LANGUAGE _____

EMAIL: _____

OCCUPATION: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: _____

PHONE: _____

RELATIONSHIP: _____

NAME OF SPOUSE _____ SPOUSE'S BIRTHDATE: _____

SPOUSE'S OCCUPATION: _____ SPOUSE'S EMPLOYER: _____

SPOUSE'S EMPLOYER'S ADDRESS: _____

SPOUSE'S EMPLOYER PHONE# _____

WHO IS YOUR PRIMARY CARE PHYSICIAN: _____ PHONE: _____

HOW WERE YOU REFERRED TO OUR OFFICE: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Insured's name, if not the same:

NAME: _____

INSURED'S SS# _____ **INSURED'S DATE-OF-BIRTH:** _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐Other

SECONDARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Insured's name, if not the same:

NAME: _____

INSURED'S SS# _____ **INSURED'S DATE-OF-BIRTH:** _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐Other

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Dimitri N. Kessaris, MD, PC for any services furnished to me by Dr. Kessaris or his authorized agents. I authorize any holder of medical information about me to be released to my insurance carriers or the Healthcare Financing Administrations or its agents any information needed to determine these benefits or benefits payable for related services. Furthermore, I understand the annual deductible and co-insurance amounts are my responsibility. If I have assigned benefits to any other party (Medicare Managed Care or other plans we do not participate with) rendering this office ineligible for payment. I understand that I will be responsible for the entire bill for service rendered. If your account becomes delinquent you will be responsible for 18% interest (APR), collection fees of 25% of the balance due, in addition to any applicable penalties.

SIGNED _____ DATE: _____

SIGNED _____ DATE: _____

SIGNED _____ DATE: _____

PROGRESSIVE UROLOGY

GenFemale

Name: _____ Date: _____

Referring/Primary Doctor: _____

Occupation: _____ Age: _____ Height: _____ Weight: _____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

Have you tried any **medicine/treatment** for this problem/pain? _____

PRESENT UROLOGIC COMPLAINTS:

Please CHECK OFF any of the following urologic problems you are CURRENTLY experiencing:

- ☐ Abdominal Pain – location: _____
- ☐ Back Pain – Right/Left/Lower Back
- ☐ Flank Pain – Right/Left
- ☐ Painful Urination – mild/moderate/severe
- ☐ Have to wait to Urinate
- ☐ Straining to Urinate – occasional/always
- ☐ Frequency of Urination – every ___ hour(s)
- ☐ Weak / Slow / Moderate Urine Stream
- ☐ Incomplete Bladder Emptying – occasional/always
- ☐ Urgency to Urinate – occasional/always
- ☐ Dribbling – occasional/always
- ☐ Urine Leakage with coughing or sneezing
  If yes: ___ #pads/day ___ #leaks/day
- ☐ Urine leakage associated with urgency to urinate
  If yes: ___ #pads/day ___ #leaks/day
- ☐ Blood in the Urine
- ☐ Urine Odor
- ☐ **Vaginal Discharge**
- ☐ **Vaginal Itching**
- ☐ **Vaginal Dryness**
- ☐ **Vaginal Irritation**
- ☐ **Vaginal Odor**
- ☐ Incomplete Bowel Movements
- ☐ Constipation
- ☐ Diarrhea
- ☐ Fever
- ☐ Chills
- ☐ Nausea
- ☐ Vomiting
- ☐ Weight Loss

How many times do you urinate at night? ____ per night

Do you have a history of Urinary Tract Infections? ☐ Yes ☐ No

If Yes, how many in the last 6 months? _____ Have you consulted with an Infectious Disease doctor? ☐ Yes ☐ No

Do you have a history of Kidney Stones? ☐ Yes ☐ No Stone Surgery: ☐ Yes ☐ No If Yes, Date: _____

Do **YOU** have a *history* of:

Kidney Cancer?: ☐ Yes ☐ No

Bladder Cancer?: ☐ Yes ☐ No

Do you have a *FAMILY HISTORY* of:

Kidney Cancer?: ☐ Yes ☐ No

Bladder Cancer?: ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No

If Yes, # vaginal births ____ (#) # of Elective Abortions ____ (#)

# of C-Sections ____ (#) # of Miscarriages ____ (#)

Have you ever been diagnosed with an STD? ☐ Yes ☐ No

If yes, ☐ Condyloma ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Other: _____

Have you had COVID? ☐ Yes ☐ No If yes, when? _____ **Are you vaccinated for COVID?** ☐ Yes ☐ No

Would you like to be tested for COVID today? ☐ Yes ☐ No

Please use the following space to tell us of any urologic problems bothering you that were not covered above:

_____

SOCIAL HISTORY:

Marital Status: (Please indicate the number of years)

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner

Alcohol Consumption: ☐ None ☐ Yes Occasional/Social # of drinks per day ____

TOBACCO USE: ☐ **NEVER SMOKED**

☐ **QUIT SMOKING:** I smoked **____ packs/day** in the past. I smoked for **____ years.**

☐ **I SMOKE: ____ packs/day**. I have been smoking for **____ years.**

Recreational Drugs: ☐ None ☐Yes If yes, please list: _____

CURRENT MEDICATIONS: Please list ALL medications you are currently taking including over the counter meds

Drug Name:	Strength:	Directions/ How you take it:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Attach list if necessary)

***ALLERGIES*:** Please list ALL types (Drug, Seasonal, Pets, environmental, Foods)

_____

_____

_____

PHARMACY NAME: _____ **Phone** #: _____

Fax#: _____

******IF YOU DO NOT HAVE THE ABOVE INFORMATION WITH YOU, PLEASE CALL OUR OFFICE WHEN YOU GET HOME AND GIVE IT TO US!!!!!!!!!!!***

PAST MEDICAL HISTORY:

Please CIRCLE if you have or have had any of the following diseases or conditions:

ADD
ADHD
Alcoholism
Allergies
Alzheimer's Disease
Anemia _____
Aneurysm
Angina
Anorexia
Anxiety Disorder
Arthritis
Arrhythmia
Aortic Aneurysm
Aortic Stenosis
Aortic Insufficiency
Asthma
Atrial Fibrillation
Back pain
BPH
Bi-polar Disorder
BLADDER CANCER
Bleeding Disorder
Blindness
Brain Tumors
Breast Cancer
Bronchitis
Cataracts
Cerebrovascular Disease
Cholecystitis
Cholelithiasis
Chronic Fatigue Syndrome
Chronic Liver Disease
Chronic Lung Disease
CHRONIC RENAL INSUFFICIENCY
CHRONIC RENAL FAILURE
Colitis
Constipation
Colon Cancer
Colon Condition
Congenital Heart Disease
Congenital Heart Failure
Crohn's Disease
Deafness
Deep Vein Thrombosis
Depression
Diabetes - Non-Insulin Dependent
Diabetes - Insulin Dependent
Diabetes - Uncontrolled
Diarrhea
Eating Disorder
Ear Infections
Emphysema
Enlarged Heart
Epilepsy
Fibrocystic Breast Disease
Fibromyalgia
Gastric Cancer
GERD
GLAUCOMA
Goiter
GOUT
Hay Fever
Heart Attack
Heart Disease
Heart Valve Problem
Heart Murmur
Hemorrhoids
Hepatitis
Herniated Disc
Hiatal Hernia
High Cholesterol
High Blood Pressure
HIV (AIDS)
Impaired Glucose Tol.
Infertility
Irritable Bowel Disease
Inflam. Bowel Disease
KIDNEY CANCER
KIDNEY DISEASE
KIDNEY INFECTION
KIDNEY STONES
Infectious Disease
Laryngeal Cancer
Leukemia
Liver Disease
Lung Disease
Lung Cancer
Lymphoma
Malaise
Melanoma
Mental Illness
Migraine
Mitral Stenosis
Mitral Insufficiency
Mitral Valve Prolapse
Mumps
Nervous Breakdown
Obesity
Osteopenia
Osteoporosis
Pancreatitis
Pancreatic Cancer
Peptic Ulcer
Phlebitis
Pituitary Disease
Polio
Pulmonary Embolism
Rectal Fissure
Rectal Cancer
Rheumatic Fever
Sexually Trans. Disease
Sickle Cell Anemia
Stroke
Suicide Attempt
THYROID DISEASE
Tuberculosis

Other: _____

_____

FAMILY HISTORY

Please CIRLCE and LIST which family member has/had any of the following: (Mother, Father, Siblings, or Children)

Arthritis: _____
Bedwetting: _____
Bladder Cancer:_____
Cancer Site _____:_____
Crohn's Disease:_____
Depression:_____
Diabetes:_____
Gout:_____
Heart Attack:_____
Hypertension:_____
Kidney Cancer:_____
Kidney Stones:_____
Leukemia:_____
Malignant Melanoma:_____
MultipleSclerosis:_____
Laryngeal Cancer:_____
Pancreatic Cancer:_____
ProstateCancer:_____
Stroke:_____
Thyroid Disease:_____
Tuberculosis:_____

Other: _____

_____

SURGICAL HISTORY;

Please CIRCLE if you <u>have had</u> any of the following surgeries and date of surgery:

Amputation
Angioplasty
Aortic Aneurysm Repair
Appendectomy
Arthroscopic Surgery
Back Surgery
Bariatric Surgery
Bladder Surgery
Bowel Resection
BRACHYTHERAPY – PROSTATE RADIOACTIVE SEED IMPLANT
Brain Surgery
Breast Surgery
BIOPSY OF PROSTATE
CABG
Carotid Artery Surgery
Carpal Tunnel Surgery (L or R or Both)
Cataract Surgery (L or R or Both)
Cervical Spine Surgery
Cholecystectomy
CIRCUMCISION
Colon Resection
Colonoscopy
Corneal Surgery (L or R or Both)
CYSTOSCOPY
CYSTO-TUR FULGURATION
Delivery's (Vaginal or C-Section)
Ear Surgery (L or R or Both)
EGD
Epididymectomy
ESWL / KIDNEY STONE LITHOTRIPSY
Eye Surgery (L or R or Both)
Facial Surgery
Foot Surgery (L or R or Both)
Gastric Surgery
Hand Surgery (L or R or Both)
Heart Surgery
Heart Transplant
Hemorrhoidectomy
Herniorrhaphy
Hip Surgery
HYDROCELECTOMY
Hysterectomy – Complete
Ilioconduit
Ileostomy
Inguinal Herniorrhaphy
Knee Surgery (L or R or Both)
LASER OF PROSTATE
Laminectomy
Laparascopy
Laparatomy
Leg Surgery (L or R or Both)
Liver Surgery
Lumpectomy
Lung Surgery
Lymphatic Node Dissection
Lysis Adhesions
Mastectomy
Mastoid Surgery
MEATOTOMY
Nasal Surgery
NEPHRECTOMY – KIDNEY REMOVAL
Neprolithotomy
Orchiectomy
Pacemaker Insertion
Parathyroidectomy
Penile Implant
PEG
PE Tubes
Pilondial Cyst Incision
RADIATION FOR PROSTATE CANCER
RADICAL PROSTATECTOMY
RENAL TRANSPLANT
Rotator Cuff Surgery
Septoplasty
Sinus Surgery
Skin Grafting
Spermatocelectomy
Splenectomy
Stomach Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery
TUMT PROSTATE
TUR PROSTATE
Umbilical Hernia
URETEROSCOPY
VARICOCELECTOMY
VASECTOMY
Vein Stripping
Ventral Hernia Repair

Other: _____

_____

REVIEW OF SYSTEMS:

******Please circle any problems you currently have today.***

<u>Constitutional</u>
Fever
Weight Loss
Weight Gain
Night Sweats
Loss of Energy
Other _____

<u>Eyes</u>
Blurred Vision
Cataracts
Blindness
Other _____

<u>Ears/Nose/Throat</u>
Hearing Loss
Nasal Stuffiness
Dry Mouth
Sore Throat
Other _____

<u>Cardiovascular</u>
Swelling
Chest Pain/ Angina
Irregular Heart Beats
Other _____

<u>Respiratory</u>
Shortness of Breath
Wheezing
Cough
Other _____

<u>Gastrointestinal</u>
Abdominal Pain
Nausea/Vomiting
Constipation
Diarrhea
Change in Bowel Habits
Incomplete Bowel Movements
Other _____

<u>Genitoruinary</u>
Pelvic Pain
Incontinence
Frequency
Retention
Blood in Urine
Other _____

<u>Musculoskeletal</u>
Sore Muscles
Back Pains
Arthritis
Other _____

<u>Skin</u>
Skin Rash
Dry Skin
Bruising
Lesions
Other _____

<u>Neurological</u>
Dizziness
Forgetfullness
Loss of Balance
Depression
Other _____

<u>Hematological/Lymphatic</u>
Swollen Glands
Bleeds Easily
Blood Clots
Other _____

PROGRESSIVE UROLOGY

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep your medical record information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is not in effect.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other healthcare providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes and for obtaining authorization for surgical procedures and prescriptions.

FOR NOTIFICATION: We may use medical information about you to notify a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible, before we share any information, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your healthcare, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

PUBLIC HEALTH ACTIVITIES: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

WORKERS COMPENSATION: We may disclose medical information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

PROGRESSIVE UROLOGY

LAW ENFORCEMENT: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

ANNOUNCEMENTS: We may use your personal information (name and address) in order to notify you of services available in our office that may be of interest to you. We may also use your information to formally introduce you to new physicians in our practice.

4. YOUR INDIVIDUAL RIGHTS

You have the right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. If you request copies, we will charge you $1.00 for each page, and postage if you want the copies mailed to you.
2. Receive a list of all the times when we shared your medical information for purposes other than treatment, payment, and healthcare operations.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about you medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted to changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of the information.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U. S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

PRIVACY PRACTICES ACKNOWLEDGMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Please list names of any person(s) whom we may inform about your medical condition (including treatment, payment and healthcare operations).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PROGRESSIVE UROLOGY

CREDIT CARD ON FILE BILLING AUTHORIZATION FORM

I authorize Progressive Urology to charge my credit card for any patient responsibility amount after claims are submitted and processed by my insurance. These balances may include:

- Patient Copay
- Deductible/HSA Deductible
- Any unpaid balance over 60 days

By signing below, you acknowledge and agree with the following:

- I have received and read the Credit Card on File Policy and agree to the terms
- I agree to provide and allow Progressive Urology to charge my HSA deductible or the personal credit card provided upon receipt of my insurance EOB.
- I understand Progressive Urology will not alter my treatment plan due to possible charges incurred.

I authorize Progressive Urology to capture my credit card on file for any balance owing on the below indicated account.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Patient Name: _____

Chart #: _____

Cardholder's Name (as shown on card): _____

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

Card Number: _____

Exp. Date: _____ Sec. Code: _____ Zip Code: _____

Cardholder Signature: _____ **Date:** _____

Your information will NOT be shared with any third parties.

****PLEASE NOTE THAT THE CHARGE WILL APPEAR AS "DIMITRI N. KESSARIS, MD PC" ON YOUR STATEMENT****

PROGRESSIVE UROLOGY

CREDIT CARD ON FILE BILLING AUTHORIZATION FAQs

Q: How does the automatic billing process work?
A: Your credit card will be captured today and stored securely. After your insurance carrier responds and provides us your remaining balance due we may charge the patient responsibility to your credit card on file, not to exceed the maximum balance due indicated in the agreement. Your credit card on file will only be charged when you have a balance owing on your account or for a non-covered service.

Q: How will I know how much you are going to charge me?
A: You will receive an explanation of benefit from your insurance carrier that explains exactly, according to your health insurance coverage and benefits, how much of your healthcare bill is your responsibility and how much the insurance paid along with any contractual adjustments.

Q: What if I need to dispute my bill?
A: We will always work with you to resolve any issues and will refund you if we have made a billing error. We will only charge the amount that we are instructed by your insurance carrier to collect from you in the same way that we normally determine how much to send you a statement for in the mail. If you disagree with how your insurance carrier processed the claim you will need to contact their customer service department directly.

Q: Will I receive a statement or receipt for the charges automatically billed to my card?
A: Not automatically. Your insurance carrier EOB and your credit card statement will be your receipt. You can at any time contact us to have an account itemization emailed to you.

Q: What is a deductible?
A: An annual deductible is the dollar amount you must pay out of your own pocketing during your plan year for medical expenses before your insurance begins to pay. For example, if the policy has a $1,000 deductible, you must pay the first $1,000 of medical expenses before your insurance will begin to pay. Your insurance company must receive a claim to process in order to apply balances towards your deductible. Even if you have a high deductible plan we encourage you to have us submit the claim to your insurance so you receive a contractual adjustment and the services can be applied towards your deductible.

Q: Is my credit card secure?
A: Yes, we do not store your sensitive credit card information in our office. Keeping your card on file, offsite, in an encrypted payment gateway actual enhances security because it reduces exposure at each visit.