KLAIMAN UROLOGY

Welcome to Klaiman Urology, P.A. We appreciate the trust and confidence you have placed in our practice. In return, we are committed to providing you with the best health care possible. To assist us in providing the best care possible for all new patients, we request the following:

- Arrive 10 minutes prior to your scheduled appointment with completed documents that you have printed from our website.
- Bring your photo ID and insurance card(s)
- If your health insurance requires a referral and/or authorization, please obtain one from your primary care provider prior to your scheduled appointment**.** If one is not received on the day of your appointment, your appointment may be rescheduled.
- Bring pertinent medical records including but not limited to: recent office notes, labs, operative report, pathology report, and radiological results that are related to the condition in which we will be treating you for.
- A list of the current medications you are taking. (doses/herbals/over the counter medication)
- Co-pay, co-insurance and/or deductible are due at the time of service. If you are unable to pay your co-pay, co-insurance and/or deductible, your appointment will be rescheduled.
- Please inform the office within 48 hours of a canceled appointment. A charge of $25.00 will be applied to broken appointments. As a courtesy, we will remind you of your appointment 2 days prior.
- Note our office is located at: 668 N. Orlando Ave, Suite 105, Maitland, FL 32751 (N. Orlando Ave is that same as 17-92). We are located in the Maitland Exchange building. **Be sure to park in the back of the building where our office is located.**

Please complete the enclosed patient registration forms in advance and present them along with your photo ID and insurance card to the Patient Care Coordinator upon your arrival.

If you have any questions, please contact the office at **407-774-2431.**

With warmest regards,

Klaiman Urology

Dr. Allan Klaiman
Ruchi Shah ARNP-C

Klaiman Urology

PATIENT REGISTRATION FORM

Patient Information (Please print in English)			
Last Name	**First Name**		**MI/*Inicial segundo*:**
Street address			
City	**State**		**Zip**
Primary Phone:	**Secondary Phone:**		
DOB	**Age**	**Sex(M/F):**	**Marital status**
Employer's name & address			
Occupation	**Social security #**		
Email Address:	**Pharmacy Name & Number**		
Name of referring physician:			

Spouse / Parent (if minor)/Emergency contact information-		
Last Name	**First Name**	**MI**
Address*:*		
Home Phone	**Employer's Phone**	**Cell Phone**
Relationship:		

Insurance information			
Primary Insurance Company		**Secondary Insurance Company**	
Policy ID #	**Group #**	**Policy ID #**	**Group #**
Policy Holders Name		**Policy Holder's Name**	
Relationship	**DOB**	**Relationship**	**DOB*:***
Policy Holder's SS #		**Policy Holder's SS #/**	

CONSENT FOR TREATMENT & LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to Klaiman Urology to provide whatever treatment they may deem necessary to the patient above. Insurred party must sign for all claims. Dependent patients must sign, if not a minor. I authorize insurance company, hospital, employer, physician, dentist and/ or pharmacist to release any information requested with regard to my claim. I certify that the information I provided to be true and correct. I know it is a crime to fill out this form with facts I know to be false or omit facts that are important. I assign payment directly to providers of Klaiman Urology which may be due from Medicare or any other insurance company. I understand I am financially responsible to Klaiman Urology for any non-covered insurance services.

Patient's or Authorized Representative's Signature/Date: _____

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Health History Form

ALLERGIES or REACTIONS TO MEDICINES, FOODS, OTHER
***MEDICINES/FOODS/OTHER*:**

Medicines	Reaction or Side effects

MEDICATION: Prescription non-prescription medicines, and vitamins, herbs

Name/Nombre	Dose/Dosis	Frequency/Frecuencia	Name/Nombre	Dose/Dosis	Frequency/Frecuencia

PERSONAL MEDICAL HISTORY:
Please indicate whether you have had any of the following medical problems

- ❑ **Heart Disease**
- ❑ **HTN (high blood pressure)**
- ❑ **Diabetes**
- ❑ **Asthma**
- ❑ **High Cholesterol**
- ❑ **Kidney/bladder problem/**
- ❑ **Cancer**
- ❑ **Thyroid problem**
- ❑ **Bleeding/clotting problem/**
- ❑ **Other Specify**

PAST SURGICAL HISTORY:

Surgical History	Date

SOCIAL HISTORY/ HISTORY SOCIAL
Cigarettes: ❑None. Packs daily_____. Date Quit_____. Years smoked___
Alcohol: ❑None Number of drinks per week_____
Marital History: Years married_____. Number of living children_____

FAMILY HISTORY: Has anyone in your family (mother, father, brother, sister) ever had:

- ❑ **Heart disease**
- ❑ **Cancer**
- ❑ **High Blood Pressure**
- ❑ **Diabetes**
- ❑ **Mental illness**
- ❑ **Bleeding disorder**
- ❑ **Other**

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Review of Systems

Do you now or have had any health problems mentioned below? If yes, please check the box.

Constitutional		**Endocrine**	
Fever, chills		**Too hot or cold**	
Headache		**Tired, fatigue**	
Eyes		**Excessive thirst**	
Blurred vision		**Integumentary/skin**	
Glaucoma		**Rash**	
Cardiovascular		**Persistent Itching**	
Chest Pain		**Skin Cancer History**	
Heart Attack		**Other**_____	
Varicose veins		**Genitourinary**	
Respiratory		**Up at night to urinate**	
Shortness of breath		**Burning with urination**	
Wheezing/ chronic cough		**Trouble controlling urine**	
Gastrointestinal		**Urinary retention**	
Abdominal pain		**Urinary frequency**	
Indigestion		**Blood in urine**	
Nausea/ Vomiting		**Frequent UTI**	
Neurological		**Genitalia-Men**	
Tremors		**Testicular lump**	
Numbness, tingling		**Penile discharge**	
Stroke		**Sore on penis**	
Musculoskeletal		**Erection difficulties**	
Joint pain		**Genitalia-Women**	
Chronic Neck Pain		**Vaginal discharge**	
Chronic Back Pain		**Pain with intercourse**	
Hematologic, Lymphatic		**Possible pregnant**	
Swollen glands			
Easy bruising		**PHYSICIAN SIGN:** _____**Date**_____	

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CONSENT FOR VERBAL RELEASE OF MEDICAL INFORMATION

☐ **I authorize the release of my medical information, i.e. blood test results, x-ray reports, pathology reports, etc. to my immediate family, care giver, pharmacist and any physician who participates in my care.**

Name: _____

_____

☐ **I authorized general messages (i.e. x-rays, lab results, appointment reminders, etc) to be left on my answering machine or voicemail.**

☐ **I do not authorize any information to be given to anyone other than myself.**

Patient's Name: _____ **Date:** _____

Patients or Guardian Signature: _____

KLAIMAN UROLOGY

Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

I have received this office's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____ _____

Printed Name Date

_____

Signature

If personal representatives' signature appears above, please describe your relationship to the patient.

_____

Note: The practice reserves the right to modify the privacy practices outlined in the notice.

KLAIMAN UROLOGY

FINANCIAL POLICY

We hope that you will recognize that our financial policy is a necessary part of assuring the resources required to maintain this health care service for our patients and for the community. We bill your insurance company for your health care costs; therefore, it is extremely important that we obtain complete information about your primary and supplemental insurance companies. We insist that when a surgery or procedure (Ultrasound, Biopsy, Urodynamics, Bio-Feedback) is scheduled, that you contact your insurance company immediately to determine, if any, preauthorization requirements are necessary prior to the procedure.

We cannot stress enough, it should be understood that if you have health insurance, this is an agreement between you and your insurance company.

If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to meet with our office manager to discuss the matter. This will avoid misunderstandings and enable you to keep your account in good standing. If credit arrangement are not made on accounts they can be later turned over to a collection agency when your bill is 90 days past due.

Contracted Insurance: We are a preferred provider for a variety of insurance companies. Your insurance will be verified for eligibility and benefits either before your arrival. Your co-pay/deductible will be collected on the day of your visit and if for some reason you are unable to pay, we will work out arrangements ahead of time. **You will need to pay any co-pays, deductibles and co-insurance at the time of service**. After the insurance payment is received, any remaining balance is due to the office within **30 days**.

Non-Contracted Insurance: Patients who have policies with non-contracted insurance companies will be responsible for payment in full at the time service is rendered. We will provide the courtesy of filing your insurance claim for you.

Medicare: We accept assignment from Medicare so all payments from Medicare will be paid directly to the physician. We bill Medicare and your supplemental insurance directly. We are required by Federal Law to collect the amount Medicare approves not just the 80% they pay. This means that the patient pays 20% of the approved charge either out of pocket or through their supplemental insurance. If you do not have a supplemental insurance, our office will collect the Medicare co-insurance amount at the time of service.

We accept Visa, MasterCard, Discover and American Express as well as personal checks, money orders and cash. If a check is returned to us for any reason, you will be charged a $35.00 returned check fee.

Your signature below authorizes Klaiman Urology, PA to bill insurance on your behalf; authorizes payment of any insurance benefits to Klaiman Urology, P.A. for services provided to you and authorizes release of any medical information necessary to process your claim for benefits. Your signature also affirms that you have read and understand our policies and that you agree to adhere to them.

_____ _____

Patient/ Authorized Representative **Date**

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Patient Portal Access Authorization

The patient portal has been designed to allow for stronger patient/provider communication.

The Patient Portal will allow you to:

- View Patient Summary Report
- View lab results (Lab results will be available to review only after they have been reviewed by the provider and after patient has been notified of the results)
- View and update medications, allergies, and past medical history
- Contact office staff to request appointments and ask questions

How the Patient Portal Works:

Once you have read, signed, and provided us with a secure email address, a link with a temporary password will be emailed to you. You will have up to 72 hours to log in and create a new password. If for some reason you are denied access or unable to log in within the first 72 hours, please contact the office to have a new temporary password sent.

Protecting your Private Health Information and Risks:

Klaiman Urology takes every measure to protect all patient records and adheres to all HIPPA guidelines. **For your protection, it is extremely important to give us only a personal and secure email address.** This portal is meant for **ONLY** you or authorized persons that you have given permission to view your health information. **IF YOU FEEL AS THOUGH YOUR PASSWORD HAS BEEN COMPROMISED, IMMEDIATLEY CHANGE IT VIA THE PATIENT PORTAL.**

Patient Portal Consent Form:

I, _____ understand that the patient portal is completely voluntary. I have read and fully understand this consent form. I understand that it is my responsibility to notify the office of any change to my email. In the event, I feel my password has been compromised it is my responsibility to request a new secure password via the patient portal.

_____ I do not wish to participate in the Patient Portal

_____ I do wish to participate in the Patient Portal. Please send the portal link to my secure e-mail address (Note your e-mail address will be your username)

Confidential e-mail address (Please print clearly)

_____

Signature_____ **Date**_____

Klaiman Urology

668 N. Orlando Avenue, Suite 105

Maitland, FL 32751

Phone: 407-774-2431/Fax: 407-774-9473

PATIENT INFORMATION

Last Name _____ First Name _____ D.O.B _____

Social Security # (last 4)_____ Phone #_____

Street Address _____City _____State _____ Zip _____

REQUEST RECORDS FROM:

Name of Health Care Facility _____

Address: _____City _____State _____Zip _____

Reason for Disclosure: CONTINUITY OF CARE AND TREATMENT

____Recent Labs ____Recent OV ____Radiology Reports ____Operative/Pathology ____Complete Record

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, , and or alcohol/drug abuse and/or AIDS(Acquired Immunodefiency Syndrome) and/or may include the results of an HIV test or the fact an HIV test was performed. I expressly consent to the release of information designated above unless initialized below or otherwise required by law. If I fail to specify an expiration date, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization was retained. I understand that I can receive a signed copy of this form upon request.

RELEASE RECORDS TO:

Name of Health Care Facility _____

Address: _____City _____State _____Zip _____

Reason for Disclosure: _____

_____ _____ _____ _____

Signature of Patient Date Parent/ Legal Representative Expiration Date

Official Use Only: _____Date: _____Faxed:_____Mailed:_____Given to Patient: _____