CLEARVIEW UROLOGY

Clearview Urology Pediatric

PLEASE COMPLETE ALL PAGES

Name: _____ Birth Sex: Female ____ Male ____
First Middle Last

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Date of Birth: _____ Drivers License: _____ Social Security: _____

Best Phone Number: _____ Email: _____

Do you have a Living Will? ☐ Yes or ☐ No (Please provide a copy)

Do you have a Power of Attorney? ☐ Yes or ☐ No (Please provide a copy)

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse/Next of Kin Name: _____ Spouse/Next of Kin Phone Number: _____

Emergency Contact (other than above): _____ Phone#: _____ Relation: _____

Primary Preferred Language: _____ Interpreter needed ☐ No ☐ Yes

Ethnicity

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (Check all that Applies)

☐ Caucasian (white)
☐ Asian
☐ Other: (Specify) _____
☐ American Indian or Alaska Native
☐ Black or African American
☐ Middle Eastern or North African
☐ Pacific Islander or Native Hawaiian

INSURANCE GUARANTOR / RESPONSIBLE PARTY

(*Parent or legal guardian who carries the insurance policy*)

Guarantor Name: _____ Relationship: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Employer: _____ Employer Phone#: _____

MEDICARE/MEDICAID INSURANCE ASSIGNMENT STATEMENT

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the SSA is correct. I Authorize any holder of medical or other information about me to release to the State of Alabama or its Fiscal agents, SSA or its intermediaries or carriers any information needed for this or a related Medicare and/or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physical services to the physician or organization furnishing the services or authorize such physical or organization to submit a claim to Medicare and/or Medicaid.

AUTHORIZATION TO PAY

I hereby authorize payment directly to Oncology Specialties, P.C. of the medical and/or emergency medical benefits, including major medical insurance, if any, otherwise payable to me for this service as described below. I understand that I am financially responsible for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf.

NOTICE OF PRIVACY POLICIES AND PRACTICES

I have received the brochure entitled "Notice of Privacy Policies and Practices" and give my consent to Oncology Specialties, P.C., Clearview Diagnostic Imaging, Clearview Retail Pharmacy and/or Clearview Cancer Institute (CCI) to use and disclose my health information in accordance with this consent and the notice provided. I have received, reviewed and accepted the New Patient Handbook.

Please be advised your physician may use a secure digital scribe to record and transcribe your conversation for your medical records.

Person Responsible for Bill: **X**_____ Date: _____
Signature

Behavioral Expectations for Treatment at Clearview Cancer Institute

Our goal is to provide the best possible care to everyone who comes into Clearview Cancer Institute. To provide the best coordinated care we wish to make the following expectations clear:

Clearview Cancer Institute employees will:

1. Act as a team and behave in a professional manner.
2. Respect your goals for treatment and care.
3. Treat every patient with equality and respect.
4. Facilitate your care by scheduling appointments as close to requested times as possible.

Clearview Cancer Institute expects patients and their caregivers to:

1. Be respectful of the staff, other patients, and their caregivers in all areas of the clinic.
2. Do not utilize derogatory statements, profanity, racial remarks or threats with staff or other patients or their caregivers.
3. Do not take unauthorized photographs, videos, or audio recordings on the premises of Clearview Cancer Institute.
4. Do not make demands to staff members that disregard Clearview Cancer Institute rules and guidelines.
5. Be compliant with follow up and/or treatment plans.
6. Keep your scheduled appointment time. If you are unable to make your appointment, please notify the clinic 24 hours in advance. A fee may occur if not rescheduled 24 hours in advance.

I have read and understand the above-listed behavioral expectations. I understand that failure to meet these expectations may result in immediate termination of the relationship between me and this provider/organization.

Signature (Patient or Authorized Representative)	**Date**
Print Name (if other than patient)	**Relationship to patient**

Patient Name: _____ **Date of Birth:** _____

HIPAA RELEASE OF MEDICAL INFORMATION FORM

Before we can discuss your medical conditions with anyone (spouse, children, significant other, etc.) we **MUST** have the following authorization on file. The physicians of Clearview Cancer Institute and their staff have my permission to discuss my medical condition, treatment, and to release all information they have available to those listed below. The individuals listed below may also pick up my medical records and hard copy prescriptions.

NOTE: *This list can be modified by the Patient, Parent, or legal Guardian in writing only.*

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ **Choose Not to Share Information (Opt-Out):**
If you do not wish to list any individuals above, select this option. This ensures your health information will not be disclosed to unauthorized individuals unless you specifically grant permission.

ADDITIONAL PHYSICIANS PARTICIPATING IN YOUR CARE

In order to obtain your medical records and to coordinate your care with your current providers, please list the physicians that are participating in your care. Please include the **physician's full name** and the city and state in which you are seen. Thank you.

Physician Name: _____ City, State: _____

Physician Name: _____ City, State: _____

Physician Name: _____ City, State: _____

Physician Name: _____ City, State: _____

_____ _____

Signature (Patient or Authorized Representative) **Date**

_____ _____

Print Name (if other than patient) **Relationship to patient**

Consent to Telephone Calls, Emails, and Text Messages

I authorize the use of any email address or telephone number I provide (including email addresses or telephone numbers that I provide for my family or designated representatives) (whether wireless or a landline and including email addresses and telephone numbers forwarded or transferred from provided information) for receiving information relating to my healthcare services and financial obligations, including, but not limited to: (i) healthcare-related information, including appointment reminders, discharge instructions, pre-operative or post-operative instructions, follow-up instructions, dietary information, prescription information, referrals, insurance or health plan eligibility or coverage, follow-ups related to a visit or other interaction, information about my condition(s), diagnosis, treatment plan, available treatment options and capabilities, reference materials, information about programs or services that might be of interest to me, invitations to participate in surveys, reviews or evaluations of my experience(s), instructions for how to access my information or records, or inquiries regarding my preferences; and (ii) financial communications, including without limitation, financial assistance and benefits screening, payment reminders, delinquent notifications, instructions, and links to practice Patient billing information.

I expressly agree and consent that you or your customer service personnel and collection agents may contact me by telephone, on a recorded line and/or using automated dialing technology, at any telephone number I have provided or you or your customer service personnel and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. I represent (if I am not the patient) that I am authorized by the patient to receive calls, text messages or email messages on their behalf and that I am involved in assisting in the patient's care and/or payment. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable. I represent that I am the account holder for any telephone number(s) that I may provide and am responsible for notifying Provider of any changes or updates to such telephone number(s).

I understand that emails and text messaging are unencrypted and that there is some risk that information included in unencrypted messages, including email and text messages, may be intercepted or received by unintended third parties and/or stored or archived by our service providers and system operators. Information included in such messages may include your name, date/time of appointments, physician/practice name, physician/practice specialty, patient account number or other information related to your financial obligation or our services. Message and data rates may apply to text messages. Additional text messaging terms may be located on the Provider's website and may be updated from time to time. To stop receiving a certain text message type (e.g., subsequent messages about my treatment plan), I understand that I can opt out of receiving additional messages of such type, by notifying The Practice in writing of my desire to opt-out of receiving such type of message, but I may continue receiving text messages of other types subject to separate opt-out notification.

Signature (Patient or Authorized Representative) **Date**

Print Name (if other than patient) **Relationship to patient**

Pediatric Medical History

Form must be COMPLETELY filled out

Name: _____ **Date of Birth:** _____
First Middle Initial Last

Chief Complaint: (Reason for Your Visit)

_____

_____

_____

History of Present Illness

Please answer the following questions

Location of the problem?
☐ Abdomen ☐ Back ☐ Kidney ☐ Bladder ☐ Other _____

When did you first notice the problem?
☐ Since Birth ☐ Days Ago ☐ Weeks Ago ☐ Months Ago
Other: _____

Does the problem interfere with normal functions? ☐ Yes ☐ No
Explain: _____

How long does the problem last?
_____ Hours _____ Days ☐ Constant

Does anything occur at the same time?
☐ Yes ☐ No Explain: _____

Has the patient had any X-rays or Ultrasounds? ☐ Yes ☐ No (*If yes, please list below*)

Date	Facility	Type of X-Ray or Ultrasound

Medical History

	Yes	No		Yes	No
Asthma	☐	☐	High Blood Pressure	☐	☐
Bleeding Disorder	☐	☐	Prenatal Hydronephrosis	☐	☐
Cancer	☐	☐	Spina Bifida	☐	☐
Cerebral Palsy	☐	☐	Urinary Tract Infections	☐	☐
Developmental Delay	☐	☐	VP Shunt	☐	☐
Hepatitis	☐	☐	Prematurely Born	☐	☐
			If yes, how early? _____		

Continued on next page →

Family History

Check all relationships that apply

	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other
Bed Wetting	☐	☐	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	☐	☐	_____
Genital Birth Defects	☐	☐	☐	☐	☐	☐	_____
What kind? _____							
Heart Disease	☐	☐	☐	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	☐	☐	☐	_____
Problems w/ Anesthesia	☐	☐	☐	☐	☐	☐	_____
Urinary Infection	☐	☐	☐	☐	☐	☐	_____
Urinary Reflux	☐	☐	☐	☐	☐	☐	_____

Social History

Race: ☐ Caucasian ☐ African American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ American Indian/Eskimo ☐ Unknown

Review of Systems

Has the patient experienced any of the following symptoms in the past 2 weeks?

	Y	N		Y	N
Constitutional Symptoms:			**Gastrointestinal:**		
Fever	☐	☐	Abdominal Pain	☐	☐
Weight Changes	☐	☐	Nausea/Vomiting	☐	☐
Feeding / Eating Problems	☐	☐	Constipation	☐	☐
Headache	☐	☐	**Cardiovascular:**		
Eyes:			Chest Pains	☐	☐
Blurred Vision	☐	☐	Heart Murmur	☐	☐
Doubled Vision	☐	☐	High Blood Pressure	☐	☐
Pain	☐	☐	**Ear / Nose / Throat / Mouth:**		
Neurological:			Ear Infection	☐	☐
Seizures	☐	☐	Sore Throat	☐	☐
Weakness	☐	☐	Sinus Problems	☐	☐
Numbness / Tingling	☐	☐	**Respiratory:**		
Integumentary:			Wheezing	☐	☐
Skin Rash / Boils	☐	☐	Frequent Cough	☐	☐
Lasting Itch	☐	☐	Pneumonia	☐	☐
Musculoskeletal:			**Hematological / Lymphatic:**		
Joint Pain	☐	☐	Swollen Glands	☐	☐
Neck / Back Pain	☐	☐	Blood Clotting Problem	☐	☐

Signature (Parent or Guardian) _____ **Relationship to Patient** _____ **Date** _____

Medications, Allergies & Surgical History

Date: _____ Account Number: _____

Patient Name: _____ **Date of Birth:** _____

Pharmacy Name & Location: _____

Drug Allergies: (List Drug & Reaction)

Latex Allergy? ☐ Yes ☐ No

Iodine/Betadine Allergy? ☐ Yes ☐ No

_____ _____

_____ _____

Current Prescription & Non-Prescription Medications:
(*Please include dosage*)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Does the patient take aspirin on a daily basis? ☐ Yes ☐ No If so, ☐ 81mg ☐ 325mg

List All Surgeries: (*Please include dates*)

_____ _____

_____ _____

_____ _____

_____ _____

Colonoscopy? ☐ Yes ☐ No Month: _____ Year: _____

Referring Physician and/or Primary Care Physician:

_____ _____

Patient Notification

If your insurance requires a referral for your visit, it is your responsibility to obtain the referral. If insurance requires labs to be sent to an outside laboratory, it is your responsibility to inform us of that required laboratory.

All payments are due at the time of service.

There is a $50 fee for no shows and late cancellations of office visits. Cancellations must be made 24 hours in advance of appointment time.

There is a $50 fee for no shows for in-office procedures, such as Vasectomy, Renal Ultrasound, Urodynamics, Prostate Biopsy, Testopel, etc. due to non-reusable equipment and extra designated time.

There is a $100 no show fee for hospital based surgeries. Unless medically necessary, a surgery must be cancelled one week prior to the scheduled date.

Please allow 48 business hours for prescription refills.
There is a $30 fee for returned checks.

There is a $15 forms fee for any non-Clearview Urology form such as: Prior Authorizations for prescriptions, FMLA and Disability.

During your visit with us it may be necessary to have an outside source process blood work, urine tests or biopsies. Please be aware these tests that are outsourced will be billed separately from our office.

Print Patient/Guarantor Name	**Relationship to patient**
Patient/Guarantor Signature	**Date**

Right to Privacy

Parent(s)/Legal Guardian must be present for initial office visit

Patient Name: _____ **Date of Birth:** _____

We at **Clearview Urology** respect your child's right to privacy. Therefore, our providers and staff will only access and use your/child protected health information (PHI) for treatment, payment, and healthcare operations such as:

1) To provide care here in our office.
2) To collect payment from your insurance company.
3) To assist your pharmacy in filling prescriptions.
4) To coordinate with specialists to whom your child may be referred to.
5) When the child reaches the age of fourteen, we can no longer discuss the child's private medical information with a parent/guardian without the child present or a written consent from the child. The exception is as follows:
    a) If a child seeks medical treatment and wishes to use the parent's medical insurance policy, it is the policy holder's right to know what their insurance company has been billed for. If the child does not wish for the policy holder to be given that information, they must pay cash upfront for that visit.

All other releases of personal information will be authorized by a signature. **THIS INCLUDES YOUR IMMEDIATE FAMILY UNLESS OTHERWISE STATED BELOW.** In the event of an emergency, we will contact your designated emergency contact.

I authorize the following people to bring my child(ren) to any appointments after the initial visit. I also authorize **Clearview Urology** to discuss my child's care with the people listed below.

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand and consent to the use of my/child protected health information for the above purposes.

_____ _____

Signature (Parent or Legal Guardian) **Date**

_____

Relationship to Patient