TEXAS UROLOGY SPECIALISTS

CONSENT/AUTHORIZATION FOR RELEASE OF INFORMATION

1.) I hereby authorize Texas Urology Specialists to release the following information from the health records of:

Patient Name: _____ Phone Number: _____

Date of Birth: _____ Treatment Dates: From: _____ To: _____

*****NOTE TO PATIENT: WE ARE UNABLE TO RELEASE RECORDS OR DISCUSS YOUR CARE WITH YOUR SPOUSE OR ANY FAMILY WITHOUT A WRITTEN RELEASE*****

2.) Information to released: (Please Circle All That Apply)
   a. Office Visit Notes — Mail Copies: _____
   b. Radiology — Patient Pick-Up: _____
   c. Labs — Fax To: _____
   d. Billing Records
   e. Complete Medical Records including demographics

3.) Information to be released to: Spouse: _____ Child: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

4.) Purpose of Disclosure (Circle One): Treatment ReferralPayment Other

5.) I understand that I may revoke this consent/authorization at any time by notifying Texas Urology Specialists in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information as acted in reliance upon this authorization.

6.) This authorization will remain in effect until revoked by me in writing.

7.) The Facility, its employees and officers, and attending providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8.) I understand that according to applicable state and or federal laws (Texas Medical Practice Act of Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care of treatment.

Signature: _____ Date: _____

Witness: _____ Relationship: _____

Patient Name: _____

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Date: _____

Preferred Language: _____

Circle Ethnicity: Hispanic or Latino Not Hispanic nor Latino

Circle Preferred Method of Contact: Home Phone Cell Phone Work Phone Email Mail

Phone Number not previously provided: _____(Home/Cell/Work)

Email Address: _____

Circle Race:

African American	Hmong	Pacific Island Nos
Asian Indian, Pakistani SRI Lankan	Japanese	Polynesian Nos
Caucasian	Kampuchean Cambodian	Samoan
Chamorran	Korean	Tahitian
Chinese	Laotian	Thai
Fiji Islander	Melanesian Nos	Tongan
Filipino	Micronesian Nos	Vietnamese
Guamanian Nos	Native American	Unknown
Hawaiian	New Guinean	Other
Hispanic	Other Asian	

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NO SHOW POLICY

Keeping your appointment is very important and crucial to good medical care; however, if you are unable to make your appointment for any reason, please call to cancel at least 24 hours prior to your scheduled appointment. Cancellations can be taken by calling the office at any time, including after business hours.

Please be aware that you may be dismissed from the practice in the event that you NO SHOW after three (3) scheduled appointments without calling to cancel or reschedule your appointment.

Dismissal from the practice will be given in writing with 30 days for you to find another physician and transfer medical care.

I agree to the terms of this notice.

Signature: _____

Thank you,

Texas Urology Specialists

TEXAS UROLOGY SPECIALISTS

PHYSICIAN ASSISTANT CONSENT FOR TREATMENT

Texas Urology Specialists has a physician assistant on staff to assist in the delivery of urologic care. Medical D. White, PA-C, MPAS, is a board- certified physician's assistant (PA) who completed his PA studies at UT Southwestern Medical Center in 2007. He attended the University of North Texas of his undergraduate studies in biology and chemistry.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting with surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my healthcare needs. I understand that at any time I can refuse to see the physician assistant and request to see a physician.

_____ _____ _____

Printed Name Signature Date

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DISCLOSURE OF PHYSICIAN OWNERSHIP

Please carefully review the information contained in the notice.

North Texas Surgery Center, Methodist Mansfield ASC and DFW Lithotripsy L. L.P are a few of several health care facilities where the physicians of Texas Urology Specialists are able to perform certain surgical procedures. These facilities are owned in part by some of the physicians of Texas Urology Specialists.

You may or may not be referred to one of the above-mentioned entities during the course of your treatment with Texas Urology Specialists. As a patient you have the right to choose the provider of your health care services. Although the physicians of Texas Urology Specialists believe that either of these facilities will meet your needs should they become involved in your health care, you do have the option of using another facility. You will not be treated differently by your physician if you choose to use a different facility; however, your physician may not be able to perform your procedure(s) at an alternative facility if he does not maintain privileges at such facility. Your physician or one of the licensed nurses can provide additional information about alternative health care facilities.

Acknowledgement of Disclosure

My Signature confirms that I have read this disclosure. I know that I can direct any questions and / or concerns regarding this disclosure to my physician during my visit.

_____ _____

Patient or Authorized Representative Signature Date

TEXAS UROLOGY SPECIALISTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Urology Specialists is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our organization and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Urology Specialists.

Printed Name: _____

Signature: _____

Name of Representative (If Appropriate): _____

Signature of Representative: _____

Date: _____

TEXAS UROLOGY SPECIALISTS

CANCELLATION & NO- SHOW POLICY

We strive to render excellent medical care to you and the rest of our patients, so we understand that situations arise in which you must cancel your appointment. In order to provide all our patients with the highest level of care and access, we request that all patients that need to cancel their appointments provide more than 24-hour notice. This will enable us to better utilize available appointments for our patients

Appointments cancelled with less than 24 hours or if the patients No- Shows without notification may be subject to a cancellation fee. The cancellation fees are provided below based on type of appointment:

Office Visits: ----------$50.00

In–Office Procedures: ----------$100.00

Hospital Surgery/ Procedures: ----------$250.00

The cancellation and No-show fees are the sole responsibility of the patient and must be paid in full on or before the patients next scheduled appointment.

Please contact our offices at 214-948-3101 (Dallas) or 972-780-0480 (Desoto), should you have any questions regarding the cancellation and No-show fees and we will be glad to assist.

_____ _____

Printed Name Date of Birth

_____ _____

Signature of patient or Representative Date

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PATIENT MEDICAL HISTORY

Name: _____ Age: _____ Date of Birth: _____

What Pharmacy do you use? (Name and City/ Street) _____

Who Referred you for this condition (Doctor Name) _____

What is the reason for this visit? _____

When did this problem start? _____ Is this the first time you are being seen for this? _____

PLEASE RESPOND TO THE PROBLEM LIST BELOW BY CIRCLING THE RESPONSE WHICH MOST ACCURATELY RELATES TO YOU

	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	Does not apply
Sensation of not emptying bladder?	0	1	2	3	4	5	( )
Urinating less than 2 hrs. after urination	0	1	2	3	4	5	( )
Stopping & Starting during urination	0	1	2	3	4	5	( )
Difficulty in postponing urination	0	1	2	3	4	5	( )
Weak urinary stream	0	1	2	3	4	5	( )
Pushing/ Straining during urination	0	1	2	3	4	5	( )
How many times do you urinate from the time you go to bed at night until you get up?	0	1 Time	2 Times	3 Times	4 Times	5 + Times	( )

TOTAL OF THE SEVEN CIRCLED NUMBERS ABOVE: _____

Do you experience any pain with urination? Y N
Do you experience any leakage of urine? Y N
Do you have blood in your urine? Y N
Are you experiencing any problems with erections? Y N
Have you ever had kidney stones? Y N
Have you ever been told you needed antibiotics before a procedure Y N

PAST MEDICAL & SOCIAL HISTORY

Have you ever had or been treated for any of the following? NO YES If yes, please check or write down any condition you have had.

High Cholesterol	**Heart Disease**	**Mumps**
High blood Pressure	**Mitral Valve Prolapse**	**Asthma**
Tuberculosis	**Diabetes**	**Cancer: _____**
Glaucoma	**Gout**	**Depression**
Gastroesophageal Reflux	**Prostatitis**	**Blood Clot**
Heart Attack	**Kidney Infection**	**Sexually Transmitted Disease**
Herpes	**HIV**	**COPD**
OTHER: _____		

Have you ever had any surgeries? NO YES If yes, circle the surgeries you have had and write the year it was performed

Colon:	**Breast:**	**Thyroid:**	**Hysterectomy:**
Bladder:	**Heart Valve:**	**Angioplasty:**	**Heart Bypass:**
Lung:	**Inguinal Hernia:**	**Umbilical Hernia:**	**Appendectomy:**
Knee Replacement:	**Hip Replacement:**	**Gallbladder:**	**Back:**
Prostate:	**Incontinence:**	**Spleen:**	**Gastric Bypass:**
Vasectomy/Tubal Ligation:	**Urinary Stone:**	**Kidney:**	**Testicular/ Scrotal:**

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Please circle any family history of medical problems, and write down who in the family has the condition

Adopted? NO YES

Heart Disease	**Sickle Cell**	**Prostate Cancer**	**Kidney Failure**
Kidney Tumors	**Kidney Stones**	**Bladder Cancer**	**Anemia**
Liver Disease	**Diabetes**	**Tuberculosis**	**High Blood Pressure**
Kidney Cysts	**Cystic Fibrosis**	**Other Cancers: _____**	**Other:**

Have you ever been or are you now on any of the below medications?

Viagra/Sildenafil Levitra/Vardenafil Cialis/Tadalafil Proscar/Finasteride Avodart/Dutasteride
Uroxatrol/ Alfuzosin Flomax/ Tamsulosin Cardura/ Doxazosin Ditropan/oxybutynin
Sanctura/Tropsium Chloride Vesicare/Solifenacin Detrol/tolterodine Hytrin/Terazosin
Enablex/Darifenacin Testosterone Coumadin Plavix

Do you have any drug allergies? YES NO

DRUG:	**TYPE OF REACTION:**

DO you take Ibuprofen, Aspirin, Coumadin, Plavix or other blood thinners? YES NO

Are you on any over the counter or prescription medications? YES NO

If yes, please list below:

DRUG:	**DOSAGE:**	**HOW MANY TIMES A DAY:**

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Do you smoke or did you ever smoke? YES NO

If yes, how many packs per day? _____ How many years? _____

Did You Quit? YES NO If yes, when did you quit? _____

Do you drink Alcohol? YES NO If yes, How much do you drink and how often? _____

Have you or do you now use Marijuana, Cocaine, Anabolic Steroids, or Heroin? YES NO

Are you Married? YES NO Divorced Widowed

Any Children? YES NO How Many? _____

What is your Occupation? _____

Did you or do you ever work around chemicals? YES NO

If yes, please list: _____

FEMALES:

Are you or could you be pregnant? YES NO

REVIEW OF SYSTEMS

HAVE YOU RECENTLY HAD ANY PROBLEMS RELATED TO ANY OF THE FOLLOWING?

CONSTITUTIONAL SYMPTOMS

Fever Y N
Chills Y N
Headache Y N
Other _____

EYES

Blurred Vision Y N
Double Vision Y N
Pain Y N
Other _____

NEUROLOGICAL

Tremors Y N
Dizzy Spells Y N
Numbness/tingling Y N
Other _____

ENDOCRINE

Excessive Thirst Y N
Too Hot/ Cold Y N
Tired/Sluggish Y N
Other _____

GASTROINTRSTINAL

Abdominal Pain Y N
Nausea/Vomiting Y N
Indigestion/Heartburn Y N
Other _____

CARDIOVASCULAR

Chest Pain Y N
Varicose Veins Y N
High Blood Pressure Y N
Other _____

INTEGUMENTARY

Skin Rash Y N
Boils Y N
Persistent Itch Y N
Other _____

MUSCULOSKELETAL

Joint Pain Y N
Neck Pain Y N
Back Pain Y N
Other _____

EAR/NOSE/THROAT/MOUTH

Ear Infection Y N
Sore Throat Y N
Sinus Problems Y N
Other _____

ALLERGIC/ IMMUNOLOGIC

Hay Fever Y N
Drug Allergies Y N
Other _____

HEMATOLOGIC/ LYMPHATIC

Swollen Glands Y N
Blood Clotting Problems Y N
Other _____

RESPIRATORY

Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N

GENITOURINARY

Urine retention Y N
Painful Urination Y N
Urinary Frequency Y N

Other _____