VENICE UROLOGY
LEADING EDGE TREATMENT CENTER
Part of the GenesisCare network

NEW PATIENT REGISTRATION PACKET

Dear Patient:

We would like to take this opportunity to welcome you to our practice. We look forward to meeting you and providing the highest quality urologic care. In order to facilitate your appointment, we ask that you please take a few moments to complete the enclosed forms. By doing this prior to your office visit, we hope to make your visit as efficient as possible. We appreciate your taking the time to help up streamline your visit and serve you as efficiently as possible.

We need you to bring the following to your appointment:

- Completed forms
- Insurance cards
- Driver's license or picture ID
- Insurance copay or coinsurance
- List of medications and allergies
- CD disk or x-ray films, if performed, relating to your current problem

If your insurance requires a referral or pre-authorization when seeing a specialist, please contact your primary care physician and confirm this has been completed.

If you have any questions or need any assistance, please call our office. We will be happy to help you in any way we can.

We are looking forward to meeting you.

Sincerely,

Venice Urology

842 Sunset Lake Blvd., Bldg. B, Ste. 403
Venice, FL 34292

VENICE UROLOGY
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NEW PATIENT REGISTRATION PACKET

From Route 41 North or South:

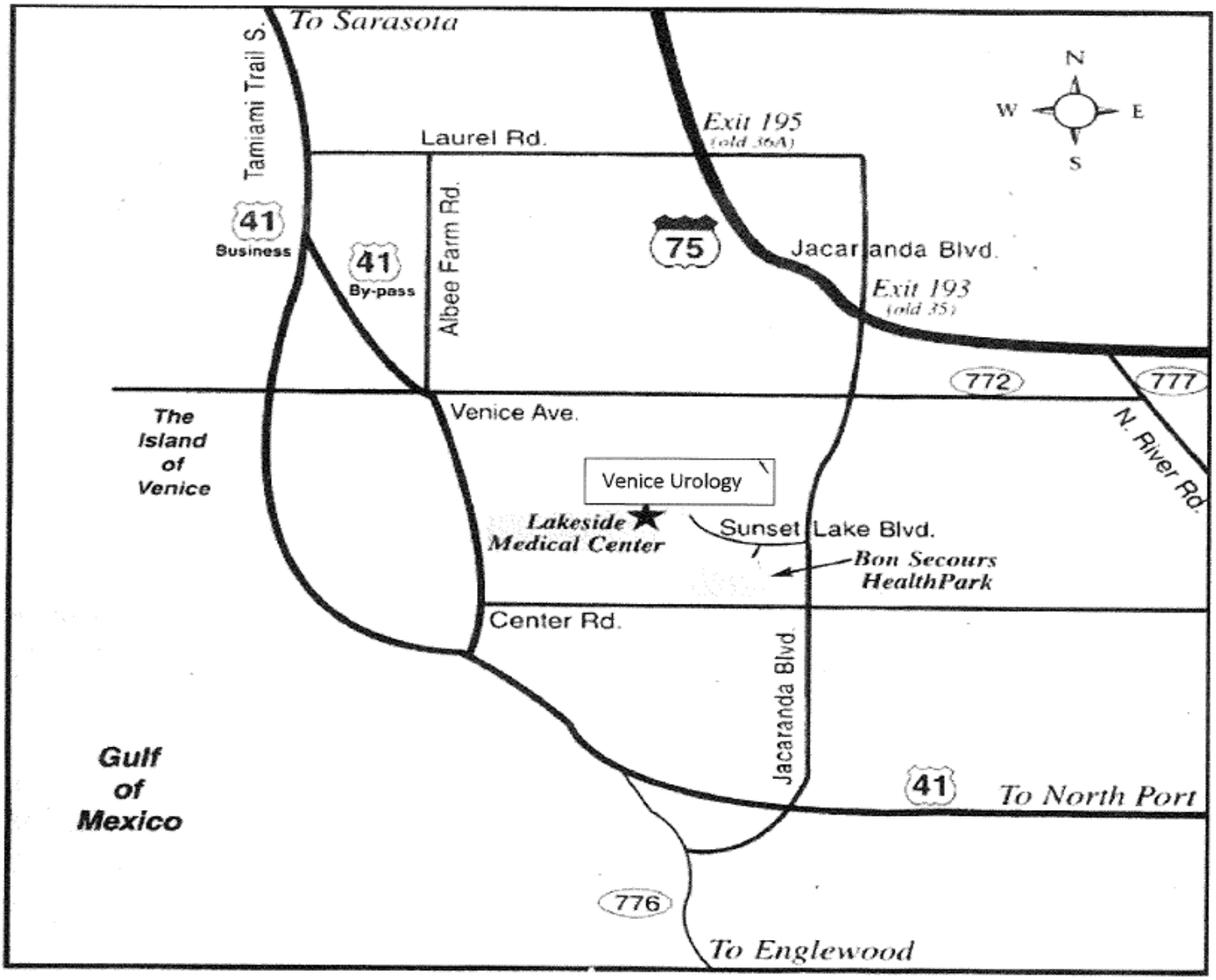
- Take Center Road East 2.3 miles to the intersection of Jacaranda Blvd.
- Take a left onto Jacaranda Blvd.
- Go .2 miles and take a left on Sunset Lake Blvd. (See the Lakeside Medical Center sign on Jacaranda Blvd.)
- Take a right into the first entrance for Lakeside Medical Center.

From I-75 North or South:

- Take Exit 193 (old 35) Jacaranda Blvd. towards Venice.
- Go 2 miles on Jacaranda Blvd. and take a right on Sunset Lake Blvd. (See the Lakeside Medical Center sign on Jacaranda Blvd.)
- Take a right into the first entrance for Lakeside Medical Center.

Venice Urology is in Building B on the right

Second Floor, Suite 403



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NEW PATIENT REGISTRATION PACKET

PATIENT INFORMATION:

Office: _____ **Date:** _____

Last Name: _____ **First Name:** _____ **M.I.:** _____

SSN: _____ **DOB:** _____ **Sex:** _____

Address: _____ **Apt/Suite #:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Mobile Phone:** _____

E-Mail Address: _____

Primary Care Physician: _____ **Referring Provider:** _____

Employer: _____ **Work Phone:** _____

Marital Status: _____ **Is your spouse working or retired?** _____

Spouse Name: _____ **Spouse DOB:** _____

Spouse SSN: _____ **Spouse Contact Number:** _____

ALTERNATE ADDRESS:

☐ **I do not have an alternate address**

Alternate Address: _____ **Apt/Suite#:** _____

City: _____ **State:** _____ **Zip:** _____

INSURANCE INFORMATION:

Primary Insurance: _____ **Plan ID:** _____

Group #: _____ **Phone Number:** _____

Secondary Insurance: _____ **Plan ID:** _____

Group #: _____ **Phone Number:** _____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Phone:** _____

Relationship to Contact: _____ **Guardian:** _____

Address: _____ **Apt/Suite #:** _____

City: _____ **State:** _____ **Zip:** _____

VENICE UROLOGY
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NEW PATIENT REGISTRATION PACKET

Are you currently admitted to a hospital or enrolled in a Hospice or Skilled Nursing Facility?
Yes_____ No_____ If **yes**, please fill out the following:

Facility Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Are you receiving benefits from the Veterans Administration?
Yes_____ No_____ If **yes**, please fill out the following:

VA Name: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR RACE?

☐ Asian	☐ Caucasian	☐ Black / African American	☐ Hispanic
☐ Subcontinent Asian American		☐ Asian Pacific American	☐ Native American
☐ American Indian/Alaskan Native		☐ Hawaiian	☐ Pacific Islander
☐ More than one race		☐ Other	☐ Decline

PLEASE SELECT ONE ETHNIC GROUP THAT BEST DESCRIBES YOUR ANCESTRY:

☐ Hispanic or Latino	☐ Non-Hispanic or Latino
☐ Decline	☐ Don't know

WHAT LANGUAGE DO YOU FEEL MOST COMFORTABLE USING WHEN DISCUSSING YOUR HEALTHCARE?

☐ English	☐ Spanish	☐ German	☐ French
☐ Italian	☐ Russian	☐ Portuguese	☐ Chinese
☐ Creole	☐ Other	☐ Decline	

WE ARE DEDICATED TO PROVIDING THE BEST CARE POSSIBLE TO OUR PATIENTS. WE CAN BETTER ACCOMPLISH THIS GOAL BY OBTAINING YOUR OPINION ON HOW WE ARE DOING. MAY WE CONTACT YOU BY MAIL, E-MAIL, TEXT, OR TELEPHONE FOR OUR SURVEY? Survey communications are sent via standard unsecure email and can place your information at risk of being read or accessed by someone else. By checking yes, you agree to receiving the survey via standard unsecure (unencrypted) email.

☐ Yes	☐ No

HOW DID YOU HEAR ABOUT US?

☐ Physician Referral	☐ Family or Friend	☐ Insurance Referral	
☐ Internet (website, search engine, Facebook, etc)		☐ Media (newspaper, magazine, billboard, radio, TV)	
☐ Hospital	☐ VA	☐ Integrative Oncology Essentials	☐ Communications Forum (Seminar, etc.)
☐ No Response			

WHEN CONDUCTING YOUR OWN RESEARCH, HOW OFTEN DO YOU USE THE INTERNET FOR GATHERING INFORMATION?

☐ Always	☐ Usually	☐ Sometimes	☐ Never

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Telephone Consumer Protection Act [TCPA] Consent Form

Active communication with our patients is a key element in providing high quality health care services. To that end, GenesisCare desires to communicate timely information regarding health care services and functions to you in the most effective means possible, including via automated telephone and text messaging. Federal law requires that we obtain your consent prior to communicating with you via these means. Please read and sign below so that we can communicate with you for these important purposes. We apologize for the formality of this consent, but it is required under law.

I, _____, authorize the use of my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I consent to receiving multiple messages per day from my healthcare provider, when necessary, and I consent to allowing messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

I also authorize any of «PracticeName» independent contractors agents and/or affiliates ("collectively, "Practice") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice or other messaging system, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods even if I am charged for the call, as well as through any email address or other personal contact information supplied by me. I expressly consent to receive any such automated calls. I understand that, depending on my plan, charges may apply to certain calls or text messages. I also understand that communication platforms may transmit information via unsecure methods which includes a risk that the information could be viewed by an unintended third party. I understand these risks and consent to having these communications sent unsecure.

_____

Patient Signature (or Signature of Patient's Authorized Representative)

_____

Patient Name

_____

Date

Patient Permission to Communicate Information With Designated Individuals

VENICE UROLOGY
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NEW PATIENT REGISTRATION PACKET

Our physicians and staff know that communicating with you about your healthcare is important. By completing this form, you give us permission to provide messages, and/or discuss information about your healthcare with the individuals designated below. I understand that I may cancel or update this information at any time by notifying a representative of the physician office.

1. **I give permission** to allow physicians and staff to discuss relevant medical, billing, and insurance information with the individuals listed below (examples, spouse, relatives, friend, etc.). I understand that my healthcare provider will use professional judgment to determine what information about my healthcare may be discussed with the designated individuals below*:

Involved Individual	Relationship to Patient	Phone Number

Patient/Authorized Representative Signature_____Date_____Time_____**

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

***If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.*

*GenesisCare expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment or healthcare operations.

Assignment Of Benefits/Right to Payment Authorization, Patient Responsibility, And Release Of Information Form

GenesisCare
DBA «PracticeName»
PO Box 862152
Orlando, FL 32886-2152

VENICE UROLOGY
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NEW PATIENT REGISTRATION PACKET

I, the undersigned, assign to the provider/entity referenced above ("Provider"), my rights and benefits in any medical insurance plan, health benefit plan, or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I authorize my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider are owed to Provider and I agree to remit those funds directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment/Authorization shall be considered as effective and valid as the original.

_____ _____
Signature of Patient/Person Legally Responsible Date

_____ _____
Print Name of Patient/Person Legally Responsible Date

_____
Relationship to Patient (if signed by Person Legally Responsible)

VENICE UROLOGY
LEADING EDGE TREATMENT CENTER
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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.

Each time you visit our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by your physician.

Our Responsibilities

We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to that protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

Uses and Disclosures - How we may use and disclose protected health information about you

For Treatment: We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to doctors, nurses, or other personnel who are involved in taking care of you. For example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

For Payment: We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

For Healthcare Operations: We may use or disclose, as needed, your protected health information in order to run our practice. For example, members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.

We may also use and disclose protected health information:

- To business associates we have contracted with to perform an agreed-upon service
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To inform you about possible treatment alternatives
- To inform you about health-related benefits or services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

Individuals Involved in Your Care or Payment for Your Care: We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

Research: We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

Future Communications: We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

As Required by Law, we may also disclose health information to the following types of entities, including but not limited to:

- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

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Uses and Disclosures - How we may use and disclose protected health information about you

For Treatment: We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to doctors, nurses, or other personnel who are involved in taking care of you. For example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

For Payment: We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

For Healthcare Operations: We may use or disclose, as needed, your protected health information in order to run our practice. For example, members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.

We may also use and disclose protected health information:

- To business associates we have contracted with to perform an agreed-upon service
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To inform you about possible treatment alternatives
- To inform you about health-related benefits or services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

Individuals Involved in Your Care or Payment for Your Care: We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

Research: We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

Future Communications: We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

As Required by Law, we may also disclose health information to the following types of entities, including but not limited to:

- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Other Uses of Your Protected Health Information That Require Your Authorization

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses and disclosures not described in this notice or required by law will be made only with your separate written permission. If you give us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any lime. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and copy protected health information. You may request access to your records by contacting us. You may also ask that we send your health information directly to another person based on your signed written instructions. We may deny your

request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records.

- Request an amendment. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information by making a request in writing that explains the reason for the requested amendment. You have the right to request an amendment for as long as the information is kept for or by us. We may deny your request for an amendment; if this occurs, you will be notified of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes.
- Request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you ask us not to disclose your health information to your health plan, we will agree as long as (i) the disclosure would be for the purpose of payment or health care operations and is not otherwise required by law and (ii) the information only relates to items or services that someone other than your health plan has paid for in full.
- Request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will grant requests for confidential communications at alternative locations and/or via alternate means only if the request is submitted in writing and the written request includes a mailing address where you will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.
- A paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Web site at www.genesiscare.com/us/.

Changes to This Notice

We reserve the right to change this notice; the revised notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be available on our website and will be provided to you upon your next visit to our facility after the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Privacy Officer toll-free at 1-866-679- 8944, or by contacting the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

For further information, contact:

Chief Privacy Officer
2270 Colonial Boulevard
Fort Myers, FL 33907
1-866-679-8944

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NEW PATIENT REGISTRATION PACKET

Language Assistance Services for Individuals with Limited English Proficiency

Attention: If you speak English, language assistance services, free of charge, are available to you.

Spanish / Español:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Por favor, póngase en contacto con su oficina médico o llame al (833)-796-9683.

Mandarin / 繁體中文: 注意：如果您使用繁體中文，您可以免費獲得語言援 助服務。请联系您的医生办公室或 請致電
(833)-796-9680。

Vietnamese/ Tiếng Việt:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Vui lòng liên hệ văn phòng bác sĩ của bạn hoặc gọi số (833)-796-9682.

Korean / 한국어:
주의 : 한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 의사 사무실에 문의하거나(833)-796-9678. 로 전화주십시오.

French Creole / Kreyòl Ayisyen:
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri kontakte biwo doktè ou a oswa rele (833)-590-0265.

Russian / Русский:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Пожалуйста, обратитесь к врачу или офис Звоните (833)-796-9677.

Armenian / Հայերէն:
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթէ խոսում եք հայերէն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Խնդրում ենք կապվել Ձեր բժշկի գրասենյակ կամ Զանգահարեք (833)-796-9675.

Italian / Italiano:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di contattare l'ufficio medico o chiamare il numero (833)-717-5678.

Persian (Farsi) / فارسی:
توجه: اگر شما فارسی، خدمات کمک زبان، رایگان صحبت می کنند در دسترس شما هستند لطفا با دفتر
پزشک خود تماس بگیرید و یا پاسخ (833) 717-5677.

Portuguese / Português:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Entre em contato com seu escritório médico ou ligue para (833)-796-9676.

Arabic / العربية:
تنبيه: إذا كنت تتكلم العربية، وخدمات المساعدة باللغوية مجانا، تتوفر
لك. يرجى الاتصال بمكتب الطبيب أو
الاتصل(833) 717-5597.

Japanese / 日本語: 注意：あなたが日本語を話す場合は、無償で言語 支援サービスは、あなたにご利用いただけます。 あなたの医師のオフィスにお問い合わせいただく か、(833) 717-5676 までお電話ください。

French / Français:
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. S'il vous plaît contacter votre bureau de médecin ou appelez le (833) 663-6209.

Polish:
UWAGA Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 833-796-9679.

Please call: (833) 796-9684

Notice of Non-Discrimination

Discrimination is Against the Law

GenesisCare USA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GenesisCare USA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GenesisCare USA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact your physician office.

If you believe that GenesisCare USA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, 2270 Colonial Blvd, Fort Myers, FL 33907, 866-679-8944, CivilRightsCoordinator@usa.genesiscare.com. You can file a grievance in person or by mail, phone, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human
Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at: https://www.hhs.gov/ocr/complaints/index.html

VENICE UROLOGY
LEADING EDGE TREATMENT CENTER
Part of the GenesisCare network

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge:
A copy of the Notice of Privacy Practices was given to me.
If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name of Patient or Representative

FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgement was not obtained:

- ☐ Patient/family member received notice but refused to sign acknowledgment
- ☐ Emergency treatment situation
- ☐ Patient was incapacitated and no family member was present
- ☐ Unable to communicate due to language barriers
- ☐ Other (please describe below)

_____
_____
_____
_____

_____ _____
Signature of Employee Date

VENICE UROLOGY
LEADING EDGE TREATMENT CENTER
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General Clinic Guidelines

As a service to our patients, and to help you better understand how our office functions, we have put together the following guidelines. These guidelines are designed to help us provide you the optimal level of patient care and service. Our number one goal is your satisfaction and to fulfill this goal it is our responsibility to provide you with information that can assist with your care as a patient in our office.

GenesisCare Affiliation: Venice Urology is Part of the GenesisCare network. GenesisCare employs or is affiliated with over 947 physicians globally, including radiation oncologists and other specialists such as urologists, medical oncologists, hematologists, gynecologic oncologists, surgeons and pathologists – working together to deliver the most advanced integrated cancer care. Our Doctors practice independently as urologists and GenesisCare functions as a management company.

Appointment Availability: Venice Urology makes every effort to schedule and keep appointments within a reasonable time frame. Once here, an appointment may take longer than planned or an emergency may arise, but every effort is made to stay on schedule. We do value our patients' time and we try our best to stay on schedule. However, there are times where the schedule may be delayed, but please note the Doctor spends as much time as needed with each patient and diagnosis. Should a patient run late, we will do our best to accommodate the patient. However, the appointment may need to be rescheduled. If an appointment is delayed or if the physician encounters a patient emergency, patients may be asked to reschedule as well. Please contact the check-in desk to inquire about the appointment and any delays encountered. Our office strives to provide appointments in a timely manner.

Arrival times: Each patient is provided an arrival time. The arrival time allows time to process paperwork, review demographics, and collect insurance cards and payment. As a new patient we ask that you arrive at the office 30 minutes prior to your scheduled appointment in order to give you time to complete your new patient paperwork. If paperwork is completed ahead of the appointment you will need to arrive 15 minutes prior. As an established patient we ask that you arrive 10-15 minutes prior to your scheduled appointment.

Telephone Systems/Appointment Reminders: Venice Urology has implemented a personalized appointment reminder system. This system will provide patients with an electronic courtesy call for upcoming appointments. This will confirm your arrival time for the check in process. Patients will be prompted to confirm their appointment. If you have provided us with your email address you will also receive a confirmation reminder via email.

Appointments: Please be prepared to review general demographic information, update some basic medical information, show your current insurance card, and picture ID. Insurance cards and photo ID must be furnished at time of visit. Copays are required at time of visit and will be collected at check in. If applicable, deductibles and co-insurance will be collected at time of service. Payment is expected as services are rendered unless prior financial arrangements have been made.

No-Show or Missed appointments: Our goal is to provide timely access to appointments for patients. When patients fail to keep appointments, routinely arrive late, or have multiple requests for reschedules, other patients needing to be seen on an urgent basis may be denied access to a timely appointment.

Scheduling: The scheduler will gather key information that needs to be entered at time of scheduling. This will include demographic and insurance information. Every effort will be made to provide you with the earliest appointment available. There are certain diagnoses that may require prompt attention and those will be brought to the Doctor's attention accordingly.

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Appointments need to be scheduled as we do not generally accept walk-ins. However, if you do have an urgent situation and you are an established patient, please try to call the office first: Our clinical staff will then review you symptoms and discuss with the Doctor on how to proceed.

Urodynamic: Tests are scheduled monthly. Our nurses travel from the east coast to perform these services at our office and we offer this as a courtesy to our patients. Unfortunately, life happens and in rare circumstances an appointment that has been scheduled may need to be canceled. We will reschedule these promptly and we do apologize for any and all inconveniences.

Phone Messages: Calls to our office are received through our automated phone service and then directed to the appropriate department. Every attempt is made to answer incoming calls. However, there are times when a patient will have to leave a voice message. All calls are returned within 24 hours. Please try not to call our office multiple times. Multiple calls can present delays in not only returning your call but other patients as well.

Nurse Calls: All patients are encouraged to call the clinical staff with any medical questions they have related to their care. Our trained and knowledgeable staff work hand in hand with our doctors. They can provide assistance and, in most cases, assist with your immediate concerns. All calls are logged into the Electronic Health Record and reviewed by the Doctors throughout the day. Communication with the clinical staff will be the primary source of information. If the doctor feels an appointment is needed, one will be provided.

Medication Lists: Please bring a complete list of all of your medications, as well as the strength and dose of each one. This will help clinical staff will ensure your medications are updated.

Medication Refills: For medication refills please contact the pharmacy first. The pharmacy will fax a prescription refill request to our office. This request will generate a response from the clinical staff. Medication refills, medication requests, and lost prescriptions require 48 hours' notice. If you have not been seen in the office for more than a year you will be asked to schedule an appointment before the refill will be approved.

Lab and Imaging Results: Our Clinical department is available to answer medical questions for our patients. However, they are not able to interpret patient lab or imaging results. Results will be discussed with each patient by their physician during a follow-up appointment. It is important for patients to come to their follow-up appointment to have their results interpreted and to ask questions if needed.

***Blood Work: Please notify the schedulers where you will be getting your labs drawn; this will help ensure that the results are sent to us prior to your appointment. Failure to provide this information can delay your results.*

Pathology/Specimens: Based on your diagnosis the Doctor may require additional testing on various specimens. This is discussed with you at the time of service. The specimen is then sent to an outside lab for further analysis. Depending on your health insurance benefits you may receive a bill from the lab.

Procedures performed in the office: Procedure appointment times are subject to change. Calls will be made the day before to confirm and provide the time of arrival. Please allow some flexibility when scheduling as times are subject to change.

Urine Check: Urine drop offs are no longer accepted without speaking to a nurse. **Please call to speak with the nurse before coming to the office.** Urine checks are for established patients *only* who suspect they may have a urinary tract infection. Therefore, in order to provide you with the best level of care and service it is necessary to collect a urine specimen. **Specimens can be collected between 8:00am to noon.** Urine cups are provided upon check in. Please fill out the provided form to let us know any and all symptoms you have been having along with your pharmacy's contact

information so we can call in medication if needed. Since urine specimens do not require an appointment; patients may be asked to go home. Once specimens are checked and discussed with the Doctors, we will call you with results. It may not be until the end of the day before this is done. If considered necessary by the doctor, the urine may be sent out for further testing. Please note you will be charged for a nurse visit for this testing.

Medical Records: Venice Urology adheres to strict confidentiality guidelines and must receive an original signature and copy of a patient's driver's license prior to the release of medical records to the patient. In order to release your records, you must sign the release form. This is required by law to protect your privacy. A written request must include the patient's full name, date of birth, SS#, physician's name, complete address, and phone number. There is no charge for medical records request sent directly to another physician's office or medical institution. All requests are complete within fifteen (15) days of receipt of the request. A release form is available at **www.veniceurology.com**. Please understand that your records contain protected health information that is highly confidential.

Seasonal residents: It is essential for patients who live here seasonally to bring your medical records from your primary or urologist's office. If you cannot personally bring your records, please arrange for them to be mailed/faxed to our office prior to your appointment. A medical records release will need to be signed prior to the release of your records.

On-Call Physician: A physician is on call 24 hours a day to deal with urological emergencies. If you believe you have a urological emergency, go directly to the emergency room. The emergency room physician will be able to assess the problem and will contact the urologist on call if immediate urological care is needed. The urologist on call will not be able to assess your symptoms on the phone. Accessing care in an urgent care or emergency room setting will help you receive the right care at the right time. On call duties are shared with the local urologists on a rotating basis. If our Doctor encounters a patient emergency during his rotation patients may be asked to reschedule.

Surgeries: All surgeries are performed at either Venice Regional Health Park or Venice Regional Hospital.

Referrals & Authorizations Explained
Referrals
The referral process serves as a way for your Primary Care Physician (PCP) and your specialist to communicate with each other. When a referral is issued to see a specialist, your PCP will tell the specialist the reasons for the referral and the goals for your visit. In other words, your PCP will help coordinate your visit and the referral helps to make sure you receive the proper care when you see the specialist.

Venice Urology is considered a specialist office and authorizations and/or referral are needed to be seen by our Doctors.

Whose responsibility is it to obtain the referral under my insurance plan?

Your PCP is responsible for issuing the referral for office visits. However, you are responsible for making sure this is done before you see a specialist. We recommend you become familiar with and understand your PCP's specific referral procedures. Every office does this a bit differently, but most offices have a referral coordinator or other staff member dedicated to helping you through the process.

Once you become an established patient at our office as a courtesy our authorizations rep will work on obtaining additional authorizations and/or referrals on your behalf. However, it is still the patient's responsibility to make sure authorizations and referrals have been obtained prior to the appointments.

When you go through the process, make sure you follow the steps listed below (as well as any other steps your office may require):

Make sure **Venice Urology** is in network with your insurance and your PCP has provided the reason for the referral.

Make sure your appointment is scheduled within the time frame covered by the referral, and that you know how many visits the referral covers.

Make sure you contact the office at least one business day before your appointment(s) to be sure your referral(s) were received and processed.

If your referral covers only one visit but we provide an appointment for additional visits our authorization rep will contact your PCP to extend the referral.

Prior Authorizations

In the prior authorization process, your physician or other health care provider gets approval from your insurance company to provide you with coverage for certain services, such as specific procedures, or medications,

Please note that prior authorization as well as referral s and authorizations are not a guarantee of payments.

How is a prior authorization different from a referral?

If your physician determines you need a service that requires a prior authorization, your physician will get approval for coverage from insurance company before this service is provided to you. If your physician determines you need to see another medical professional for specialized services, your physician will give you a referral, which is an approval from your physician to see the specialist. Both insurance company and the specialist are told of your physician's approval.

VA Insurance (Veterans Health Insurance)
The VA requires authorization to be obtained for each patient to be seen at our office. As a courtesy to our patients, we try to obtain authorizations for your visits by contacting the primary care physician and/or the VA insurance. Without authorization we can't see you in the office as the VA will deny the charges and the patients will become the responsible party for the bill. This is not an option we want to provide to our patients. We believe if you have insurance, it should be used, and authorizations should be given in a timely manner.

Bayfront employee YES or NO (please circle one)
Lastly, we value each and every one of our patients. We seek to provide the highest level of customer service and we strive to be efficient with providing care. We look to our patients to provide feedback and suggestions on how we can assist you or your loved ones. We appreciate you choosing us to provide you with the highest quality urological care.

I acknowledge receipt of a copy of the Clinic Guidelines

Date: _____

Patient's Name: _____

_____
Patient's Signature

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PATIENT SELF-HISTORY FORM

Patient Name: _____ **Date of Birth:** _____
Marital Status: □ Single □ Married □ Partnered □ Separated □ Divorced □ Widowed

I. PLEASE LIST THE NAMES AND ADDRESSED OF PHYSICIANS YOU WOULD LIKE CORRESPONDENCE SENT TO:

Name: Address: Phone:

_____
_____
_____

Preferred Pharmacy

_____

Name: _____

Phone Number: _____

City or Zip Code: _____

PAST MEDICAL HISTORY

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clot
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ DVT
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDs
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ PE
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____
_____
_____

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PAST SURGERIES

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other

_____

_____

_____

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PAST UROLOGICAL HISTORY

Have you had any of the following?

- ☐ Prostate nodule
- ☐ Cancer (Bladder)
- ☐ Cancer (Kidney)
- ☐ Cancer (Penile)
- ☐ Cancer (Prostate)
- ☐ Cancer (Testicular)
- ☐ Cystinuria
- ☐ Elevated PSA
- ☐ Hematuria
- ☐ Hereditary Lelomyomatous Renal Cell Carcinoma
- ☐ Birt-Hogg-Dube Syndrome
- ☐ Beckwith Weidemann Syndrome
- ☐ Hydronephrosis
- ☐ Infertility
- ☐ Li Fraumeni Syndrome
- ☐ Neurogenic Bladder
- ☐ Polycystic Kidney Disease
- ☐ Priopism
- ☐ Prostatitis
- ☐ Renal Insufficiency
- ☐ Renal Tubular Acidosis
- ☐ Sexual Dysfunction
- ☐ Sexually Transmitted Disease
- ☐ Genitourinary Trauma
- ☐ Tuberculosis
- ☐ Tuberous Sclerosis
- ☐ Undescended Testis
- ☐ Urethral Stricture
- ☐ Urinary Incontinence
- ☐ Urinary Retention
- ☐ Urinary Tract Infection
- ☐ Urolithiasis
- ☐ Vesicoureteral Reflux (VUR)
- ☐ Von Hippel Lindau
- ☐ NONE
- ☐ Other

_____

_____

_____

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UROLOGICAL SURGICAL HISTORY

- ☐ Burch Colposuspension
- ☐ Cystectomy
- ☐ Extracorporeal Shock Wave Lithotripsy
- ☐ Herniorraphy (with mesh?)
- ☐ Hysterectomy
- ☐ Insertion of Artificial Urinary Sphincter
- ☐ Insertion of Penile Prosthesis
- ☐ Marshall-Marchetti-Krantz Urethropexy
- ☐ Midurethral Sling
- ☐ Nephrectomy
- ☐ Orhiectomy
- ☐ Percutaneous Nephrostolithrotripsy
- ☐ Pelvis Irradiation
- ☐ Penile Reconstruction
- ☐ Prostate Biopsy
- ☐ Prostate Radiation Therapy
- ☐ Prostatectomy
- ☐ Pubovaginal Sling
- ☐ Renal Ablation
- ☐ Transobturator Tape
- ☐ Transurethral Resection of Bladder Tumor
- ☐ Transurethral Resection of Prostate
- ☐ Transvaginal Tape
- ☐ Ureteral Stent Placement
- ☐ Ureteroscopy
- ☐ Urethroplasty
- ☐ NONE
- ☐ Other

_____
_____
_____

FAMILY HISTORY

- ☐ Birt-Hogg-Dude Syndrome
- ☐ Cancer (Bladder)
- ☐ Cancer (Kidney)
- ☐ Cancer (Prostate)
- ☐ Cancer (Testicular)
- ☐ Cystinuria
- ☐ Hereditary Leiomyomatous Renal Cell Carcinoma
- ☐ Polycystic Kidney Disease
- ☐ Renal Insufficiency
- ☐ Renal Tubular Acidosis
- ☐ Urolithiasis
- ☐ Von Hippel Lindau
- ☐ Other _____
- ☐ NONE

MEDICATIONS

List all current medications:

Medication	Dose	Frequency	`Route	Prescribing Physician

ALLERGIES

Are you allergic to latex? Yes_____ No_____
Are you allergic to IV Contract? Yes_____ No _____ If yes, reaction:_____
Are you allergic to any medications? Yes _____ No _____ If yes, _____
Others (drug, food, tape, etc.) _____

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SOCIAL HISTORY

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking: mm/dd/yyyy _____ Quit Smoking: mm/dd/yyyy _____
Number of Packs Per Day: _____ Total Years Smoking: _____

Alcohol Intake (please chose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night
- ☐ Never

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month

Occupation and Workplace:

_____

_____

Place of Residence:

_____

_____

Family History (First Degree Relatives)

MOTHER ALIVE _____DECEASED_____ (AGE)_____FROM WHAT:_____
FATHER ALIVE _____DECEASED_____ (AGE)_____FROM WHAT:_____

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REVIEW OF SYSTEMS

Please check yes or no for the following:

Symptom	Yes	No
FEVER/CHILLS		
RECENT WEIGHT LOSS		
CATARACTS PRESENT		
CATARACTS REMOVED		
GLAUCOMA		
MACULAR DEGENERATION		
MEMORY PROBLEMS		
PARALYSIS		
HISTORY OF SEIZURES		
DIZZY SPELLS		
DIABETIC		
HISTORY OF HEPATITIS		
THYROID PROBLEMS		
ABDOMINAL PAIN		
NAUSEA OR VOMITING		
INDIGESTION		
DIARRHEA		
CONSTIPATION		
USE A CANE, WALKER, OR A WHEELCHAIR		
ARTHRITIS		
BACK PAIN		
ASTHMA		
COPD/EMPHYSEMA		
HISTORY OF TUBERCULOSIS		
TAKE BLOOD THINNERS		
BLOOD CLOTTING PROBLEM		
CHEST PAIN		
HIGH BLOOD PRESSURE		
HISTORY OF HEART ATTACK		
PACEMAKER		
IRREGULAR HEARTBEAT		
HISTORY OF STROKE		
HISTORY OF HEART VALUE PROBLEM		
FREQUENCY		
PAIN WITH URINATING		
URINE LEAKAGE		
HISTORY OF KIDNEY FAILURE		
HISTORY OF KIDNEY STONES		
VISIBLE BLOOD IN URINE		

Influenza Vaccination:	☐ Yes	☐ No	Date:
Pneumonia Vaccination:	☐ Yes	☐ No	Date:
Colonoscopy:	☐ Yes	☐ No	Date:
Sigmoidoscopy:	☐ Yes	☐ No	Date:

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II. HAVE YOU EVER RECEIVED RADIATION THERAPY?

Yes _____ No _____ If yes, when? _____
Physician's Name/Facility: _____
City: _____ State: _____ ZIP: _____
What part of the body/area was treated? _____
_____

III. HAVE YOU EVER RECEIVED CHEMOTHERAPY?

Yes _____ No _____ If yes, when? _____
Physician's Name/Facility: _____
City: _____ State: _____ ZIP: _____

IV. HAVE YOU EVER RECEIVED HORMONE THERAPY?

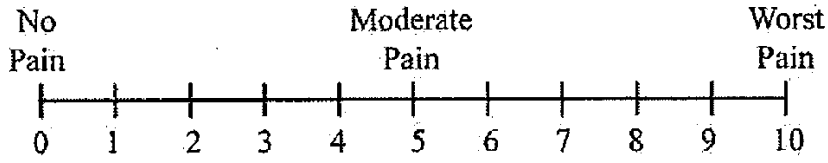
Yes _____ No _____
If yes, which medication? _____ When? _____
Physician's Name/Facility: _____
City: _____ State: _____ ZIP: _____

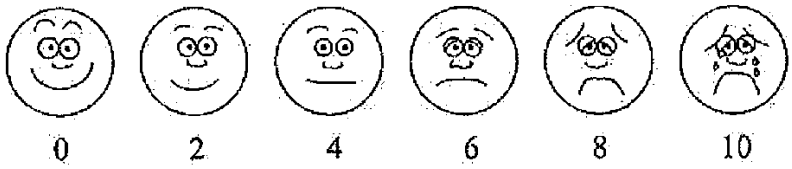
V. WE SCREEN ALL PATIENTS FOR DOMESTIC VIOLENCE OR ABUSE:

Does anyone at home hurt, hit or threaten you? Yes _____ No _____
If yes, please explain: _____
_____
How are you protecting yourself? _____

VI. PAIN

Are you in pain now? ☐Yes ☐No
On a scale of 1-10, 10 being the worst pain, how severe is your pain? _____





Location of pain: _____
How long have you been experiencing this pain? _____
How is your pain currently being managed? _____
Do you have lower back pain? Yes _____ No _____
If yes, have you been treated for lower back pain in the last 30 days?
Yes _____ No _____ Please explain: _____
_____

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VII. MOBILITY – FALL RISK ASSESSMENT

Do you need assistance? Cane _____ Walker _____ Wheelchair_____
Have you fallen before or been injured because of a fall? Yes _____ No_____
Do you feel weaker than you used to or have less strength in your arms or legs? Yes _____ No_____
Have you stopped or avoided exercise/daily activities because of a fear of falling? Yes _____ No_____
Do you have foot ulcers, bunions, hammertoes or calluses that hurt or cause you to adjust your steps?
Yes_____ No_____
Do you feel unsteady on your feet or shuffle when you walk? Yes _____ No_____
Do you feel dizzy when you stand up? Yes_____ No_____
How many falls have you had in the last 12 months? _____
Did you suffer an injury from your falls? Yes _____ No_____Explain:_____

VIII. FEMALE: PLEASE COMPLETE THE FOLLOWING INFORMATION:

When did you start having menstrual periods?_____Age/Year of 1st Period:_____
Are you currently having menstrual periods? Yes_____ No_____Last Period: _____
Are you now, or is there a chance, you might be pregnant? Yes_____ No_____
Number of pregnancies: _____Number of deliveries: _____Your age when first child born_____
Did you breast feed any of your children? Yes _____ No_____
Did you ever take hormones (I.e. Estrogens, birth control pills, androgens)? Yes _____ No_____
If yes, for how long? _____Prescribing physician:_____
Type of Delivery: _____

Date of last mammogram: _____Results: Positive Negative Unknown

Do you have a medical Durable Power of Attorney? ☐Yes ☐No

Do you have an Advanced Directive? ☐Yes ☐No

Do you have a Living Will? ☐Yes ☐No

If you answered 'yes' to any of the above questions, please provide a copy of the document.

As the patient you acknowledge with the completion of this form it constitutes your complete clinical history summary.

Patient Signature: _____ Date: _____
Nurse's Signature: _____ Date: _____
Physician Signature: _____ Date: _____

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MALE ONLY

CHECK THE FACTS Date:_____

About your urinary activities_____

Patient Name

Circle your score for each below

Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

0	1	2	3	4	5
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

Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?

0	1	2	3	4	5
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

Over the past month or so, how often have you found that you stopped and started again several times when you urinate?

0	1	2	3	4	5
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

Over the past month or so, how often have you found it difficult to postpone urination?

0	1	2	3	4	5
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

Over the past month or so, how often have you had to push or strain to begin urination?

0	1	2	3	4	5
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

Over the past month or so, how often have you had a weak urinary stream?

0	1	2	3	4	5
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

Over the last month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?

0	1	2	3	4	5
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

Total your score here

Total Symptoms here = Sum of Questions 1-7= ☐

Quality of Life:

How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?

0	1	2	3	4	5	6
Delighted	Pleased	Mostly satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible

From the American Urological Associate (AUA) Symptom Index for BHP

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MALE ONLY

Name: _____ Date of Birth: _____ Date: _____ MD: _____

TALKING TO YOUR DOCTOR

Many men feel embarrassed to talk to a doctor about ED. But talking about it is the first step toward getting past it. Your doctor may ask you some questions such as the ones below. Whether you're asked or not, tell your doctor anything that might shed light on the problem. Your doctor may do an exam and may run some tests to help find the cause of your ED.

FIVE KEY QUESTIONS

Circle your answer to each question. Then add up the numbers. Whether your doctor uses your score or not, it will help put your ED in perspective.

Over the past 6 months:
How do you rate your confidence that you could get and keep an erection?

1	2	3	4	5
Very Low	Low	Moderate	High	Very High

When you had erections with sexual stimulation, how often were your erections hard enough for you to penetrate (enter) your partner?

1	2	3	4	5
Almost never/Never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time	Almost Always/Always

During sexual intercourse how often were you able to maintain your erection to completion of intercourse?

1	2	3	4	5
Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult

When you attempted sexual intercourse, how often was it satisfactory for you?

1	2	3	4	5
Almost never/Never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time	Almost Always/Always

What your score means
Add up the numbers that go with your answers. If your Total score is 22 or higher, your ability to get an erection would be considered normal. The lower the score, the more likely it is that ED is a problem for you.

Write in your score
Add up the numbers you circled above. Write the total here. ☐

VENICE UROLOGY
LEADING EDGE TREATMENT CENTER
Part of the GenesisCare network

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (POLICY 085-H09)

I hereby authorize use or disclosure of the names individual's health information as described below.

Patient Name	Date of Birth	Physician Location Acronym RUF
Patient Address (Street, City, State, ZIP Code)		
The following individual or organization is authorized to make the disclosure: ○ GenesisCare Other (must be specific) Venice Urology, 842 Sunset Lake Blvd., Bldg. B, Ste. 403, Venice, FL 34292 Phone Number 941-485-3351 (fax# 941-485-7677)		
This information may be disclosed to and used by the following individual or organization (must include name and address, phone number) _____ _____		
Treatment Dates (if applicable)		Purpose of Request:

The following information is to be disclosed: (check all that apply – must be specific)

Yes	No	
□	□…	Consultation Reports
□	□…	Diagnostic Films
□	□…	Laboratory Results
□	□…	Physician Dictation
□	□…	Progress Notes
□	□…	Radiology or imaging reports
□	□…	Surgery/Pathology
□	□…	Complete record
□	□…	Other_____
□	□…	Other_____

Sensitive Information: I understand that the information in my record my include information relating to sexually transmitted diseases, AIDs, or HIV infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

Reclosure: I understand that any disclosure of information carried with it the potential for redisclosure, and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CRF 164.524. If I have questions about disclosure of my health information, I can conduct the GenesisCare Privacy Officer at (866)679-8944.

Signature of Patient or Legal Representative	**Date:**
If signed by Legal Representative, Relationship to Patient	