Urologic Surgical Associates of Delaware

Patient Name: ___________________________ Date of Birth: ____________

What is the reason for your visit: _______________________________________

Patient History

___Psychiatric Disorders
___ Glaucoma
___ High blood pressure
___ Coronary artery disease
___ Afibrillation
___ Heart attack, when ____
___ Stroke, when ____
___ Seizures
___ Diabetes, diagnosed when ____
___ Thyroid problems
___ Blood clots (leg clots,pulmonary embolus)
___ Bleeding disorder
___ AIDS/HIV
___ Kidney failure
___ COPD or emphysema
___ Asthma
___ Hepatitis or Jaundice
___ Other ________________

Smoking/Tobacco use:

___ Never used
___ currently use tobacco, what kind ___
How many years___
____ Quit Tabacco, How many years___
How many years of use___

Family History

___ prostate cancer, who and what age ____________
___ Bladder cancer
___ Kidney cancer
___ Kidney stones

Surgical History

___ Cardiac defibrillator or pacemaker
___ Heart bypass, when ____
___ Cardiac stents, when ____
___ Knee replacement side____ when____
___ Hip replacement side____ when ____
___ Appendectomy, when_____
___ Gallbladder removal, when ____
___ Colon resection-left,right,sigmoid?, when ____
___ Hysterectomy, when ____

Are you on hospice?
____

If So, why? _________________

Are you taking any medications? No ___ Yes ____ Which ones(s)
____

Do you take a blood thinner? No______Yes_____

Allergies:

____ IV contrast/Seafood ____ Penicillin ____ Aspirin ____ Tylenol ____ Sulfa ____Latex ____ Surgical tape
_____ Other____________________________

What is your preferred pharmacy?

Name: ____________________________

Location:
____

Do you have a heart condition, heart pace maker, or heart defibrillator?
List your Cardiologist: __________________________ **Phone** __________________________

VITALS (for office use only)
Vitals: BP______/______, BPM ______ RR ______ HT ______ WT ______ T ______

Urologic Surgical Associates of Delaware
Specializing in Robotic Surgery
Welcome to Our Practice

1815 W. 13th Street, The Station, Suite 4
Wilmington, DE 19806-4070
Tel. 302.571.8958 Fax 302.571.1320

Francis J. Schanne, M.D., F.A.C.S. **Katie Scanlon, PA-C** **Sadashiva Rao, M.D.**

Patient Information **(Please print.)**
Circle One Mr. Mrs. Ms. Miss Dr. Date ______________________
LAST Name of Patient ____________________FIRST Name of Patient__________________M.I.____
Street Address_____________________________________City_____________State____ Zip________
Social Security # ______________________________Date of Birth (DOB)_____________ Age _______
Sex__ Married __Single __Divorced __Widowed___ Home Phone ___________________
Work Phone ___________Cell Phone ______________ Email Address_________________________
Patient's Occupation:____________Employer & Address: ______________________________________

Referral Information How did hear about us? Ad? (Where______________________________)
Phone Book?___Website?____Friend? (Name: _____________) Physician?_____________________
Please provide: Your Primary Care Physician_____________________Phone ___________________
Referring Doctor ____Phone _____________________
Emergency Contact: Name ____________________________Relationship: Phone _________________
With whom can we share test results, lab results and other information regarding your care(check all that apply) Parents:__Spouse/Partner:___Children:___Siblings:___ Other: (specify)________________

Person Responsible for Payment
Name ___________________Relationship_________________DOB________Home Phone________
Address__________________Work Phone__________________________

Insurance Information (Please provide us with a card to copy)
Ins. Company ______________________ ID or Policy # __________________Group #___________
Subscriber's Name ____Sex______________
Relationship to patient ____________________SS# ________________________DOB_____________
Address ____ Phone_____________
Employer Information ____
Does your insurance require a referral? _______ If so, please provide us with it.

Secondary Insurance Information (Please provide us with a card to copy)
Ins. Company ______________________ ID or Policy # _______________________Group #________
Subscriber's Name (if other than patient) ______________________________________Sex_____
Relationship to patient ________________ SS# __________________DOB_________
Address ____Phone_____________
Employer Information ____
Does your insurance require a referral? _______ If so, please provide us with it.

Payment Authorization

I hereby authorize my benefits to be paid directly to Urologic Surgical Associates of Delaware and am financially responsible for non-covered services and/or balances not paid by the insurance carrier. I also authorize release of my income information required to process these claims. I authorize you to give me reasonable and proper medical care, including diagnosis, treatment (medical and surgical), by today's standards. In addition, I agree to pay a $25 fee for any missed appointments ($100 for procedures) not cancelled by 3:00 pm on the business day before my scheduled appointment.

SIGNATURE____
DATE______________________________

Release
I, the undersigned certify that I (or my dependent) have insurance coverage with the insurance company noted above and assign directly to the physician providing care for me all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

______________________________ _________________ _______________

Signature of responsible party Relationship Date

Preference for Communication
We are committed to providing private and efficient communication with you. Please complete the following information as specifically as possible. Please indicate the preferred method(s) if we need to reach you by phone.

HOME: Yes _____ No_________Phone Number ________________
If you are unavailable, may we leave a message:
With another person? Circle Yes/No Voicemail or answering machine? Yes/No
WORK : Yes _____ No_________Phone Number ________________
If you are unavailable, may we leave a message:
Circle Yes/No Voicemail or answering machine? Yes/No
CELL: Yes _____ No_________Phone Number ________________
If you are unavailable, may we leave a message:
Circle Yes/No Voicemail or answering machine? Yes/No
EMAIL: Yes _____ No_________Email Address ________________
If we leave you a message, which would you prefer?
Detailed message? __________ or Request for you to call our office? _________________

Thank you for choosing Urologic Surgical Associates of Delaware for your care.

Urologic Surgical Associates of Delaware

PRIVATE INSURANCE AUTHORIZATION FOR ASSESSMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize and direct payment of my medical benefits to Urologic Surgical Associates of Delaware for any services furnished to me by the physicians. I authorize the doctors to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such treatment to third party payers and/or health practitioners. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf, including fees for collection services needed. If my insurance company does not pay the practice within 30 days, I will be responsible for the bill. Payment is due upon receipt of a statement from our office.

____ Date ____________________________

Patient (or responsible party) Signature

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Urologic Surgical Associates of Delaware for any services furnished to me by the physicians. I authorize any holder of medical information about me needed to determine these benefits payable for related services, to be released to the Health Care Financing Administration and its agents.

____ Date ____________________________

Patient (or responsible party) Signature

MEDIGAP AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

If Medicare Crossover is not available to my secondary insurance, I understand it is my responsibility to submit claims. I authorize any holder of medical information about me to release Medigap insurer or name of supplemental insurer), any information needed to determine these benefits payable for related services. If no payment is received from my secondary insurance, I agree to be financially responsible for the balance due after Medicare payment. Payment is due upon receipt of a statement from our office.

____ Date ____________________________

Patient (or responsible party) Signature

ACKNOWLEDGEMENT OF RECEIPT AND CONSENT OF NOTICE OF PRIVACY PRACTICES and HEALTH INFORMATION

I have received a copy of the Urologic Surgical Associates of Delaware Notice of Privacy Practices.

_______________________________________ Date____________________________

Print name

_______________________________________ _______________________________________

Signature Signature of Patient representative/relationship

Purpose of Consent:

By signing this form below, you are giving the Urologic Surgical Associates of Delaware consent to use and disclose PHI (Private Health Information) to carry out treatment, payment, and healthcare options as listed in the Notice of Privacy Practices provided by Urologic Surgical Associates of Delaware.

Right to Revoke:

You have the right to revoke this consent at any time by giving Urologic Surgical Associates of Delaware written notice of your revocation to our office staff. Please understand that the revocation of this consent will not affect any use of your PHI prior to your revocation. Upon revocation of this consent, we reserve the right to discontinue your treatment.

With this consent, Urologic Surgical Associates of Delaware may call your home or other designated location and leave a message or voice mail message in reference to any subject that assists our practice with insurance matters, payment issues, appointment reminders, and overall clinic care. No personal information will be divulged and a return call will be requested. Urologic Surgical Associates of Delaware may mail to your home or designated location, any items that assist in your care. These items will be marked "personal and confidential." You have the right to request restrictions on how your PHI is disclosed. We are not required to agree to your requested restrictions, however we will make every effort to comply, and therefore is bound by this agreement.

_______________________________________ _______________________________________

Signature of Patient or Legal Guardian Date

Urologic Surgical Associates

Medical Records Release Form

Francis J. Schanne, M.D. | Katie Scanlon PA-C | Sadashiva Rao, M.D.

Please fax or mail medical records for the patient below to:

Urologic Surgical Associates of Delaware
1815 West 13th Street, The Station, Unit 4
Wilmington, DE 19806
Phone Number (302) 571-8958
Fax Number (302) 571-1320

I authorize you to release any/all information including the diagnosis and records of any treatments or examination that were rendered while under the care of your practice.

PATIENTS NAME: ____

PATIENTS D.O.B: ____

PATIENTS SIGNATURE: ____