CENTER FOR UROLOGY
DR. ABRAHAM L. WOODS, III
106 BOSTON AVENUE
SUITE 103
ALTAMONTE SPRINGS, FL 32701
PHONE: 407-830-4777 FAX:407-8304762

WELCOME TO OUR PRACTICE

PLEASE USE BLACK INK PEN

PLEASE COMPLETE THE ENCLOSED DOCUMENTS AND BRING THEM WITH YOU TO YOUR APPOINTMENT.

WE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD AND YOUR DRIVERS' LICENSE OR PICTURE ID.

PLEASE BRING WITH YOU ANY X-RAY FILMS OR MEDICAL RECORDS PERTAINING TO YOUR VISIT WITH US. WE WILL ALSO NEED A LIST OF ALL CURRENT MEDICATIONS.

IF YOUR INSURANCE CARRIER REQUIRES A REFERRAL OR AUTHORIZATION, PLEASE BE SURE TO BRING THAT WITH YOU OR HAVE IT FAXED TO (407) 830-7462. IF WE DO NOT HAVE A REFERRAL ON FILE, YOUR APPOINTMENT WILL BE RESCHEDULED.

IF YOU DO NOT HAVE INSURANCE, PAYMENT WILL BE EXPECTED AT THE TIME OF YOUR VISIT. WE ACCEPT CASH, CHECK, MASTERCARD AND VISA.

ALL CO-PAYS WILL BE COLLECTED AT SIGN-IN.

Directions to Center for Urology

FROM ORLANDO TRAVELING EAST

VIA I-4, EXIT RIGHT ON S.R. 436
CONTINUE TO BOSTON AVENUE (WENDY'S ON RIGHT)
TURN RIGHT ON BOSTON AVENUE – OFFICE BLDG ON RIGHT
106 BOSTON AVENUE, SUITE 103

FROM ORLANDO TRAVELING WEST

VIA I-4, EXIT S. R. 436. MAKE LEFT
CONTINUE TO BOSTON AVENUE (WENDY'S ON RIGHT)
TURN RIGHT ON BOSTON AVENUE – OFFICE BLDG ON RIGHT
106 BOSTON AVENUE, SUITE 103

FROM WINTER PARK TRAVELING NORTH

VIA U.S.17-92 TO S.R. 436, MAKE LEFT ON S.R. 436.
CONTINUE TO BOSTON AVENUE; TURN LEFT (WENDY'S ON CORNER)
OFFICE BLDG ON RIGHT
106 BOSTON AVENUE, SUITE 103

ABRAHAM L. WOODS, III., M.D., P.A.

PATIENT INFORMATION:

Referred By: _____ **Ph:#** _____

Name: _____ **Sex: M / F Date of Birth** ___/___/_____ **Age** ____

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

Home Phone: _____ **Wk Phone:** _____ **Cell Phone:** _____

Social Security#: _____ **Marital Status: M / S / D / W**

Email: _____

EMPLOYMENT:
Place of Employment: _____
Phone: _____ **Ext:** _____ **Occupation:** _____
Address: _____

Student Status (if 18 years or older): Full Time: _____ **Part time:** _____

SPOUSE INFORMATION: Name: _____ **DOB** _____
Place of Employment: _____ **Address:** _____

Person Responsible for account: _____ **Ph #:** _____

PRIMARY CARE DOCTOR: _____ **Ph:** _____

INSURANCE INFORMATION: PLEASE PRESENT YOUR INSURANCE CARD

PRIMARY INSURANCE: _____ **ID#** _____ **GRP#** ____

SECONDARY INSURANCE: _____ **ID#** _____ **GRP#** ____

Do you have a Health Surrogate? Y / N
Living Will? Y / N
Are you an Organ Donor? Y / N

I read and agree to the assignment and financial responsibility shown on the back of this form.

Date: _____ **Signed:** _____ **Staff Initials** _____

MALE

DATE OF VISIT:_____ CONSULT SENT BY:_____ NP EST

PATIENT NAME:_____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

CHIEF COMPLAINT: What is the main reason for your visit today?

_____

_____

_____

HISTORY OF PRESENT ILLNESS

Please answer the questions that apply to you.
Do you have:

Frequent daytime urination? ___Yes ___No
If yes, how often? _____

Frequent night time urination? ___Yes ___No
If yes, how often? _____

Decrease in urinary flow? ___Yes ___No
Frequent bladder infections? ___Yes ___No

Leakage of urine? ___Yes ___No
If yes, with cough, straining? ___Yes ___No

Blood in urine? ___Yes ___No
Unable to get to restroom in time? ___Yes ___No

PAST MEDICAL AND SOCIAL HISTORY

List all personal illnesses and previous surgeries with date.

	Date		**Date**

Do you smoke? ___Yes ___No If yes, how much? _____
Do you drink alcohol? ___Yes ___No If yes, how much? _____
Are you on any medications? ___Yes ___No If yes, list all. _____

_____

_____

_____

Do you have allergies to any drugs or medications? ___Yes ___No If yes, please list.

_____

_____

_____

PHYSICIAN USE ONLY: (Comments/Notes)

_____

ASSESSMENT/PLAN:

_____

PLEASE COMPLETE BACK PAGE

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following? Circle Yes or No

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:_____

Allergic/Immunologic
Hay fever Y N
Drug allergies Y N
Other:_____

Neurological
Tremors Y N
Dizzy spells Y N
Numbness/tingling Y N
Other:_____

Gastrointestinal
Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other:_____

Integumentary
Skin rash Y N
Boils Y N
Persistent rash Y N
Other:_____

Cardiovascular
Chest pain Y N
Varicose veins Y N
High blood pressure Y N
Other:_____

Musculoskeletal
Joint pain Y N
Neck pain Y N
Back pain Y N
Other:_____

Genitourinary
Urine retention Y N
Painful urination Y N
Urinary frequency Y N
Other:_____

Respiratory
Wheezing Y N
Frequent cough Y N
Shortness of breath Y N
Other:_____

FAMILY HISTORY: Has a member of you family ever had any of the following problems? Please circle Y or N and indicate which family member in the space provided.

Lung Disease Y N_____
Stroke Y N_____
Cancer Y N_____
High Blood Pressure Y N_____
Heart Attack Y N_____
Diabetes Y N_____
Type of Cancer:_____

MALE PHYSICAL EXAMINATION (PHYSICIAN USE ONLY)

Constitutional
Vital sign: T_____ P_____ R_____ General Appearance:_____ Normal

	Normal	Comments
Neurological/Psychiatric		
Mood and Affect:	_____	_____
Neck		
Neck:	_____	_____
Cardiovascular		
Auscultation:	_____	_____
Skin		
Inspection/Palpation:	_____	_____
Respiratory		
Respiratory Effort:	_____	_____
Lymphatic		
Palpation:	_____	_____

	Normal	Comments
Gastrointestinal		
Abdomen: (Organs)	_____	_____
Bladder/Kidney:	_____	_____
Hernia:	_____	_____
Liver and/or Spleen:	_____	_____
Genitourinary		
Anus and Perineum:	_____	_____
Scrotum:	_____	_____
Epididymides:	_____	_____
Testes:	_____	_____
Urethral Meatus	_____	_____
Penis:	_____	_____
Prostate:	_____	_____
Seminal Vesicles:	_____	_____
Sphincter Tone:	_____	_____

Physician:_____ **Date:**_____
Diplomate, American Board of Urology

The UroCuff® Test

I-PSS Patient Questionnaire

Patient Name: _____

DOB: _____ ID: _____

Date of Assessment: _____

Instructions: Place an "X" in the column that best describes your urinary habits. Leave the gray boxes blank.

	0	1	2	3	4	5	
In the past month...	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	Patient Score
How often have you had a sensation of not emptying your bladder completely after you finished urinating?							
How often have you had to urinate again less than two hours after you finished urinating?							
How often have you found you stopped and started again several times when you urinated?							
How often have you found it difficult to postpone urination?							
How often have you had a weak urinary stream?							
How often have you had to strain to begin urination?							
In the past month...	None	1 time	2 times	3 times	4 times	5+ times	Patient Score
How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?							
	Total Patient Score:						

Regarding your quality of life...	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel?	0	1	2	3	4	5	6

291-058 (Rev A)

SRS MEDICAL

FINANCIAL POLICY

Payments of charges, co-pays, co-insurances are due at the time services are rendered. As a courtesy we will file charges to your insurance company, however financial responsibility remains with the patient. Any amounts not covered by the insurance company are due from the patient. Accounts that have balances over 90 days past due could be turned over to a collection agency unless previous arrangements have been made. If your account is assigned to an attorney for collection and/or suit, the patient shall be responsible for attorney's fees and cost of collection.

HMO & PPO CONTRACTS:

The office will file charges for the plans we participate with. Co-payments are due at the time services are rendered. Patients are responsible for obtaining the necessary referrals from their Primary Care Physicians failure to obtain referrals may result in the patient being charged for their visit.

MEDICARE:

The Center for Urology accepts assignments on all Medicare claims. Please provide us with any additional insurance you may have.

Your signature will serve for any or all of the following:

I hereby give consent to the Center for Urology to provide necessary treatment.

Authorization for medical release: I authorize any physician examining and or treating me to release to any third party (such as an insurance company or government agency) any medical information requested for use in determining claim for payment. I also request payment benefits either to myself or to the party who accepts assignment.

Lifetime signature authorization for Medicare

I certify that the information given me in applying for payment under Title XVIII of the Social Security Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physicians or organization to submit a claim to Medicare for payment for me. I request that this also applies to any other insurance I may have.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

PrintName: _____

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW ABRAHAM L. WOODS, III, M.D., P.A. MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Abraham L. Woods, III, M.D., P.A. is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Abraham L. Woods, III, M.D., P.A. or received by Abraham L. Woods, III, M.D., P.A. from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Abraham L. Woods, III, M.D., P.A. will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

Abraham L. Woods, III, M.D., P.A. reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Abraham L. Woods, III, M.D., P.A. may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:
- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Abraham L. Woods, III, M.D., P.A. may determine that you require the services of a specialist. In referring you to another doctor, Abraham L. Woods, III, M.D., P.A. may share or transfer your healthcare information to that doctor.

Payment activities may include:
- Activities undertaken by Abraham L. Woods, III, M.D., P.A. to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, Abraham L. Woods, III, M.D., P.A. will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include
- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Abraham L. Woods, III, M.D., P.A. may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

ham L. Woods, III, M.D., P.A. may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do wish to receive appointment reminders.

nay not disclose your protected health information to family members or friends who may be involved with your treatment or care out your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; personal representative or spouse of a deceased patient.

are additional situations when Abraham L. Woods, III, M.D., P.A. is permitted or required to use or disclose your protected health nation without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

  For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

s Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient _____ DOB___/___/_____

Street Address_____ City_____ State_____ Zip_____

I hereby authorize Dr. Abraham Woods, 106 Boston Avenue Suite 103 Altamonte Springs Florida 32701 to disclose my protected health information, as described below to:

Name of individual or Entity_____

Street Address _____ City _____ State _____ Zip_____

Information to be released:

___Medical History, Examination Reports
___Treatment or Tests
___X-ray Reports
___Laboratory Reports
___HIV Test Results*
___Mental Health
___Sexually Transmitted Disease
___Alcoholism
____Surgical Reports
____Hospital Records Including Reports
____Developmental Disabilities
____Prescriptions
____Consultations
____Allergy Records
____Drug Abuse
____Other (Please specify)_____

*A listing of the statutory exceptions to release of HIV test results without consent is available,

Purpose for Need of Disclosure
____At the request of the individual

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

- Receive Copy of This Authorization
- Refuse to Sign This Authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- Revoke this authorization, except to the extent that the person(s) and or organization(s) listed above have already made in reference this authorization.

This authorization will remain in effect until the following date(s) _____

Signature of Patient(or Legal Representative)_____ Date_____

CENTER FOR UROLOGY
Abraham L. Woods, M.D.
106 Boston Avenue Suite 103
Altamonte Springs Florida 32701
Office: 407-830-4777 Fax: 407-830-4762

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Dr. _____

Phone _____ Fax _____

I authorize you to furnish a copy of medical records of:

Patients Name (Please Print) _____

DOB _____ **SS#** _____

Covering the period from _____, 200_ **to** _____200_

I release you from all legal responsibility or liability that may arise from this authorization

This authorization includes consent to FAX records if necessary

____ **YES** ____ **NO**

Signed _____

Date _____

Witness _____

ABRAHAM L. WOODS, III, M.D., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a copy of Abraham L. Woods III, M.D., P.A.'s Notice of Privacy Practices. This Notice describes how Abraham L. Woods III, M.D., P.A. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____

(Signature of Patient, or Personal Representative) **Date**

_____

(Relationship to Patient)

ABRAHAM L. WOODS, M.D.

Medication Flowsheet

Patient's Name________________________**Allergies**________________________

Date	Medication	Dose	Refills Start/Stop

CENTER FOR UROLOGY

PROCEDURE LOG

PATIENT'S NAME _____ **DOB** _____

	A	B	C	D	E	F
	DATE	PSA	DATE	PSA	DATE	PSA
1						
2						
3						
4						
	DATE	PROSTATE BX	DATE	PROSTATE BX	DATE	PROSTATE BX
1						
2						
3						
4						
	DATE	DX PROCEDURE	DATE	DX PROCEDURE	DATE	DX PROCEDURE
1						
2						
3						
4						
	DATE	SURGICAL PROC	DATE	SURGICAL PROC	DATE	SURGICAL PROC
1						
2						
3						
4						
	DATE	X-RAY	DATE	X-RAY	DATE	X-RAY
1						
2						
3						
4						
	DATE	MISC LABS	DATE	MISC LABS	DATE	MISC LABS
1						
2						
3						
4						

PROGRESS NOTE

Patient Name: _____

Date of Birth: _____ SSN: _____

Today's Date: _____

Today's Chief Complaint:

Date of Original History: _____
Original History in Chart: _____Y_____N
Reviewed History Today: _____Y_____N
No Change Noted in ROS or PFSH
From Original History _____

Changes in History:

Medications/Prescriptions:

Assessment

1)

2)

3)

Plan:

1)

2)

3)

Physical Exam
Scrotum:
_____ Normal
Epididymitis:
_____ Normal
Testes:
_____ Normal
Urethral Meatus:
_____ Normal
Penis:
_____ Normal
Prostate:
_____ Normal _____
Sphincter Tone:
_____ Normal
Seminal Vesicles:
_____ Normal
Anus/Perineum:
_____ Normal
Abdomen:
_____ Normal
Hernia:
_____ Absent
Liver and/or Spleen:
_____ Normal
Heart:
_____ Normal
Lung:
_____ Normal

U/A____U c/s ____ U cytology

PH _____ Ketone _____
Blood _____ Glucose _____
Leuk _____ Urobili _____
Nitrite _____ Sp. Gr. _____
Protein _____ Bilirubin _____

Sig: _____
Diplomate American Board of Urology

SUBSEQUENT VISITS AND FINDINGS

PATIENT'S NAME: ______________________________ **SS#** ___________

MO	DAY	YR	