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? _____

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:

REVIEW OF SYSTEMS

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

Constitutional Symptoms

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No

Other: _____

Eyes

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Pain	☐ Yes	☐ No

Other: _____

Allergic/Immunologic

Hay fever	☐ Yes	☐ No
Drug allergies	☐ Yes	☐ No

Other: _____

Neurological

Tremors	☐ Yes	☐ No
Dizzy spells	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No

Other: _____

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No

Other:

Integumentary

Skin rash	☐ Yes	☐ No
Boils	☐ Yes	☐ No
Persistent rash	☐ Yes	☐ No

Other:

Cardiovascular

Chest pain	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No

Other: _____

Musculoskeletal

Joint pain	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No

Other: _____

Genitourinary

Urine retention	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No
Urinary frequency	☐ Yes	☐ No

Other: _____

Respiratory

Wheezing	☐ Yes	☐ No
Frequent cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

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	☐ Yes	☐ No	_____	Heart Attack	☐ Yes	☐ No	_____
Stroke	☐ Yes	☐ No	_____	Diabetes	☐ Yes	☐ No	_____
Cancer	☐ Yes	☐ No	_____	Type of Cancer:			_____
High Blood Pressure	☐ Yes	☐ No	_____				

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

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

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	6 times
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

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 address: _____

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 DR: _____ Ph:# _____

INSURANCE INFORMATION: PLEASE PRESENT YOUR INSURANCE CARD

PRIMARY INSURANCE: _____ ID# _____ GRP# _____

SECONDARY INSURANCE: _____ ID# _____ GRP# _____

Do you have a Health Surrogate? ☐ Yes ☐ No

Living Will? ☐ Yes ☐ No

Are you an Organ Donor? ☐ Yes ☐ No

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

Signed: _____ Date: _____

Staff Initials _____

FINANCIAL POLICY

Payments of charges, co-pays, co-insurances are due at the time services are rendered. As a courtesy will file charges to your insurance company, however, financial responsibility remains with 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 collections 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 collections.

HMO & PPO CONTRACTS:

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

MEDICATE:

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.

Signature:_____ Date: _____

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 _____

Witness _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW ABRAHAM L. WOODS. III, M.D., PA 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., PA, 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., PA, 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., PA. 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., PA, 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., PA. 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., PA. 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., PA. 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.

Abraham L. Woods, III, M.D., PA. may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

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

There are additional situations when Abraham L. Woods, III, M.D., P.A. is permitted or required to use or disclose your protected health information 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.

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