Southeast Alaska Urology

John W. Huffer, M.D.

ADULT REGISTRATION FORM

Do you wish your family financial record to be listed in the patient or spouse name? Please check one: ❑ Patient ❑ Spouse

Race: Ethnicity: Preferred Spoken Language:

PLEASE PRINT PATIENT INFORMATION

Patient Name | Date of Birth | Sex | Social Security No.

Mailing Address | City | State | Zip

Home Phone | Mobile Phone | E-mail Address | Marital Status

Employer (If self, name of business) | Dept. /Position Held | Union/Local No. | Work Phone/Ext

In case of emergency notify: Name / Relationship / Phone / Mailing Address

SPOUSE INFORMATION

Spouse Name | Date of Birth | Sex | Social Security No.

Mailing Address | City | State | Zip

Employer (If self, name of business) | Dept. /Position Held | Union/Local No. | Work Phone/Ext.

INSURANCE INFORMATION

COMPLETE FOR EACH COMPANY (please bring your insurance card to your appointment)

	Primary Insurance	Secondary Insurance	Tertiary Insurance	Other Insurance
Insurance Company				
Policy Holder's Name				
Policy Holder's Date of Birth				
Patient's Relation to Policy Holder				
Identification No. / Policy or Group No.				
Insurance Company Address				

AUTHORIZATION: I understand full payment received is my responsibility regardless of my insurance coverage.
I hereby authorize the Clinic to release my insurance information acquired in the course of examination or treatment. I further authorize my insurance company to pay directly to the Clinic any medical/surgical benefits due to me that have not been paid in full. This authorization shall expire upon written notice or one year from this date.

SIGNATURE Date

HIPAA CONSENT FORM

I give Southeast Alaska Urology, LLC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Southeast Alaska Urology, LLC's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Southeast Alaska Urology, LLC is not required to agree to the request. If Southeast Alaska Urology, LLC agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

May we leave a detailed message at the phone numbers you have listed? Yes No ☐

Signature: ____ Date:_______________

Patient, parent or guardian

Please list any family member(s) that you would like to allow us to discuss your medical treatment and care with:

____

If signed by patient representative, state relationship to patient: _______________

Southeast Alaska Urology

A clear understanding of your financial responsibility for care is essential in assuring a professional relationship with our staff. Please read this form carefully and have your questions answered before signing.

Payment: We accept cash, checks or visa and mastercard.

Insurance: Remember-You are ultimately responsible for your bill. If you have private insurance, as a courtesy, we will bill your Insurance for our services once per visit or procedure. All patients are asked to pay the full amount for services at the beginning of each year until deductible is met. You will then be expected to pay your "copay" at each following visit. Any overpayments will be refunded to the appropriate party. If there is a balance left after your insurance has paid, you will be billed; that amount is due upon receipt of your first statement from our office. If your Insurance has not paid for any reason, you will be billed and are responsible for the charges on receipt of your first statement from our office. Please remember that insurance is a contract between you and your insurer. We will be happy to help if we can but will not become involved in disputes concerning deductible, co-payments, secondary insurance or so-called "usual and customary" reductions by your insurer.

Medicare Patients: Please remember that you have a yearly deductible and copay for each visit. Medicaid Patients: Please be prepared to pay your $3.00 copay at time of service.

Veteran's Administration Patients: You are required to get PRE-AUTHORIZATION before each visit if you want VA to pay. A 5 day notice is now required by VA; it is your responsibility to see this is done. VA authorization must be received in our office before each visit. If no authorization is received, you will be expected to pay in full at the time of service.

Chief Andrew Isaac Health Center Patients: You must bring a purchase order from Contract Health for each and every visit. This is their requirement for us to be paid. If no purchase order is provided, you will be expected to pay at the time of service unless you have Medicaid coupons.

Workers Compensation: No retroactive filing will be done by our office. If it is work related, you must state that at the time of service and be prepared will all necessary information.

If you fail to cancel and do not show for any appointment, you will be charged a $30 fee. This fee will be billed directly to you and not your insurance. After 3 no shows, no further appointments will be made for you. Mail Returns (no forwarding address): Upon return to our office, these accounts will be sent immediately to our Collection Agency.

Delinquent Accounts: Past due accounts may be referred to our Collection Agency for collections. You will be responsible for all collection fees incurred in addition to the past due balance. There will be a 50% handling fee added if your account is sent to collections. Once an account has been placed with the Collection Agency, all questions must be directed to their office. Additionally we will not be liable for any consequences which may result from a collection agency's effort to obtain payment.

____

Printed Name Signature Date

Southeast Alaska Urology ASSIGNMENT OF BENEFITS

I authorize and request that payment be made to Southeast Alaska Urology for services rendered. I agree that this authorization will cover *all* medical services rendered until such authorization is revoked by me. A copy of this form may be used in lieu of original document.

Your insurance company may request chart notes in order to process your claim. By signing below, you are authorizing us to release pertinent clinical information to your insurance company.

____

Patient Signature

____

Parent Signature (if patient is minor child)

____

Date

Southeast Alaska Urology

Urology Patient Questionnaire

Name: ____**DOB**:_________________**Date**:_______________

These questions are intended to allow Dr. Huffer to better understand your condition, and to understand your goal(s). You can choose to skip most or all questions, or provide as much detail as you feel comfortable answering.

List in order of importance what problems you want to address with the doctor:

____

____

When did your specific problem(s) begin?

Problem(s) constant, or come and go?

What makes the problem(s) better or worse?

What goal(s) do you hope to achieve visiting Dr. Huffer?

Referring Physician/Clinic: ____
Other Physician involved in your care:

Would you like a copy of clinical note(s) to go to any physician or organization? Who? Yes No____

Medications- Please list all current medications.

- ____Dose/Strength:________________
- ____Dose/Strength:________________
- ____Dose/Strength:_______________
- ____Dose/Strength:________________
- ____Dose/Strength:________________
- ____Dose/Strength:________________
- ____Dose/Strength:________________
- ____Dose/Strength:________________

Do you have any allergies? **Y/N** If yes, list: ____

Do you have a pain contract with another doctor? **Y/N** If yes, please list where: _______________________

What is your preferred pharmacy? ____

Name:____DOB:_____________________Date_____

Social History

Marital Status(circle one) Married Spouse's name____
Single Divorced If other, specify: ____
Do you have children? Yes No If so, how many? __________ age(s)__________________________
Current occupation(s):
____
If retired, what was your occupation?: ____
Alcohol use in the past: **Yes No** If yes, please specify
amount:____
Alcohol use currently: **Yes No** If yes, please specify
amount:____

Tobacco use in the past: **Yes No** If yes, please specify
amount:____

Tobacco use currently: **Yes No** If yes, please specify
amount:____

Recreational Drugs in the past: **Yes No** If yes, please specify
amount:____

Recreational Drugs currently: **Yes No** If yes, please
specify:____

Have you had in the past, or do you currently have any reason to believe you might have a sexually transmitted infection? Yes No If yes, please specify
incident(s):____

Today's Symptoms (check boxes for any that apply)

Genitourinary/Urologic

- ☐ Blood in Urine
- ☐ Dribbling or Weak Stream (Circle One)
- ☐ Burning with Urination
- ☐ Erection/Ejaculation Problem (Circle One)
- ☐ Kidney/Bladder Stone(s) (Circle One)
- ☐ Bladder/Kidney Infection (Circle One)
- ☐ Sensation of Not Emptying
- ☐ Bladder Pain
- ☐ Testicular/Scrotal Swelling
- ☐ Urgency/Frequency
- ☐ Hesitancy
- ☐ Urinary Incontinence
- ☐ Urinary Tract Infection
- ☐ Inability to Urinate
- ☐ Bedwetting
- ☐ Vaginal Bleeding/Discharge (Circle One)
- ☐ Flank/Kidney Pain

Constitutional

- ☐ Appetite Change
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Weight Loss

Eyes

- ☐ Blindness
- ☐ Blurred Vision

Neurological

- ☐ Dizzy Spells
- ☐ Headache
- ☐ Leg or Arm Weakness (Circle One)
- ☐ Memory Loss
- ☐ Numbness/Tingling

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Rectal Bleeding/Bloody Stools
- ☐ Black, tarry Stool

Cardiovascular

- ☐ Chest Pain/Angina
- ☐ short of breath

☐ **Skin**

- ☐ Rash
- ☐ Other___________________

Musculoskeletal

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Cramps/Spasms
- ☐ Other___________________

Ears/Nose/Throat

- Ear Infection
- Sinus Congestion
- Other___________________

Name: ____DOB:______________________Date_____________

Health History (Check boxes for any conditions that apply, past or present)

- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Aortic Aneurysm
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Chronic Fatigue
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
  - o Type 1
  - o Type 2
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Herniated Disc
- ☐ Hiatal Hernia
- ☐ Hypertension
- ☐ Irritable Bowel Disease
- ☐ Kidney Disease
- ☐ Migraine
- ☐ Mitral Stenosis
- ☐ Mitral Insufficiency
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Peptic Ulcer
- ☐ Phlebitis
- ☐ Prostatitis
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Heart Attack
- ☐ **Date:** _________________
- ☐ Stroke
- ☐ **Date:** _________________
- ☐ Transplant Recipient
- ☐ **Site:** __________________
- ☐ Cancer
- ☐ **Type:** _________________
- ☐ Other:____________
- ☐ Other:____________

Surgical History (Please list any surgeries you can remember)

Please feel free to share any additional information, if you wish, about you, your health and your life that is important or meaningful to you: