



UROLOGY, P.C.

5500 Pine Lake Road Lincoln, Nebraska 68516 (402) 489-8888 Fax (402) 421-1945

The physicians and staff of Urology, P.C. would like to welcome you to our facility. Please bring all completed forms with you to your appointment.

Please arrive 30 minutes prior to your appointment time, this will allow us to make your experience here more pleasant and efficient. It is important for us to meet your medical needs; therefore, we feel the following information is needed:

- 1) Medical information pertaining to your visit
- 2) List of your prescriptions or over-the-counter or herbal medications including doses
- 3) Lab results (urine cultures, PSA, blood work, etc.)
- 4) X-rays (actual films preferred)
- 5) Referrals or Pre-authorizations if required by your Insurance
- 6) All Insurance Cards (Medicare, Medicaid, etc.)
- 7) Photo ID (Driver's License, Military ID, etc.)

We are located on the NW corner of 56th & Pine Lake Road in Lincoln, Nebraska. If you have any further questions or concerns regarding the above information please feel free to contact us at (402) 489-8888 and we will be happy to assist you.

Please Note: Due to the unpredictability of a surgical practice, our surgeons may be called to emergency surgery during your appointment time. Under these circumstances, you will see your physician's specific Urology-trained Physician Assistant or Nurse Practitioner.

We look forward to caring for you.

Urology, P.C.

Visit us at www.lincolnurologypc.com

UROLOGY P.C. & UROLOGY SURGICAL CENTER – Patient Registration					
Referring Physician:					Today's Date
Primary Care Physician:					
Patient's LEGAL Name PATIENT INFORMATION					
Last Name:		First:	M.I.	Birth Date:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Nickname:			Former/Maiden name(s):		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated				SSN:	
Street Address:			Billing Address (if different):		
City		State	Zip Code	Home Phone: ()	
				Cell Phone: ()	
Email address:					
Current Work Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Not Employed					
Occupation:		Employer Name	Address:	Work Phone & Ext.: ()	
Current College Student: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			Name of School:		
PRIMARY CONTACT PERSON (SPOUSE, PARENT, SIGNIFICANT OTHER, ETC.)					
Name:			Relationship:		
Address:			Employer:		
Home Phone: ()		Work Phone: ()		Cell Phone: ()	
SECONDARY CONTACT PERSON (PARENT, CHILD, NEXT OF KIN, ETC.)					
Name:			Relationship:		
Address:			Employer:		
Home Phone: ()		Work Phone: ()		Cell Phone: ()	
INSURANCE COVERAGE					
Is this patient a Ward of the State? <input type="checkbox"/> Yes <input type="checkbox"/> No			Case Manager:	Phone:	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete appropriate insurance information below.					
MEDICARE COVERAGE (specify)			MEDICAID (WELFARE) COVERAGE		
Is Medicare Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is this patient covered by Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medicare #			NE Total Care #		
Railroad Medicare #			Wellcare #		
Medicare (Hospital Only) #			UHC Community Plan #		
Medicare Advantage Plan (Unicare, Secure Horizons, etc.)					
Plan Name:					
Plan #		Group #			
SUPPLEMENTAL or OTHER INSURANCE COVERAGE					
Insurance Company & Address:				Primary Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber's Name		Subscriber's SSN		Subscriber's Date of Birth	
			Is this a Self/Individual Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Policy #		Group #		Subscriber's Relationship to Patient	
			Subscriber's Employer		
SUPPLEMENTAL or OTHER INSURANCE COVERAGE					
Insurance Company & Address:				Primary Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber's Name		Subscriber's SSN		Subscriber's Date of Birth	
			Is this a Self/Individual Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Policy #		Group #		Subscriber's Relationship to Patient	
			Subscriber's Employer		

What is your preferred pharmacy? _____ Location _____

Race/Ethnicity (circle one): **White** **Hispanic/Latino** **Black/African American** **Asian** **Multi-Racial** **Decline to specify**

Preferred Language (circle one): **English** **Other** _____ Interpreter Required

Is this medical condition due to an accident of any kind? **YES** **NO**

If yes, was it (choose one): **Work Related** **Auto** **Home** **Other**

Do you have a Living Will or Advanced Directive (please bring a copy with you)? **YES** **NO**

Do you have a Medical Power of Attorney (please provide documentation)? **YES** **NO**

If yes, please indicate name, address & phone: _____

MEDICARE PATIENTS ONLY complete information in box:

If you are not a Medicare patient, please continue below the box.

1. Are you a Veteran? **YES** **NO**

If yes, were you referred to us by the VA? **YES** **NO**

If yes, do you have a written referral for today? **YES** **NO**

2. Do you have a Federal Black Lung Card? **YES** **NO**

3. Do you have a Veterans FEE BASIS ID card? **YES** **NO**

4. Are you covered by a current employer's health insurance plan through you or your spouse's employer?

YES **NO**

5. Are you entitled to Medicare because of disability or End Stage Renal Disease? **YES** **NO**

→ **AUTHORIZATION TO TREAT**

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

→ **ASSIGNMENT OF BENEFITS**

I hereby assign all medical and/or surgical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. **I understand that I am financially responsible for all allowed charges or co-insurance amounts which are not paid by my insurance company in full within 30 days of the first statement received.**

→ **RELEASE OF INFORMATION TO INSURANCE COMPANY**

I authorize Urology, PC and/or Urology Surgical Center to release to the Medicare carrier and/or the Insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to Urology, PC or Urology Surgical Center.

→ **NEBRASKA STATE LAW REGARDING MINORS** - Nebraska state law defines a minor as anyone 18 years of age and younger. These patients are required by this law to have a legal guardian present or if this is not possible, you must make prior arrangements with our office. If prior arrangements are not made, it could result in the appointment needing to be rescheduled.

→ I understand there will be a \$25 fee for a no show appointment or returned check (See also Financial Policy) payable only by cash, money order, credit or debit card.

I understand that I will be responsible for all charges if the listed insurance information is not correct.

Signature _____ Date _____

Urology PC Health History

Date:	Name:	DOB:	Sex:	Ht:	Wt:
REASON FOR VISIT:			Preferred Pharmacy Name & Address:		

Tobacco Use: (please circle) Never Current Former Age Quit? _____
Type: Cigarettes Cigar Pipe Smokeless How much daily? _____

Please circle YES or NO for each of the following:

Do you have high blood pressure? NO YES Do you have diabetes? NO YES
 Do you have any heart disease (bypass, stent, surgery)? NO YES
 Have you had a flu shot? NO YES When? _____ Pneumonia Vaccination? NO YES When? _____

List all Current Medications. Including over-the-counter, aspirin products, fish oil, inhalers and vitamins.

List all Allergies to medications and your reactions.

Allergy to Latex? NO YES **Allergy to Iodine or shell fish?** NO YES

Past Medical History: (please circle appropriate answer)

Neurological Diseases: Multiple Sclerosis Parkinson's Muscular Dystrophy None

Cancer: NO YES **Type of Cancer:** _____ **Treatment:** Surgery Chemo Radiation

Diabetes: NO YES If yes, do you take medication for this? NO YES

Arthritis: NO YES	Asthma: NO YES	COPD: NO YES
Heart Disease: NO YES	Hepatitis / Liver Disease: NO YES	HIV: NO YES
Hypertension: NO YES	Osteoporosis: NO YES	Kidney Disease: NO YES
History of Stroke or TIA: NO YES	History of Seizure: NO YES	Thyroid Problems: NO YES
Urinary or Kidney Stones: NO YES	Pacemaker or Defibrillator: NO YES	

Please List all Previous Surgeries and year performed.

Surgery	Year	Surgery	Year

Have you ever had a Colonoscopy? NO YES What year was it performed? _____

Family History: (Please mark those that apply with an 'X')

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Heart Disease								
Diabetes								
Hypertension								
Anesthesia problems								
Cancer (include type)								

I was adopted and have no available health history.

Personal Alcohol Use: None How Much: _____ How Often: _____

Personal Caffeine Use: None How Much: _____ How Often: _____

Total Joint Replacements or been told to take antibiotics prior to surgery or dental procedures? NO YES
 If yes, What joint? _____ When was surgery? _____

Heart Attack: NO YES If yes, when: _____

Congestive Heart Failure: NO YES

TMJ or difficulty opening your mouth wide: NO YES

Back or neck disorder: NO YES

Fever during surgery: NO YES

Trouble putting a breathing tube in your airway for surgery: NO YES

Do you experience any shortness of breath at rest or during exercise: NO YES

Can you walk up 2 flights of steps without having to stop and "catch your breath": NO YES

If patient is 19 or younger:

Was patient born prematurely? NO YES If yes, how many weeks early? _____

Any developmental delays as a child? NO YES

Form Completed by: _____ Date: _____



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EVALUATION QUESTIONNAIRE FOR IMPOTENCY OR SEXUAL DYSFUNCTION

Your responses to the items on this questionnaire will allow us to make a preliminary decision about arrangements necessary for the proper diagnostic and treatment program.

1. IDENTIFICATION INFORMATION

Name _____ Birth Date _____

Address _____
Street City State Zip Code

Occupation _____

Height _____ Weight _____

Your Doctor's Name _____

Your Doctor's Address _____
Street City State Zip Code

Your Doctor's Telephone Number (____) _____

Your Doctor's Specialty: __General Practice __Urology __Other (specify) _____

2. Please describe in your own words your past sexual history. Include in this description your current problem, how the problem began, and how this problem affects your life now.

3. Please give a brief description of your social-educational background (parents, marital status, children, social environment, etc.). Include the items that *you* feel may be important to us in assessing the potential value of this treatment or in selecting the best treatment to suit your case.

PLEASE CHECK THE CORRECT BOX TO THE YES/ NO QUESTIONS

4. CHARACTERISTICS OF ERECTION

- | | YES | NO |
|--|--------------------------|--------------------------|
| A. Do you have erections at all? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Are you able to get sufficient erection to make penetration?
___ Never ___ Rarely ___ Half the Time
___ Most of the Time ___ Always | | |
| C. Do you ever awaken in the morning with an erection? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Does the quality of your erections improve occasionally? | <input type="checkbox"/> | <input type="checkbox"/> |

5. CHARACTERISTICS OF PENIS

- | | | |
|--|--------------------------|--------------------------|
| A. Are you concerned about the size of your penis?
If so, what is the problem? _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

6. CHARACTERISTICS OF ORGASM OR CLIMAX

- | | | |
|---|--------------------------|--------------------------|
| Can you <i>now</i> have orgasms or climaxes?
If so, how often? _____
If so, how is orgasm achieved?
___ Vaginal Penetration ___ By Hand ___ Orally
___ Conventional Method with Partner but without Penetration
___ Other (describe) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Can you masturbate to climax?
If so, does the penis get hard then? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. How often did you have orgasms before your problem developed? _____ | | |

7. CHARACTERISTICS OF SEXUAL DESIRE

- A. How strong is your desire for sexual intercourse?
___ Poor ___ Fair ___ Strong ___ Very Strong
- B. How strong is the desire of your wife or sexual partner?
___ Poor ___ Fair ___ Strong ___ Very Strong
- C. How long have you been with your current partner? _____
- D. What is your partner's attitude about your possibly having an operation to treat impotence? _____

8. TREATMENT

- | | YES | NO | | | | | | | | | | |
|--|--------------------------|--------------------------|-------|-------|-------|-------|-------|-------|-------|-------|--------------------------|--------------------------|
| A. Have you seen a doctor for treatment of your problem?
If so, please describe the treatment and results: _____

_____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | |
| B. Have you consulted any kind of mental health counselor (specialist, psychiatrist, psychologist, or social worker) about your problem?
If so, please describe when and the results. (The counselor's name and address are necessary so that we may obtain his or her report, which in some cases, is extremely helpful to us.) _____

_____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | |
| C. Do you take any daily or weekly medication?
If so, list them and indicate the purpose of each:
<table border="1"><thead><tr><th><u>Medication</u></th><th><u>Purpose</u></th></tr></thead><tbody><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr></tbody></table> | <u>Medication</u> | <u>Purpose</u> | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Medication</u> | <u>Purpose</u> | | | | | | | | | | | |
| _____ | _____ | | | | | | | | | | | |
| _____ | _____ | | | | | | | | | | | |
| _____ | _____ | | | | | | | | | | | |
| _____ | _____ | | | | | | | | | | | |
| D. Have you ever had a heart attack?
If so, describe the severity and results: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | |
| E. Have you had any major surgery?
If so, describe and indicate the results: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | |
| F. Have you had any serious injury from an accident?
If so, describe it: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | |

9. If there are any questions that you cannot answer or that you feel need further discussion for clarification, at what phone number would you want to be reached?

	Residence	Business
Telephone Number	(____) _____	(____) _____
Time To Call	_____	_____
Other Instructions:	_____	

10. This space is provided for any further information that you feel is pertinent and might have been overlooked: _____

11. Are you aware of the use of prosthetic implants for treatment of impotence? If so, where did you learn of this? How do you feel about this possibility?

Signature _____ Date _____



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International Index of Erectile Function (IIEF) Questionnaire*

(Write the number that best describes your erectile function for the past 4 weeks in the spaces provided.)

Over the past four weeks:

1. How often were you able to get an erection during sexual activity? _____

- 0 = No sexual activity
- 1 = Almost never/never
- 2 = A few times (much less than half the time)
- 3 = Sometimes (about half the time)
- 4 = Most times (much more than half the time)
- 5 = Almost always/always

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?

- 0 = No sexual activity
- 1 = Almost never/never
- 2 = A few times (much less than half the time)
- 3 = Sometimes (about half the time)
- 4 = Most times (much more than half the time)
- 5 = Almost always/always

3. When you attempted sexual intercourse, how often were you able to penetrate (enter) your partner? _____

- 0 = Did not attempt intercourse
- 1 = Almost never/never
- 2 = A few times (much less than half the time)
- 3 = Sometimes (about half the time)
- 4 = Most times (much more than half the time)
- 5 = Almost always/always

4. During intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner? _____

- 0 = Did not attempt intercourse
- 1 = Almost never/never
- 2 = A few times (much less than half the time)
- 3 = Sometimes (about half the time)
- 4 = Most times (much more than half the time)
- 5 = Almost always/always

5. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse? _____

- 0 = Did not attempt intercourse
- 1 = Extremely difficult
- 2 = Very difficult
- 3 = Difficult
- 4 = Slightly difficult
- 5 = Not difficult

6. How many times have you attempted sexual intercourse? _____

- 0 = No attempts
- 1 = One to two attempts
- 2 = Three to four attempts
- 3 = Five to six attempts
- 4 = Seven to ten attempts
- 5 = Eleven or more attempts

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

- 0 = Did not attempt intercourse
- 1 = Almost never/never
- 2 = A few times (much less than half the time)
- 3 = Sometimes (about half the time)
- 4 = Most times (much more than half the time)
- 5 = Almost always/always

8. How much have you enjoyed sexual intercourse? _____

- 0 = No intercourse
- 1 = No enjoyment
- 2 = Not very enjoyable
- 3 = Fairly enjoyable
- 4 = Highly enjoyable
- 5 = Very highly enjoyable

9. When you had sexual stimulation or intercourse, how often did you ejaculate?

- 0 = No sexual stimulation/intercourse
- 1 = Almost never/never
- 2 = A few times (much less than half the time)
- 3 = Sometimes (about half the time)
- 4 = Most times (much more than half the time)
- 5 = Almost always/always

10. When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax? _____

- 0 = No sexual stimulation/intercourse
- 1 = Almost never/never
- 2 = A few times (much less than half the time)
- 3 = Sometimes (about half the time)
- 4 = Most times (much more than half the time)
- 5 = Almost always/always

11. How often have you felt sexual desire? _____

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

12. How would you rate your sexual desire? _____

- 1 = Very low/none at all
- 2 = Low
- 3 = Moderate
- 4 = High
- 5 = Very high

13. How satisfied have you been with your overall sex life? _____

- 1 = Very dissatisfied
- 2 = Moderately dissatisfied
- 3 = About equally satisfied and dissatisfied
- 4 = Moderately satisfied
- 5 = Very satisfied

14. How satisfied have you been with your sexual relationship with your partner? _____

- 1 = Very dissatisfied
- 2 = Moderately dissatisfied
- 3 = About equally satisfied and dissatisfied
- 4 = Moderately satisfied
- 5 = Very satisfied

15. How would you rate your confidence that you could get and keep an erection?

- 1 = Very low
- 2 = Low
- 3 = Moderate
- 4 = High
- 5 = Very high

Signature: _____

Date: _____

UROLOGY, P.C./UROLOGY SURGICAL CENTER

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In order to accommodate the needs and requests of our patients we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of service *exactly* what those guidelines are.

Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

Additionally, we will collect a co-pay as indicated on your insurance card. However, insurance policies vary and the possibility remains your insurance company may apply your charges to a deductible or require additional co-insurance to be paid by the patient. We have no control over how your claim is processed by your insurance company and any issues related to processing of claims must be addressed with your insurance carrier.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Printed Name: _____

Signature: _____ Date: _____

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FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office and to assure you that Urology, P.C. / Urology Surgical Center is committed to providing you with the best possible care. Please read the following information regarding our Financial Policy.

If you have insurance coverage, as a courtesy, we will file ALL insurance claims, as long as an assignment of benefits is given to us. We participate with most of the major insurance companies. Please contact your insurance company if you have any questions regarding participation. Please remember the following regarding insurance:

- You are ultimately responsible for follow up with your insurance company regarding payment of your claim
- Your insurance is a contract between you and your insurance company
- Not all services are a covered benefit in all insurance policies
- You are responsible for any balance due on your account
- We reserve the right to pre-collect on any medical condition which may not be covered by insurance.

Please contact our billing department promptly at **402-489-8888 option 4** if you have questions or are unable to pay your bill in full within 30 days of the first statement you receive.

If you have no insurance coverage, you will be required to pay \$50 at the time of your visit; you will be billed for any additional charges. Payment arrangements are made in advance with our Patient Account Manger or billing department. To assist you, we accept cash, check, MasterCard, Visa and Discover. There will be a \$25 charge on all returned checks. Remember to bring the following items along with you to your appointment:

- Your current insurance card
- Co-pay required by your insurance company
- A referral from your primary care physician, if your insurance requires one

Should you desire, we can provide you an estimate of your financial obligations regarding any proposed treatment/surgery. Please contact us promptly for assistance in the management of your account. We do use outside agencies as a means of collections should we deem it necessary. If you have any questions about the above information or any uncertainty regarding insurance coverage, do not hesitate to contact us at **402-489-8888 option 4**.

THERE WILL BE A \$25 FEE FOR ANY NO SHOWS WHICH MUST BE PAID PRIOR TO RESCHEDULING PAYABLE ONLY BY CASH, CREDIT OR DEBIT CARD, OR MONEY ORDER.