SHENANDOAH UROLOGIC SPECIALISTS
a division of Internal Medicine Consultants

148 Linden Dr STE 103
Winchester, VA 22601
Phone (540) 722-0627
Fax (540) 722-9533

Confidential Patient Information and Agreement

PLEASE PRINT CLEARLY

Patient Name: _____

Address: _____

City:_____State:_____Zip:_____

Home Phone: ( ) _____Work Phone: ( ) _____

Cell Phone: ( ) _____ Email: _____

Date of Birth: _____/_____/_____ Gender Identity: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: American Indian or Alaska Native White Other Race

Black or African American Native Hawaiian or Pacific Islander

Occupation: _____

Pharmacy (Local): _____

Pharmacy (Mail): _____

Emergency Contact: _____Ph: ( ) _____

Emergency Contact Relation: _____

Responsible Person Name: _____Ph: ( ) _____

Primary Insurance: _____

Secondary Insurance: _____

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Please list your primary care physician's information:

Primary Doctor (PCP): _____

PCP Phone: _____

PCP Fax: _____

Please list ALL of your current doctors besides your PCP (i.e. pulmonologist, oncologist, internist, cardiologist, etc...):

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Please list your referring doctor's information:

Referring Doctor: _____

Referring Doctor Phone: _____

Referring Doctor Fax: _____

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Patient and Responsible Party Authorization

I authorize SHENANDOAH UROLOGIC SPECIALISTS on behalf of _____ (your insurance company) to apply for benefits on my behalf for their covered services rendered and request payments from the above named insurance company be paid directly to SHENANDOAH UROLOGIC SPECIALISTS for the treated person named. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above named agent. I permit a copy of this authorization to be used in place of the original. IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN, AND/OR PARENTS RESPONSIBILITY. Patient or responsible party further agree to pay any and all collection fees incurred and legal expenses, including but not limited to Collection Agency and attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest agreed to or that may be adjudicated for the collection of past due debt on accounts for _____ (your name). A missed appointment, not canceled with 24 hours notice, will be billed for the time allowed and is not covered by insurance. If Medicare and/or my commercial insurance should deny any or all charges then I agree to be personally and fully responsible for any and all balances due.

Print Name: _____ Date: _____

Signature: _____

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Acknowledgement of 2022 Updated SUS Policies & Regulations

1. You may be asked to schedule an appointment for prescription refills. We will occasionally refill certain prescriptions over the phone, but that will be left up to the discretion of the provider and based on patient follow up compliance. Prescription refill requests for non-emergent issues may take up to 72 hr to process.
2. **Narcotics**: This practice does not treat conditions involving chronic pain and the use of narcotics. This office takes pain very seriously and therefore this office is not comfortable treating ongoing pain management. Ethically, we believe individuals suffering from chronic pain should be treated by physician specialists. We would be delighted to provide you with a list of those specialists who can meet your needs.
3. **Co pays and balances are collected** at check in.
4. You may be asked to **reschedule** your appointment if you are **late** for your scheduled appointment.
5. **Canceling appointments and No-Shows:** Any patient wishing to cancel or reschedule an appointment must **call 24 hours prior** to the appointment; otherwise they will be charged a non-negotiable **fee** of **$70.00**. This fee will be due before the next patient visit. A **$300.00** fee will be charged if the appointment is for an in-office procedure such as a prostate biopsy or vasectomy.
6. All **questions** regarding a **lab order will be addressed by Privia Lab.** Please contact the lab at **540-546-2620**. If you do not use Privia Lab, please get your lab order at the time of your appointment.
7. **You consent to receive test results** on your **patient portal**. You can access this portal by giving the receptionist your email and they will give you a temporary password which you can later change under the security settings. You can also visit www.priviamedicalgroup.com and sign up on your own. There will be a note left by the doctor/provider or medical staff with any important information needed.
    a. Be aware that Shenandoah Urologic Specialists is not responsible for any test, procedure, or radiology result ordered by physicians/providers (including Internal Medicine Consultants' primary care providers) outside of the Shenandoah Urologic Specialists practice. Please follow up with the ordering physician/provider to receive your results.
    b. It is your responsibility to check lab results over the patient portal and to follow up with your provider.
    c. If you need urgent medical help, or need a response within 72 hr, do *not* leave a portal message - instead, please call the office.

Please sign and date, showing that you understand our Policy & Regulations.

Print Name: _____ Date: _____
Signature: _____

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HIPAA Statement

The ***Notice of Privacy Practices*** document has been made available and explained to me and my questions about the document have been answered.

I hereby authorize Shenandoah Urologic Specialists (SUS) to furnish my insurance company or other authorized agency my protected health information (PHI) for the purpose of treatment, payment, or healthcare.

I also authorize Shenandoah Urologic Specialists to discuss my medical condition and treatments with the following people:

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

I authorize Shenandoah Urologic Specialists to be able to leave detailed messages regarding:

- ☐ Test results
- ☐ Medical Information
- ☐ Diagnosis

on my voice mail / email given below. If you DO NOT give permission for this, DO NOT fill out the information:

_____ Phone Number

_____ Email

Patient Authorization (Print Name & Sign Below):

Print Name: _____

Signature: _____ **Date:** _____

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Health Questionnaire

Patient Name:_____

Date: _____

Allergies to medications, X-Ray Dyes, or Other Substances: ___ No ___ Yes

If yes, please list allergies: _____ _____ _____

_____ _____ _____

Are you taking Blood Thinners Such As:

☐ Aspirin ☐ Advil ☐ Eliquis

☐ Plavix ☐ Fish Oil ☐ Other (please list):

☐ Coumadin/Warfarin ☐ Vitamin E _____

☐ Xarelto ☐ Pradaxa _____

Current Medications:

	Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency
1				7			
2				8			
3				9			
4				10			
5				11			
6				12			

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Past Medical History – Family History:

	No/Yes	Who (Mom, Dad, Siblings, Children)
Diabetes	_____	_____
Enlarged Prostate	_____	_____
High Blood Pressure	_____	_____
Kidney Stones	_____	_____
Kidney Failure	_____	_____
Prostate Cancer	_____	_____
Stroke	_____	_____
Urinary Tract Infections	_____	_____
Cancer, type: _____	_____	_____
Other (please list):	_____	_____
	_____	_____

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Prevention:

NO/YES

Do you or have you ever smoked? _____

# of packs per day___ # of years_____

date quit_____

NO/YES

Do you drink alcoholic beverages? _____

If yes, how many drinks per week? _____

NO/YES

Do you use drugs? (Marijuana, Cocaine, etc.) _____

If yes, please list drugs and frequency of usage:

_____

_____

_____

Reason I am here:

☐ Urinary Infection	☐ Overactive Bladder	☐ Prostate Cancer
☐ Urinary Leakage	☐ Kidney Stones	☐ Sexual Problems
☐ Difficulty w/ Urination	☐ Kidney Tumor	☐ Testicle Problems
☐ Frequency of Urination	☐ Kidney Cyst	☐ Low Testosterone
☐ Blood in the Urine	☐ High/elevated PSA	☐ Fertility Problems
☐ Bladder Cancer	☐ Prostate Infection	☐ Other (please specify):

_____

_____

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My other medical problems are or have been:

☐ Heartburn	☐ Diverticulitis	☐ Liver Disease
☐ Anemia	☐ Enlarged Prostate	☐ Low Testosterone
☐ Arthritis	☐ Glaucoma	☐ Lupus
☐ Asthma	☐ Gonorrhea/Chlamydia	☐ Migraine Headaches
☐ Atrial Fibrillation	☐ Gout	☐ Multiple Sclerosis
☐ Blood Clots in Legs or Lungs	☐ Gynecological Problems	☐ Overweight/Obesity
☐ Chronic Back Pain	☐ Heart Attack	☐ Osteoporosis
☐ Cancer, type: _____	☐ Heart Failure	☐ Parkinson's
☐ Chronic Urinary Infections	☐ Hepatitis C	☐ Peptic Ulcer Disease
☐ COPD/Emphysema	☐ High Blood Pressure	☐ Peripheral Vascular Disease
☐ Crohn's	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Dementia	☐ HIV	☐ Seizures
☐ Depression	☐ Irritable Bowel	☐ Stroke
☐ Drug/Alcohol Abuse	☐ Kidney Disease	☐ Thyroid Disease
☐ Sugar Diabetes	☐ Kidney Stones	☐ Other (please list):

_____

_____

_____

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Please list and supply the names and dates of:

Operations: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please CIRCLE if *YOU* are experiencing any of the following symptoms TODAY:

Constitutional	**Respiratory**	Urinary Leakage/Accidents	**Hematologic/Lymphatic**
Chills	Asthma	Night time urination	Anemia
Fatigue	Bronchitis	Blood in the Urine	Blood/platelet disorder
Fever	Cough (persistent)	Urinary Urgency (can't hold)	Cancer
Loss of height	Expectoration	Venereal disease/STD	Leukemia
Sweats	Pneumonia	Foreskin problems	Lymphoma
Weight gain/weight loss	Shortness of breath		Swollen lymph nodes
Eyes	Snoring		**Allergic/Immunologic**
Change in vision	Tuberculosis	**Musculoskeletal**	Auto-immune disease
Wear contacts/glasses	Wheezing	Arthritis	Immune deficiency
Eye disease	**Gastrointestinal**	Back pain	Itching
Eye injury	Abdominal pain/discomfort	Deformities	Rash
Ear/Nose/Throat	Anorexia	Gout	
Deafness	Blood in stool	Head pain	**Female Health**
Difficulty swallowing	Change in appetite	Joint pain/swelling	Change in Libido (sex drive)
Dizziness	Colitis	Muscle pain	Heavy Period Bleeding
Ear ache	Constipation	Neck stiffness/pain	Painful Intercourse
Hay fever	Diarrhea	Radiating leg pain	Vaginal Dryness
Headache	Gallbladder disease	**Neurological**	Vaginal Discharge
Nasal drainage	Heartburn/indigestion	Confusion	Vaginal Bleeding
Post nasal drip	Hemorrhoids	Lightheadedness	Irreg. Monthly Cycles
Ringing in ears	Hepatitis/jaundice	Memory loss	Fertility Problems
Sinus problems	Kidney disease	Tingling/numbness	Irregular Monthly Cycles
Sore throat	Kidney stones	Tremors	Recent STD
Cardiovascular	Nausea	Unsteady gait	
Chest pain/tightness	Painful bowel movements	**Psychological**	**Other**
Edema (hands, ankles, etc)	Painful swallowing	Agitation	
Fainting	Ulcers	Alcohol abuse	
Heart disease	Vomiting	Anxiety	
High blood pressure	**Male Health**	Depression	
Palpitations	Frequent Urination	Drug abuse	
Rheumatic fever	Painful Urination	Insomnia	
Shortness of breath lying flat	Urinary Infections	Relationship problems	

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Authorization to Release Health Care Information

Patient's Name: _____ ***Date of Birth:*** _____

I request and authorize _____ to release health care information of the patient named above to:

Shenandoah Urologic Specialists
148 Linden Drive, Ste 103
Winchester, VA 22601
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This request and authorization applies to:

Service dates requested from _____ to _____

___Last Two Years **___Surgical Reports** **___Entire Chart**
___Office Notes **___Lab/Path Reports** **___Other_____**
___Radiology Reports **___Testing - Be Specific_____**

List any records that you DO NOT authorize for release:

_____ _____ _____

_____ _____ _____

Purpose of Disclosure:
___Referral To Specialist ___Insurance ___Workers Comp ___Leaving Practice
___New Primary Care ___Legal Investigation ___Disability Determination ___Personal
___Relocation/Moving

Note: A fee of $0.25 per page will be charged for personal copy/transfer of records. This includes labor and supplies. Prepayment is required prior to release of records.

I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Patient Signature: _____ ***Date:*** _____