NORTH ALABAMA UROLOGY, PC

825 ADAMS ST
HUNTSVILLE, AL 35801

460 LANIER RD, STE 204
MADISON, AL 35758

(256) 536- 9020

JOSEPH PETTUS, MD **PAUL ZBELL, MD** **JOSEPH HICKS, MD** **RYAN BLACK, MD**

We welcome you to North Alabama Urology. In order to make your visit more pleasant, please take a few moments to read this letter and complete the enclosed forms in their entirety (front and back) for your first appointment. Complete all paperwork with black or blue ink, pencil or color ink will not appear when scanned in your medical chart.

Appointment Date, Arrival Time, and Location: ____________________________________

Huntsville Office **Madison Office**

Please bring these completed forms, your **insurance card(s)**, and your **driver's license** or **non-driver picture ID**. (Proper ID is required by law for treatment.) Also, be prepared to pay your co-pay, co-insurance, or unmet deductible at the time service is rendered. ***All minors under the age of 14 must be accompanied by their parent or legal guardian.***

Office visits and treatments not covered by insurance are payable at the time of service. As a courtesy to you, we will file your insurance claim at no charge. We are providers of Medicare and Blue Cross. We also participate with most commercial insurance plans.

Our Office allows 24- hour turn around for prescriptions and refills. All non-urgent phone calls to the doctor or nurse are returned after clinic or the following day.

For your convenience, we have two office locations, Huntsville and Madison. The offices are opened 8:00 A.M. to 5:00 P.M. Monday through Thursday and Friday from 8:00 A.M. to 2:00 PM. Our patients are seen by appointment only. However, if you have an acute problem that needs immediate care, we will make every effort to see you between scheduled patients. For true emergencies after hours, go to the emergency room. A Physician will be on duty there. If our assistance is needed, he or she will know how to reach the Physician immediately.

Cancellation Policy – We require a 24 hour notice when cancelling or rescheduling appointments. No Shows are subject to a fee of $25. We do call at least 24 hours prior to the appointment as a courtesy to our patients.

We look forward to having you as our patient. Please let us know if you have any questions prior to your appointment.

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Patient Portal

We strive to make it quick and easy for you to be provided with your medical records, answers to your questions and concerns, refill your prescriptions and other types of medical concerns. In order to do so, **as of January 1, 2017, we will be utilizing our patient portal.** Each patient will have a log in to this portal. You will be asked to provide our office with an email address in which you will receive a welcome letter through our patient portal. This email will enclose a temporary password and a link to the portal. When you click on the link provided in the email, it will direct you to the website and walk you through the set up process. The temporary password will expire after 72 hours. If you are unable to access the portal before that time has expired; please call the office and we will reset your password. **All lab and urine culture results, medication refill request, and questions for the nurses should to be sent through this portal.** The portal messages will immediately be sent to the nurses to answer your questions or concerns in a timely manner. In the event of an emergency we would request that you call the office and speak with a receptionist. If you have questions or require help to set up your patient portal, our staff will assist you. You may contact our office at 256-536-9020. Thank you for your understanding and cooperation.

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DR. JOSEPH HICKS   DR. PAUL ZBELL   DR. JOSEPH PETTUS   DR. RYAN BLACK

ACCOUNT NUMBER: ___________ **EMAIL:** ______________________________

Name: ____ Male _____ Female _____
FIRST MIDDLE INITIAL LAST

Date of Birth: ______/______/______ Social Security Number: _________-_______-__________

Address: ____ Apt # ____________

City: ______________________ State: _________ Zip Code: ____________

Primary Number: (____) _______-________ CELL/ WORK/ HOME Permission to leave voicemail Yes or No

Secondary Number: (____) ______-_________ CELL/ WORK/ HOME Permission to leave voicemail Yes or No

Employer: _____________________________ Phone Number: (_____) _______-____________

Date Retired: _______________ Referring Physician: __________________________

Marital Status: Married Single Divorced Widowed Legally Separated

Emergency Contact: ____
FIRST LAST PHONE NUMBER RELATIONSHIP TO PATIENT

RESPONSIBLE PARTY INFORMATION: PLEASE PROVIDE PARENT OR GUARDIAN INFORMATION IF PATIENT IS UNDER THE AGE OF 18 AND/OR NOT RESPONSIBLE FOR THE ACCOUNT

Name: ____
FIRST MIDDLE INITIAL LAST RELATIONSHIP TO PATIENT

Address: ____________________________________ State: _____ Zip Code: __________

Date of Birth: _____/_____/________ Social Security Number: ________-______-_________

Employer: _____________________________ Phone Number: ___________________

INSURANCE INFORMATION: HOLDER OF INSURANCE POLICY

Insurance Company: ______________________________ Effective Date: ____/____/______

Policy/Contract Number: ________________________ Group Number: _______________

Name: ____________________________ Relationship to Patient: __________________

DOB: ____/____/______ Phone Number: (____) ______-_______ Employer: _______________

Address: _______________________________ State: ______ Zip Code: ______________

SECONDARY INSURANCE: IF PATIENT HAS TWO OR MORE INSURANCES

Insurance Company: ______________________________ Effective Date: ____/____/______

Policy/Contract Number: ________________________ Group Number: _______________

Name: ____________________________ Relationship to Patient: __________________

DOB: ____/____/______ Phone Number: (____) ______-_______ Employer: _______________

Address: _______________________________ State: ______ Zip Code: ______________

I/We, the undersigned, hereby agree to pay all amounts and charges hereafter incurred by me or members of my family for services rendered by this office. I hereby authorize Dr. Hicks, Dr. Pettus, and Dr. Zbell to furnish information to insurance carriers concerning my illness and treatment. It's customary that payment be made when the service is rendered unless prior arrangements have been made. I authorize benefits payable to the above physicians. I understand that I am responsible for any amount not covered by insurance. In the event of non-payment, either by insurance or myself, I agree to pay all cost of collection, including 33 1/3% of total amount due, and a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract. I/We, further agree to waive my/ our rights of exception under the laws of the State of Alabama or of any other state. You agree, in order for us to service your account or to collect monies you may owe, North Alabama Urology and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contract may include using prerecorded/ artificial voice messages and/or use of automatic dialing devices, as applicable.

Signature: ______________________________ **Date:** ______________

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DR. JOSEPH P. HICKS / DR. PAUL J. ZBELL / DR. JOSEPH A. PETTUS / DR. RYAN D. BLACK

Date: ____/____/______ Account Number: ______________

Patient Name: ________________________________ Date of Birth: ____/____/______

Pharmacy Name & Location: ____

Drug Allergies:
(List Drug & Reaction)

Latex Allergy? Yes or No
Iodine/ Betadine Allergy? Yes or No

________________________________ ________________________________

________________________________ ________________________________

Current Prescription & Non-Prescription Medications:
(Please include dosage)

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Do you take aspirin on a daily basis? (Please circle) Yes No If so, 81mg or 325mg

List All Surgeries:
(PLEASE INCLUDE DATES)

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Colonoscopy? Month ____ Year:____
Yes No

Referring Physician and/ or Primary Care Physician:

________________________________ ________________________________

________________________________ ________________________________

North Alabama Urology, PC

Chart #________

Adult Medical History

Form must be COMPLETELY filled out

Name: ______________________________ **Date of Birth:** ____/____/________
First Middle Initial Last

Chief Complaint: (Reason for Your Visit)

____

____

History of Present Illness

Location of problem: Abdomen Back Other: ______________________ SPECIFY OTHER

When did you first notice the problem? ______________________

Is the problem Constant or Variable?

Do any other problems seem to occur at the same time? Y or N ______________________

Personal Medical History: (Past or Present)

	YES	NO		YES	NO		YES	NO
Arthritis	____	____	Heart Attack	____	____	Rubella	____	____
Asthma	____	____	Measles	____	____	Scarlet Fever	____	____
Bleeding Problems	____	____	Mumps	____	____	Seizures	____	____
Broken Bones	____	____	Pneumonia	____	____	Stroke	____	____
Chicken Pox	____	____				Tuberculosis	____	____
Pneumonia Vaccine	____	____						

If yes, list treating physician:

COPD	________	________________
Coronary Artery Disease	________	________________
Diabetes	________	________________
Heart Failure	________	________________
High Blood Pressure	________	________________

Family History:

Circle Relationship

Cancer	Y	N	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other
Diabetes	Y	N	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other
Heart Attack	Y	N	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other
High Blood Pressure	Y	N	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other
Stroke	Y	N	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other

Other: ____

Continue on Reverse Side →

Social History

(Circle Answer)

Marital Status: Married Single Divorced Widowed Legally Separated

Smoking Status: (Circle Answer)

Current Everyday Smoker

Packs per day? __________

How many years? __________

Current Some Day Smoker

Packs per day? __________

How many years? __________

Former Smoker **Packs per day in Past?** __________ **Date Quit smoking?** __________

Never Smoked

Drinking Status (Alcohol): (Circle Answer) **Yes** **Not Anymore** **NO**

Drinks per month? ____________________

Type: Beer Wine Liquor

Habit: Social Light Moderate

Race:

___ Caucasian ___ African American ___ Hispanic/ Latino ___ Native Hawaiian/ Pacific Islander

___ Asian ___ American Indian/ Eskimo ___ Unknown

Review of Systems

Have you experienced any of the following symptoms in the past 2 Weeks?

Constitutional Symptoms:

Fever	Y N
Chills	Y N
Headache	Y N
Other: __________	

Eyes:

Blurred Vision	Y N
Doubled Vision	Y N
Pain	Y N

Allergic/Immunologic:

Hay Fever	Y N
Drug Allergies	Y N
Other: __________	

Neurological:

Seizures	Y N
Weakness	Y N
Numbness/Tingling	Y N

Gastrointestinal:

Abdominal Pain	Y N
Nausea/Vomiting	Y N
Indigestion/Heartburn	Y N

Cardiovascular:

Chest Pains	Y N
Varicose Veins	Y N
High Blood Pressure	Y N

Musculoskeletal:

Joint Pain	Y N
Neck Pain	Y N
Low Back Pain	Y N
Back Pain	Y N

Ear / Nose / Throat / Mouth:

Ear Infection	Y N
Sore Throat	Y N
Sinus Problems	Y N

Genitourinary:

Urinary Retention	Y N
Painful Urination	Y N
Urinary Frequency	Y N

Respiratory:

Wheezing	Y N
Frequent Cough	Y N
Shortness of Breath	Y N

Psychological:

Generally satisfied with your life?	Y N
Do you feel severely depressed?	Y N
Have you considered suicide?	Y N

Signature: ______________________________ **Date:** __________

Patient's Signature Only

Chart #: __________

Patient Notification

If your insurance requires a referral for your visit, it is your responsibility to obtain the referral. If insurance requires labs to be sent to an outside laboratory it is your responsibility to inform us of that required laboratory.

All payments are due at the time of service.

There is a $25 fee for no shows and late cancellations of office visits. Cancellations must be made 24 hours in advance of appointment time.

There is a $50 fee for no shows for in-office procedures, such as Vasectomy, Renal Ultrasound, Urodynamics, Prostate Biopsy, Testopel, etc. due to non-re-useable equipment and extra designated time.

There is a $100 no show fee for Hospital based surgeries. Unless medically necessary, a surgery must be cancelled one week prior to the scheduled date.

Please allow 48 business hours for prescription refills.
There is a $30 fee for return checks.

There is a $15 forms fee for any non North Alabama Urology form such as; Prior Authorizations for prescriptions, FMLA and Disability.

During your visit with us it may be necessary to have an outside source process blood work, urine tests or biopsies. Please be aware these tests that are outsourced will be billed separately from our office.

______________________________	______________________________
Print Patient/Guarantor Name	Relationship to patient
______________________________	______________________________
Patient/Guarantor **Signature**	Date

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ______________________________, understand that as part of my health care, North Alabama Urology (NAU) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that my protected health information (PHI) serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that NAU is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that NAU reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should NAU change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I give permission to disclose my PHI to:

____
____
____

I do not give permission to disclose my PHI to:

____
____
____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, i.e., lab, treatment/testing facility, insurance company, claims clearing house, physician or pharmacy, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent. I further acknowledge that I have received a statement of the privacy practices of North Alabama Urology.

____
Patient / Guardian Signature

____
Date

FOR OFFICE USE ONLY

[ ] Consent received by ______________________________ on ____________________.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on ____________________.

Notice of Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At North Alabama Urology, PC we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 1, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit North Alabama Urology, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- A tool in educating heath professionals.
- A source of data for medical research.
- A source of information for public health officials charged with improving the health of this state and the nation.
- A source of data for our planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Your Health Information Rights

Although your health record is the physical property of North Alabama Urology, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.524.
- Amend your health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

North Alabama Urology is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, you will be notified upon your next visit. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Linda Aufderhar at (256) 536-9020.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. **For example:** Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment. **For example:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. **For example:** Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.