

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.

www.northalaurology.com

NORTH ALABAMA UROLOGY, PC

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.

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 contact may include using prerecorded/ artificial voice messages and/or use of automatic dialing devices, as applicable.

Signature: _____ **Date:** _____

825 ADAMS ST
HUNTSVILLE, AL 35801

NORTH ALABAMA UROLOGY, PC

460 LANIER RD, STE 204
MADISON, AL 35758

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

Right to Privacy

Parent(s)/Legal Guardian must be present for initial office visit

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

We at **North Alabama Urology** respect your child's right to privacy. Therefore, our providers and staff will only access and use your/child protected health information (PHI) for treatment, payment, and healthcare operations such as:

- 1) To provide care here in our office.
- 2) To collect payment from your insurance company.
- 3) To assist your pharmacy in filling prescriptions.
- 4) To coordinate with specialists to whom your child may be referred to.
- 5) When the child reaches the age of fourteen, we can no longer discuss the child's private medical information with a parent/guardian without the child present or a written consent from the child. The exception is as follows:
 - a. If a child seeks medical treatment and wishes to use the parent's medical insurance policy, it is the policy holder's right to know what their insurance company has been billed for. If the child does not wish for the policy holder to be given that information, they must pay cash upfront for that visit.

All other releases of personal information will be authorized by a signature. **THIS INCLUDES YOUR IMMEDIATE FAMILY UNLESS OTHERWISE STATED BELOW.** In the event of an emergency, we will contact your designated emergency contact.

I authorize the following people to bring my child(ren) to any appointments after the initial visit. I also authorize **North Alabama Urology** to discuss my child's care with the people listed below.

_____ Relation _____

_____ Relation _____

_____ Relation _____

I understand and consent to the use of my/child protected health information for the above purposes.

Signature: _____ **Date:** _____

Relationship to Patient: _____

North Alabama Urology, PC

Pediatric Medical History

Chart # _____

Form must be COMPLETELY filled out

Name: _____
First
Middle Initial
Last

Date of Birth: ____/____/____

Chief Complaint: (Reason for Your Visit)

History of Present Illness

Please answer the following questions

Location of the problem?

Abdomen Back Kidney Bladder Other

How long does the problem last?

____ Hours ____ Days ____ Constant

When did you first notice the problem?

Since Birth Days ago Weeks Ago Months Ago

Other: _____

Does anything occur at the same time? Y or N

Explain: _____

Does the problem interfere with normal functions? Y or N

Explain: _____

Has the patient had any X-rays or Ultrasounds? Yes or No

(If yes, please list below)

Date	Facility	Type of X-Ray or Ultrasound

Medical History

	Yes	No
Asthma	_____	_____
Bleeding Disorder	_____	_____
Cancer	_____	_____
Cerebral Palsy	_____	_____
Developmental Delay	_____	_____
Hepatitis	_____	_____

	Yes	No
High Blood Pressure	_____	_____
Prenatal Hydronephrosis	_____	_____
Spina Bifida	_____	_____
Urinary Tract Infections	_____	_____
VP Shunt	_____	_____
Prematurely Born	_____	_____
If yes, how early?	_____	

Continue on Reverse Side →

Family History

Circle Relationship

Bed Wetting	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other: _____
Cancer	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other: _____
Diabetes	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other: _____
Genital Birth Defects	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other: _____
What kind?							
Heart Disease	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other: _____
High Blood Pressure	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other: _____
Problems w/ Anesthesia	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other: _____
Urinary Infection	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other: _____
Urinary Reflux	Mother	Father	Sister	Brother	Grandmother	Grandfather	Other: _____

Social History

Race:

Caucasian
 African American
 Hispanic/ Latino
 Native Hawaiian/ Pacific Islander
 Asian
 American Indian/ Eskimo
 Unknown

Review of Systems

Has the patient experienced any of the following symptoms in the past 2 Week?

Constitutional Symptoms:

Fever Y N
 Weight Changes Y N
 Feeding / Eating Problems Y N
 Headache Y N

Eyes:

Blurred Vision Y N
 Doubled Vision Y N
 Pain Y N

Neurological:

Seizures Y N
 Weakness Y N
 Numbness / Tingling Y N

Gastrointestinal:

Abdominal Pain Y N
 Nausea/Vomiting Y N
 Constipation Y N

Cardiovascular:

Chest Pains Y N
 Heart Murmur Y N
 High Blood Pressure Y N

Integumentary:

Skin Rash / Boils Y N
 Lasting Itch Y N

Musculoskeletal:

Joint Pain Y N
 Neck / Back Pain Y N

Ear / Nose / Throat / Mouth:

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

Respiratory:

Wheezing Y N
 Frequent Cough Y N
 Pneumonia Y N

Hematological / Lymphatic:

Swollen Glands Y N
 Blood Clotting Problem Y N

Signature: _____

Parent or Guardian

Relationship to Patient

Date: _____

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

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 health 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 services 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.