Urology
SPECIALISTS OF OREGON

Room #_____

PATIENT MEDICAL INFORMATION

Date of Service_____

Full Name:_____ Date of Birth:_____

Reason for today's visit: _____

Primary Care Physician:_____ Pharmacy:_____

Current Medications

Medications	Dose	How Often	Medication	Dose	How Often

Allergies to Medications

1._____ Reaction_____ 2._____ Reaction_____

3._____ Reaction_____ 4._____ Reaction_____

5._____ Reaction_____ 6._____ Reaction_____

Past surgeries: _____

_____

Urologic Family History: (Please check if anyone in your family has a history of any of the following):

☐ Bladder Cancer ☐ Kidney Stones ☐ Kidney Cancer ☐ Prostate Cancer

Past Medical History: (Please check only if **you** have a history of any of the following):

Office use only

☐ Abnormal Heart Rhythm
☐ Alzheimer's
☐ Anemia
☐ Asthma
☐ Osteoarthritis
☐ Congestive Heart Failure
☐ COPD
☐ Depression
☐ High Blood Pressure
☐ High Cholesterol/Lipids
☐ Hypothyroidism
☐ Neurologic Disorder
☐ Kidney Cancer
☐ Osteoporosis
☐ Sleep Apnea
☐ Stroke
☐ GERD
☐ Bladder Cancer/Prostate
☐ Incontinence
☐ Infertility
☐ Kidney Failure
☐ Kidney Stone(s)
☐ Urinary Tract Infection

VITALS:
BP_____
P_____
WT_____
HT_____
Temp_____

Other Issues Not Listed _____

Social History (Please check your answers to the following):

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Significant Other
☐ Employed
☐ Unemployed
☐ Disabled
☐ Retired
☐ Occupation_____
☐ Children
☐ Religious Preference Affecting Care
☐ Live at Home
☐ Live in Care Facility

Risk Factors (Please check your answers to the following):

Tobacco Use: ☐ Current ☐ Never ☐ Quit

Year Quit:_____ Caffeine Use(drinks/day)

Year Started:_____ Pack/Years_____ _____

Cigarettes ☐ Yes ☐ No

Amount pk/day:_____

Cigars ☐ Yes ☐ No Passive Smoke Exposure: Alcohol Use: ☐ Yes ☐ No

☐ Yes ☐ No Type:_____

Smokeless ☐ Yes ☐ No Other Drug Use:_____ Amount/Day:_____

Review of systems (Please check only if you are **currently** suffering from any of the following):

Cardiovascular

☐ Chest Pain ☐ Palpitations ☐ Shortness of Breath/lying
☐ Fainting ☐ Swelling of Legs
☐ Heart Attack ☐ Shortness of Breath

Dermatologic

☐ Dryness ☐ Rash ☐ Itching

Ear/Nose/Throat

☐ Decreased Hearing ☐ Hoarseness ☐ Sore Throat
☐ Ear Discharge ☐ Nasal Congestion ☐ Tinnitus
☐ Earache ☐ Nosebleeds

Endocrine

☐ Cold Intolerance ☐ Excessive Thirst ☐ Increased Urine Output
☐ Excessive Eating ☐ Heat Intolerance ☐ Unusual Weight Change

Eyes

☐ Blurring ☐ Double Vision ☐ Irritation
☐ Discharge ☐ Light Sensitivity ☐ Vision Loss

Gastrointestinal

☐ Abdominal Pain ☐ Dark Stool ☐ Indigestion/Heartburn
☐ Bloody Stool ☐ Diarrhea ☐ Vomiting
☐ Change in Bowel Habits ☐ Difficulty Swallowing ☐ Nausea
☐ Constipation ☐ Gas/Bloating ☐ Pain with Swallowing

General

☐ Chills ☐ Loss of Appetite ☐ Weight Loss
☐ Fatigue/Weakness ☐ Sleep Disorder ☐ Sweats

Genitourinary

☐ Blood in Urine ☐ Burning with Urination ☐ Incontinence
☐ Urinary Frequency/____hr ☐ Pelvic Pain/_____Urgency ☐ Urinary Hesitancy
☐ Erectile Dysfunction ☐ Decreased Sex Drive

Musculoskeletal

☐ Arthritis ☐ Joint Pain ☐ Muscle Cramps
☐ Back Pain ☐ Joint Swelling

Neurologic

☐ Difficulty Walking ☐ Frequent Falls ☐ Dizziness ☐ Frequent Headaches

Psychiatric

☐ Anxiety ☐ Depression ☐ Memory Loss/Confusion

Respiratory

☐ Asthma ☐ Chest Pain ☐ Wheezing
☐ Blood in Sputum ☐ Cough

☐ NONE OF THE ABOVE APPLY:

Patient signature_____ Physician signature_____

Today's Date: _____

PRAXIS
MEDICAL GROUP

PATIENT INFORMATION

Date of Birth: _____ Age: _____ Sex: ____ Gender Identity: _____Sexual Orientation: _____

First Name: _____ MI: ___ Last Name: _____ SSN#:_____

Marital Status: S___ M___ D___ W___ Email Address: _____

Race: _____ Ethnicity (Circle One): Hispanic/Non-Hispanic Primary Language: _____

Street Address: _____ Mailing Address (If Different):_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work phone:_____ Employer/Occupation:_____

Emergency Contact: _____ Relationship: _____ Phone: _____

ACCOUNT RESPONSIBILITY (If different than above)

Who is responsible for this account? _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____

Cell Phone: _____ Home Phone: _____ Date of Birth: _____SSN#: _____

MEDICAL INSURANCE

Name of Primary Insurance Company: _____

Subscriber Name: _____ Group # _____

Member ID: _____ Subscriber Date of Birth: _____

Name of Secondary Insurance Company: _____

Subscriber Name: _____ Group # _____ Member ID: _____

Subscriber Date of Birth: _____ Medicare ID (If on Medicare): _____

CASH PAY POLICY

Patients without medical insurance are required to pay $125.00 at the time of service to see a primary care provider, and $175.00 at the time of service to see a specialist or have imaging performed. Please note that your balance may be more than the above stated amounts, and will be determined based on actual services rendered during your office visit. Any patient without medical insurance who is paying in cash for an office visit will receive 20% off of their end balance.

By signing below you state that you have read and understand the above cash pay policy.

Patient/Guardian Signature: _____

CLINIC BILLING AND EXPECTATIONS

Please sign below to indicate you have read and understand the following:

1. **Responsibility for payment of your account remains with you at all times**; and although you may have a pending insurance claim, we will require you to pay regardless of the circumstances involved. Please contact us immediately if there is a problem with your claim or if your claim is related to OREGON WORKERS COMP, AUTO RELATED, OR THE RESPONSIBILITY OF A THIRD PARTY PAYOR.

2. Copays and other estimated out of pocket amounts due are to be collected at the time of service.

3. You will receive a monthly statement showing itemized charges and the total amount due on your account. Payment in full is required within 30 days of the statement date, unless arrangements are made with our billing office.

4. If you need to set up a payment plan, our Praxis Main billing phone number is (877)708-1119. For Oak Street Medical billing please call (844)379-9930, and for Pendleton Family Medicine billing please call (844)379-9931.

5. A $45.00 fee will be charged to your account if you do not cancel your appointment 24 hours in advance. After three no show appointments, you will be subject to discharge from Praxis Medical Group.

6. There is a $35.00 fee for all returned checks and for stop payments.

7. No credit will be extended to patients having a past due account, or to patients who have been referred to a collections agency. If your account has been referred to a collections agency two times, you will be discharged from Praxis Medical Group.

8. If you arrive more than seven minutes late to an appointment, you may be asked to reschedule.

9. Praxis Medical Group requires 2 business days to respond to all medication refill requests. Medications will not be refilled after clinic hours. Please contact your pharmacy to initiate refill requests.

CONSENT FOR TREATMENT

By signing below, I am requesting Praxis Medical Group to provide health care related treatment and consultation to the below named patient, and that I may refuse treatment or services at any time. I understand Praxis Medical Group does not guarantee any outcome for any services or treatments, either stated or implied.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian) : _____Date:_____

Acknowledgment
Privacy Policy Offered

My health information may be created or reviewed by Praxis Medical Group and may be in the form of written or electronic records, or spoken words. My health records may include information on my health history, health status, test results, diagnoses, treatments, procedure, prescriptions and similar types of related health information.

I understand that I have the right to receive and review a written description of how Praxis Medical Group will handle my health information. This written description is known as a **Notice of Privacy Practices**. This notice describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Praxis Medical Group and my right regarding my health information. I may obtain a copy of the **Notice of Privacy Practices** at the reception desk or view it on the clinic website.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy or summary of the most current version of the Praxis Medical Group's **Notice of Privacy Practices** in effect will be posted in the waiting/reception area and on the clinic website.

By signing, I agree that I have reviewed and understand the above information and that I am entitled to receive a copy of Praxis Medical Group's Notice of Privacy Practices.
Notice of Privacy Practices copies are available at the reception desk.

Patient Confidential Communication

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following.

I give permission to Praxis Medical Group to leave messages regarding appointments, billing and medical information on any of the following phone numbers: _____

I give permission to Praxis Medical Group to share health and billing information with:

_____

Relationship: _____

This release will be revoked by written permission only. I understand that I must send a written request to Praxis Medical Group in order to revoke this request.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian) : _____Date:_____

FORMULARY BENEFITS MANAGEMENT (PBM) CONSENT FORM

Formulary Benefit data are maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below I give permission for Praxis Medical Group to access my pharmacy benefits data electronically through RxHub. This consent will enable Praxis Medical Group to:

- Determine the pharmacy benefits and drug copays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies
- Download a histories list of all medications prescribed for a patient by any provider

In summary, we ask your permission to obtain formulary information and information about other prescriptions by other providers using RxHub. This consent will be in place until revoked in writing.
I give permission for Rx History consent: (yes/no) _____

Care Management Services Financial Agreement

With the transformation of health care across the country, there were new government billing guidelines established in 2015 for services identified as "Care Management". These services are non-face to face and include but are not limited to: follow ups for emergency room visits, inpatient hospitalizations, as well as coordination of care for ongoing chronic conditions. Examples: Diabetes, Hypertension.

These services are rendered by multiple means, to include but are not limited to: telephone and/or email contact, directly with client or their designated health contact, other health care professionals, as well as verbal and written reports.

These services are billable to your insurance plan; their payment processing will depend on your individual plan coverage. By signing below you agree to allow us to provide these services for you.

I give permission for care management services: (yes/no) _____

By signing below you state that you have read and understand the above statements regarding PBM consent and Care Management Services financial agreement.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian) : _____Date:_____