Metroplex Urology & Transplant Surgery

David L. Gould, MD, FACS

Callye Russell, APRN, FNP-C

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

PLEASE ARRIVE 10 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME.

Dear New Patient

We would like to take this opportunity to welcome you to our practice and to thank you for choosing ***Metroplex Urology & Transplant Surgery***. We look forward to providing you with personalized comprehensive health care.

Our office is open Monday through Friday from 8:30am-4:30pm. Please note that our schedulers are available every day and will do their best to accommodate you. Please let us know as soon as possible if you need to cancel or reschedule your appointment. A $25 fee will be assessed for failure to cancel your appointment within 24 hours of your scheduled appointment time.

Please refer to the check list below regarding your upcoming appointment. During your initial visit, we will be reviewing your health status and these forms contain information necessary to complete this process. If you do not have the appropriate documentation at the time of your initial appointment, we may need to reschedule you.

Sincerely,
Metroplex Urology & Transplant Surgery

PLEASE REMEMBER TO BRING THE FOLLOWING DOCUMENTATION:

- ☐ COMPLETED NEW PATIENT PAPERWORK (ATTACHED)
- ☐ PICTURE ID
- ☐ INSURANCE CARD(S)
- ☐ CO-PAY
- ☐ COMPLETE LIST OF MEDICATIONS/STRENGTH/DOSAGE
- ☐ MEDICAL RECORDS – IF REQUESTED
- ☐ REFERRAL – IF REQUIRED BY YOUR INSURANCE COMPANY

900 Jerome St., Suite 304
Ft. Worth, TX 76104
P: 817-348-8399 – F: 817-348-8380

Patient Registration Form – Metroplex Urology & Transplant Surgery

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address:_____ City_____ State_____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____Ext. _____

Primary Care Provider (PCP):_____ PCP Phone: _____

Referring Provider _____ Ref Provider Phone: _____

Pharmacy Name/Address: _____

E-Mail Address:_____ Date of Birth: _____/_____/_____

Sex ☐ F – Female ☐ M - Male ☐ Transgender Race: _____ Declined ☐

Language: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number: _____-_____-_____ Employer Name: _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Name: _____ Phone Number: _____

Relationship to Patient: _____ Do you have a living will? Yes ☐ No ☐

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last): _____ (First): _____ (MI): _____

Date of Birth: _____/_____/_____ Social Security Number _____-_____-_____ Telephone_____

E-Mail Address_____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Address Line 1 _____

City, State _____ Zip_____

Employer_____ Employer Phone Number_____

PRIMARY INSURANCE INFORMATION

Insurance Company/Phone Number_____(___)_____

Name of Insured_____Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____Group ID_____ Copay Amt_____

Effective Date_____ Termination Date_____ Date of Birth MM_____/DD_____ YYYY_____

SECONDARY INSURANCE INFORMATION

Insurance Company/Phone Number_____(___)_____

Name of Insured_____Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____Group ID_____ Copay Amt_____

Effective Date_____ Termination Date_____ Date of Birth MM_____/DD_____ YYYY_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date*** _____

METROPLEX UROLOGY & TRANSPLANT SURGERY

PERSONAL HISTORY

HISTORY OF PRESENT ILLNESS

_____

_____

_____

_____

ALLERGIES TO MEDICINE

_____

_____

_____

_____

MEDICAL HISTORY

Diabetes	Yes	No	
High Blood Pressure	Yes	No	
Cancer/What Type?	Yes	No	
Stroke	Yes	No	
Heart Trouble	Yes	No	
Arthritis / Gout	Yes	No	
Lung Problems	Yes	No	
Bleeding Tendency	Yes	No	
Acute Infection	Yes	No	
Venereal Disease	Yes	No	
Other	Yes	No	
LMP/Date	Yes	`No	

SOCIAL HISTORY

Married ☐ Single ☐ Widowed ☐ Divorced ☐

Legally Separated ☐

Employed ☐ Unemployed ☐ Retired ☐

Student ☐ Active Military ☐

Tobacco Use:
Never ☐ Yes ☐ Packs/Day:

Year Started: _____ Quit/Year: _____

Alcohol Use:
Never ☐ Rarely ☐ Moderate ☐ Daily ☐ Quit ☐

Children: Yes ☐ No ☐ _____

Drug Use: Yes No _____

PRIOR SURGERY OR TRAUMA HISTORY

Year	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS/STRENGTHS

_____

_____

_____

_____

_____

FAMILY HISTORY

Diabetes	Yes	No	
High Blood Pressure	Yes	No	
Cancer	Yes	No	
Stroke	Yes	No	
Heart Trouble	Yes	No	
Arthritis/Gout	Yes	No	

HERBS

Print Patient Name _____ ***Date*** _____

Print Signature _____ ***Date*** _____

IN THE PAST MONTH, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:
please check or circle all that apply

	Diabetes		**GENITOURINARY**
	Hypertension		Frequent Urination
	Cancer (Type)		Burning or Painful Urination
	Stroke		Blood in Urine
	Heart Trouble		Change in Force or Strain when Urinating
	Arthritis/Gout		Incontinence or Dribbling
	CONSTITUTIONAL SYMPTOMS		Kidney Stones
	Good General Health		Ejaculation Problems
	Recent Weight Change		Nocturia (Waking at Night to Urinate)
	Fever		Male – Testicle Pain
	Fatigue		Number of Pregnancies -
	Headaches		Number of Miscarriages -
	EYES		**MUSCULOSKELETAL**
	Eye Disease or Injury		Joint Pain
	Wear Glasses or Contacts		Joint Stiffness or Swelling
	Blurred or Double Vision		Weakness of Muscles or Joints
	Glaucoma		Muscle Pain or Cramps
	EAR/NOSE/MOUTH/THROAT		Cold Extremities
	Hearing Loss or Ringing		Difficulty in Walking
	Earaches or Drainage		**INTEGUMENTRY (SKIN/BREAST)**
	Chronic Sinus Problems or Rhinitis		Rash or Itching
	Nose Bleeds		Change in Skin Color
	Mouth Sores		Change in hair or nails
	Bleeding Gums		Varicose Veins
	Bad Breath or Bad Taste		Breast Pain/Lump/Discharge
	Sore Throat or Voice Change		**NEUROLOGICAL**
	Swollen Glands in Neck		Frequent or Recurring Headaches
	CARDIOVASCULAR		Light-Headed or Dizzy
	Heart Trouble		Convulsions or Seizures
	Chest Pain or Angina Pectoris		Numbness or Tingling Sensations
	Palpitation		Tremors
	Shortness of Breath w/Walking or Lying Flat		Paralysis
	Swelling of Feet, Ankles or Hands		Stroke
	RESPIRATORY		Head Injury
	Chronic or Frequent Coughs		**PSYCHIATRIC**
	Spitting Up Blood		Memory Loss or Confusion
	Shortness of Breath		Nervousness
	Asthma or Wheezing		Depression
	GASTROINTESTINAL		Insomnia
	Loss of Appetite		Psychosis
	Change in Bowel Movement		**ENDOCRINE**
	Nausea or Vomiting		Glandular Problems
	Frequent Diarrhea		Hormone Problems
	Painful Bowel Movements or Constipation		Excessive Thirst
	Rectal Bleeding or Blood in Stool		Tired/Sluggish
	Abdominal Pain or Heartburn		Diabetes
	Peptic Ulcer		**HEMATOLOGIC /LYMPHATIC**
	Convulsions		Slow to Heal after Cut
	Bleeding Tendency		Anemia
	Acute Infections		Phlebitis

Print Patient Name _____ ***Date*** _____

Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN (optional)**

Provider's Name:	**Recipient's Name:** David L. Gould, M.D., FACS		
Provider's Address:	**Address 1:** 900 Jerome St.		
	Address 2: ***Suite 304***	**Recipient's Phone:** 817-348-8399	
	City: *Ft. Worth*	**State:** TX	**Zip:** 76104

Request Delivery (If left blank, a paper copy will be provided): ☐ Paper Copy ☐ Electronic Media, if available (*e.g.*, USB drive, CD/DVD, eDelivery) ☐ Encrypted Email ☐ Unencrypted Email *X FAX 817-348-8380*

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure: Medical Care

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Office Visit Notes:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

I may refuse to sign this authorization and that it is strictly voluntary.
My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes **X** No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes **X** No

If yes, describe: N/A

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes **X** No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

Patient Last Name (Printed)	Patient First Name (Printed	Date of Birth (MM/DD/YYYY

Notice of Privacy Practice/clinics

_____ **(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinics health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

CONSENT
PATIENT HIPAA ACKNOWLEDGEMENT AND FORM

Patient Last Name (Printed)	Patient First Name (Printed	Date of Birth (MM/DD/YYYY

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) with other health care providers may be made available to METROPLEX UROLOGY & TRANSPLANT SURGERY to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Patient name: _____ DOB: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, METROPLEX UROLOGY & TRANSPLANT SURGERY will bill my insurance company initially for services provided to me.
- I understand it is my responsibility to provide both accurate and current insurance information, and that it is my responsibility to inform the clinic of any insurance changes to my policy.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge METROPLEX UROLOGY & TRANSPLANT SURGERY may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Verification of Benefits. I acknowledge METROPLEX UROLOGY & TRANSPLANT SURGERY utilizes Availity and other such websites to verify my insurance benefits.

Assignment of Benefits. I hereby assign to METROPLEX UROLOGY & TRANSPLANT SURGERY any insurance or other third-party benefits available for health care services provided to me. I understand METROPLEX UROLOGY & TRANSPLANT SURGERY has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to METROPLEX UROLOGY & TRANSPLANT SURGERY, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to METROPLEX UROLOGY & TRANSPLANT SURGERY by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for METROPLEX UROLOGY & TRANSPLANT SURGERY, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that METROPLEX UROLOGY & TRANSPLANT SURGERY or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or METROPLEX UROLOGY & TRANSPLANT SURGERY or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _____

NO SHOW/LATE CANCELLATION POLICY

If you do not cancel or reschedule your appointment within 24 hours of yours scheduled appointment time, a $25 "NO SHOW" charge will be billed to you. This fee is not reimbursable by your insurance. Three consecutive "NO SHOWS" may result in discharging you from the practice.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

Patient Consent to Treat

I hereby authorize agents of METROPLEX UROLOGY & TRANSPLANT SURGERY including mid-level providers, medical assistants and other employees and staff members to render medical evaluations and care to the patient indicated below. The duration of the consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in emergent situations.

Patient/patient representative signature: _____ **Date:** _____

Complete this Section ONLY if the Patient is a Minor

I consent for _____to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Patient/patient representative signature: _____ **Date:** _____

CARE TEAM

P**lease list other providers involved in your care such as cardiologist, nephrologist, neurologist, infectious disease, pulmonologist, etc. This information will help us facilitate the best care possible.**

Provider Name: _____ Specialty: _____

Address: _____ Phone/Fax: _____

Provider Name: _____ Specialty: _____

Address: _____ Phone/Fax: _____

Provider Name: _____ Specialty: _____

Address: _____ Phone/Fax: _____

Provider Name: _____ Specialty: _____

Address: _____ Phone/Fax: _____