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Samuel P. Robinson, M.D.

Lauren Adkinson, FNP - C
Barbara W. Lathrop, FNP-C
Frieda A. Underwood, NP-C
Kathleen Cage NP-C

Dear Patient:

You have an appointment scheduled with one of our providers. The specific provider, date of appointment, and time is listed below. If this appointment is not convenient, please contact our office today to reschedule.

Please fill out the attached paperwork and bring it with you to your appointment. Also, we ask that you arrive 15 minutes early to fill out some additional paperwork. Be sure to bring in a current form of picture identification (i.e. Driver's License) and all current Insurance Cards. The attached paperwork includes the following:

- Patient Appointment Letter
- Medical History (Please include a hand written medication list on separate paper)
- Two Bubble sheets
- Patient Demographic Sheet
- Directions to the Office

Other important information:

- All copays and deductibles are collected at check in. We reserve the right to reschedule your visit if this financial obligation is not met. Please contact our business office prior to your appointment (478.745.6576) if financial arrangements are needed.

- It is the patient's responsibility to inform our office if your insurance company requires a preferred laboratory company. Failure to accurately provide this information could result in patient responsible lab charges.

It is our goal to provide our patients with the highest quality urological care in a compassionate, professional and efficient atmosphere. Please ask to speak with our Office Administrator if you have any concerns following your visit. We thank you for placing your trust in us and we look forward to your visit to our office!

Your appointment is _____
in our _____ office. Please see address listed below.

Urology Specialists of Georgia Bubblesheet

Past Medical History

Heart Attack	O Yes	O No	Date of heart attack: _____
High blood pressure	O Yes	O No	
Heart murmur	O Yes	O No	
Breathing problems	O Yes	O No	Asthma: _____
Diabetes, type 1	O Yes	O No	
Diabetes, type 2	O Yes	O No	
Gout	O Yes	O No	
Reflux	O Yes	O No	
Bowel problems	O Yes	O No	
Stroke	O Yes	O No	Date of stroke: _____
Seizures	O Yes	O No	
Prostate cancer	O Yes	O No	
Kidney stones/disease	O Yes	O No	
Hepatitis C	O Yes	O No	
Hepatitis B	O Yes	O No	
Cirrhosis	O Yes	O No	
Vascular disease	O Yes	O No	
AIDS/HIV	O Yes	O No	
Pacemaker	O Yes	O No	
Defibrillator	O Yes	O No	

Social History

Past Tobacco use	O Yes	O No	
Present Tobacco use	O Yes	O No	How many packs a day:_____
			How many years: _____
Alcohol	O Yes	O No	How often: _____
Illegal drug use	O Yes	O No	

Review of Systems

Recent weight change	O Yes	O No	
Blurred Vision	O Yes	O No	
Chest pain	O Yes	O No	
Shortness of Breath	O Yes	O No	Do you use oxygen at home: ____
Blood in stool	O Yes	O No	
Blood in urine	O Yes	O No	
Thyroid Disease	O Yes	O No	
Back pain	O Yes	O No	
Dizziness	O Yes	O No	
Confusion	O Yes	O No	

Family History

O **Adopted/Unknown/N/A**

Does your mother, father, brother or sister have any of the following?

Bladder cancer	O Yes	O No
Sickle cell	O Yes	O No
Prostate cancer	O Yes	O No
Diabetes	O Yes	O No
On dialysis	O Yes	O No
Kidney stones	O Yes	O No

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5400 Bowman Road Macon, GA 31210
116A Tommy Stalnaker Drive Warner Robins, GA 31088
(478) 745-6576/phone (478) 746-0018/fax

Lauren Adkinson, NP-C
Barbara W. Lathrop, NP-C
Frieda A. Underwood NP-C
Kathleen Cage, NP-C

Your Name: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Who is your primary care physician? _____
Who is the physician who referred you? _____
What is the reason for your visit today? _____
Who is your heart doctor? _____
Who is your lung doctor? _____
Who is your kidney doctor? _____

Allergies to Drugs, IVP Dye, Fish, Shellfish, etc.? (Please circle) Yes No
(LIST)_____
_____
_____

Prescription Drug & dose	How many times per day?	Prescription Drug & dose	How many times per day?
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Medical History – Please list any other health condition not otherwise listed on the bubble sheet.

_____
_____
_____

Surgical History – Please take your time to let us know about all your past surgeries. If not applicable, check box. ☐

_____
_____
_____

Family History – Does your father, mother, brother or sister have a history of conditions which could be related to a urologic problem not otherwise listed on the bubble sheet?

_____
_____
_____

I, _____, voluntarily give my permission to the health care providers of Urology Specialists of Georgia and such assistants and other health care providers as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Urology Specialists of Georgia providers, or until I withdraw my consent in writing.

Signature _____

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UROLOGY SPECIALISTS of Georgia

5400 Bowman Rd.
Macon, GA 31210
116A Tommy Stalnaker Dr.
Warner Robins, GA 31088

Phone (478) 745-6576
Fax (478) 746-0018

www.USofGA.com

Registration Form

(please print)

Today's Date: **Patients Date of Birth:**

PATIENT INFORMATION

Patient's Last Name:	**First:**	**MI:**	☐ Mr. ☐ Dr. ☐ Mrs.	☐ Miss ☐ Ms.	**Marital Status:** Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Home Address: **City:** **State:** **Zip Code:**

Mailing Address (if different from above): **City:** **State:** **Zip Code:**

Home phone number: ( ) -
Cell phone: ( ) -
Patient Social Security #: - -

Preferred method of contact (please circle): Home phone / cell phone / work phone / email

Email Address:
Are you currently employed? Yes / No Full time / Part time

Employer's Name:
Occupation:
Work Phone #: **Ext.**

INSURANCE INFORMATION

Is patient covered by insurance? Yes / No

Name of primary insurance:	**Policy / ID #:**	**Group #:**
Subscriber's name (if different than patient):	**Subscriber's S.S. #:**	**Subscriber's DOB:**
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	**Subscriber's Policy / ID #:**	**Group #:**
Name of Secondary insurance:	**Policy / ID #:**	**Group #:**
Subscriber's name (if different than patient):	**Subscriber's S.S. #:**	**Subscriber's DOB:**
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	**Subscriber's Policy / ID #:**	**Group #:**

EMERGENCY CONTACT

Name of local friend or nearest relative:

Relationship to patient:	**Home phone #:**	**Work phone #:**
Pharmacy Name:	**Pharmacy Address:**	**Pharmacy phone #:**

I hereby authorize Urology Specialists of Georgia to release to Medicare or any other insurance company information concerning my medical health condition. I authorize my insurance benefits to be paid directly to Urology Specialists of Georgia. I understand that I am financially responsible for any balance. I also authorize Urology Specialists of GA or insurance company to release any information required to process my claim.

_____
Patient/Guardian Signature

Primary Care Physician _____

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Brian T. Geary, M.D.
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Kathleen Cage, NP

I understand that the patient's health information is private and confidential. I understand that Urology Specialists of Georgia works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand Urology Specialists of Georgia may use and disclose the patient's personal health information to help provide health care to the patient, handle billing and payment, and to take care of other health care operations. (*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. This type situation would very rare. One example would be if a patient threatened to hurt someone.)

Urology Specialists of Georgia has a detailed document called the *"Notice of Privacy Practices"*. It contains more information about the policies and practices protecting the patient's privacy and is posted in our office for you to read.

Urology Specialists of Georgia may update the Acknowledgement and *"Notice of Privacy Practices"*. If I ask, Urology Specialists of Georgia will provide me with the most current *"Notice of Privacy Practices"*.

Within the *"Notice of Privacy Practices"* is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to: access to my medical records; restrictions of certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specified methods of communications or alternative location.

Urology Specialists of Georgia has established procedures that help them meet their obligations to patients. These procedures may include: other signature requirements, written acknowledgements and authorization; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist by following these procedures if I choose to exercise any of my rights described in the *"Notice of Privacy Practices"*. If you do not wish your name to be spoken out loud when bringing you from the waiting room, please notify the person checking you in and you will be assigned a number.

My signature below indicates that I have been given the chance to review a current copy of Urology Specialists of Georgia's *"Notice of Privacy Practices"*.

_____ _____ _____

Patient or legally authorized Individual signature **Date** **Time**

_____

Relationship to patient if signed by anyone other than patient (parent, legal guardian, personal rep., etc)

PLEASE LIST THE NAME(S) AND RELATION OF INDIVIDUALS/FAMILY MEMBERS WE MAY RELEASE RELEVANT INFORMATION TO REGARING YOUR CARE:

_____

_____

_____

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FINANCIAL POLICY

Thank you for choosing our practice. We are committed to the success of your medical treatment and care.

All patients must complete our Patient Information Form. We believe a good relationship is based on understanding and open communications.

If you need further information about any of these policies, please ask to speak with our Business Office Staff. Please understand that payment of your bill is part of this treatment and care.

It is essential that the office have all your correct information, including your secondary insurance, to make sure your information has not changed and the information we have on file is correct and complete.

The office attempts to verify and pre-certify as needed. Because there are numerous policies and changes made to existing policies, the patient should be knowledgeable about, and notify us of any requirements in your policy, thus allowing the patient to avoid unnecessary costs.

Recent Federal Law requires that all medical providers bill and collect any co-payments and deductibles as provided in your policy. This regulation applies to private insurance, in addition to Medicare and Medicaid. Therefore, we must ask that all co-payments and unmet deductibles be satisfied at the time of the visit.

The law does allow for adjustments for financial hardship. Under no circumstances do we want patients to forgo necessary treatments because of financial concerns.

How may I pay?

We accept payment by cash, check, money order, and debit card by phone, Visa or MasterCard. For your convenience, our Business Office is staffed Monday through Thursday from 9:00 a.m. until 5:00 p.m. and Friday, 9:00 a.m. through 12:00 noon.

When is my account delinquent?

An account is considered past due 30 days following billing unless other arrangements are made. Unpaid accounts beyond 90 days are considered delinquent and will be forwarded to our collection agency.

Legal Fees

Any patient sent to collections will be responsible for all collection fees. If a patient is taken to small claims court the patient will be responsible for all fees/charge

Do I need a referral?

If you have an HMO/POS plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, your appointment will have to be rescheduled until an authorization is received.

As specialists, we limit our practice to urological problems therefore we may ask your primary care provider to see you for an evaluation to ensure your problem is indeed urologic in nature.

Cancellation Policy

We would appreciate your help and courtesy of a call if you are unable to keep an appointment. Please notify our office at least twenty-four (24) hours prior to appointment time. Three (3) non cancelled or missed appointments are grounds for patient discharge from our practice.

Procedure Cancellation Policy

If you have scheduled a procedure or diagnostic test such as a vasectomy, cystoscopy, CAT scan, prostate biopsy, placement of Vantas or Testopel, etc twenty-four (24) hour notice must be given.

OFFICE POLICIES

How are my medicine refills handled?

Our policy is for the patient to call their pharmacy and ask them to fax the refill request for your medication to (478)746-0018. Requests are usually handled within 48 hours depending on the availability of the physician, who for your safety must review each request prior to completion. Refills on medications that require approval from your insurance company could take up to five (5) business days to refill. We will not be able to refill medications if you have not been seen in our office in the last 12 months or in some cases, the last 6 months.

Refills will be done on Monday through Thursday only. Calls for refills on Friday will be processed on Monday.

Phone calls to the Physician

Our physician cannot treat you over the phone. If you need to speak with your physician, we will give you an appointment. Calling physicians after hours is reserved for urgent/emergent problems only. Please understand that abuse of this policy may reflect additional charges to you which cannot be billed to your insurance company. Abuse could also lead to dismissal from the practice.

What if my child needs to see the physician?

Our practice does not provide care for pediatric patients. We will defer care to a pediatric urologist.

Copying of chart

We are glad to provide you a copy of your chart when requested. There is a cost associated with providing records. The charge will be as follows:

$24.88 for administrative search fee
$0.97 per pages 1-20
$0.83 per pages 21-100
$9.70 Certification fee

Please contact our office five (5) business days prior to record pick up for us to get your chart copied. If your chart has been stored off site, please allow seven (7) business days to get your chart copied and ready for pick up.

FMLA/Disability forms

There is a $25 charge for filling out and completing all FMLA and disability forms. Please allow 7-10 business days for completion.

FINANCIAL POLICY ACKNOWLEDGEMENT

I have read, understand and agree to the Financial Policy for Urology Specialists of Georgia.

I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Urology Specialists of Georgia.

I authorize Urology Specialists of Georgia to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____

Patient/Legal Guardian Signature

_____

Print Name

_____

Date

CENTRAL GEORGIA HEALTH EXCHANGE

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

_____	_____	_____
Printed Name of Patient/Representative	*Signature of Patient/Representative*	*Date*

AUTHORITY OF REPRESENTATIVE:

I, _____, *do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient):* _____

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; ; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet,
"A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Heath Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange*.

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5400 Bowman Road, Macon, GA 31210 116A Tommy Stalnaker Drive Warner Robins, GA 31088

(478) 745-6576/p (478) 746-0018/f

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Printed Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: _____

Information to Be Released -- Covering the Periods of Health Care From (date) _____to (date) _____All_____

Please check type of information to be released:

__ Pertinent Documentation	**__ Operative Report**	**__ Lab Results**
__ Complete health record	**__ History and physical**	**__ Consultation reports**
__ Progress notes	**__ EKG**	**__ Discharge Summary**
__ X-ray reports	**__ X-ray films/images**	**__ Photographs, videotapes**

Other, (specify) _____

Purpose of Request

___ Treatment or consultation ___ At the request of the patient ___ Billing or claims payment

I, the undersigned authorize and request Urology Specialists of Georgia to:

___Release information to _____

___ Obtain my information from _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological Care, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release. I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 5400 Bowman Rd. Ste. 100 Macon, GA 31210. Unless revoked, this authorization will remain in effect from the date of signature forward.

Re-disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that once information is released, it may be re-disclosed by the recipient and no longer protected by federal privacy regulations. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under **Purpose of Request**.

I can inspect or copy the protected health information to be used or disclosed. I authorize Urology Specialists of Georgia to use and disclose the protected health information specified above. **Under HIPPA with a patient's written request, records must be provided with 30 days of request.**

Signature: _____ Date: ____/____/____

(Patient, parent if minor child, or legal guardian)

Relationship to Patient (if other than self): _____