CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
(HIPPA CONSENT)

Protected health information (PHI) will be disclosed or used by Treasure Valley Pllc for the purposes of treatment, obtaining payment, or supporting day-to-day health care operations.

I understand that I have a right to request restrictions of the uses and disclosures of my PHI for the above stated purpose.

I understand I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

We may need to contact you regarding information pertaining to your treatment. If we are unable to reach you, it may be necessary to leave a message. Any message we leave may contain confidential information not intended for others. To avoid any breach in confidentiality, please review the choices below and check those that apply:

___ Yes, the doctor's office may leave messages on my answering machine/voice mail.

___ No, do not leave messages.

Signature of Patient/Guardian ____________________________________ Date ______________________________

Patient Registration Form Today's Date ____________________

Last Name:__________________________ First:______________________ M __________Date of Birth _____/_____/ ______

Sex: M F SSN___________________________________

Mailing Address ____City ____________ State ______ Zip Code________

Email ____ Marital Status: Single Mar Div Sep Wid

Home Phone __________________________ Work Phone _______________________ Cell Phone ___________________________

Occupation_____________________________ Employer____

Preferred Pharmacy (including location)____

Primary Language___________________ Race__________________ Ethnicity__________________ Decline to Report ☐

Insured Name (if different than patient or if patient is a minor)

Name ____ DOB__________________ Phone_____________________

Mailing Address ____ City ______ State ______ Zip Code ________

Relationship to Patient __________________________________

Primary Care Physician ____ Phone ______________________

Referring Physician ____ Phone ______________________

Emergency Contacts /Release of Protected Health Information to:

Name____ Relationship_____________________ Phone_________________

Name____ Relationship_____________________ Phone_________________

I hereby authorize Treasure Valley Urology Pllc (TVU) to provide medical treatment services to me and/or my dependents, and to use my Personal Health Information to file a claim for service with my insurance company. In doing so, I assign to the physician all payments for medical services provided. I understand that I am responsible for any amount not covered by my insurance. I also understand that if I do not have insurance, I am responsible for all charges associated with my visit and that payment is due at the time of my visit.

Medicare Beneficiaries - I request that payment of authorized Medicare benefits be made to TVU . I authorize any holder of personal or medical information about me to release to CMS and its agents any information needed to determine these benefits payable for related services.

Signature ____ Date ______________________

Treasure Valley Urology **Patient Health History Questionnaire**

Name:_____________________________________ Date of Birth ___ / ___ / ___ Today's Date ___ / ___ / ___

MEDICATION OR FOOD ALLERGY No___ Yes___ Please list:____

LATEX ALLERGY No___ Yes ___

Current Medications (please include Prescription, Herbal, Vitamins, and over the counter)

Name	Dose (ie. mg, ml)	How Often do you take it?	Why are you taking this?

DIAGNOSES Please **CIRCLE** if you have been diagnosed with any of the following. For **BOLD** conditions, please put date when diagnosed. (month/yr)

Abdominal Aortic Aneurysm	Chronic Renal Failure	DVT (blood clot in legs)	Heart Failure	Neuropathy	**Bladder Cancer**
Aortic Valve Disease	Colitis, Ulcerative	Elevated Blood Pressure	Hematuria(blood in urine)	Nocturnal Enuresis	**BPH(enlarged prostate)**
Aortic Valve Replacement	Congestive Heart Failure	Elevated PSA	Hepatitis	Parkinson's Disease	**Breast Neoplasm, Malignant**
Asthma	COPD	Emphysema	HIV/AIDS	Peripheral Vascular Disease	**Cervical Cancer**
Cardiac Dysrhythmia	Crohn's Disease	Fibromyalgia	Incontinence	Senile Dementia	**Colon Cancer**
Carotid Stenosis	Cystitis (bladder infections)	Frequent UTIs	Infection of Kidney	Sleep Apnea	**CVA (stroke)**
Cataracts	Cystocele	Gastroesophageal Reflux	Kidney Stones	Urethral Stricture	**Myocardial Infarction (heart attack)**
Cesarean Delivery	Diabetes, Type 1	Glaucoma	Mitral Valve Repair	Other	**Prostate Cancer**
Chronic Prostatitis	Diabetes, Type 2	Heart Disease	Multiple Sclerosis	Other	**Testicular Cancer**

PAST SURGERIES **MONTH/YEAR**

1.____
2.____
3.____
4.____
5.____
6.____

INFECTION HISTORY

C Diff Infection Date: __________________ MRSA Infection Date:_____________________ Location: ____________________

FAMILY HISTORY Please indicate family member diagnosed with following. M=Mother, F=Father, S=Sibling, MG=Maternal Grandparent, and PG=Paternal Grandparent

Bladder Cancer		Kidney Stones		BPH		Other:	
Kidney Cancer		UTIs		Heart Disease			
Prostate Cancer		Polycystic Kidney Disease		Hypertension			
Testicular Cancer		Kidney Disease		Liver Disease			

Circle any that are deceased (age/reason) Mother________________ Father__________________ Sibling_________________

TOBACCO No ☐ Yes ☐ How many packs per day ?______ Age started?____ Age quit?____ Type(circle) Cigarettes or Chewing

ALCOHOL No ☐ Yes ☐ Servings per week_______ **MARIJUANA /RECREATIONAL DRUGS** ____________________

REVIEW OF SYSTEMS Please check any current problems / symptoms **NO PROBLEM**

General ☐appetite change ☐chills ☐sweats ☐fatigue ☐fever
☐weight loss #______ ☐weight gain ☐weakness ☐hot flashes ☐

Genitourinary ☐painful urination ☐increased frequency ☐urinary urgency
☐blood in urine ☐urinary leakage ☐urinary tract infections
☐kidney stones ☐urinating at night (# of times)______ ☐urinary retention ☐

Male reproductive ☐testicular pain ☐swelling ☐sexual dysfunction ☐

Female reproductive ☐pelvic pain ☐menopause ☐abnormal bleeding
☐painful intercourse ☐Last menstrual period_________
☐Currently pregnant Number of pregnancies_______ Number of children_____ ☐

Skin ☐itching ☐rash ☐mole change ☐

Breast ☐breast mass ☐breast tenderness ☐nipple discharge ☐

Eyes ☐vision change ☐cataracts ☐glaucoma ☐

Ears, nose, mouth ☐dizziness ☐ringing in the ears ☐hoarseness ☐

Lungs ☐choking ☐cough ☐shortness of breath ☐coughing blood ☐wheezing ☐

Heart ☐chest pain ☐palpitations ☐fainting ☐leg pains ☐leg swelling ☐

Gastrointestinal (GI) ☐abdominal pain ☐difficulty swallowing ☐nausea ☐vomiting
☐diarrhea ☐constipation ☐jaundice (yellow appearance of skin)
☐black stools ☐blood in stool ☐hemorrhoids ☐

Musculoskeletal ☐arthritis ☐stiffness ☐weakness ☐backache ☐

Nervous System ☐dizziness ☐seizures ☐headaches ☐tremors ☐memory loss
☐paralysis ☐numbness ☐tingling ☐anxiety ☐depression
☐personality change ☐suicidal thoughts ☐

Hematologic/Lymphatic ☐bruising ☐easy bleeding ☐recurrent infections
☐groin node enlargement or tenderness ☐neck lymph node enlargement ☐

Name of person completing form (if not patient) ____

Treasure Valley Urology, PLLC
Main: (208) 229-9009
Fax: (208)229-9010

AUA Urinary Symptom Index Questionnaire

Patient Name:______________________________DOB:_____________________Date Completed:______

	Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your Score
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
2. Over the past month, how often have you had to urinate again less than two hours after you finish urinating?	0	1	2	3	4	5	
3. Over the past month, how often have you stopped and started again several times when you urinate?	0	1	2	3	4	5	
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
	None	1 Time	2 Times	3 Times	4 Times	5 or More	
7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	
Total Symptom Score							

Score: 1-7 Mild 8-19 Moderate 20-35 Severe

Bother Score Due to Urinary Symptoms

Rate the bothersomeness of your symptoms by circling the number below that best describes your feelings.

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
Bothersomeness of Urinary Symptoms How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Disclaimer: This material is provided for information purposes only and it is not a substitute for a consultation. You should consult with an urologist regarding your specific symptoms or medical conditions.

Sexual Health Inventory for Men (SHIM)

Patient Instructions:

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor. Although erections may not be an issue for you we still administer this questionnaire because some medical treatments can affect erections and it's important to establish your baseline erectile function

Each question has several possible responses. Circle the number of the response that best describes your own situation. Please be sure that you select only one response for each question.

Patient Name: **D.O.B.** **Today's Date**

1. How would you rate your confidence that you could get and keep and erection?		**Very Low 1**	**Low 2**	**Moderate 3**	**High 4**	**Very High 5**
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	**No Sexual Activity 0**	**Almost Never or Never 1**	**A Few Times(Much less than half the time) 2**	**Sometimes (About half the time) 3**	**Most Times (Much more than half the time) 4**	**Almost Always or Always 5**
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	**Did Not Attempt Intercourse 0**	**Almost Never or Never 1**	**A Few Times(Much less than half the time) 2**	**Sometimes (About half the time) 3**	**Most Times (Much more than half the time) 4**	**Almost Always or Always 5**
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	**Did Not Attempt Intercourse 0**	**Extremely Difficult 1**	**Very Difficult 2**	**Difficult 3**	**Slightly Difficult 4**	**Not Difficult 5**
5. When you attempted sexual intercourse, how often was it satisfactory for you?	**Did Not Attempt Intercourse 0**	**Almost Never or Never 1**	**A Few Times(Much less than half the time) 2**	**Sometimes (About half the time) 3**	**Most Times (Much more than half the time) 4**	**Almost Always or Always 5**

Add the numbers corresponding to questions 1-5. **Total:**

The Sexual Health Inventory for Men further classifies erectile dysfunction (ED) severity with the following breakpoints:

1-7 Severe ED **8-11 Moderate ED** **12-16 Mild to Moderate ED** **17-21 Mild ED**

PATIENT FINANCIAL POLICY

Welcome to Treasure Valley Urology and thank you for placing your trust in us! We are committed to providing the best possible care and ensuring there is clarity in your financial responsibilities is an essential part of your care.

- YOUR HEALTH INSURANCE POLICY
  - It is a contract between you and your insurance company. It is your responsibility to know the specifics of your insurance coverage and whether Treasure Valley Urology is in or out of network.
- REFERRAL OR PREAUTHORIZATION
  - If needed, we will engage your referring physician or insurance company. However, it is ultimately your responsibility to ensure the referral or authorization is received in advance.
- HEALTH CARE COMPANIES/PLANS
  - Please call your insurance company prior to your appointment to determine if your physician is in network with your plan. We will submit a claim to your plans and you will be expected to pay the co-payment and/or other financial obligations. **Per your insurance company, we are expected to collect all co-payments and co-insurance/deductibles when you arrive for your appointment**.
  - Treasure Valley Urology is NOT contracted with any out-of-state Medicaid programs
- PAYMENT IS DUE AT TIME OF SERVICE
  - We accept checks, VISA, MasterCard, Discover, American Express, or cash. If you are not able to make your co-payment, pay toward your balance, or your co-insurance/deductible, your appointment could be cancelled or rescheduled.
- INSURANCE CARD AND REFERRAL PAPERWORK
  - Please bring a current copy of your insurance card and current authorization if required by your insurance company. If proof of insurance is not provided, you could be expected to make payment in full at the time of your appointment.
  - Medicaid patients are required to bring a current copy of their card or proof that an application is in process and Medicaid documentation that the visit will be a covered service.
  - Healthy Connections patients also will need to bring their Healthy Connections referral or make arrangements for their Primary Care Physician to send it to us prior to their visit.
- PATIENTS WITHOUT INSURANCE COVERAGE
  - If you do not have insurance coverage, charges incurred will be your responsibility and payment is expected at time of service.

FOR THE FOLLOWING ITEMS, PLEASE INDICATE YOU UNDERSTAND BY INITIALING EACH OF THE FOLLOWING:

______ Accounts with a past-due patient balance can be sent to a financial management/collection agency without further notice.

______ Insurance may not cover all services and supplies. If your health plan determines a service or supply is not covered, you will be responsible for the non-covered charges. Payment for non-covered services is due upon receipt of a statement or notice from our billing office.

______ There will be a $25.00 charge for returned checks (insufficient funds).

______ There will be a $25.00 charge for all no shows. (Charged at our discretion.) This is not covered by your insurance.

I have read and understand the financial policy of Treasure Valley Urology Pllc and agree to be bound by its terms. I also understand that such terms may be amended without notice by the practice and if I refuse to sign and continue to seek/receive care, my agreement with this policy is implied.

Signature of Patient and/or Guardian ____ Date__________________