TREASURE VALLEY UROLOGY

8854 W Emerald St Suite 180
Boise, ID 83704
208-229-9009

Health History Questionnaire

Name:_____ DOB:_____

Date of completion:_____ Chief Complaint:_____

Height:_____ **Weight:**_____

What is your primary concern? What issues do you wish to discuss at your visit?:

_____

Medication/Food Allergy: Y N **Latex Allergy:** Y N **Nickel Allergy:** Y N

If yes please list with reactions: _____

_____

Current Medications (include prescription, herbal supplements, vitamins and over-the-counter):

Name:	Dosage:	Frequency:	Reason for taking:

Surgical History and Hospitalizations:

Year:	Surgery/Hospitalization:	Year:	Surgery/Hospitalization:

Social History:

Smoke/Chew Tobacco/Vape: Age Started_____ Age Quit_____ How often:_____

Drink Alcohol: How much/How often_____

Family History:

Please list the age of death and reason of death for any of the following:

Mother_____ Father_____ Siblings_____

Please indicate **ANY** family members diagnosed with the following.

___ Bladder Cancer ___ Kidney Cancer ___ Prostate Cancer ___ Testicular Cancer

___ Kidney Stones ___ Kidney Disease ___ Liver Disease ___ Heart Disease

Have you been diagnosed with any of the following? (please circle):

Heart:	**Lung:**	**Gastrointestinal:**	**Nervous System:**
Murmur	Asthma	Hiatal Hernia	Stroke
Heart Disease	Emphysema/COPD	Reflux	Paralysis
High Blood Pressure	Pneumonia	Ulcer	Multiple Sclerosis
High Cholesterol	Tuberculosis	Hepatitis A B C	ALS
Congestive Heart Failure	Sleep Apnea	Liver Disease	Dementia/Alzheimer's
Heart Attack		Inflammatory Bowels	Neuropathy
Anemia	**Endocrine:**	Ulcerative Colitis	Parkinson's Disease
Blood Clot	Thyroid Disease	Crohn's Disease	CVA (stroke)
Peripheral Vascular Disease	Diabetes		
Atrial Fibrillation			
Genitourinary:	**Men's Health:**	**Cancer:**	**Other:**
Incontinence	Elevated PSA	Breast Cancer	HIV/AIDS
Kidney Disease	Erectile Dysfunction	Kidney Cancer	History of MRSA
Kidney Stone	Low Testosterone	Prostate Cancer	History of C.Diff
Cystitis (bladder infections)	Testicular Pain	Bladder Cancer	
Frequent UTI's	Enlarged Prostate	Colon Cancer	
Hematuria (blood in urine)		Lung Cancer	
Nocturnal Enuresis		Other_____	
Urethral Stricture			
Pelvic Pain			

Completed by_____

AUA BPH Symptom Score 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. 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:**

How would you rate your confidence that you could get and maintain an erection?		**Very Low 1**	**Low 2**	**Moderate 3**	**High 4**	**Very High 5**
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**
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**
During sexual intercourse, how difficult was it to maintain your erection to complete intercourse?	**Did Not Attempt Intercourse 0**	**Extremely Difficult 1**	**Very Difficult 2**	**Difficult 3**	**Slightly Difficult 4**	**Not Difficult 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 Registration Form

Last Name:_____ First:_____ M _____Date of Birth _____/_____/ _____

Sex: M F SSN_____ Advanced Directive: _____Yes _____No

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 _____

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
  - I, the undersigned, assign all medical benefits to which I am entitled including Medicare, Medicaid, private insurance, and third-party payors Treasure Valley Urology PLLC and authorize the assignee to release all information necessary including medical records to secure payment.
- PAYMENT IS DUE AT TIME OF SERVICE
  - We accept checks, VISA, MasterCard, Discover, 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. We charge 3.5% on Credit and Debit card transactions to recover the 3.5% charged to us by the credit card processors. Returned checks incur a $50 fee. If you have trouble paying her bill please communicate with the billing office so monthly payments can be arranged. Overdue balances incur an 18% annual interest.
- 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.
- HOSPITAL OWNERSHIP DISCLOSURE:
  - Dr. Heiner has an ownership interest in Treasure Valley Hospital which is a partially physician-owned surgical Hospital that offers the lowest cost hospital care in the Treasure Valley with excellent clinical outcomes. A patient has the right to choose where to receive their medical care and should actively research the various facilities and communicate their preferences to us.
- 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 incur an interest penalty of 18% annually and 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 $50.00 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_____

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.

I understand that I may ask for a copy of the Privacy Practices for Treasure Valley Urology.

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 via voicemail and/or text message.

___ No, do not leave messages.

Signature of Patient/Guardian _____ Date _____