NEW PATIENT INTAKE – CHILD FORM

Welcome to Urology Associates, P.C. This questionnaire is intended to be a COMPLETE account of your medical history. Please answer completely, including details and dates, if known. Incomplete answers to these questions could lead to improper treatment.

Chart: _____ **Date_____**

Name: _____ Nickname: _____ D.O.B: _____ Age: _____

Birth Sex: __Male __Female **Preferred Pronoun Sex:** __Male __Female __Gender Neutral

Identifies as: __Male __Female __Transgender: __Male to Female or __Female to Male __Non-Conforming Gender

Address (Street, City, State,Zip) _____

Home Phone: _____ Cell: _____ Work: _____

Mom's Name: _____ Dad's Name: _____ Email: _____

Emergency Contact: _____ Relation to Patient: _____

Home: _____ Cell: _____ Work: _____

Referring Dr. _____ Primary Care Dr. _____

Required Fields: ☐ Not Reporting **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language: _____ Race: _____

Pharmacy Name, Address, Phone _____

Who referred you to see us today? __Hospital or Urgent care __ Primary care doctor __Other doctor __Self Referred

What problem or reason are you being seen for?_____

MEDICAL HISTORY Child's Height: _____ ft _____in Weight: _____ lbs

Past Medical History (Circle yes or No)

Complications with pregnancy or delivery	Y N	Pre-Maturity	Y N	Urinary Tract Infections	Y N
Abnormal prenatal ultrasounds or exams	Y N	Unexplained Fevers	Y N	Bedwetting	Y N
Wets or Soils Underwear	Y N	Persistent Constipation	Y N	Known Medical Disease	Y N
Heart Problems	Y N	Lung Problems	Y N	Intestinal Problems	Y N
Nervous Disorder	Y N				

PAST SURGICAL HISTORY (Please list any surgeries your child has had and approximate date):

_____

_____

ALLERGIES – Is your child allergic to: __Latex __Iodine __Shellfish

MEDICATIONS THAT CAUSE ALLERGIES (i.e. hives, rash, difficulty breathing)

_____

CURRENT MEDICATIONS ____My Child currently takes no medications.

List Medications with dose

1._____ 2._____ 3. _____

Urology Associates, P.C.

Child's Name: _____ _____ **DOB**: _____ **Age**:_____

SOCIAL HISTORY

Does your child enjoy and participate normally in school or social activities? Y N If No, please explain:

_____

Tobacco Use (13yrs or older): ___ Never Smoked ___ Smoker: ___ packs per day ___ Former Smoker: quit___ years

FAMILY HISTORY

Birth Defects Y N Kidney, Bladder or Genital abnormalities Y N

Other_____

_____

REVIEW OF SYSTEMS No symptoms at this time _____

Fever	Y N	Swollen Glands	Y N	Chest Pains	Y N	Joint/Back Pains	Y N
Fatigue	Y N	Cough	Y N	Abdominal Pain	Y N	Dizziness/Lightheadedness	Y N
Rash/Itching	Y N	Wheezing	Y N	Nausea/Vomiting	Y N	Depressed/Sad	Y N
Headache	Y N	Shortness of	Y N	Blood in Urine	Y N	Extreme sensitivity to cold/heat	Y N
Visual change	Y N	Breath	Y N	Urinary Problems	Y N	Bleed Easily	Y N

Please elaborate on any *"yes"* answers from above (be as specific as possible):

_____

_____

(For Office Use Only)

REASON FOR VISIT: Was patient referred from another doctor or facility for this visit? No Yes =(use Transition Into Care ROV)

ASSESMENT OF PLAN: __Flow Rate __Bladder Scan __UA w/ micro ___Culture __Cytology __Renal U/S __Pelvic U/S

BMI in range? Yes / No =(CQM folder) Tobacco: Current or Former? No Yes = (CQM folder)

Urology Associates, P.C.

Child's Name: _____ _____ **DOB**: _____ **Age**:_____

HIPAA NOTICE ACKNOWLEDGEMENT

The Practice of Urology Associates, P.C. is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in providing our services to you. Such information may include documentation of your symptoms, examinations and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law, the Health Insurance Portability & Accountability Act of 1996 (HIPAA), to use and disclose your PHI for the purposes of treatment, payment and health care operations without your written authorization.

We will use your PHI during the course of your treatment if the physician determines we will need to consult with a specialist in another area. He will share the information with the specialist and obtain his/her input. We will also use your PHI to contact you by phone, if we need to speak to you about a medical condition, or to remind you of medical appointments. We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We also want you to know that we support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. You may revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office (except to the extent action has already been taken based on a previous authorization).

You have the right to receive the Notice of Privacy Practices for Protected Health Information from our office or visit our website at www.uradenver.com. I acknowledge that I have been given the option to receive a copy of the Notice of Privacy Practices for the practice of Urology Associates, P.C.

FINANCIAL SERVICE AGREEMENT

BILLING PRACTICES: Our policy is to bill the patient's insurance company for service rendered. However, Insurance coverage is another form of payment but ultimately it is your responsibility to pay for all services rendered. If you do not have insurance, payment is due at the time services are rendered. We will collect any known or estimated co-payments, co-insurance or deductibles at the time of service. Additionally, the responsible party will be billed for services rendered in full, should the insurance company deny coverage due to non-covered benefits, lack of referral, lack of proper reporting of incident/accident or lack of individual coverage, where applicable.

COLLECTION ACTIVITY: Any account balance(s) that are not paid within ninety (90) days from the date of service may be forwarded to a collection agency. If deemed necessary, Urology Associates PC reserves the right to forward the account balance(s) to a collection agency prior to ninety (90) days from the date of service. Any and all phone numbers provided to our office be it residential, employment or wireless, are authorized methods of communication by our office or by a collection agency in regards to any outstanding collection balances. Should litigation be necessary to collect an amount owed, the responsible party agrees to pay all costs of collection including, but not limited to, collection fees, attorney fees, interest and court costs.

PAYMENT FOR SERVICES: For payment of your financial obligation we accept Cash, Check, Visa, MasterCard or Discover.

If you have any questions or concerns, please speak with the billing dept. at (303)733-0662. ***Please note:*** *It is the patient's responsibility to understand their individual insurance benefits.*

I hereby assign to Urology Associates, PC all benefits for medical expenses. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I authorize the provider named above to release my medical records and all medical information requested by my insurance company.

Patient/Parent/Legal Guardian Signature: _____ **Date:** _____

Parent/Legal Guardian (Printed Name)_____

Urology Associates, P.C.

Child's Name: _____ _____ **DOB**: _____ **Age**:_____

CONSENT TO CONTACT / LEAVE INFORMATION

I authorize Urology Associates and associated employees to speak with or leave a message regarding my child's appointments, medical conditions, test results, and or billing matters with the following individuals:

___ Mother: ___ ALL **or** ONLY: ___ Appointments ___ Medical Conditions ___ Test Results ___ Billing Matters

Name_____ Phone: _____

___ Father: ___ ALL **or** ONLY: ___ Appointments ___ Medical Conditions ___ Test Results ___ Billing Matters

Name_____ Phone: _____

___ Guardian: ___ ALL **or** ONLY: ___ Appointments ___ Medical Conditions ___ Test Results ___ Billing Matters

Name_____ Phone: _____

Patient/Parent/Legal Guardian Signature: _____ **Date:** _____

Parent/Legal Guardian (Printed Name)_____

AUTHORIZATION TO COMMUNICATE BY UNENCRYPTED EMAIL

Email Communications: Information stored on our computers is encrypted; however, most popular email services (e.g.,Gmail,Hotmail,Yahoo, etc.) do not utilize encrypted email. As a result, when we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information. In addition, once the email is received by you, someone may be able to access your email account and read it. Email is a very popular and convenient way to communicate, so in a modification to the HIPAA act, the federal government provided guidance on email and HIPAA (this information is available at the U.S. Department of Health and Human Services website). The guidelines now state that as long as a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

I have read the above HIPAA notice and understand the risks of unencrypted email and do hereby give permission to Urology Associates and associated employees to send my child's personal health information via unencrypted email to below listed email address. I understand that this authorization is valid until revoked by me in writing, or when my child turns 15 years old. This authorization will be void without my signature below.

Email: _____

Patient/Parent/Legal Guardian Signature: _____ **Date:** _____

Parent/Legal Guardian (Printed Name)_____