Urology

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Pediatric Urology

Daniel Hirselj, MD
Kelly Bartholomew, PA-C
Caitlin Fleming, CPNP

Welcome to Northwest Urology! For more than 40 years, our board-certified physicians have provided the Portland area with the highest standard of comprehensive urologic care. We are delighted to have you as our patient.

To expedite your registration and check-in process, please complete the enclosed registration and medical history forms and bring them with you to your appointment. Please remember to also bring your insurance card and photo identification. Your appointment may need to be rescheduled if insurance information or photo identification is not provided.

Please review the enclosed financial policy for information about our policies on payment at time of service, self-pay patients, no-show/cancellation policy, and more. If you have healthcare insurance, we strongly encourage you to contact your insurance company prior to your appointment to verify coverage and understand your benefits for your upcoming visit.

Checklist for your upcoming appointment:

- O Completed registration/medical history forms (enclosed)
- O Signed and dated financial policy (enclosed)
- O Photo identification
- O Insurance card, and copay/coinsurance (contact your insurance company to verify coverage)

If you have any questions on the contents of this packet or about your appointment, please contact the appropriate office:

For patients scheduled at:

St. Vincent location:	Phone: (503) 297-1078
NW Portland, Peterkort, or Vancouver locations:	Phone: (503) 223-6223
Sherwood location:	Phone: (503) 972-8760
McMinnville location:	Phone: (503) 435-2561

Thank you for choosing Northwest Urology. We look forward to partnering with you in your urologic health.

Sincerely,

The Physicians and Staff of Northwest Urology

Patient Registration

Patient Name: ______________________________ **Preferred Name:** ______________

Last First M.I.

Gender: M F **DOB:** ____/____/____ **SSN:** ____-____-____

Mailing Address: ______________________________

City: ______________ **State:** ______________ **Zip Code:** ______________

Street Address (if different than mailing): ______________________________

Home Phone: ______________ **Mobile Phone:** ______________

Work Phone: ______________ **Email:** ______________

Contact Preference: Home Phone Work Phone Mobile Phone Mail

Marital Status: Married Single Divorced Separated Widowed Partner

Language: ______________ **Race:** ______________

Ethnicity: Hispanic or Latino/Spanish Not Hispanic or Latino Other

May we send emails possibly containing your private medical information to the email address you provided above? *Yes No*

May we leave voice messages at your preferred phone number possibly containing your private medical information? *Yes No*

Would you like to receive automated reminder calls? If you receive the calls via your mobile device, carrier rates may apply. *Yes No*

Would you like to receive automated text message alerts regarding appointment reminders and more? *Yes No*

Employer Name: ______________________________

Employer Phone: ______________ **Occupation:** ______________

Primary Care Physician: ______________ **Phone:** ______________

Referring Physician: ______________ **Phone:** ______________

Preferred Pharmacy Name: ______________ **Location or Phone:** ______________

How did you hear about us? Advertising PCP Specialist Dr. Word of Mouth Patient Hospital

Insurance Company Other (please specify): ______________

Emergency Contact Name: ______________ **Relationship:** ______________

Home Phone: ______________ **Mobile Phone:** ______________

Spouse (Next of Kin) Name: ______________ **DOB:** ____/____/____

Home Phone: ______________ **Mobile Phone:** ______________

(continued on back)

Responsible Party for Minor Children (if applicable):

1) Parent/Guardian Name: ______________________________ **DOB:** ____/____/____
Last First M.I.

Relationship to patient: ______________________________

Mailing Address: ______________________________

City: ______________ **State:** ______________ **Zip Code:** ______________

SSN: ____-____-____ **Phone:** ______________ **Email:** ______________

2) Parent/Guardian Name: ______________________________ **DOB:** ____/____/____
Last First M.I.

Relationship to patient: ______________________________

Mailing Address: ______________________________

City: ______________ **State:** ______________ **Zip Code:** ______________

SSN: ____-____-____ **Phone:** ______________ **Email:** ______________

Insurance Information:

Primary Insurance: ______________________________ **Effective Date:** ____/____/____

ID #: ______________________________ **Group #:** ______________________________

Subscriber Name: ______________ **DOB:** ____/____/____ **Relationship to patient:** ______________

Secondary Insurance: ______________________________ **Effective Date:** ____/____/____

ID#: ______________________________ **Group #:** ______________________________

Subscriber Name: ______________ **DOB:** ____/____/____ **Relationship to patient:** ______________

ASSIGNMENT OF BENEFITS

I hereby assign any medical surgical insurance benefits to Northwest Urology, LLC to allow my provider to obtain payment for services I receive. A photocopy of this assignment is as valid as the original. I understand that I am financially responsible for all charges, whether or not paid in part by insurance. I further authorize Northwest Urology, LLC to release financial information to a health insurer in order to obtain payment for services.

RELEASE OF INFORMATION

It is sometimes necessary for Northwest Urology, LLC to provide information regarding a patient's medical or pharmaceutical history and treatment to other medical providers, hospitals, pharmacies, or medical facilities when required for the patient's medical needs, to facilitate treatment, or to verify benefits. It is also sometimes necessary for those providers to request similar information from Northwest Urology, LLC. I give my authorization for such sharing of information.

Patient/Responsible Party Signature: ______________________________ **Date:** ______________

Print Responsible Party Name (if other than patient): ______________________________

Relationship Patient: ______________________________

Northwest Urology LLC

Medical History for Date: ______________________

Patient Name: ______________________ Date of Birth: ______________

The reason for your visit: ______________________

Past Medical History (Circle **Y**es or **N**o. If **Y**es, please explain):

Bleeding Disorder	Y N ________		**Heart Disease**	Y N ________
Cancer	Y N ________		**High Blood Pressure**	Y N ________
Chemo/Radiation	Y N ________		**Lung Problems**	Y N ________
Claustrophobia	Y N ________		**Metal in your body**	Y N ________
Diabetes	Y N ________		**Neurologic (Parkinson's, MS)**	Y N ________
Enlarged Prostate	Y N ________		**Stroke**	Y N ________

Have you received the Pneumonia Vaccine? Y N Date: ________ **Flu Shot** Y N Date: ________

Have you fallen in the past year? No falls or 1 fall without injury 2+ falls or any fall with injury

Have you had a Sigmoidoscopy Y N Colonoscopy Y N Date: ________

Other: ______________________

FOR WOMEN

Day of Last Menstrual Period	________	**Number of Deliveries**	________
Number of Pregnancies	________	**Currently Pregnant?** Y N	Due Date: ________
Mammogram	Y N Date: ________	**Pap Smear** Y N	Date: ________

Past Surgical History (Circle **Y**es or **N**o. If **Y**es, please explain):

FOR MEN		***FOR WOMEN***	
Bladder	Y N ________	**Bladder**	Y N ________
Kidney	Y N ________	**Caesarean Section**	Y N ________
Prostate	Y N ________	**Hysterectomy**	Y N ________
Vasectomy	Y N ________	**Kidney**	Y N ________
		Tubal Ligation	Y N ________

Other: ______________________

List all **MEDICATIONS** and **DOSAGES** you are **CURRENTLY** taking including Over-the-Counter and Supplements:

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

(continued on back)

Do you have any **ALLERGIES** to the following: (Circle **Y**es or **N**o. If **Y**es, please explain)

Medications	Y N	______________	**Latex**	Y N	______________
Betadine	Y N	______________	**Other**	Y N	______________

Social History (Circle **Y**es or **N**o. If **Y**es, please explain):

Marital Status: Married Single Divorced Widowed Partner

Have you ever used tobacco products? Y N How often/how long? ______________

Do you currently smoke cigarettes? Y N How often/how long? ______________

Do you ever drink alcohol? Y N How often/how long? ______________

Do you ever use recreational drugs? Y N How often/how long? ______________

Family History

Does anyone in your **FAMILY** have a **HISTORY** of the following? (Circle **Y**es or **N**o. If **Y**es, please explain)

Diabetes	Y N	______________	**Prostate Cancer**	Y N	______________
Heart Disease	Y N	______________	**Kidney/Bladder Cancer**	Y N	______________
Kidney Disease	Y N	______________	**Kidney Stones**	Y N	______________

Other: ______________

Are you **CURRENTLY** experiencing any of the following:

Constitutional Problems:			Endocrine Problems:		
Fevers/Chills	No	Yes	Increased Thirst or Appetite	No	Yes
Low Energy	No	Yes	Other: ______________		
Other: ______________			Neurologic Problems:		
Cardiac (Heart) Problems:			Dizziness	No	Yes
Chest Pain	No	Yes	Lightheadedness	No	Yes
Other: ______________			Other: ______________		
Respiratory Problems:			Hematologic/Lymphatic Problems:		
Shortness of Breath	No	Yes	Swollen Glands	No	Yes
Other: ______________			Other: ______________		
Gastrointestinal Problems:			Musculoskeletal Problems:		
Abdominal Pain	No	Yes	Back Pain	No	Yes
Nausea/Vomiting	No	Yes	Other: ______________		
Other: ______________			Genitourinary Problems:		
Skin Problems:			Blood in Urine	No	Yes
Genital Lesion(s)	No	Yes	Pain During Urination	No	Yes
Other: ______________			Other: ______________		
Psychiatric Problems:					
Depression	No	Yes			
Anxiety	No	Yes			
Other: ______________					

Authorization for Use or Disclosure of Protected Health Information

This form allows us disclose your health information to family members/friends, physicians, and/or organizations you would like involved in your care.

Patient Name: ______________________________ **Date of Birth:** ______________________________

I request and authorize **Northwest Urology, LLC** to release protected healthcare information of the above named patient to:

____

Name of Individual and/or Organization   Relationship to patient   Phone   Fax

____

Name of Individual and/or Organization   Relationship to patient   Phone   Fax

____

Name of Individual and/or Organization   Relationship to patient   Phone   Fax

Information to be used or disclosed:

Entire Medical Record

Pertinent Records (last 2 years)

Radiology Report(s)

Laboratory/Pathology Report(s)

Other______________________________

SPECIALLY PROTECTED RECORDS

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that the information below will be disclosed if I place my **initials** in the applicable space next to the type of information.

_______ HIV/AIDS Information

_______ Mental Health Information

_______ Genetic Testing Information

_______ Drug/Alcohol Diagnosis, treatment, or referral information

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Note: Unless revoked, this authorization will expire one year from date of signing.

______________________________   ______________________________

Patient/Legal Guardian Signature   Date

____

Printed Name

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Financial Policy

Thank you for choosing Northwest Urology as your health care provider. As a specialist clinic, it is our policy that patients pay at the time of service for the minimum portion of their bill that is not covered by insurance. Patients who are not prepared to pay may be required to reschedule their appointment. ***Patients may still receive a bill*** for in-house labs, additional services ordered during their appointment, if the appointment took longer than expected, if their insurance company adjusts the bill, or if new information is acquired bringing about new charges. **These bills are non-negotiable.**

IF YOU ARE INSURED:

What an insurance company pays depends on their policies and the coverage purchased by the patient. It is the patient's responsibility to review their coverage with their insurance carrier prior to their appointment. In order for us to bill an insurance company, the patient must provide us with complete and current insurance information. However, regardless of coverage, the patient is still responsible for the balance of charges incurred. If the patient is a minor, all current insurances must be provided and the appropriate primary policy must be indicated. The responsible party for any supplemental payment must also be designated, as well as their current mailing address. If you request to use our **Card on File**, we will only collect your copayment, if applicable, at the time of service. The remaining balance will be billed to your Visa, Discover, American Express, or MasterCard once your claim is processed by your insurance.

IF YOU ARE NOT INSURED:

If you do not have insurance, are unable to provide proof of insurance in a timely manner or are on a plan that we do not participate in, full payment is due at the time of service. If you were not already notified, feel free to contact us in advance to receive the estimated amount due for your appointment. As a courtesy for paying in full, you will receive non-elective services at a 20% discount.

FOR ALL PATIENTS:

- Missed appointments or cancellations made with less than 24-hour notice may incur a $55 fee. This fee may also be assessed if a patient is more than 15 minutes late for their appointment. If the physician is delayed in the operating room or running behind in the clinic, a patient is welcome to reschedule his/her appointment.
- Each returned check for stop payment or non-sufficient funds (NSF) will generate a $40 fee.
- Medical records can be downloaded instantly, and free of charge, on our portal at www.nwurology.com. We also offer a password protected CD containing your medical records via mail or pick up for a $5 fee. Printed record requests containing 10 pages or less can be provided for a $30 fee, and $0.25 for each additional page. An additional charge of $5 will be applied for records requests processed within 7 business days. A signed authorization from the patient may be required to release information.
- Accounts with balances exceeding 90 days that are released to a collection agency incur a late fee of $35.
- Additional payment options may be applied for by calling our billing office prior to your visit at 971-244-0798.

I have read, understand, and agree to these financial policies.

______________________________ ______________

Signature of Patient or Responsible Party **Date**

____

Printed Name of Patient or Responsible Party