Affix Label Here

MINNESOTA UROLOGY

Patient Authorization and Consent Form

Consent for Treatment: I consent to and authorize my health care provider to examine and treat me. I understand this could include lab tests or other diagnostic procedures, education or images which may result in separate billable charges. I understand my provider is available to explain the purpose of the procedure(s) and treatment(s), and I have the right to refuse such procedure(s) or treatment(s).

- I authorize Minnesota Urology (MNU) to verbally communicate regarding my personal health care or billing information with me by leaving voicemail messages on phone number: ________________________________.

Privacy: I acknowledge I have received a copy or have been made aware of MNU's privacy practices. I understand I may request a copy of this notice. I authorize MNU to discuss and disclose health care/billing information to others as provided below:

- I authorize MNU to verbally communicate regarding my personal health care or billing information with:
  Name: ____Relationship:___________________________

Assignment of Benefits and Release of Information: I request payment of authorized benefits directly to the provider for services rendered to me at this facility or other facility owned or operated by MNU, including physician services, any provider under contract with MNU or participating in a provider network in which MNU or its affiliates participates. I consent to MNU releasing my health records and other information related to my health care services for payment and healthcare operational purposes. I agree that MNU may release my health records and other information to my insurance company.

Release of Information by Payers and Networks: I authorize Medicare, my insurance company or HMO, other payers, payer network organizations including accountable care organizations, their contractors and 3rd party administrators to share my health records and information obtained by MNU or any other provider, with MNU, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and 3rd party administrators of these parties as needed for payment and health care operations.

Release of Information to Health Care Providers: I consent to the release of my health records created and received by MNU for my treatment to other health care providers who are involved in my treatment.

Lab Billing/Outside Lab Billing: I understand that if my provider decides to order lab work during my visit, some tests may require evaluation by an outside (third party) laboratory. In this case, I understand I may receive a separate bill from the outside lab.

Payment Agreement: I understand that I am financially responsible for and agree to promptly pay any charges for the care and treatment of non covered services rendered to me that are not covered by my insurance plan. If I do not have active insurance coverage, I understand: 1) my billing status will be listed as 'self-pay,' 2) I will be required to make a $100 down payment prior to receiving an evaluation and treatment, and 3) I will be billed for the remainder of all charges related to my evaluation and treatment. Regardless of insurance coverage, I understand my past due balances may be assessed a finance charge.

No Show/Late Cancellation Policy: I acknowledge that by not cancelling my appointment in at least 24 hours in advance or not showing up for your appointment prevent other patients from being scheduled. I understand I may be assessed a $100 fee for each missed appointment after my second *Office Visit* no-show Further, I understand that I will be assessed a $50 fee for any *Procedure* no show appointment or late cancel for any appointment.

When electronically signing this form, I acknowledge I have read and agree to all of the above.

You may withdraw this consent at any time by advising us in writing at: Minnesota Urology, 6025 Lake Road, Suite 200, Woodbury MN, 55125. I understand my revocation shall have no effect on releases that have already been completed.

____

Signature of Patient/Personal Representative   Print Patient Name   Date of Birth   Today's Date

______________________________   ____

Relationship to Patient (if patient unable to sign)   Reason Patient Unable to Sign

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Patient Label

Patient Medical History – Adult Female

Height ____________ Weight ____________

Pharmacy name, address, phone number ____

Telephone number to patient contacted: (H) ________________________(Cell) ______________________________

Email Address ____

Employment / Occupation: ____

Emergency contact: Name __________________________________ Phone ________________________

Who referred you for this consultation? (Self? Doctor? If so, from what clinic?) ______________________________

____

Describe the location/symptom/problem that is the reason for your visit: ______________________________________

____

When did this problem start?____

Does anything make this problem better or worse? Please describe:______________________________

Are there other associated problems? ☐ No If yes, describe____________________________________

Please mark on the line the severity of your problem: 0 ······ 1 ······ 2 ······ 3 ······ 4 ······ 5 ······ 6 ······ 7 ······ 8 ······ 9 ······ 10
None Moderate Severe

ALLERGIES

ALLERGY	TYPE OF REACTION (RASH, NAUSEA, ETC)

MEDICATIONS

NAME	DOSE	HOW OFTEN TAKEN

PAST SURGICAL HISTORY

SURGERY		DATE / YEAR
Appendix	☐	
Back	☐	
Bladder	☐	
Breast	☐	
Colon	☐	
Gallbladder	☐	
Heart Bypass	☐	
Heart Valve	☐	
Hernia	☐	
Hysterectomy	☐	
Kidney	☐	
Lung	☐	
Pelvic Laparoscopy	☐	
Thyroid	☐	
Total Joint Replacement	☐	
Right: ☐ Hip ☐ Knee	☐	
Left: ☐ Hip ☐ Knee	☐	
Urethra	☐	
Other/Explain:	☐	

MEDICAL AND FAMILY HISTORY

	You	Family Member	If family member, relationship to you
Anemia	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Cancer	☐	☐	
Depression	☐	☐	
Diabetes	☐	☐	
GERD / Acid Reflux	☐	☐	
Gout (high uric acid)	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Kidney Stones	☐	☐	
Liver Disease	☐	☐	
Mitral Valve Prolapse	☐	☐	
MRSA	☐	☐	
Osteoporosis	☐	☐	
Positive Mantoux/PPD	☐	☐	
Rheumatic Fever	☐	☐	
Thyroid Problems	☐	☐	
Toxic Exposure	☐	☐	
Tuberculosis	☐	☐	
Other/Explain:			

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SOCIAL HISTORY

Bolded questions in this section are Government required due to the Health Care Reform Act.

Marital Status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Annulled ☐ Life Partner

Smokeless Tobacco (chewing) ☐ Yes ☐ No

Smoking Status? ☐ Current Every day ☐ Current Some Days ☐ Former ☐ Never

How many years if current ? ____________________ When did you quit? _____________________

How many caffeinated drinks do you have each day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Do you ever drink alcohol? ☐ Yes ☐ Not Anymore ☐ Never Drank

Do you use Recreational Drugs ☐ Yes ☐ No

Race?__________________________

Have you had a blood transfusion? ☐ No ☐ Yes

Ethnicity? ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Preferred Language?**__________________

Could you be pregnant? ☐ No ☐ Yes Do you have children? ☐ No ☐ Yes

# of pregnancies_______ ______#Vaginal ___________#Caesarean

Have you ever had MRSA? ☐ No ☐ Yes

Positive Mantoux/PPD? ☐ No ☐ Yes

Are you on a special diet? ☐ No ☐ Yes If yes, explain _______________________________

REVIEW OF SYSTEMS

Do you have any problems NOW related to the following systems? Please circle No or Yes.

Constitutional Symptoms

Fever	No	Yes
Chills	No	Yes
Other __________	No	Yes

Eyes

Blurred vision	No	Yes
Double vision	No	Yes
Pain	No	Yes
Other __________	No	Yes

Endocrine

Excessive thirst	No	Yes
Too hot/cold	No	Yes
Tired/sluggish	No	Yes
Other __________	No	Yes

Cardiovascular

Chest pain	No	Yes
Varicose veins	No	Yes
High blood pressure	No	Yes
Other __________	No	Yes

Integumentary

Skin rash	No	Yes
Boils	No	Yes
Persistent rash	No	Yes
Other __________	No	Yes

Respiratory

Wheezing	No	Yes
Frequent cough	No	Yes
Shortness of breath	No	Yes
Other __________	No	Yes

Gastrointestinal

Abdominal pain	No	Yes
Nausea/vomiting	No	Yes
Indigestion / heartburn	No	Yes
Constipation	No	Yes
Irritable bowel syndrome	No	Yes
Other _________	No	Yes

Musculoskeletal

Joint pain	No	Yes
Neck pain	No	Yes
Back pain	No	Yes
Other _________	No	Yes

Neurological

Tremors	No	Yes
Dizzy spells	No	Yes
Numbness/Tingling	No	Yes
Headache	No	Yes
Other __________	No	Yes

Genitourinary

Urine retention	No	Yes
Painful urination	No	Yes
Urinary frequency	No	Yes
Urinary tract infections	No	Yes
If yes, # per year ___________		
Other _____________	No	Yes

Ear/Nose/Throat/Mouth

Ear infection	No	Yes
Sore throat	No	Yes
Sinus problems	No	Yes
Other __________	No	Yes

Allergic/Immunologic

Hay fever	No	Yes
Drug allergies	No	Yes
Other ________	No	Yes

Hematologic/Lymphatic

Swollen glands	No	Yes
Blood clotting problem	No	Yes
Pulmonary embolism	No	Yes
Other _________	No	Yes

Sexual History

Sexually active?	No	Yes
Pain with intercourse?	No	Yes
Leaking urine with intercourse?	No	Yes

Psychologic

Are you generally satisfied with your life?	No	Yes
Do you feel severely depressed?	No	Yes
Have you ever considered suicide?	No	Yes
Other ___________	No	Yes

Gynecologic

Heavy periods	No	Yes
Irregular periods	No	Yes
Menopause	No	Yes
If yes, when? ____________		
Hormone therapy	No	Yes
If yes, type: ______________		

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UDI-6 Urogenital Distress Inventory

Do you experience the following? If so, how much are you bothered by:	**NOT AT ALL**	**SLIGHTLY**	**MODERATELY**	**GREATLY**
Frequent urination?	0	1	2	3
Urine leakage related to the feeling of urgency? (sudden desire to urinate)	0	1	2	3
Urine leakage related to physical activity, coughing or sneezing?	0	1	2	3
Small amounts of urine leakage (drops)?	0	1	2	3
Difficulty emptying your bladder?	0	1	2	3
Pain or discomfort in the lower abdominal or genital area?	0	1	2	3

Symptom Score ________________

IIQ-7 Incontinence Impact Questionnaire

Over the past month has the leakage of urine and/or prolapse affected:	**NOT AT ALL**	**SLIGHTLY**	**MODERATELY**	**GREATLY**
your ability to do household chores (cooking, housecleaning)?	0	1	2	3
your physical recreation such as walking, or other exercise?	0	1	2	3
your ability to attend entertainment activities (movie, concerts)?	0	1	2	3
your ability to travel by car more than 30 minutes from home?	0	1	2	3
your participation in social activities outside your home?	0	1	2	3
your emotional health (nervousness, depression, etc)?	0	1	2	3
made you feel frustrated?	0	1	2	3

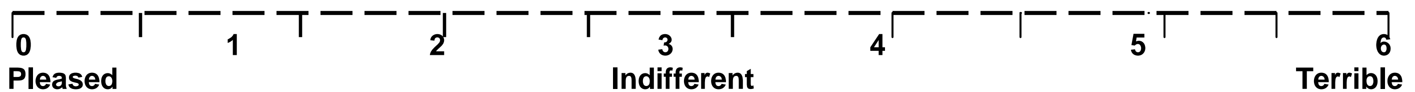
How many **times** a **day** are you using the restroom? ___________

Bother Score _______________

- How **frequently** do you use the restroom? Every __________ hours?
- How many **accidents** are you having per day? ___________
- How many **pads** are you using per day? ___________

***We will use these questions throughout your treatment to gauge your progress**

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? Circle the number that best reflects your feelings about your urinary problem.



0 **1** **2** **3** **4** **5** **6**

Pleased **Indifferent** **Terrible**

QOL Score ___________

Physician use only: (Comments/Notes)

Physician Signature:____ ***Date:***____________________________

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