Piedmont Urology

Dear Patient:

We would like to take this opportunity to thank you for choosing our office for your urologic care and to welcome you to our office. We are pleased that you have chosen us to provide you with your medical services. For your convenience, wireless internet access is available.

Please bring the medications you are currently taking. If you had x-rays made, please bring the films with you when you come to the office.

Enclosed are forms that you need to complete and bring back with you. Please be sure that you bring your current insurance card/s with you so that your claims can be filed properly. If your insurance company requires a referral, please be advised that it is YOUR RESPONSIBILITY TO ENSURE THAT THE REFERRAL IS PUT INTO PLACE TO SEE THE DOCTOR. ALL COPAYS AND ANY FEES FOR SERVICE DUE TO NO INSURANCE ARE DUE PRIOR TO SEEING THE DOCTOR. Cash, check, or credit cards are accepted.

You will be seeing Dr. Hettiarachchi for urology problems. Therefore, it is very important that you are able to give a urine specimen at the time of your arrival to the office.

Your appointment is scheduled on _____at _____.

Thank you for your cooperation. We look forward to your visit with us and should you have any questions, please give us a call.

I AGREE WITH THE ABOVE TERMS

_____ _____

Signature

Dr. John Hettiarachchi, DO, FACS

200 West Park Circle, Suite A • North Wilkesboro, NC 28659 • Tel: 336-838-5655 • Fax: 336-838-7556 • piedmonturology.net

Piedmont Urology

Patient Information (Please Print)

Date: _____

Last Name: _____ First Name: _____ MI: ___

Mailing Address: _____

City/Town: _____ State: _____ Zip Code: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Mobile Phone: _____-_____-_____ E-Mail :_____(Required)

Date of Birth: _____ SSN: _____ Gender: M / F

Primary Care Physician: _____ Referring Physician: _____

Marital Status: (Circle one) Single Married Divorced Separated Widowed

Work Status: (Circle one) Employed Unemployed Disabled Retired Student

Race / Ethnicity: (Circle One) White Hispanic Black or African American

More than one race Native American Alaskan Native Asian Native Hawaiian

Refuse to answer other:_____

Preferred Language: (Circle One) English Spanish other: _____

Preferred Pharmacy: _____

Pharmacy Address: _____

Emergency Contact Information

Last Name: _____ First Name: _____ MI: ___

Mailing Address: _____

City/Town: _____ State: _____ Zip Code: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____

Mobile Phone: _____-_____-_____ Date of Birth (if patient is a minor): _____

Relationship to patient: _____

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Patient History and Review of Systems

Date: _____ Patient Name: _____

Personal History: Please answer all of the following questions:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Children # _____
Alcohol Use: ☐ No ☐ Yes: How Often?
Smoking: ☐ No ☐ Yes: How Much?
Do you have a history of drug abuse? ☐ No ☐ Yes: Substance Abused:
Are you sexually active? ☐ No ☐ Yes
Please list all allergies below:
Please list any past medical history below:
Please list any past surgeries and the year they were completed:
Family History: Is there any family history of the following? ☐ Stroke ☐ High Blood Pressure ☐ Arthritis ☐ Kidney Disease ☐ Diabetes ☐ Heart Disease ☐ Hemophilia ☐ Lung Disease ☐ Kidney Stone ☐ Incontinence ☐ Prostate Cancer ☐ Bladder Cancer ☐ Kidney Cancer ☐ Cancer (type) _____

Review the following list and check all that apply:

	Current	Past		Current	Past		Current	Past
HEAD AND NECK			**HEART AND CIRCULATION**			**KIDNEYS & BLADDER**		
Headaches			High Blood Pressure			Frequent Urination		
Fevers/Chills			Chest Pain/Tightness			Kidney Stone		
Hay Fever			Swelling Feet & Legs			Kidney/Bladder Infection		
EYES			Leg Cramps/Pain			Difficulty Urinating		
Vision Problems			Stroke			Painful Urination		
Glasses			**SKIN**			Blood in Urine		
Neurological			Rashes			Hesitancy		
Numbness in Extremities			Itching			Incomplete Emptying		
Seizure			**MUSCLES AND JOINTS**			Leaking or Dribbling		
Dizziness/Vertigo			Joint Pain/Swelling			Urinating at Night		
Depression/Nervousness			Muscle pains			Incontinence		
Excessive Tiredness			Back Pain			Split Stream		
DIGESTIVE			**EARS / NOSE / THROAT**			Urgency		
Stomach Pains			Sinus Problems			**Respiratory**		
Constipation			Sore Throat			Cough		
Digestion/Swallowing			Hearing Loss			Asthma		
Diarrhea			Earaches			Emphysema		
Nausea/Vomiting						Shortness of Breath		
Severe Weight Loss			Other:					
Anemia or Low Blood								
Cups of coffee / Tea / Soda How many per day?								

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Authorization to Release Information

Patient: _____

Date of Birth: _____

Social Security #: _____

I, _____ hereby authorize
(Patient's Name)

_____ to release any information
in the course of my examinations and treatments to:

Piedmont Urology, PLLC
John A. Hettiarachchi, DO, FACS
200 West Park Circle, Suite A
North Wilkesboro, NC 28659
Phone: 336-838-5655 | Fax: 336-838-2692

Signature: _____ Date _____

Witness: _____ Date _____

FOR OFFICE USE ONLY

Information Requested

- ☐ All Records
- ☐ History & Physical
- ☐ Procedure Notes
- ☐ Lab Results
- ☐ Radiology Report
- ☐ Pathology Reports
- ☐ Medication Sheet
- ☐ Insurance Information
- ☐ ER Notes
- ☐ Other_____

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HIPAA Information Release Form

The **Health Insurance Portability and Accountability Act** has set restrictions on how your health information is maintained and who has access to the information.

You are the patient of **Piedmont Urology, PLLC**, you can decide who can receive information about your health and / or medical information from the office. It is the goal of Piedmont Urology to meet these requirements, as well as allow you to **designate an individual(s), if you so choose**, that you feel may be of benefit in managing your health care. This individual may receive information abut test / lab results, diagnosis, medications, appointments, referrals, or other information. However, you are not required to make a designation.

*****THIS IS NOT A HEALTH CARE POWER OF ATTORNEY DECLARATION FORM!**

Designated Person	Relation to Patient	Phone Number	Address

The office can disclose my health information to the people I have designated who are involved in my care. I understand that I may change the individuals on the list at anytime by signing a new form.

Patient
Signature: _____ Date: _____

Witness: _____ Date: _____

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AUTHORIZATIONS and NOTIFICATIONS

TREATMENT: The undersigned hereby consents for the physician and staff of Piedmont Urology, PLLC to administer treatment deemed advisable for the patient. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatment or examination.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I give my permission to Piedmont Urology, PLLC to release any medical information about my treatment (including copies of my medical records) needed for payment of my insurance claim, to provide my medical care, and as required by Piedmont Urology, PLLC for its health care operations. I understand that if my Medical Information contains behavioral health, mental health, substance abuse, AIDS and/or HIV records, that this may also be released only for payment of my insurance claim, to provide my medical care, and/or as required by Piedmont Urology, PLLC for its healthcare operations. Any other use would require my separate, written authorization before Piedmont Urology, PLLC can disclose my Medical Information except when such released by law.

PAYMENT OF CO-PAYS AND CO-INSURANCE: I understand that Piedmont Urology, PLLC is committed to providing me with the highest quality care possible. I also understand that Piedmont Urology, PLLC is committed to controlling costs. I acknowledge that I have a responsibility to assist with controlling costs by paying my co-pays at the time of each service, or paying my co-insurance amount at the time of each service.

CANCELLED VISITS: I understand that it is my responsibility to give my provider at least a 24 hours notification if I cannot keep a scheduled appointment. If I do not provide adequate notification, the practice reserves the right to charge me for the missed appointment.

MEDICARE-MEDICAID CERTIFICATION: (Applicable to Medicare and Medicaid recipients only) I have given correct information on my application for payment under Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act. I ask that any authorization on Medicare and/or Medicaid benefits be paid on my behalf, for any physician or other services furnished to me by Piedmont Urology, PLLC.

NON-COVERED SERVICES: I understand that my physician may recommend that certain tests be performed to assist in his/her treatment/diagnosis, If my physician thinks the tests may not be covered by my insurance payor, I will receive advance notification and will be asked to sign a waiver stating that I accept responsibility for payment. I also understand that I have the option to decline having the test performed.

ASSIGNMENTS OF INSURANCE/LIABILITY BENEFITS: I hereby authorized payment to Piedmont Urology, PLLC and all physicians involved in my treatment or diagnosis at Piedmont Urology, PLLC by the group insurance, major medical insurance, hospital, surgical medical, and any other insurance payable to or on behalf of the undersigned, by virtue of treatment of the below named patient. I unconditionally assign any insurance benefits or any other payments received from any source, to the payment of other unpaid bills of the below named patient of the undersigned or any individual who is financially responsible for the patient or guarantor. I understand that I am financially responsible to Piedmont Urology, PLLC and Physicians for charges not paid by insurance. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees, expenses, and/or interest associated with collection of the debt.

REFERRALS AND AUTHORIZATIONS: I realize that my physician may recommend that I receive additional treatment from a specialist, and that my insurance carrier may require that my primary care provider complete a referral and/or authorization for such treatment. I acknowledge that it is my responsibility to make sure the specialist has received the completed referral authorization prior to my scheduled appointment with the specialist. If the referral/authorization is not completed prior to the visit, I will be required to pay for the visit in full at the time of service.

By signing this document I acknowledge that I have read, understand, and will comply with its contents.

_____ _____ _____ _____

Patient Signature Date Responsible Party if not Patient Date

_____

Witness

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