



Midtown Urology Patient Registration Form

Appointment Reason	
How Did You Hear About Us?	

Patient Information

First Name & MI		Last Name	
Date of Birth		E-mail	
Address			
City		State	
Zip Code		Home Phone	
Cell Phone		Work Phone	

Referred by

Primary Physician	
Referring Physician	
Cardiologist	

Insurance Information

Primary Insurance		Secondary Insurance	
Policy #		Policy #	
Group #		Group #	
Subscriber's Name		Subscriber's Name	
Relationship to Subscriber		Relationship to Subscriber	
Subscriber's DOB		Subscriber's DOB	
Subscriber's Gender		Subscriber's Gender	

Pharmacy Information and Emergency Contact Information

Preferred Pharmacy		Emergency Contact	
Address/Intersection		Relationship	
City, State, Zip		Primary Number	
Phone #		Alternate Number	



Midtown Urology Medical History Questionnaire

Date: _____

Patient Name: _____

Reason for Visit: _____

When did your problem start: _____

Allergies to medications or food: _____

Medications, supplements, OTC: _____

Blood Thinners: (Ex: aspirin) _____

Most recent Pneumonia Vaccine: _____ Last Colonoscopy: _____

Surgical History (please check all that apply and include year)

- | | | | |
|---|---|--|---------------------------------------|
| ☐ Cystoscopy | ☐ Kidney Removal | ☐ Urethral Stricture Surgery | ☐ Vasectomy |
| ☐ Lithotripsy/ESWL | ☐ Testical Removal | ☐ Enlg. Prostate Surgery/TURP | ☐ Hysterectomy |
| ☐ Bladder Cancer/TURBT | ☐ Prostate Needle Biopsy | ☐ Gallbladder Removal | ☐ Heart Bypass |
| ☐ Prostatectomy | ☐ Pelvic Prolapse/Sling | ☐ Vaginal Deliveries # | ☐ Appendectomy |
| ☐ Other _____ | | | |

Medical History (please check all that apply)

- | | | | |
|--|---|--|---------------------------------------|
| ☐ Prostate Cancer | ☐ Hypogonadism (Low T) | ☐ Kidney Stones | ☐ Heart Attack |
| ☐ Bladder Cancer | ☐ Erectile Dysfunction | ☐ Chronic UTI | ☐ Hypertension |
| ☐ Kidney Cancer | ☐ Elevated PSA | ☐ Incontinence | ☐ Diabetes |
| ☐ Testicular Cancer | ☐ Enlarged Prostate | ☐ Menopause | ☐ Hepatitis |
| ☐ Breast Cancer | ☐ Urinary Retention | ☐ Rash/Warts | ☐ Last Period: |
| ☐ Other _____ | | | |

Family History (please check all that apply)

	Father's Side	Mothers' Side	Brother	Sister
Prostate Cancer	☐	☐	☐	☐
Kidney Cancer	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

Social History (please circle all that apply)

Marital Status: Single Married Divorced Widowed Smoke: Yes Not Anymore Never

Drink Alcohol: Socially Not Anymore Never Daily Caffeine Intake: 0 1 2 3 4+

Blood Transfusion: Yes No

Weight: _____ Height: _____

Urological Symptoms (please check all that apply)

General:	☐ Fever	☐ Weight Loss	☐ Chills
Eyes:	☐ Blurry Vision	☐ Double Vision	☐ Cataracts
Ears, Nose, Throat:	☐ Hearing Loss	☐ Nasal Stuffiness	☐ Sore Throat
Cardiovascular:	☐ Chest Pains	☐ Swollen Ankles	☐ Irregular Heartbeat
Respiratory:	☐ Shortness of Breath	☐ Wheezing	☐ Chronic Cough
Gastrointestinal:	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels
Genitourinary:	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine
Musculoskeletal:	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles
Integumentary:	☐ Rash	☐ Persistant Itching	☐ Skin Cancer History
Neurologic:	☐ Numbness	☐ Tingling	☐ Dizziness
Hematologic:	☐ Swollen Glands	☐ Abnormal Bleeding	☐ Transfusion History

Medical Records Release Form

From: _____

Fax: _____

I hereby authorize and request the release of the copies of the following information:

Complete Medical Records _____

All PSA Levels _____

Laboratory Records _____

X-Rays _____

Procedure Reports _____

Pathology Reports _____

Office Visits _____

Other _____

Including current and previous medical records from other practices, practioners, hospitals, and/or clinics which are a part of my medical records.

To: Dr. Michael Trotter

Phone: 512-451-7935

Fax: 512-451-7965

911 W. 38th Street Suite 200 Austin, TX 78705

This information has been released to you specifically with the consent of the patient or his/her authorized representative. It is strictly confidential and no further release or use of this information is authorized without the consent of the patient or authorized representative.

Patient Name: _____ Date of Birth: _____

Patient Social Security #: _____ Phone #: _____

Single Disclosure

Continuing disclosure for 90 days

Expiration Date: _____

I hereby release the facility from any liability, which may arise as a result of the use of the information contained in the records released.

MIDTOWN UROLOGY – PATIENT PAYMENT AGREEMENT

Please read carefully and sign to indicate you understand our financial policy.

Insurance co-pays are due **at the time of service and before you see the doctor. If you are unable to pay your co-pay you will be asked to reschedule your appointment.** Due to the fact that Midtown Urology is a specialty practice, higher copays may be indicated (consult your individual insurance policy benefits for clarification).

In-office procedures are typically applied by your insurance company towards your deductible, co-insurance or other out-of-pocket expense. **All fees are due in advance of the procedure or surgery performed** unless an alternate arrangement is made *prior* to your appointment date.

If you have not met your deductible and/or your co-insurance your payment will be due at time of your visit. All other payments of shared costs will be billed to you after your insurance has completed the processing of your claim. Payment of your bill is due upon receipt. Please be aware that our office may not always know in advance whether your procedure or surgery will be applied to a copay, coinsurance, or deductible. We make every effort to verify your benefits prior to scheduling, but in some cases the claim must be processed by your insurance first. If your insurance determines that any out-of-pocket costs apply, those amounts may be billed to you after the claim has been reviewed.

If we do not participate with your insurance company, and your insurance plan is out-of-network with us, you will be considered a “self-pay” patient. See the Self-Pay Patient policy below.

Midtown Urology enforces a \$25 fee for appointments and a \$75 fee for procedures or surgeries that are not cancelled 24 hours or more prior to your scheduled appointment/procedure/surgery. As a courtesy our office does send out appointment reminders to patients well in advance to remind patients of their future appointment. This is a courtesy only and it is ultimately the patient’s responsibility to keep track of appointments made.

It is the patient’s responsibility to obtain all referral certifications/authorizations from the primary care or referring physician when required by your insurance plan. Otherwise you may be responsible for the full cost of your office visit to Midtown Urology.

It is the patient’s responsibility to know from whom your insurance company requires that you obtain any labs, x-rays, or any other ancillary services from. Please let our office staff know so that they may schedule/send orders for these services accordingly.

Many insurance plans cover ancillary services (labs, x-rays, CT scans, etc.) under alternate benefits, such as higher deductible or co-insurance amounts, even additional co-pays. These additional out-of-pocket expenses are not associated with our contract/participation with your insurance company. Instead, it is simply a matter of your plan benefits. Midtown Urology Associates must comply with both contractual obligations and government regulations, **thus we cannot alter your insurance plan benefits and will bill you accordingly.**

Midtown Urology accepts cash, checks, and all major credit cards for non-self-pay services only. A \$40 fee applies to all returned checks. Additional fees may apply to special financing arrangements and bad debt collections.

I am aware that the providers at Midtown Urology may have financial interests in procedures, facilities, and/or products that are recommended and/or discussed with me.

I am aware that a list of their financial disclosures is available upon request.

SELF-PAY PATIENTS

If you (1) do not have insurance coverage, (2) choose not to use your insurance coverage, or (3) are seeking treatment/services that are not covered by your insurance plan, you are a “self-pay” patient. Self-pay rates will be applied for your office visits/procedures/surgeries, and payment is required at the time of your visit. We only accept debit or credit for all self-pay payments.

Any labs or imaging done at a third party facility does not apply towards your payment to our office. These services will be at an additional cost to you. (Your first appointment to establish care with our office is \$300.) Our office can quote you any other self-pay rates needed for future appointments if requested.

Patients who are self-pay or having a procedure or surgery not covered by insurance must pay in full before a procedure or surgery date can be secured. Payment plans are not available for self-pay services or non-covered services.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept the above financial policy.

Patient Signature: _____

Date: _____

**CONSENT TO RELEASE PROTECTED HEALTH INFORMATION
& ASSIGNMENT OF BENEFITS**

(initial) I have read and acknowledge Midtown Urology's Notice of Privacy Practices. Midtown Urology complies with all regulatory guidelines with regard to safeguarding your protected health information (PHI). For example, sharing of my PHI may only occur between authorized entities such as my insurance company and my physician, but not with my spouse. These guidelines and our policies are published in this notice. A for my records will be provided at my request.

(initial) I authorize my primary care physician, referring physician and other care providers to furnish any and all information concerning my present illness or injury to Midtown Urology.

Please list any authorized entities with whom we can share your PHI: None _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

ASSIGNMENT OF BENEFITS

I authorize assignment of my insurance plan benefits directly to Midtown Urology for services provided. I understand that I am financially responsible to Midtown Urology for all cost-share expenses (co-pay, co-insurance, and deductible), as well as any services not covered by my insurance plan.

Patient Name

Patient DOB

Patient Signature

Date Signed

Guarantor Signature (if different than patient)

Date Signed