GREGORY HALENDA, M.D., F.A.C.S.
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KRISTEN N. GREGORY, PA-C
CHELSEA WORKMAN, PA-C

PROSTATE CANCER

BENIGN PROSTATIC HYPERPLASIA

LASER TREATMENT OF PROSTATE

STONE DISEASE
LASER / LITHOTRIPSY

MINIMALLY INVASIVE SURGERY

IMPOTENCE

INCONTINENCE

BLADDER CANCER

MALE INFERTILITY

NO-SCALPEL VASECTOMY

BRACHYTHERAPY

2790 MOSSIDE BLVD.
SUITE G110
MONROEVILLE, PA 15146
(412) 372-6330
FAX (412) 372-3319

575 COAL VALLEY ROAD
SUITE 571
CLAIRTON, PA 15025
(412) 469-7107
FAX (412) 469-8160

Dear:___________________________________

We want to take this opportunity to thank you for choosing our office for your urological care and to welcome you to our practice.

This letter will confirm your appointment on ______________________________.
If you are unable to keep this appointment, please call us as soon as possible and we will reschedule a more convenient time for you.

If your insurance requires a referral for specialist visits, you are responsible for obtaining your referral from your Primary Care Physician. **Please bring your current insurance card (s) with you, along with your driver's license or other valid photo ID. COPAYS WILL BE COLLECTED AT REGISTRATION. YOUR APPOINTMENT MAY BE RESCHEDULED FOR NONPAYMENT OF COPAY. OUR BILLING DEPT WILL VERIFY ELIGIBILITY AND INFORM YOU OF ANY ADDITIONAL AMOUNTS, SUCH AS DEDUCTIBLE AND COINSURANCE, THAT WILL ALSO BE COLLECTED AT THE TIME OF SERVICE. Also, if applicable, please bring all test results and x-rays with you to your visit.**

We have enclosed forms that **must be completed** for your medical record. Please take this opportunity to complete these forms at home and **bring them with you to your appointment**.

We look forward to seeing you and if you have any questions, please feel free to call the office and our staff will be happy to assist you.

Sincerely,

Suburban Urologic Associates

Enclosures

SUBURBAN UROLOGIC ASSOCIATES
Please Print

PATIENT INFORMATION

Patient Name: ______________________________ Birth Date: __________________
Last *First* *M.I.*

Address: ______________________________ Age: __________________
Street

____
City *State* *Zip*

SS#: __________________ Sex: __________ Marital Status: __________________

Home Ph #: __________________ Cell Ph #: __________________

Occupation: __________________ Work Ph #: __________________

Employer Name & Address ______________________________

Name of Insurance Co: ______________________________

Name of Insured: ______________________________

Birthday of Insured: ______________________________

Please show your latest insurance card to the receptionist

PRIMARY CARE PHYSICIAN INFORMATION

Name of Primary Care Physician: ______________________________

Address: ______________________________

Phone #: ______________________________

Referring Physician: ______________________________

OTHER INFORMATION

Spouse Name: __________________ Spouse Employer: __________________

Work Phone: __________________ Cell Phone: __________________

In Case of Emergency, Contact (*not at same address*)

Name: __________________ Relationship: __________________

Phone #: __________________

IMPORTANT: *All charges and/or co-payments are due at time of service*

Insurance Authorization and Assignments: I request that payment of authorized benefits be made in my behalf to Suburban Urological Associates for any services furnished me by the physician. I authorize release of any medical information necessary to process my claims. I understand that I am responsible for all charges regardless of insurance coverage. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non covered services.

Patient Signature: ______________________________ Date: __________________

Updated __________ Initials __________________

PATIENT HISTORY FORM #2

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE: _______ / _______ / _______

Last Name: _____________________________ First Name: ___________________________ Middle: _______

DATE OF BIRTH: _______ / _______ / _______ REFERRING MD: ______________________________________

PAST MEDICAL & SOCIAL HISTORY

List and Date All Past Surgeries:

____Date: _________________
____Date: _________________
____Date: _________________
____Date: _________________
____Date: _________________

List All Past Chronic Medical Conditions:

____
____
____
____

Complete the attached medication list or attach your own medication list.

Do you take Aspirin or Blood Thinners every day? Y N Please list ____________________________
Do you take antibiotics prior to dental procedures? Y N
Do you have Latex Allergies? Y N
List ALL Allergies to medication:

_____________________________ ______________________________ _____________________________
_____________________________ ______________________________ _____________________________

Do you use tobacco? Y N If Yes, type and how much ____________________________________
Do you drink? Y N If Yes, how much ____
List all serious illnesses in your immediate family (Example: diabetes, tuberculosis, cancer, heart disease, etc)

_____________________________ ______________________________ _____________________________
_____________________________ ______________________________ _____________________________
_____________________________ ______________________________ _____________________________

M.D. Signature: ____

Date	Pt. Init.	Provider Init.	Date	Pt. Init.	Provider Init.

Patient Name: ____ D.O.B.: _____________________________

MEDICATION LIST

Be sure to include **ALL** prescription drugs, over-the-counter drugs, vitamins, and herbal supplements

WHAT ARE YOU TAKING	DOSAGE	HOW MUCH AND WHEN

Reviewed by: _________________________/__________________________ Date: ___________________________

Reviewed by: _________________________/__________________________ Date: ___________________________

Reviewed by: _________________________/__________________________ Date: ___________________________

Reviewed by: _________________________/__________________________ Date: ___________________________

Reviewed by: _________________________/__________________________ Date: ___________________________

Reviewed by: _________________________/__________________________ Date: ___________________________

SUBURBAN UROLOGIC ASSOCIATES

PATIENT PHARMACY INFORMATION

Today's Date: ___________________

Patient Name: ____________________________ Birth Date: ___________________

Name of **Retail** Pharmacy: ____

Street: ____

City: ____

Phone Number: ____

Name of **Mail Order** Pharmacy: ____

If Medco, please list your Medco ID Number: _______________________________

Suburban Urologic Associates

FINANCIAL POLICY

Thank you for choosing our office as your health care provider. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We will submit medical services to your insurance company if you have given us all the required information. We must have the most current copy of your insurance card**.** You must notify us immediately of any charge in your insurance coverage. Please be aware that some, and perhaps all, of the services provided may be considered “non-covered services” according to your policy. You will still be responsible for payment of these services. You are also responsible for obtaining the necessary referrals from your PCP and/or insurance company if applicable. However, authorization from your insurance company does not guarantee payment.

We are participating with most major insurance companies. Please check with your insurance company to determine if we are participating providers. We will collect the current co-payment required for a specialist office at the time of service. All patients are responsible for presenting the most current information and paying the most current specialist co-pay. **COPAY WILL BE COLLECTED AT REGISTRATION. YOUR APPOINTMENT MAY BE RESCHEDULED FOR NONPAYMENT OF COPAY. You will also be responsible for payment of any deductible, co-insurance or non-covered services.**

Deductible and co-insurance responsibilities for select procedures will be determined and collected prior to the service. In this instance, our Billing Department will discuss this with you. These amounts must be paid in full or the procedure and/or office visit will be rescheduled.

BILLING

If you have financial problems, please ask to discuss a payment plan with our Billing Department (proof of income may be required as verification). A billing statement of medical services received will be mailed to you on a monthly basis. If an extended payment plan has been offered to you, we require regular payments or the plan is void. After that, the account may be turned over to our collection agency and a fee will be assessed. We accept cash, checks, Visa, MasterCard or Discover for payment. In the event that a personal check is returned unpaid from your bank for any reason, your account will be charged with a return check fee.

OTHER INSURANCE FORM PREPERATION

If you have insurance forms that need to be prepared by our office (i.e. disability, FMLA), we will do these as quickly as possible but they may take several days for completion. A fee will be assessed and collected prior to completion of these forms. Please provide us with the correct address for the forms’ return.

FINANCIAL POLICY

MINOR PATIENT (UNDER 18 YEARS OF AGE)

The parent/guardian/adult accompanying a minor child is responsible for full payment. Any patient 18 or over is legally an adult and responsible for his/her bill (regardless of attending college, living at home or being covered by parent's insurance). We, therefore, cannot release financial or medical information to a parent/guardian without the patient's written permission. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurance. Please check with your insurance policy to determine which company is the primary before your appointment. In divorce cases, the parent who brings the child in for services is the responsible party.

COLLECTION BALANCES

All collection balances transferred to an outside collection agency, will be assessed a collection fee. If you have had a previous collection balance or are presently in collection, it will be required that you pay your previous balance prior to being seen again. If you are seen by the doctor, we must verify current insurance coverage. You will be responsible for payment of co-payment, deductible and any non-covered service prior to appointment.

CANCELLATION POLICY

Please help us provide better service by keeping your scheduled appointment. Notify us at least 24 hours in advance if you are unable to keep your scheduled appointment. Repeated failure to keep appointments may jeopardize your next visit to our office. There is a $100 Cancellation/No Show fee for select office procedures. Our scheduling department will review this with you when the procedure is scheduled.

MEDICAL RECORDS RELEASE

Please contact our office if it becomes necessary for you to obtain a copy of your medical records. We have a standard records release form that must be completed and signed by the patient. An administrative fee may be assessed for this process.

I have read the above financial policy. I understand and agree to this financial policy.

____ __________________________

Signature of Patient or Responsible Party Date

____

Print Name

SUBURBAN UROLOGIC ASSOCIATES

ACKNOWLEDGMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: ____ Birth Date:__________

This acknowledgment of notice and consent authorizes Suburban Urologic Associates to use and disclose health information about you for treatment, payment and health care operation purposes.

Notice of Privacy Practices. Suburban Urologic Associates has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent. You may, upon request, receive a copy of our Notice of Privacy Practices.

Amendments. We reserve the right to change our Notice of Privacy Practices and make the terms of any change effected for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Privacy Officer Contact Information. You may contact our Privacy Officer at the following address: Privacy Officer, Suburban Urologic Associates, 2790 Mosside Blvd. #G110 Monroeville, PA 15146

The doctors and staff of Suburban Urologic Associates are dedicated to protecting the privacy of your medical information (including treatment, payment, and health care operations). Therefore, we WILL NOT discuss any of this information with anyone other than yourself There are, however, circumstances where patients may want us to speak with a family member or a friend. If this is your request, please complete the following information;

(Family or Friend) Name: ____

Relationship: _______________________ Phone Number: (   ) ______________________

If the above information is not completed, we WILL NOT discuss your medical information with anyone other than yourself.

Confidential information regarding your care will not be left on answering machines, voicemail, or with someone other than yourself.

Acknowledgment and Consent

I acknowledge that I have read Suburban Urologic Associates' Notice of Privacy Practices. I understand my rights regarding my protected health information.

____ _____________________________________

Signature of Patient (or Guardian) Date

Infertility Document

Patient Name:________________________________ DOB _________________ Occupation __________________

Wife's Name:________________________________ DOB _________________ Occupation __________________

Referring Physician & Address ____

____

Primary Care Physician & Address ____

____

Wife's OB/GYN & Address ____

____

CURRENT HISTORY

What has been the duration of the current infertility? ____

Has there been a previous pregnancy with your current partner? ______________________________________

Have you been involved in a pregnancy with another partner? ____

How often do you have intercourse? ____

Is the intercourse timed to your partner's ovulation? ____

Are lubricants used during intercourse? (K-Y Jelly, Saliva, Vaseline) ________________________________

What forms of birth control have been used? ____

Which infertility tests has your partner undergone? ____

____

What treatment have you and your partner undergone for infertility? ________________________________

____

Have you had a prior evaluation for male factor infertility? ____

Have you had prior treatment for male factor infertility? ____

SURGICAL HISTORY ----- Have you had:

Surgery to bring the testes into the scrotum?.......................Y N
Hernia repair as an adult or child?......................................Y N
Injury or trauma to the genitals?..Y N
Testicular torsion?..Y N
Pelvic or retroperitoneal surgery?.......................................Y N

Other surgeries? ____

Medications: (Please list all medications including over the counter medications) ________________________

____

Allergies: ____

____

Name:____ DOB: ________________

ASSOCIATED DEVELOPMENTAL HISTORY

Were both testicles in the scrotum at birth? ____
At what age did puberty begin? ____
Which childhood illnesses have you had? ____
Did you ever have breast development or lactation? ____

REVIEW OF SYSTEMS

Have you ever had any of the following?:

Urinary tract infection……………………..Y N
Prostatitis…………………………………..Y N
Epididymitis……………………………….Y N
Mumps……………………………………..Y N
Sexually transmitted disease………………Y N
Recent febrile illness………………………Y N
High blood pressure………………………..Y N
Respiratory infections……………………...Y N
Diabetes……………………………………Y N

Colitis……………………………………Y N
Multiple Sclerosis………………………..Y N
Renal Failure / Kidney disease…………..Y N
Testicular cancer…………………………Y N
Radiation therapy/exposure………………Y N
Chemotherapy……………………………Y N
Blurred or double vision…………………Y N
Recent weight loss/gain…………………Y N
Other medical illness ______________________________
____

OCCUPATION AND HABITS

Have you had occupational exposure to chemicals or heat? ....Y N
Have you had radiation exposure? ……………………………………………………Y N
Do you take hot baths or steam baths? ………………………………………………Y N
Do you smoke? Quantity per week? ....Y N __________________________
Do you consume alcohol? Quantity per week? ....Y N __________________________
Have you ever had exposure to recreational drugs (marijuana, cocaine)? ....Y N
Have you taken steroids? ………………………………………………………………Y N

FAMILY HISTORY

Is there a family history for infertility? ……………………………………..…………Y N
Is there a family history for cystic fibrosis? ……………………………………………...Y N

All diagnostic testing and treatment recommended by the physician is necessary to evaluate the patient. Coverage issues are the sole responsibility of the patient and not this office. If you have any questions regarding the coverage of infertility testing, they are to be directed to your insurance company.

____ _________________________________

Patient Signature **Date**

Please bring with you the results from all prior lab work and semen analysis.