REGIONAL UROLOGY, PLLC

Joseph Cottone, Jr., M.D.

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Patient's Full Name _____ Date of Birth _____

Mailing Address_____
(Please include city, state, zip) *City* *State/zip*

Age/Sex:_____Phone: Home_____ Work _____ Cell _____

***Circle Preferred Method to contact*: HOME WORK CELL**

How would you like to be contacted for appointment reminders? **TEXT VOICEMAIL**

Family Doctor _____ Referred By _____

Patient's Employer _____ How Long? _____

Patient's SS Number _____ Occupation _____

Spouse's Full Name _____ Date of Birth _____

Spouse's Employer _____ Work Telephone _____

Spouse's SS Number _____ Occupation _____

Emergency Contact Person (not living in your home) _____

Address _____ Phone Number _____

****

Insurance Information:

Primary Insurance _____ Number _____

Secondary Insurance _____ Number _____

****

Please sign below for authorization of treatment and release of information that may be necessary for insurance purposes.

Date: _____ Signature: _____

Regional Urology, P.L.L.C.
129 Donna Street
Gulfport, MS 39503

Consent to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Regional Urology PLLC or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day – to –day health care operation of the practice.

Please list any individuals you give permission to receive your protected health information. (This would include family members or friends.)

Name: _____ Relationship: _____

Name: _____ Relationship:_____

Name: _____ Relationship: _____
(If more space is needed please list on back of page)

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the use or disclosure of your protected health information
Regional urology PLLC may or may not agree to restrict the use or disclosure of your health information. If Regional Urology PLLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Regional Urology PLLC reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to Regional Urology PLLC to use and disclose my health information in accordance with it.

_____
Name of Patient (print)

_____
Signature of Patient or Guardian

_____
Date

REGIONAL UROLOGY, PLLC
DR. JOSEPH COTTONE, JR.

AUTHORIZATION/RESPONSIBILITY AGREEMENT – CONSENT FOR TREATMENT

THIS IS TO CERTIFY THAT THE UNDERSIGNED AUTHORIZES THE EXAMINATION, OPERATION OR TREATMENT AS MAY BE NECESSARY OR ADVISABLE BY REGIONAL UROLOGY, P.L.L.C.

1. I, the undersigned as the patient or his/her authorized representative, do hereby authorize **REGIONAL UROLOGY, P.L.L.C.** to release to my insurance company or other appropriate agency that information which is necessary to validate this claim. **REGIONAL UROLOGY, P.L.L.C.** is also hereby authorized to release to any other physician, either as individuals or as a professional association, who perform services for me, such information as is necessary for billing purposes.

2. I hereby authorize any insurance company to pay the proceeds of any benefits due to me directly to **REGIONAL UROLOGY, P.L.L.C.** A copy of this can be considered as an original for insurance purposes. On all major procedures and diagnostic testing your insurance will be filed for you. All elective services including minor surgeries must be paid for at the time of service.

3. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I have requested the doctor bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

4. If this bill is not paid within a ninety (90) day period from demand or billing, **REGIONAL UROLOGY, P.L.L.C.** may return the collection of this account over to a collection agency or an attorney. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, 50% including any/all costs of collection, attorney fees and/or court costs, if such be necessary. I waive now and forever my rights of exemption under the laws of the constitution of the State of Mississippi and any other State.

5. I, the undersigned, give **REGIONAL UROLOGY, P.L.L.C.**, its employees and/or agents express prior consent to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance or payment.

6. I have read this agreement and understand the contents.

_____ _____

Patient or responsible party *DATE*

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PHYSICIAN

I request that payment of authorized Medicare benefits be made on my behalf to **REGIONAL UROLOGY, P.L.L.C.** for services furnished to me by physicians associated with **REGIONAL UROLOGY**, **P.L.L.C.** I authorize **REGIONAL UROLOGY, P.L.L.C.** to release Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on Medicare card *DATE*

PAST MEDICAL HISTORY

Please circle Y (yes) or N (no) in response to listed items and fill in blank spaces where appropriate.

Medical Problems

Y N Diabetes
Y N Stroke
Y N Neurologic Disorder
Y N High Blood Pressure
Y N Heart Attack
Y N Cancer

Other:

1 _____
2 _____
3 _____

Surgeries

Y N Back
Y N Prostate
Y N Pelvic

Other:

1 _____
2 _____
3 _____
4 _____

Family History

Y N Diabetes
Y N High Blood Pressure
Y N Heart Disease
Y N Cancer

Other:

1 _____
2 _____

Social History

Occupation _____

Marital Status _____

Y N Smoker

Y N Drink Alcohol

Allergies to Medications

1 _____
2 _____
3 _____
4 _____

	Medications	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			

Name: _____ Date: _____

Review of Symptoms

Please circle Y (yes) or N (no) in response to listed items and fill and blank spaces where appropriate.

Constitutional Symptoms

Y N Fevers

Y N Chills

Eyes

Y N Glasses

Y N Pain

Allergies/Immunologic

Y N Hay Fever

Y N Medications

Neurologic

Y N Dizziness

Y N Blackouts

Y N Confusion

Endocrine

Y N Too hot/cold

Y N Excessive Thirst

Gastrointestinal

Y N Abdominal Pain

Y N Nausea/Vomiting

Integumentary

Y N Skin Rash

Y N Itching

Musculoskeletal

Y N Joint Pain

Y N Back Pain

Y N Leg Cramps

ENT

Y N Hearing Problems

Y N Sore Throat

Y N Nasal Stuffiness

Respiratory

Y N Chronic Cough

Y N Shortness of Breath

Y N Wheezing

Heme/Lymph

Y N Bleeding Problems

Y N Blood Clotting Problems

Y N Swollen Glands

Psychologic

Y N Depression

Y N Mood Swings

Genitourinary

Y N Strain to Urinate

Y N Slow Stream

Y N Failure to Empty Bladder

Y N Urinate too Frequently

Y N Urinate at Night

Y N Blood in Urine

Y N Burning with Urination

Y N Urinary Tract Infections

Y N Kidney Stones

Y N Enlarged Prostate

Y N Incontinence

Cardiovascular

Y N Chest Pain

Y N Chills

NAME:_____ **DATE:**_____