METRO UROLOGY

Dear Patient:

Welcome to Metro Urology! The physicians and staff look forward to serving your urologic healthcare needs. We strive to provide our adult and pediatric patients with cost-effective, quality care. In order to best serve you, we ask that you bring the following to your appointment:

- The completed history questionnaire form that was sent to you. This form may also be filled out online at our website - www.metro-urology.com.
- Your insurance card, all recent lab work, x-ray films or CD's.
- Please contact your primary physician and verify that **if** your insurance plan requires a **referral**, that one has been issued for you.
- Please **be prepared to pay any co-payments** that your insurance requires. We accept cash, checks, MasterCard, Visa, Discover and American Express.

YOU MUST CALL AND PRE-REGISTER BEFORE YOUR APPOINTMENT. FAILURE TO PRE-REGISTER COULD SIGNIFICANTLY DELAY YOUR APPOINTMENT OR RESULT IN A CANCELLATION.

Please **call the Business Office at 651-999-7021 to pre-register.** Please have your insurance card available at the time you call.

Thank you for your attention to these matters. We look forward to seeing you!

Sincerely,

Metro Urology

COMMENTS:

APPOINTMENT DATE: ______________________ **AT** ______________________

WITH ____.

Your appointment is at our:

[ ] Fridley Office [ ] Maplewood Office [ ] Lake Elmo Office
[ ] Plymouth Office [ ] St. Paul – 400 [ ] St. Paul – 450
[ ] Coon Rapids Office [ ] Children's - Minneapolis

METRO UROLOGY
www.metro-urology.com
Main phone number: 651-999-6800

METRO UROLOGY

FINANCIAL POLICY

Metro Urology is pleased that you have selected our practice to provide Urologic care for you or your family. In order to better serve your needs and avoid confusion, it is important for you to understand our financial policy.

Metro Urology will process any and all U.S. based insurance claims on behalf of our patients. Since it is impossible for us to keep track of every insurance plan and how it works, we expect you to know your coverage, (especially for supplies), copay and/or deductible levels. Metro Urology will assist you with your insurance coverage and paperwork to the best of our ability if you present your current insurance card or information at the time of service. Without current insurance information, you will be entered into our system as self-pay and will be required to pay at time-of-service (before treatment).

Forms of Acceptable Payment: Metro Urology accepts cash, checks or major credit cards. In the event that a check is returned as non-payable, Metro Urology may charge a service fee. In cases of dual custody, payment is required at the time-of-service regardless of who brings the child in for the appointment. If you do not have insurance, we will require payment at the time of service. You should contact our Business Office at (651) 999-7020 to discuss payment arrangements if necessary.

Copays/coinsurance/deductibles: All copays/coinsurance/deductibles required by your insurance plan are collected at the time of service. Patients receiving urodynamic services should be aware that although these services are diagnostic in nature, they may be considered surgical by your insurance company and therefore may require a separate copay or coinsurance.

Referrals/pre-cert/prior auth: If an insurance referral from your primary care physician is required, you must present it at the time of service. If you choose to be seen without the appropriate referral in hand, you agree to be responsible for the charges should they not be covered by your insurance. Patients are also responsible to do prior authorizations, pre-certifications, or to complete any other insurance requirements as necessary.

Supplies: In most cases we require payment for supplies when they are issued. We will submit all supply charges to your insurance company and will reimburse you should they pay. (e.g. Erec-aid devices, EMG sensors, vasectomy clips). Supplies purchased will be accepted for return only according to the manufacturer's warranty. Metro Urology is NOT liable for any defects arising from the use or misuse of any manufactured products that it distributes and provides no warranty as to their performance or result.

Disputes: If for any reason you dispute coverage or payments made by your insurance company, it is your responsibility to contact your insurance company and to resolve the matter based on your insurance company's arbitration or resolution process. We will provide documentation (providing your signature of authorization is on file) to assist in the dispute resolution process. During this time, you will be asked to pay in full the balance or schedule payment arrangements by contacting the Business Office at (651) 999-7020.

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance of my account for any services rendered.

Patient Medical History – Adult Male

Patient Label

Height __________ Weight__________

Emergency contact person: 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:______________________________

____

Circle the severity number of the problem on a scale of 1-10: (1=low) 1 2 3 4 5 6 7 8 9 10 (10=high)

When did this problem start?____

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

____

Please circle/check the response that most accurately relates to you.

Problem	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
Sensation of not emptying bladder.	0	1	2	3	4	5
Urinating less than 2 hours after urination	0	1	2	3	4	5
Stopping & starting during urination	0	1	2	3	4	5
Difficulty in postponing urination	0	1	2	3	4	5
Weak urinary stream	0	1	2	3	4	5
Pushing/straining during urination	0	1	2	3	4	5
How many times do you urinate from the time you go to bed at night until you get up?	0 times	1 time	2 times	3 times	4 times	5 times

Total of the 7 circled items above____________

Problem	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
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?	0	1	2	3	4	5	6

Do you experience any pain with urination? ☐ No ☐ Yes

Do you experience leaking urine? ☐ No ☐ Yes

Do you have blood in your urine? ☐ No ☐ Yes

Are you experiencing any impotence problems? ☐ No ☐ Yes

Have you ever had a kidney or bladder infection? ☐ No ☐ Yes

Physician use only: (Comments/Notes)

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

Are you or a blood **relative** having problems (now or in the past) with any of the following? ☐ No ☐ Yes
If yes, please check all boxes that apply.

	You	Family Member
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Type of cancer:		
Depression	☐	☐
Diabetes	☐	☐
GERD / Acid Reflux	☐	☐
Gout (high uric acid)	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Kidney Stones	☐	☐
Liver Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Osteoporosis	☐	☐
Rheumatic Fever	☐	☐
Thyroid Problems	☐	☐
Toxic Exposure	☐	☐
Tuberculosis	☐	☐
Other/Explain:	☐	☐

Have you had **surgery** on any of the following? ☐ No ☐ Yes
If yes, please check all boxes that apply. INCLUDE SURGERY DATE:

Surgery	
Appendix	☐
Back	☐
Bladder	☐
Breast	☐
Colon	☐
Gallbladder	☐
Heart Bypass	☐
Heart Valve	☐
Hernia	☐
Incontinence	☐
Kidney	☐
Lung	☐
Prostate	☐
Testicle	☐
Thyroid	☐
Total Joint Replacement	☐
Right: ☐ Hip ☐ Knee	☐ Shoulder
Left: ☐ Hip ☐ Knee	☐ Shoulder
Urethra	☐
Vasectomy	☐
Other/Explain:	☐

Do you have any allergies? ☐ No ☐ Yes If yes, please list: Latex allergy? ☐ No ☐ Yes

Allergy	Type of Reaction (rash, nausea, etc.)

Are you taking Aspirin, Coumadin, blood thinners?
☐ No ☐ Yes

Are you taking any medications including herbal and over the counter? ☐ No ☐ Yes
If yes, please list:

Name of Medication	Dose	How many times a day?

Do you or did you ever smoke? ☐ No ☐ Yes
If yes:
How many packs per day? ____________

How many years? ____________
When did you quit? ____________

Do you drink alcohol? ☐ No ☐ Yes
If yes, how much? ____________________

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

Are you married? ☐ No ☐ Yes
☐ Divorced
☐ Widowed

Are you employed? ☐ No ☐ Yes ☐ Retired
What is your occupation? ____________________

Do you have children? ☐ No ☐ Yes
Year(s) of Birth:____________________________

REVIEW OF SYSTEMS

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

Constitutional Symptoms

Fever	No	Yes
Chills	No	Yes
Headache	No	Yes
Other___________	No	Yes

Eyes

Blurred vision	No	Yes
Double vision	No	Yes
Pain	No	Yes
Other_____________	No	Yes

Neurological

Tremors	No	Yes
Dizzy spells	No	Yes
Numbness/tingling	No	Yes
Other____________	No	Yes

Endocrine

Excessive thirst	No	Yes
Too hot/cold	No	Yes
Tired/sluggish	No	Yes
Other___________	No	Yes

Gastrointestinal

Abdominal pain	No	Yes
Nausea/vomiting	No	Yes
Indigestion/heartburn	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 itch	No	Yes
Other___________	No	Yes

Musculoskeletal

Joint pain	No	Yes
Neck pain	No	Yes
Back pain	No	Yes
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
Other______________	No	Yes

Respiratory

Wheezing	No	Yes
Frequent cough	No	Yes
Shortness of breath	No	Yes
Other___________	No	Yes

Genitourinary

Urine retention	No	Yes
Painful urination	No	Yes
Urinary frequency	No	Yes
Other__________	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

Physician use only: (Comments/Notes)

Physician Signature: ____ ***Date:*** ______________________________