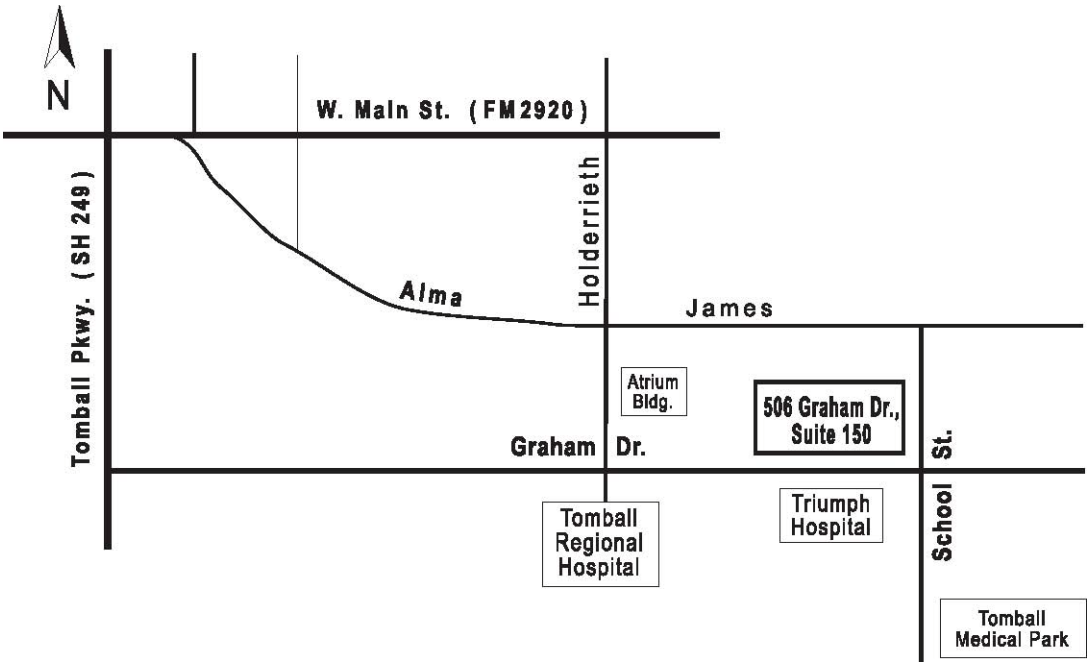
TEXAS UROLOGY SPECIALISTS

Urology Specialists, P.A.

Steven W. Sukin, M.D.
Diplomate, American Board of Urology
Patrick J. Zielie, M.D.
Diplomat, American Board of Urology



-Most Insurance & Major Credit Cards Accepted-

281-351-5174

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www. DrStevenSukinUrology.com

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506 GRAHAM DRIVE, SUITE 150
TOMBALL, TEXAS 77375
PHONE: 281-351-5174 FAX: 281-351-5172

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name_____Date of Birth_____Social Security #_____(optional)

I authorize the following individual or organization to disclose the above named individual's health information

Address _____ Phone _____

For the purpose of ☐ Continued Care ☐ Attorney/Legal ☐ Personal use ☐ Insurance ☐ Other

Please release the following:

___Problem List
___Progress Notes
___History/Physical Exam
___Medication List
___Immunization Record
___List of Allergies
___X-Ray/Imaging Reports from (date)_____to (date)_____
___X-Ray Films (date) _____
___Laboratory Results from (date) _____to (date) _____
___EKG Reports
___Genetic Testing Information
___Other Diagnostic Reports (Specify) _____
Other (Specify)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

X _____
If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provide in CFG 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact office the manager/privacy officer.

X_____ X_____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient or Legal Representative

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Texas Urology Specialists liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for correct interpretation:

X_____ X_____
Signature of Patient or Legal Representative Date
X_____ X_____
Relationship to Patient)if Legal Representative) Witness

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Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Texas Urology Specialists for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the practice's health care operations. I understand that diagnosis or treatment of me by Dr. Steven W. Sukin, Dr. Patrick J. Zielie or Dr. Brenda Tharian may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" encompasses health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This is protected health information relates to my past, present or future physical or mental health and identifies me or provides reasonable basis for identifying me.

I understand I have the right to request a restriction as to how my protected heath information is used or disclosed to carry out treatment, payment or the practices healthcare operations. Urology Specialists is not required to agree to the restrictions that I may request, however if Texas Urology Specialists agrees to a requested restriction, that restrictions binding on both the practice and the attending physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Texas Urology Specialists has taken action in relevance on this consent.

I understand I have a right to review Texas Urology Specialists ***Notice of Privacy Practices*** prior to signing this document. This Notice of Privacy Practices has been provided to me and is available upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or the performance of health care operations of Urology Specialists. It also describes my rights and Texas Urology Specialists duties with respect to my protected health information.

Texas Urology Specialists reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

I authorize Texas Urology Specialists to call my home or work to remind me of an appointment or to reschedule an appointment. I also authorize Texas Urology Specialists to leave scheduling information on my answering machine, or voicemail system.

X_____ X _____

Signature of Patient or Personal Representative Date

X _____

Printed name of Patient or Personal Representative

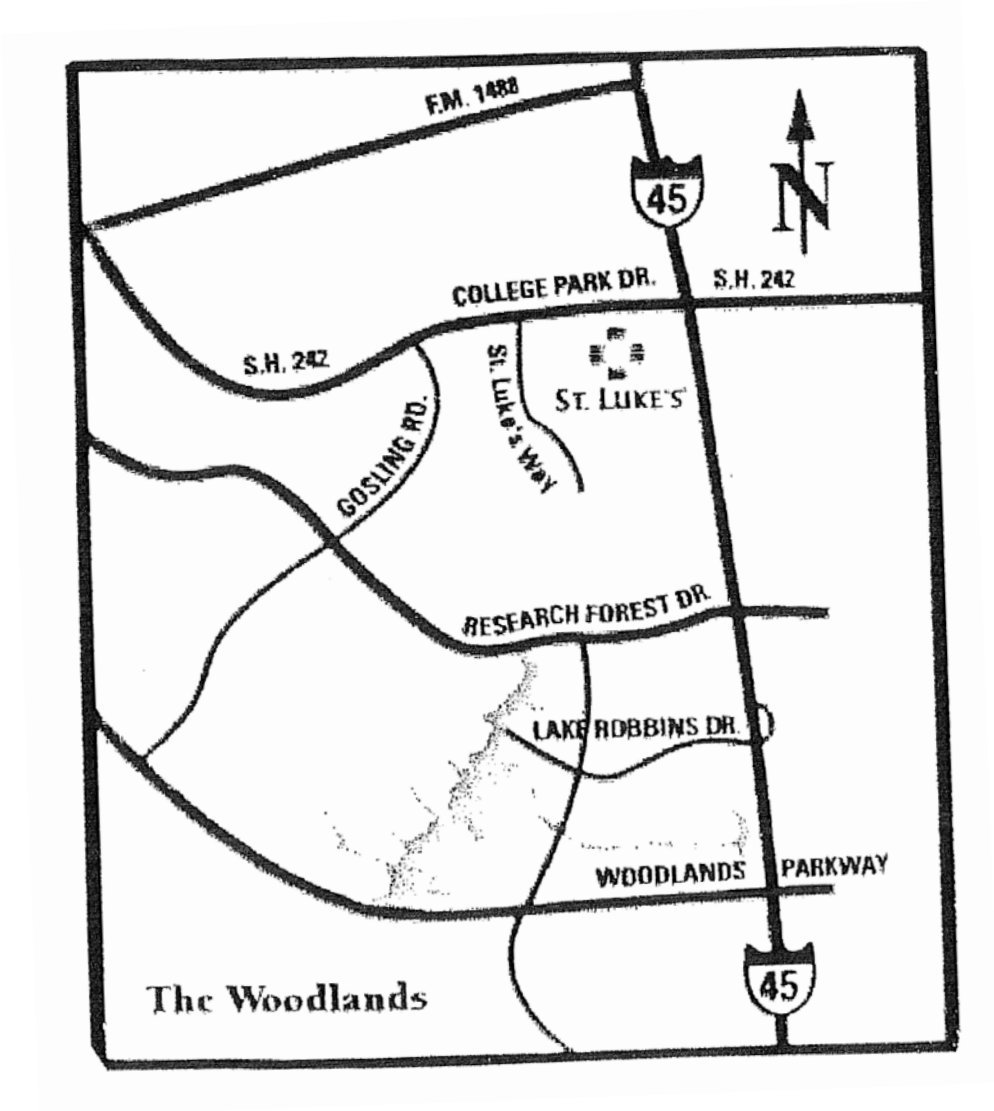
X _____

Description of Personal Representative's Authority

Directions to Urology Specialists of The Woodlands
ST. Luke's Medical Center
17198 St. Luke's Way
Suite 410
The Woodlands, Texas 77384

<u>From Houston</u>

Travel North on I-45
Take exit 79 toward S.H.242
(College Park Drive)
Turn Left on St. Luke's Way
Follow signs to St. Luke's Medical Center
Enter the parking lot
(Dr. Sukin's offices are in the building on the left West entrance, 4th floor suite 410)



TEXAS UROLOGY SPECIALISTS

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(Please Fill Out Completely)

Date:_____

Home Phone # _____
Cell Phone # _____
Work Phone # _____
e-mail:_____

Date of Birth:_____Age:_____Marital Status: M S D W Sex: Male Female

Patient Last Name:_____First:_____Middle:_____

Address:_____City:_____State_____ZIP_____

Patient Employer_____Occupation:_____

Ok to release Medical Information? ☐ **YES** ☐ **NO** (*To the following persons*)

1._____2._____3._____

Parent Name:_____ Parent Name:_____
Applies only to parents of minor children or children insured under the parents insurance

Referring Doctor:_____Phone:_____

Primary Care Doctor_____ Phone:_____

Pharmacy Name / Location_____Phone:_____

Emergency Contact_____Phone:_____

Race: ☐ Caucasian □ African American □ Hispanic □ Asian/Indian/Pakastani/Sri Lankan □ Chamorran □ Chinese □ Fiji Islander □ Fillipino □ Guananian NOS □ Hawaiian □ Hmong □ Japanese □ Kampuchean/Cambodian □ Korean □ Laotian □ Melanesian NOS □ Micronesian NOS □ Samoan □ Tahitian □ Thai □ Tongan □ Vietnamese □ Other_____

RESPONSIBLE PARTY INFORMATION

Primary Insurance_____ **Name of Insured:**_____
Date of Birth of Insured:_____
Policy #_____Group #_____ **Insured Employer**:_____
Insurance Address_____
Customer Service Phone Number_____

Secondary Insurance_____ **Name of Insured:**_____
Date of Birth of Insured:_____
Policy #_____Group #_____
Insurance Address_____
Customer Service Phone Number_____

Signature of Patient X_____

Signature of Responsible Party X_____

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Patient Name:_____**Age:**_____**Date:**_____

REASON FOR YOUR VISIT TODAY:_____
_____

Have you or do you have any of the following: Check / Circle all that applies to you

☐ Heart Disease	☐ Urinary Infections
☐ High Blood Pressure	☐ Prostatitis
☐ Heart attack	☐ Kidney disease
☐ Aneurysm	☐ Emphysema / Bronchitis
☐ Mitral valve prolapse	☐ Lung Disease
☐ Blood Clots in legs	☐ Asthma
☐ Stroke	☐ Glaucoma Open or Closed
☐ Diabetes Date Diagnosed:_____	☐ Hearing loss
☐ Hyperthyroidism **or** Hypothyroidism	☐ Depression
☐ Stomach Ulcers	☐ Cancer_____
☐ Hepatitis A B Or C	
☐ Hemorrhoids	
☐ Hernia	
☐ Liver disease	

Previous Surgery / Hospitalization (LIST ALL) _____
_____

Medications: (INCLUDE OVER THE COUNTER MEDICATIONS AND HERBAL SUPPLEMENTS)_____
_____

DRUG ALLERGIES:_____

FEMALE PATIENTS ONLY

Are you or could you be pregnant? Yes / No # of pregnancies:_____
Date of Last Menstrual Period:_____Type of Birth Control_____

FAMILY HISTORY

Do any of the following medical problems run in your family?

☐ Prostate Cancer	☐ Diabetes
☐ Heart Disease	☐ High Blood Pressure
☐ Arthritis	☐ Cancer Type:_____
☐ Stroke	

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Patient Name:_____**Age:**_____**Date:**_____

SOCIAL HISTORY

Exercise: Yes / No Alcohol: Yes / No Amount:_____ Caffeine: Amount per day_____

Tobacco Usage Yes / No # of Years_____, Quit _____

Employment:_____Occupation:_____

UROLOGICAL HISTORY:

(PLEASE CHECK ALL THAT APPLY)

☐ Urological Surgeries / Problems, Please List _____
_____

☐ Any pain or burning when voiding / urinating?
☐ Any urgency or need to run to the bathroom?
☐ Any Urinary frequency or need to void many times during the night?
☐ Any sense of incomplete emptying of your bladder?
☐ Any leakage of urine?
☐ Any blood in urine?
☐ Any pain? If yes, where is your pain located?_____

DO NOT WRITE BELOW THIS LINE

_____/_____

(FOR PHYSICIAN USE ONLY) **VITALS: T BP P R WT**

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Patient Name:_____**Age:**_____**Date:**_____

REVIEW OF SYSTEMS: PLEASE CHECK ALL THAT YOU CURRENTLY HAVE

CONSTITUTIONAL
- ☐ FEVER
- ☐ CHILLS
- ☐ WEIGHT CHANGE

EYES
- ☐ BLINDNESS
- ☐ DOUBLE VISION
- ☐ BLURRED VISION
- ☐ BURNING
- ☐ GLAUCOMA OPEN / CLOSED

IMMUNOLOGICAL
- ☐ FOOD SENSITIVITY
- ☐ ASTHMA
- ☐ RECENT VACCINATIONS

NEUROLOGICAL
- ☐ TREMORS
- ☐ DIZZINESS
- ☐ HEADACHES
- ☐ SEIZURES
- ☐ NUMBNESS / TINGLING

ENDOCRINE
- ☐ HEAT / COLD INTOLERANCE
- ☐ INCREASED THIRST
- ☐ FREQUENT URINATION
- ☐ HAIR LOSS
- ☐ TIRED / SLUGGISH

GASTROINTESTINAL
- ☐ ABDOMINAL PAIN
- ☐ DIARRHEA
- ☐ NAUSEA / VOMITING
- ☐ CONSTIPATION
- ☐ INDIGESTION / HEARTBURN
- ☐ BLOATING

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ IRREGULAR HEART BEAT
- ☐ ANKLE SWELLING
- ☐ HEART FAILURE

MUSCULOSKELETAL
- ☐ MULTIPLE JOINT SWELLING
- ☐ GOUT
- ☐ MULTIPLE FRACTURE
- ☐ NIGHT CRAMPS
- ☐ NECK PAIN
- ☐ BACK PAIN

EAR, NOSE, THROAT
- ☐ RINGING IN THE EARS
- ☐ HEARING LOSS
- ☐ HOARSENESS
- ☐ SORE THROAT
- ☐ RECURRENT NOSE BLEEDS
- ☐ MOUTH ULCERS
- ☐ EAR INFECTION

URINARY
- ☐ PAINFUL URINATION
- ☐ URINARY FREQUENCY
- ☐ BLOOD IN URINE
- ☐ LOSS OF BLADDER CONTROL
- ☐ URINARY DISCHARGE

RESPIRATORY
- ☐ COUGH
- ☐ SHORTNESS OF BREATH
- ☐ COUGH WITH BLOOD
- ☐ WHEEZING

HEMATOLOGIC
- ☐ SPONTANEOUS BLEEDING
- ☐ BRUISING
- ☐ ENLARGED LYMPH NODES
- ☐ ANEMIA
- ☐ JAUNDICE

PSYCHOLOGICAL

ARE YOU GENERALLY SATISFIED WITH YOUR LIFE?
☐ YES ☐ NO

DO YOU FEEL SEVERLY DEPRESSED?
☐ YES ☐ NO

HAVE YOU EVER CONSIDERED SUICIDE?
☐ YES ☐ NO