Havkin Urology
Dr. Boris Havkin

EMR# _____

CONSENT TO TREAT, INSURANCE, ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT

1. Consent to Treatment and/or Surgical Procedures

The undersigned consents to the medical and/or surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia or other services rendered the patient under the general and special instructions of the patient's physician. _____ (initials)

2. Assignment of Insurance Benefits and Authorization to Release Information

In consideration of services rendered, I hereby transfer and assign to Havkin Urology all rights, title and interest in any payment due to me for services rendered. Havkin Urology may disclose all or any part of my record (including psychiatric, alcohol and drug abuse information) to any part, person or corporation which is or may be liable under contract to Havkin Urology or to my family member or employer for all or part of Havkin Urology's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or my employer. _____ (initials)

3. Financial Agreement

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of Havkin Urology in accordance with the regular rates and terms of Havkin Urology. Should the account be referred to an attorney for collections, the undersigned shall pay reasonable attorney's fees and collection expense. The undersigned certifies he/she has read the foregoing, receiving a copy thereof, and is the patient or is duly authorized by the patient as patient's general agent to execute this document and accepts its terms. _____ (initials)

4. Medicare/Medicaid

Patient's certification authorization to release information and payment request. I certify the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to Havkin Urology. _____ (initials)

5. Use of Copies

I permit a copy of these authorizations and assignments to be used in place of the original, which is on file with Havkin Urology. This assignment will remain in effect until revoked by myself or an agent in writing. _____ (initials)

6. Patient Responsibility

I understand certain insurance claims my be filed as a courtesy, however, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any co-pay, deductible, co-insurance or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed 60 days. _____ (initials)

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received on this, or a prior occasion, the Havkin Urology Notice of Privacy Practice and acknowledge I have a copy of the notice or that I requested, and was given a copy.

Received Copy this Date: □ Yes □ No Previously Received Copy: □ Yes □ No

☐ Patient Representative: _____ Witness: _____

☐ Patient unable to acknowledge receipt of the Notice of Privacy Reason: _____

I authorize Havkin Urology and all of its affiliated entities, employees and Independent Contractors permission to call me through the use of dialing equipment, artificial voice or similar technology, even if I am charged for the call. I expressly agree that such automated calls may be made by Havkin Urology and all of its affiliates, contractors and agents. I expressly consent to such automated calls and with such consent, I specifically waive any claim I may have against Havkin Urology and all of its affiliates, contractors, employees or agents for making of such calls, including any claim under the Telephone Consumer Protection Act. I also expressly agree that this provision applies to the use of text messaging. I authorize Havkin Urology and all of its contractors, affiliates and agents to use any cell phone or other telephone number to contact me for any perupose including outstanding bills.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

Signature if different from patient (proxy/agent or guardian if patient is under 18) _____

Havkin Urology
Dr. Boris Havkin

EMR# _____

Havkin Urology
HIPAA Contact Information Forms

In order to assist you in receiving your health information from Havkin Urology, please complete this form.

Initial one:

_____ (initial) Havkin Urology is permitted to share any and all medical information with the individuals listed below, including test results, sensitive information as stipulated by the State of Florida and information disclosed during office visits.

_____ (initial) Havkin Urology is permitted to share any and all medical information with the individuals listed below, including test results, sensitive information as stipulated by the State of Florida and information disclosed during office visits except: _____.

Persons authorized to receive any medical information (full name, relationship and phone number):

Name	Relationship	Phone Number

You may notify me with test results, appointment reminders and other information regarding my health information as follows:

☐ Message on answering machine Phone number: _____

☐ Message on cell phone Phone number: _____

☐ Message on work voicemail Phone number: _____

☐ Email Address: _____

Havkin Urology agrees never to sell your information. By submitting your email address you expressly agree to receive promotional information from Havkin Urology regarding information, events, promotions, specials and patient satisfaction surveys. You also understand that you have the right to "opt out" at any time through request in a reply to the email. By law we must remind you that Privacy & Security is not assured when sending information over unsecured email.

I understand this authorization will remain in effect until it is revoked by me in writing.

_____ Patient (print name)

_____ Signature

_____ Date of birth

_____ Date

This authorization is not valid for the request of copies of your medical records. You or your legal personal representative must sign a Health Information Release Form to obtain copies of your medical records.

EMR # _____

UROLOGY PATIENT HISTORY

Date_____ Date of Birth_____ Age_____

Name_____ Primary/Referring Physician_____

Additional Physicians_____ _____ _____

CHECK REASON(S) FOR TODAY'S VISIT:

- O Burning/Painful Urination
- O Chills
- O Fever
- O Kidney Stones
- O Other _____
- O Size Of Stream
- O Intermittent voiding
- O Blood in urine
- O Flank Pain __Right __Left __Both
- O Frequency
- O Frequency at night
- O Incontinence (bladder leaking)
- O Follow up visit

MEDICAL HISTORY: Check any below which you have been diagnosed with:

- O Bleeding Tendency
- O Bronchitis/Emphysema
- O Glaucoma
- O Heart Disease
- O Heart Attack
- O Stroke
- O Thyroid Disease
- O Kidney Trouble
- O High Blood Pressure
- O Kidney Stones
- O Diabetes
- O Tuberculosis
- O Gout
- O Cancer
- O CAD/CHF/A-Fib
- O Erectile Dysfunction
- O BPH
- O LUTS
- O GERD
- O Low Testosterone
- O Overactive Bladder
- O Hypercholesterolemia
- O Depression
- O Anxiety
- O Back Pain
- O
- O
- O

SURGICAL HISTORY:

	OPERATION	YEAR	DOCTOR
1.			
2.			
3.			
4.			
5.			

ALLERGIES:

			Adverse Reaction
Penicillin	No	Yes	_____
Sulfa	No	Yes	_____
Cipro	No	Yes	_____
IVP Dye/Contrast	No	Yes	_____
Codeine	No	Yes	_____
Iodine/Shellfish	No	Yes	_____
Other_____			

MEDICATIONS: List names and dosages of **all medications** you are taking.
This section must be completed.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Aspirin (Ecotrin)_____

FAMILY HISTORY: Please check if present in any of your immediate family and also note which family member the condition applies to:

- O Bleeding Disorder
- O Kidney Stones
- O Blood in Urine
- O Cancer (type)
- O Kidney Cancer
- O Tuberculosis
- O Kidney Disease
- O Prostate Cancer

PERSONAL / SOCIAL HISTORY

Tobacco Use

- O Currently, smoke _____ packs per day for _____ years
- O Quit in _____ (year). Previously smoked _____ packs per day for _____ years
- O Never smoked

Alcohol Use

How many alcoholic drinks do you consume per day_____ per week_____.

Current/former occupation_____Retired?_____

Do you use illegal substances? Yes No

What pharmacy do you use? Local: _____ Mail order: _____

REVIEW OF SYSTEMS: Do you have any of the following symptoms or conditions?

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other_____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other_____

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Other_____

Allergy

Hay Fever	Y	N
Drug allergies	Y	N

Other_____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other_____

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other_____

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Other_____

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N

Other_____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other_____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other_____

Neurologic

Weakness	Y	N
Seizures	Y	N
Fainting/Dizziness	Y	N

Other_____

Endocrine

Weight Change	Y	N
Excessive thirst	Y	N
Cold or Heat intolerance	Y	N

Other_____

Psychiatric

Depression	Y	N
Anxiety	Y	N
Memory Loss	Y	N

Other_____

Hematology

Abnormal bruising	Y	N
Abnormal bleeding	Y	N
Enlarged lymph nodes	Y	N

Other_____

PHYSICAL EXAM: