ELITE
UROLOGY
OF SOUTHWEST FLORIDA

Dear Valued Patient,

Thank you for choosing Elite Urology of Southwest Florida for your urological needs. Elite Urology of Southwest Florida strives to provide the best possible healthcare. Please complete the enclosed forms. Bring these forms with you, along with a photo ID, your insurance cards, and your copayment for your appointment. Please wear a mask into our office. This is to protect our patients and our staff. We will also take your temperature when you check in. Please also be advised that we will ask for a urine sample at your visit.

For patients residing in a nursing home or facility it is required that all attached documents are filled out and sent back with the patient along with their insurance cards or copies of their insurance cards, prior to the scheduled appointment. We also require that a family member or caretaker who is familiar with the patient's history accompany the patient during their visit. If the patient is not accompanied, they may be rescheduled.

We will contact you by phone or mail with your lab/test results, if necessary, within a reasonable time frame. If you have not heard from us in 10 – 14 days please contact our office.

Our phones are answered by our staff from 8:30 am to 4:30 pm, with lunch daily between 12:00 to 1:00 pm. Our answering service takes calls 24/7.

If you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance to avoid a $25.00 charge.

If you have questions or need assistance, please do not hesitate to ask.

Sincerely,

Elite Urology of Southwest Florida Staff

Office: 941-260-4440 www.eliteurologyofswfl.com Fax: 941-260-4441
401 Commercial Ct, Ste E
Venice, FL 34292
2302 60th St Ct W
Bradenton, FL 34209

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Patient Name: _____

D.O.B.: _____ PCP: _____

Referring Physician: _____

This questionnaire is intended to establish a number of basic health facts which are important to the analysis of your problem(s) and to gain a comprehensive picture of your health. It is not intended to substitute for a personal interview, but rather to ensure that as much time as possible will be spent discussing the problems that concern you.

CHIEF COMPLAINT: (Briefly describe your main reason(s) for coming to the doctor today: _____

_____

_____

_____

MEDICAL HISTORY: (Circle **Y** or **N** for every question)

High Blood Pressure	Y	N	Heart Disease	Y	N	Diabetes	Y	N
Stroke	Y	N	Artif. Joint / Heart Valve	Y	N	Kidney Stones	Y	N
Cancer	Y	N	If **Y**, type of cancer:					

COVID-19: Have you been tested for COVID-19? __**Y** __**N** If **Y:** what date and state were you tested? _____
Did you test positive? __**Y** __**N** If you tested positive, how long did you quarantine for? _____ Do you have proof of being tested again and it being negative? __**Y** __**N** Have you recently been exposed, in the last 14 days, to someone that has tested positive? __**Y** __**N**

PREVIOUS SURGERIES: (Please list all with approximate dates)

TYPE OF SURGERY	APPROXIMATE DATE

SOCIAL HISTORY:

Tobacco Use: ___Current ___Former ___Never Packs/Units Per Day: _____ Year Quit: _____
Type: ___Chewing Tobacco ___Cigar ___Cigarettes ___Pipe ___Smokeless Tobacco ___Vape
Years Used: _____ Ever try to quit?: ___Yes ___No
Alcohol Use: ___ Yes ___No What Kind: _____ How Often: _____
Employment Status: ___Full Time ___Part Time ___Retired ___Disabled Military Experience: ___Y ___N
What kind of work do you do?: _____
Level of Education Completed: ___GED ___High School Graduate ___Some College ___College Graduate

FAMILY HISTORY: (Check **Y** or **N** for all that apply)

___No relevant Family History ___Patient adopted

Diabetes	Y	N	Bleeding Problems	Y	N	Heart Disease	Y	N
Kidney Stones	Y	N	Prostate Cancer	Y	N	Kidney Cancer	Y	N
Bladder Cancer	Y	N	Other Cancer	Y	N	If **Y** which type of cancer:		
Other:								

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Patient Name: _____

D.O.B.: _____ PCP: _____

Referring Physician: _____

ALLERGIES:

Are you allergic to iodine or shell fish? ___Y ___N

Are you allergic to latex? ___Y ___N

Other allergies: _____

_____

_____

Reaction: _____

Reaction: _____

Reaction: _____

_____

_____

RECENT DIAGNOSTIC STUDIES: (Please give date and which facility it was done at)

X-RAY (specify type): _____

CT: _____

KUB: _____

IVP: _____

Ultrasound: _____

EKG: _____

Proctoscopy/Colonoscopy: _____

REVIEW OF SYMPTOMS: (Please check any of the problems below that you have now or have had recently)

CARDIOVASULAR:
__Chest Pain
__Heart Murmur
__Palpitations
__Varicose Veins

CONSTITUTIONAL:
__Chills
__Fever
__Weight Loss

GASTROINTESTINAL:
__Abdominal Pain
__Blood in Stool
__Constipation
__Diarrhea
__Heartburn
__Loss of Appetite
__Nausea
__Vomiting

IMMUNOLOGIC:
__Asthma
__Food Allergies

HEENT:
__Blurred Vision
__Double Vision
__Ear Infection
__Eye Pain
__Hearing Loss
__Sinus Infection
__Sore Throat

HEMALOTOGICAL/LYMPHATIC:
__Easy Bleeding
__Lymphadenopathy
__Petechiae

INTEGUMENTARY:
__Contact Allergy
__Hives
__Itching Skin
__Rash

PSYCHIATRIC:
__Anxiety
__Depression
__Insomnia

MUSKULOSKELETAL:
__Arthritis
__Back Pain
__Joint Pain
__Neck Pain

NEUROLOGICAL:
__Difficulty Walking
__Headache
__Memory Loss
__Seizures
__Tremors

METABOLIC/ENDOCRINE:
__Cold Intolerance
__Excessive Thirst
__Fatigue
__Gynecomastia
__Heat Intolerance
__Hot Flashes

GENITOURINARY:
__Dysuria
__Erectile Dysfunction
__Hematuria
__Urinary Frequency
__Urinary Incontinence
__Urinary Retention

REPRODUCTIVE:
__Breast Lumps
__Breast Pain
__Vaginal Discharge
__Sexual Dysfunction
__Penile Discharge
__Testicular/Scrotal Swelling

RESPIRATORY:
__Chronic Cough
__Dyspnea
__Known TB Exposure
__Wheezing

OTHER/MISC: _____

_____

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PATIENT NAME: _____ DATE OF BIRTH: _____

ALLERGIES: _____

_____

_____

MEDICATION LIST

NAME	*DOSE*	*REASON*	*TIMES DAILY*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

PREFERRED PHARMACY: _____

Pharmacy Phone number: _____

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Bladder Symptom Questionnaire

Name: Date:

Doctor:

Which symptoms best describe you? Select all that apply.

- Frequent urination—day, night, or both
- Sudden or strong urge to urinate
- Leakage with little or no warning—sometimes unable to make it to the bathroom in time
- Unable to completely empty bladder—feels like there is more even after going to the bathroom
- Accidental leakage with physical activity—exercising, sneezing, or coughing
- Bladder or pelvic pain
- Problems with bowel function (if checked, please select symptom below)
  - Accidental loss or leakage of stool Constipation Other
- No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms?

Have you tried medications to help your bladder symptoms? Yes No

If yes, how many different medications have you tried?

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select number.

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Complete Symptom Relief***

Are you still taking any of these medications? Yes No

if no, why have you stopped taking them?

Did not work as well as expected Side effects Expense
Interaction with other medications Other

If Side effects or Other checked, please explain:

Behavior modifications tried?

(i.e, reduced fluid intake, caffeine reduction, Kegel exercises, physicial therapy, or lifestyle changes)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Select a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Very Frustrated***

Are you interested in learning more about additional treatment alternatives to bladder medications?

Yes No

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REGISTRATION FORM

PATIENT NAME: _____ DATE OF BIRTH: _____
SOCIAL SECURITY NUMBER: _____ SEX: ___MALE ___FEMALE ___GENDER NEUTRAL
HOME PHONE NUMBER: _____ MOBILE PHONE NUMBER: _____
EMAIL ADDRESS: _____
LOCAL ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
OUT OF STATE ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
EMERGENCY CONTACT: _____ PHONE: _____
MARITAL STATUS: _____ OCCUPATION: _____
WERE YOU REFERRED BY ANOTHER PHYSICIAN? __Y __N IF YES, PHYSICIAN'S NAME: _____
RACE: _____ PREFERRED LANGUAGE (if other than English): _____
ETHNICITY: ___CAUCASION ___AFRICAN AMERICAN ___HISPANIC/LATINO ___NON-HISPANIC ___OTHER: _____
HOW DID YOU HEAR ABOUT OUT PRACTICE?: ___GOOGLE ___NEWSPAPER ___FRIEND ___OTHER: _____

WOULD YOU LIKE TO BE ADDED TO OUR MAILING LIST TO RECEIVE INFORMATION REGARDING NEWS AND EVENTS? ___Y ___N

INSURANCE INFORMATION:
PRIMARY INSURANCE COMPANY: _____ EFFECTIVE DATE: _____
POLICY #: _____ GROUP #: _____
GUARANTOR NAME (if different from above): _____

SECONDARY INSURANCE COMPANY: _____ EFFECTIVE DATE: _____
POLICY #: _____ GROUP #: _____
GUARANTOR NAME (if different from above): _____

Authorization and Agreement- I hereby authorize my insurance benefits to be paid directly to Elite Urology of SWFL, a division of MAXHealth. I acknowledge that I am responsible to pay non covered services, benefits paid directly to me, and services which are not paid by my insurance in a timely manner. I hereby authorize the release of my medical records to my insurance carrier, other treating physicians, and my attorney in response to subpoena duces tecum, or to my representative.

PATIENT SIGNATURE: _____ DATE: _____

LEGAL GUARDIAN/POA: _____ RELATIONSHIP: _____

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PATIENT GENERAL CONSENT TO TREAT

I, _____, the undersigned, hereby consent to the following:

- Administration and performance of general treatment
- Use of prescribed medication
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after the specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize Elite Urology of SWFL, a division of **MAXhealth** to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services at **MAXhealth.**

I acknowledge that I have been notified of MAXhealth Privacy Practices and understand that if I have a question or complaint that I should contact the Privacy Official. (Patient Initials _____).

I, the undersigned, authorize MAXhealth to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient Signature Date

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ASSIGNEMENT OF BENEFITS & FINANCIAL POLICY

ASSIGNMENT OF BENEFITS

If you have no insurance:

I agree to pay my medical expenses, in full, when I am seen by the doctor. If for any reason there is a balance owed on my account, I agree to pay promptly upon receipt of the monthly statement.

If you have Medicare:

I request that payment of authorized Medicare benefits be made on my behalf to the rendering physician for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services. I agree to pay any portion of my charges that my Medicare carrier determines to be my responsibility.

If you have HMO, PPO, or Commercial insurance:

I authorize any holder of medical information about me to release to my insurance company or its agents any information (including HIV, alcohol, and mental health) needed to determine benefits payable for related services. I agree to comply with the terms of my insurance coverage, including payment of my co-payment, at the time of service rendered and payment of any portion of charges that my insurance carrier determines to be my responsibility, upon receipt of my monthly statement.

If you have Medigap insurance (Medicare supplement):

I request that payment of authorizes Medigap benefits be made either to me or on my behalf to the rendering physician for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my Medigap carrier any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services.

STATEMENT OF FINANCIAL RESPONSIBILITY

All insurance forms processed by this office prior to payment in full are assigned to this practice. Your cooperation in complying with the terms of this assignment will be appreciated. If your visit is related to an auto accident or work-related injury, this information must be provided prior to seeing the physician and all claim and billing information must be furnished prior to the appointment.

Patients who cancel an appointment without a 24 hour notice may be subject to an administrative fee depending upon the length of the scheduled appointment (this fee also applies to diagnostic testing).

I, the undersigned, have read the above and realize that all medical charges incurred by me, or my dependents, are my financial responsibility. All court fees, attorney fees, or other fees necessary to collect this balance for this account, should it become delinquent, are payable by me.

_____ _____

Patient Signature Date

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called PHI, Protected Health Information, under a federal health privacy law as described below.

I, _____, authorize Elite Urology of SWFL, a Division of MAXhealth, to release and obtain my private health information to / from (check all that apply):

_____My spouse / partner — Name of spouse/partner: _____

_____My Primary Care Physician — Name of Physician: _____

_____My Pharmacy — Name of Pharmacy: _____

_____My parent / child(ren) — Name(s): _____

_____My Personal Representative — Name of Representative: _____

_____Other — Name(s): _____

_____None of the above

May our office leave a message on your machine? _____Yes _____No

Are they are restrictions on PHI to be disclosed? _____Yes _____No

If yes, please describe: _____

_____

_____

The PHI will be disclosed to confirm any appointments, to render to caregivers counseling on my treatment, for prescription pick ups, and any other reason to ensure that I obtain optimum treatment and care while I am a patient with MAXhealth. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: *Attention: Privacy Officer at PO Box 25487, Sarasota, FL 34277.* I understand that my revocation will not affect any actions taken by MAXhealth prior to receiving my revocation. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use of disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective for 1 year from the date signed, at which time this authorization to obtain and release PHI expires.

_____ _____

Patient Name Printed — Patient Signature

_____ _____

Authorized Representative — Date

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CONSENT FOR PELVIC /RECTAL EXAM

A Pelvic Examination is an examination of the vagina, cervix, uterus, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis and/or prostate. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation.

By signing this consent, I authorize Dr Ercolani and/or the staff of Elite Urology of Southwest Florida to perform a pelvic examination and/or rectal exam.

Print Name:_____ DOB: _____

Signature:_____ Date:_____

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Patient Information:

Name:_____ Date of Birth: _____

Address: _____

City: _____ State:_____ Zip: _____ Phone:_____

REQUEST MEDICAL INFORMATION FROM:

☐ Elite Urology of Southwest Florida

Dr Matthew Ercolani / Dr. Jordan Luskin / Elina Belilovskiy, ARNP / Jennifer Fernandez, APRN / Arin Stephens, PA-C

☐ Other

Name/ Doctor: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone:_____ Fax: _____

SEND MEDICAL INFORMATION TO:

☐ Elite Urology of Southwest Florida

Dr Matthew Ercolani / Dr. Jordan Luskin / Elina Belilovskiy, ARNP / Jennifer Fernandez, APRN / Arin Stephens, PA-C

☐ Other

Name/ Doctor: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone:_____ Fax: _____

☐ Release the following (most recent dates, unless otherwise noted)

For the service dates of: _____

☐ Procedures (Colon, EGD, ERCP, etc) ☐ Office Notes ☐ Labs/Path/Radiology/Nuclear Med

☐ Other: _____

☐ The complete medical records in your possession, concerning my illness and / or treatment during the period from _____ to _____.

REASON FOR YOUR REQUEST:

☐ Moving out of the area ☐ Primary physician needs records ☐ Copy for northern physician

☐ Change of provider. If so, name: _____

☐ Other (please specify):_____

_____ _____

Patient or Legal Representative Date

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the express written consent of the person to whom such information pertains, or as otherwise permitted by state law. With regards to HIV/AIDS, substance abuse or psychiatric records, a specific written consent is required-a general authorization for the release of medical information is NOT sufficient for this purpose. In the event that these records are being requested other than for the personal use of the patient or an attending physician, fees may apply in accordance with Florida State Statute 395.3025.

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