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

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:								

ELITE UROLOGY OF SOUTHWEST FLORIDA

Patient Name: ______________________

D.O.B.: ____________ PCP: ____________

Referring Physician: ______________________

ALLERGIES:

Are you allergic to iodine or shell fish? ___Y ___N Reaction: ______________________

Are you allergic to latex? ___Y ___N Reaction: ______________________

Other allergies: ______________________ 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

OTHER/MISC: ______________________

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

ELITE UROLOGY
OF SOUTHWEST FLORIDA

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: ______________________________

International Prostate Symptom Score (IPSS)

Patient Name: ______________________ Today's Date: ______________

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

Total International Prostate Symptom Score = ________

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms
Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	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

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)									
1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No

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SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: ______________________________ **TODAY'S DATE:** __________

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question.**

OVER THE PAST 6 MONTHS:

Question						
1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than half the time)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than half the time)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than half the time)	Almost Always or Always
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. **TOTAL:** __________

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED **8-11 Moderate ED** **12-16 Mild to Moderate ED** **17-21 Mild ED**

ELITE
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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: ______________

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

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

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

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

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:____________________

ELITE UROLOGY
OF SOUTHWEST FLORIDA

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.