UROLOGY ASSOCIATES OF KINGSPORT, P.C.

Jim R. Littlejohn, MD • Logan G. Elliott
822 Broad Street • Kingsport, TN 37660 • (423) 246-6251

Appointment Date_____

Name: _____DOB_____ Date: _____

Social Security Number_____Height_____Weight _____

Which Doctor in our office are you here to see?_____

Referring Doctor: _____ Family Doctor: _____

Why are you seeing the doctor today? _____

How long have you had this problem/pain? _____

What improves/worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

_____

Is the problem/pain continuous, or does it come and go? _____

_____

What is the nature of the pain? (sharp, dull, etc.) _____

Have you tried any medicine/treatment or seen a doctor for this problem before this visit? _____

_____

_____

Review of Genitourinary Systems

Please answer Yes (Y) or No (N) if you have or have ever had any of the following:

Back pain	Y	N	Up at night to urinate	Y	N	Urine Retention	Y	N
Bedwetting	Y	N	Prostate Infection	Y	N	Urologic Cancer	Y	N
Blood in urine	Y	N	Sexual Dysfunction	Y	N	Urologic Surgery	Y	N
Dribbling	Y	N	Sexually Transmitted Diseases	Y	N	Vaginal Bleeding	Y	N
Burning on urination	Y	N	Suprapubic Pain	Y	N	Vaginal Discharge/ Problems	Y	N
Erection/Ejaculation Problems	Y	N	Testes/Scrotal Swelling	Y	N	Weak Stream	Y	N
Flank pain	Y	N	Urgency	Y	N	Other _____		
Kidney Failure	Y	N	Urinary Frequency	Y	N	_____		
Kidney Infections	Y	N	Urinary Hesitancy	Y	N	_____		
Kidney stones	Y	N	Urinary Incontinence	Y	N			
Leak after voiding	Y	N	Urinary Tract Infections	Y	N			

For each of the eight questions below, please check the one box that best describes your symptoms.

The International Scientific Committee (SCI), under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), has agreed to use the symptom index for BPH, which has been developed by the American Urological Association (AUA) Measurement Committee, as the official worldwide symptoms assessment tool for patients suffering from prostatism.	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
1. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. Nocturia Over the past month, 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)	1 Time	2 Times	3 Times	4 Times	5+ Times

8. Quality of Life Due to Urinary Symptoms	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

Past Medical History

Please answer Yes (Y) or No (N) if you had any of the following diseases or conditions:

CARDIOVASCULAR

Anemia	Y	N
Angina	Y	N
Aortic Aneurysm	Y	N
Arrhythmia	Y	N
Atrial Fibrillation	Y	N
Bleeding disorder	Y	N
Congestive Heart Failure	Y	N
Deep Vein Thrombosis	Y	N
Heart attack	Y	N
Heart murmur	Y	N
Hypertension	Y	N
Mitral Insufficiency	Y	N
Mitral Valve Prolapse	Y	N
Rheumatic Fever	Y	N
Stroke	Y	N

ENDOCRINE / METABOLIC

Diabetes Mellitus	Y	N
Insulin Dependent	Y	N
Gout	Y	N
Impaired Glucose Tolerance	Y	N
Thyroid Disorder High or Low	Y	N

GENERAL

Hepatitis A, B, C	Y	N

(If yes, please circle type)

GI

Colitis	Y	N
Constipation	Y	N
Crohn's Disease	Y	N
GERD	Y	N
Hemorrhoids	Y	N
Hiatal hernia	Y	N
Irritable Bowel Disease	Y	N
Peptic ulcer	Y	N

GU

Bladder infection	Y	N
Kidney disease	Y	N
Kidney infection	Y	N
Kidney Stone	Y	N
Prostatitis	Y	N
Prostate cancer	Y	N
Renal cell cancer	Y	N

MUSCULOSKELETAL

Arthritis	Y	N
Fibromyalgia	Y	N
Osteoporosis	Y	N

NEUROLOGICAL/ PHYSCHOLOGICAL

Alcoholism	Y	N
Alzheimer's disease	Y	N
Anxiety	Y	N
Chronic Fatigue	Y	N
Depression	Y	N
Epilepsy	Y	N
Migraine	Y	N
Parkinson's Disease	Y	N
Herniated disc	Y	N

RESPIRATORY

Asthma	Y	N
Bronchitis	Y	N
Emphysema	Y	N
Sleep Apnea	Y	N
Tuberculosis	Y	N

OTHER

_____

_____

_____

_____

_____

Surgical History

Please list all surgeries you have had and note the date:

_____

_____

_____

Family History Please indicate which family member has / had any of the following:

❑ Bedwetting _____ ❑ Colon cancer _____ ❑ Kidney stones _____
❑ Bladder cancer _____ ❑ Diabetes mellitus _____ ❑ Lung cancer _____
❑ Breast cancer _____ ❑ Kidney cancer _____ ❑ Prostate cancer _____
❑ Cervical cancer _____

❑ Other_____

Social History

Marital Status

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Life Partner ❑ Common Law Spouse

Dependents # of Children_____

Tobacco per day: __ None __ Yes __ # Packs /day __ Cigarettes /day __ Smokeless Tobacco
If you previously stopped, when? _____ Never Smoked_____

Caffeinated beverages per day: 0 1 2 3 4+

Alcohol Consumption: ___No ___ Yes ___ Occasional/social ___ # of drinks per day ___ never drank

Recreational drugs: ___ None If yes, please list:_____

Occupation:

Please circle one that applies: None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, or Other _____

Recent Foreign Travel (please circle all that apply)

None
Americas: Canada, Mexico, Latin America, South America, Other _____
World Wide: Europe, Africa, Middle East, Asia, Australia, Other _____

Current Medications

Please list ALL medications you are currently taking. Include any over-the-counter drug (s).

Drug Name Strength Directions/How you take it

_____
_____
_____
_____
_____
_____
_____
_____
_____

Pharmacy Name: _____ **Phone** #: _____

Allergies: Please list ALL types (drug, seasonal, pets, animals, environmental, foods)

_____
_____
_____
_____

Review of Systems: Please answer Yes (Y) or No (N), if you have.

Constitutional

Chills	Y	N
Fatigue	Y	N
Fever	Y	N
Hot Flashes	Y	N
Night Sweats	Y	N
Weight Loss	Y	N

Other _____

Eyes

Blindness	Y	N
Blurred vision	Y	N
Cataracts	Y	N
Glaucoma	Y	N
Macular Degeneration	Y	N

Other _____

Neurological

Dizzy Spells	Y	N
Headache	Y	N
Leg or arm weakness	Y	N
Memory loss	Y	N
Numbness/tingling	Y	N
Seizures	Y	N
Stroke	Y	N
Tremors	Y	N

Other _____

Endocrine

Diabetes	Y	N
Pituitary disease	Y	N
Thyroid disease	Y	N

Other _____

Gastrointestinal

Acid reflux	Y	N
Abdominal pain	Y	N
Bloody stools	Y	N
Constipation	Y	N
Diarrhea	Y	N
Indigestion/heartburn	Y	N
Nausea/vomiting	Y	N
Rectal bleeding	Y	N
Tarry stools	Y	N
Trouble swallowing	Y	N

Other _____

Cardiovascular

Chest Pain	Y	N
Chest pain/angina	Y	N
Heart attack	Y	N
Heart failure	Y	N
Heart murmur	Y	N
High blood pressure	Y	N
Irregular heartbeat	Y	N

Other _____

Skin

Skin rash	Y	N

Other _____

Musculoskeletal

Arthritis	Y	N
Back pains	Y	N
Joint pains	Y	N
Muscle cramps	Y	N
Osteoporosis	Y	N

Other _____

Ears/Nose/Throat

Hearing Problems	Y	N

Other _____

Respiratory

Asthma	Y	N
Black Lung	Y	N
Emphysema-Bronchitis	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other _____

Hematologic/Lymphatic

Blood clotting problem	Y	N
Bleeding problems	Y	N
Hepatitis - A, B, or C	Y	N
(If yes, please circle type)		
HIV (AIDS)	Y	N
Sickle Cell	Y	N
Swollen glands	Y	N

Other _____

Psychological

Anxious	Y	N
Depressed	Y	N

Other _____

Update_____

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423-246-6251

JIM R. LITTLEJOHN, M.D
LOGAN ELLIOTT, N.P.

MRN: Patient Name:		Date of Birth:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		Sex:

PATIENT INFORMATION

Social Security #: _____-_____-_____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Sex: Male Female DOB: _____ Email: _____

Referring Doctor: _____ PCP: _____

Marital Status: Single Married Divorced Widowed Separated

IF PATIENTS INSURANCE IS NOT THROUGH EMPLOYER OR PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION.

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Sex: Male Female Date of Birth : _____/_____/_____ Social Security #: _____-_____-_____

Responsible Party Employer: _____

Relationship to Patient: _____

MEANINGFUL USE DATA

Race: African American Asian Caucasian Hispanic Indian Native American Pacific Islander

Ethnicity: Hispanic Non-Hispanic Preferred Language: English Spanish Other: _____

IN CASE OF EMERGENCY

Relative/Friend: _____ Relationship: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Urology Associates of Kingsport, PC or my insurance company to release any information required to process my claims.

PATIENT SIGNATURE: _____ **DATE:** _____

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MRN:	Patient Name:	Date of Birth:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand the, under Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
1. Obtain payment from third-party payers
2. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have read and/or received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy Practices from time to time and that I may contact this organization at any time to the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

Office Use Only: I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as document below:

Date: _____ **Initials:** _____ **Reason:** _____

CONTACT CONSENT

I, _____, acknowledge and agree that Urology Associates of Kingsport, PC and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Urology Associates of Kingsport, PC if I have given up ownership or control of any such telephone number.

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

MAY WE LEAVE A MESSAGE AT ANY OR ALL OF THESE NUMBERS? YES OR NO

IF YES, WHICH NUMBERS: HOME WORK CELL OR ALL

PLEASE LIST ANY FAMILY MEMBER OR CARE GIVER THAT YOU WOULD LIKE FOR US TO PROVIDE INFORMATION ABOUT YOUR MEDICAL CARE TO IF ANY. (ANYONE YOU MAY HAVE US CALL FOR YOU TO CANCEL YOUR APPOINTMENT, OBTAIN TEST RESULTS, OR RESCHEDULE PROCEDURES MUST BE LISTED BELOW.)

1. NAME/NUMBER/RELATIONSHIP: _____
1. NAME/NUMBER/RELATIONSHIP: _____
2. NAME/NUMBER/RELATIONSHIP: _____

SIGNATURE: _____ DATE: _____

Contact Consent

I, _____, acknowledge and agree that Urology Associates of Kingsport, PC and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephone number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers such as Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Urology Associates of Kingsport, PC if I have given up ownership or control of any such telephone number.

Print Name Date Signature

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MRN:	Patient Name:		Date of Birth:
Address:	City:	State:	Zip:

FINANCIAL POLICY

Thank you for choosing us to provider healthcare for you. Our staff is committed to providing you with the best medical care possible and to assisting you with the administrative process. The following is our financial policy.

Please read and sign.

The following applies to every visit:

* **Bring your insurance card.**
* **Be prepared to pay your co-pay or deductible if we participate with your insurance. You will need to pay minimum payment of $100 at the time of your office visit ($150 for office procedures) if you have a high deductible plan. Please see below for our policy regarding office procedures and surgery.**
* **If self pay, full amount of your visit is expected. We accept cash, checks, MasterCard and Visa.**
* **For medical care not covered by your insurance, payment in full is due at the time of your visit.**

Insurance: Our office participates in a variety of insurance plans, which we will files with your insurance company. We cannot bill your insurance company without the proper information. Please make sure all of your insurance information is up to date, including your address and phone numbers. We will not be responsible for any liability insurance (i.e. Disability, FMLA, cancer policies, etc.) Payment for services on any liability claims is due and payable at the time of service.

Referrals: As a specialty office, we see new patient with a referral from their primary care physician. Many insurance plans also require your primary care to make the referral to the specialist. To avoid delays, please call our office prior to your appointment to confirm we have the referral or bring any required referral for treatment at the time of your visit. If you do not have a referral, your visit may be rescheduled or you may be financially responsible.

Copayments and Deductibles: All co-payments and deductibles for office visits are due at the time of check-in. Co-payments and deductible for surgery will need to be paid at the time of your pre-operative appointment. If your insurance plan changes from the time you see the physician for the preoperative visit and/or surgery, please notify our office so necessary changes can be made prior to your surgery. You will be financially responsible if this is not done.

High Deductible Plans: If you have a high deductible plan you may use a cash, debit &/or credit card for the entire balance that is payable for surgery. We will collect $100 at the time of your office visit and $150 for in-office procedures. You will be billed if there is a remaining balance after insurance. We will arrange a three month or less installment plan. Statement charges may be applied.

Self Pay: Patients having no health insurance are required to pay at the time of service unless other arrangements are made prior to your visit. If you are unable to pay in full for necessary medical at the time of service, our Patient Account Representative will attempt to assist you in setting up a short-term payment plan.

Billing: Statement will be mailed monthly and the payment is due within 30 days. If you have not paid your bill, or have not arranged for a payment plan, we may ask for the assistance of an outside collection agency. If your account is turned over to a collection agency, you will be dismissed from our practice. We will try to work with you to avoid this.

No-Show / Cancellations: To cancel or reschedule, please call 48 hours prior to your appointment. You may receive a $20.00 charge for failure to keep an office visit appointment. On missed procedures in our office, you may be charged $50.00. This fee will be your responsibility, not your insurance. Failure to call us in a timely manner results in other patients needing to see the physician being denied access to an appointment. We appreciate your assistance.

Thank you for understanding the need for our financial policy. Please feel free to contact us with any questions and/or concerns you may have. We are here to work with you in any way we can.

I have read and understand this financial agreement.

_____	_____	_____
Signature of patient and/or responsible party	**Print Patient Name**	**Date**

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LOGAN ELLIOTT, N.P.

MRN:	Patient Name:		Date of Birth:
Address:	City:	State:	Zip:

JIM R. LITTLEJOHN, M.D.

LOGAN ELLIOTT, N.P.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made whether to me or on my behalf to Urology Associates of Kingsport, PC, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature **Date**

MEDIGAP OR SECONDARY INSURANCE

I request that payment of authorized Medigap benefits be made on my behalf to Urology Associates of Kingsport, PC, for any services furnished to me by that physician/suppliers. I authorize any holder of medication information about me to release any information needed to determine these benefits.

_____ _____

Signature **Date**