Roscoe S. Nelson, MD, FACS
Diplomat, American Board of Urology

Dear Patient,

Welcome to our Practice! Thank you for choosing Arizona Urology Specialists for your urologic care, we look forward to meeting you. At Arizona Urology Specialists, we pride ourselves in offering the highest quality urologic care with compassionate, responsive, competent, and excellent customer service. We will make every effort to make your experience with us a positive one. If we fall below this standard, please let us know!

Please take a moment to read the information below to answer frequently asked questions. Most information can be found on our websites at www.arizonaurologyspecialists.com and www.peedoc.com.

Office Location and Hours: Our office is located at 6320 W Union Hills Drive., Suite B-2600, Glendale, AZ 85308. Our office is open Monday thru Thursday 8:00am-5:00pm and Friday until 12:30pm. The phone hours are Monday thru Friday 8:00 to 4:30pm. If you need to speak with your physician urgently after hours please call our main line and you will be transferred to our answering service. We always have a doctor on call 24/7.

What to Bring to Your Appointment: If you have x-rays, labs or other pertinent medical records please bring with you to your appointment. To help expedite your appointment, please arrive 30 minutes early (if it's your first appointment). Please print, complete and bring with you to your visit the following forms:

1. Patient Demographic Information and Consents
2. Patient History Form

Insurance & Billing: Please bring your insurance card(s) and photo ID with you to your appointment. It is important to bring the correct insurance information and immediately notify our staff of any insurance changes. If a referral is needed from your primary care physician, please ensure they are informed so they may send your referral prior to yours visit. Co-pays, deductibles, and co-insurances are due at the time of service. We accept most credit cards, check, or cash. Payment options are offered for selective treatments to make your treatment affordable and convenient. For billing questions you may contact the business office at (602) 557-0007.

Once again, thank you for selecting our office. We are a referral practice, so many of our patients found us through direct referrals from friends, family, referring physicians or positive online reviews. Please do not hesitate to let us know how we can serve you better.

Sincerely,

Roscoe S. Nelson, MD

6320 WEST UNION HILLS DRIVE
SUITE NUMBER B-2600
GLENDALE, ARIZONA 85308
P 602-942-5600
F 623-825-6386
E DRNELSON@PEEDOC.COM
W PEEDOC.COM

Arizona Urology Specialists
New Patient Registration Form

PLEASE PRINT

Last Name:____________________________ First Name: ___________________________ MI: __________

Gender: Male / Female Date of Birth:________________________ Age:_________________

Race (i.e. Caucasian/Hispanic/Asian):__________Ethnicity (i.e. American/Mexican/German):_________

Primary Language:___________________________________ Last 4 of Social Security #: ___________

Address: ____City: ________________Zip:____________

(H) Phone:__________________ (C) Phone_____________________(W) Phone:___________________

Preferred number to reach you? Home Cell Work OK to leave message at this number? Yes No

In case of emergency number:________________________Contact name:___________________________

E-mail:

Preferred Appointment Reminder Method: Phone Mail E-mail

Primary Care Physician (PCP) / Family Doctor:________________________ Phone:_________________

Referring Physician:____ Phone:_________________

***Local Pharmacy Name:**__________________________________ **Phone:**________________________

Address or Cross-Streets:_______________________________ **Phone:**________________________

***Mail Order Pharmacy Name:**____

Primary Insurance Name:____

Primary Holder Name:______________________________ Date of Birth:____________________________

Secondary Insurance Name:____

Primary Holder Name: _____________________________ Date of Birth:___________________________

ASSIGNMENT OF BENEFITS
I hereby authorize my benefits to be paid directly to Arizona Urology Specialists, LLC and I am financially responsible for non-covered services and/or balances not paid by the insurance carrier. I also authorize release of my information required to process these claims. I authorize you to give me my medical care, including diagnosis and/or treatment.

____ __________ ___________________________
Signature of the Patient or the Patient's Legal Representative Date Relationship to Patient

Patient Name: ___________________________DOB:_____________________ Date: _____________________

Arizona Urology Specialists, LLC

Consents Form

Would you like a copy of the Notice of Privacy Practices? Declined ☐ Accepted ☐

Do you have an Advance Directive? (Legal document expressing your critical care wishes when you are unable to decide for yourself
Yes ☐ No ☐

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Arizona Urology Specialists, LLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Arizona Urology Specialists, LLC at any time to obtain a current copy.

**Signature:____ Date:______________________

Authorization of Release of Health Information:

I authorize the following individual(s) to have access to my personal health information.

Name:__________________________________Relationship:________________Phone: ______________________

Name:__________________________________Relationship:________________Phone:______________________

Name:__________________________________Relationship:________________Phone:______________________

**Signature:____ Date:______________________

Notice of Limited English Proficiency:

I have been offered a copy of the Notice of Limited English Proficiency. I understand that if I have Limited English Proficiency, I must provide a reliable, competent and proficient translator. If I cannot provide this translator, I must notify Arizona Urology Specialists, LLC in writing.

**Signature: ____Date: _____________________

Consent to Obtain Electronic Medication History:

To optimize the use of electronic prescribing of medications and coordinate care between my providers, I hereby authorize Arizona Urology Specialists, LLC to access my medication history without limitation or exclusion as is reasonably necessary to disclose, retrieve, and view medications issued by a provider.

**Signature:____ Date:______________________

Portal Authorization:

The Patient Portal is a secure web-based system that allows for protected communication and transfer of information between the clinic and the patient. By signing below, you agree to the terms and conditions set forth in the Patient Portal Authorization Policy.

**Signature:____ Date:______________________

Arizona Urology Specialists

Patient History Form

To prevent medical errors it is critical you complete this form completely and accurately!

Patient Name: ______________________ DOB: ______________ Date: ______________

Height: ______ ft ______ in Weight: ______ lbs Have you seen another urologist about this same problem? ☐ No ☐ Yes

How did you hear about us: ☐ Friend ☐ Internet (which site?) ________ ☐ Insurance Company ☐ Other, How? ______________

CHIEF COMPLAINT (Why do you want to see the doctor?) ______________________________

____

How long have you had this complaint? ______________________________

MEDICATIONS (List all **Prescription** drugs you are taking with dosage and schedule) ☐ See Attached List

1. ______________ 4. ______________ 7. ______________

2. ______________ 5. ______________ 8. ______________

3. ______________ 6. ______________ 9. ______________

List all **Non-Prescription** drugs:

Vitamins: ______________________ Aspirin / Ibuprofen: ______________________

Other (including supplements):______________________________

ALLERGIES (List all allergies to drugs or foods): ☐ No Known Allergies ☐ Iodine ☐ Hibiclens ☐ Lidocaine/Marcaine ☐ Latex

____

____

PATIENT MEDICAL HISTORY (Do you have any of the following:)

Asthma	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Osteoarthritis	☐ Yes	☐ No
Atrial Fibrilation	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Peripheral Vascular Dis.	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Type:______________			Hyperlipidemia	☐ Yes	☐ No	Thyroid Disorder	☐ Yes	☐ No
CVA / Stroke	☐ Yes	☐ No	**Hypertension**	**☐ Yes**	**☐ No**	Urinary Incontinence	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	UTI Recurrent	☐ Yes	☐ No
Diabetes	**☐ Yes**	**☐ No**	Myasthenia Gravis	☐ Yes	☐ No	Vascular Disease	☐ Yes	☐ No
DVT	☐ Yes	☐ No	Neurologic Disorder	☐ Yes	☐ No	No Medical Problems	☐ Yes	☐ No

Other Medical Problems/Prior Hospitalizations: ☐ No ☐ Yes. If yes, type and date:______________

____

PREVIOUS SURGERIES: ☐ Yes ☐ No (If yes, please complete the below)

Type	Date	Type	Date

Patient Name: ____________________ DOB: ______________ Date: ______________

FAMILY HISTORY (Please fill out as complete as possible – # of children, status, check boxes)

	Status (Alive/Dead)	Age	Prostate Cancer	Kidney Cancer	Bladder Cancer	Breast Cancer	Diabetes	High Blood Pressure	Heart Disease
Daughters (#)			☐	☐	☐	☐	☐	☐	☐
Sons (#)			☐	☐	☐	☐	☐	☐	☐
Father	A/D		☐	☐	☐	☐	☐	☐	☐
Mother	A/D		☐	☐	☐	☐	☐	☐	☐
Grandparent			☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐
Other Family History?:									

SOCIAL HISTORY

Occupation: ______________ Retired: ☐ Yes ☐ No Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Current Tobacco use? ☐ Yes ☐ No Prior Tobacco use? ☐ Yes ☐ No Alcohol use? ☐ Yes ☐ No Current Drug use? ☐ Yes ☐ No

Exercise? ☐ Yes ☐ No Type/How Often?:______________ Caffeine use? (Cups / Day): Coffee: ______ Tea: ______ Cola: ______

REVIEW OF SYSTEMS (Have you currently or recently had)

General
Fatigue ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Weight Gain ☐ Yes ☐ No
Weight Loss ☐ Yes ☐ No

Allergy
Drug Allergies ☐ Yes ☐ No
Seasonal Allergies ☐ Yes ☐ No

Opthalmologic
Blurred Vision ☐ Yes ☐ No

ENT
Dry Mouth ☐ Yes ☐ No
Nosebleeds ☐ Yes ☐ No

Endocrine
Cold Intolerance ☐ Yes ☐ No
Excessive Sweating ☐ Yes ☐ No
Heat Intolerance ☐ Yes ☐ No

Cardiovascular
Chest Pain ☐ Yes ☐ No
Edema (swelling) ☐ Yes ☐ No

Respiratory
Shortness of Breath ☐ Yes ☐ No
Are you on oxygen ☐ Yes ☐ No

Gastrointestinal
Constipation ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Nausea ☐ Yes ☐ No

Hematology
Bleeding Problems ☐ Yes ☐ No

Musculoskeletal
Back Pain ☐ Yes ☐ No
Muscle Pains ☐ Yes ☐ No
History of Gout ☐ Yes ☐ No
Muscle weakness ☐ Yes ☐ No

Peripheral Vascular
Blood Clots in Legs ☐ Yes ☐ No

Skin
Rashes ☐ Yes ☐ No

Neurologic
Leg or Arm Weakness ☐ Yes ☐ No
Balance Difficulty ☐ Yes ☐ No
Headaches ☐ Yes ☐ No

Psychiatric
Depressed Mood ☐ Yes ☐ No
Seeing a psychiatrist? ☐ Yes ☐ No

Urology
Frequency ☐ Yes ☐ No
Urgency ☐ Yes ☐ No
Nocturia (pee at night) ☐ Yes ☐ No
Burning ☐ Yes ☐ No
Blood in Urine ☐ Yes ☐ No
Hard to start ☐ Yes ☐ No
Leak with Cough etc ☐ Yes ☐ No
Leak with Urge ☐ Yes ☐ No
Start/Stop ☐ Yes ☐ No
Empty Completely ☐ Yes ☐ No
Dribbling After ☐ Yes ☐ No

Sexual History
Change in sex drive? ☐ Yes ☐ No
Performance satisfactory? ☐ Yes ☐ No

Males
Testicular Pain/Swelling ☐ Yes ☐ No
Discharge from penis ☐ Yes ☐ No
Blood in Semen ☐ Yes ☐ No

Females
Mammogram ______________
Annual Pap ______________

Date of Last (Mo/Yr):
Colonoscopy ______________
DEXA Scan ______________
Pneumonia Vaccine ______________

Form Completed By: ______________________________ Date: ______________

No Show Policy

At **Arizona Urology Specialists, we** strive to meet and exceed the expectations of all of our patients and we are dedicated to providing you with the best care and services possible. We also strive to meet your needs by providing appointments times that best fit your schedule.

Time is specifically reserved for you on your schedule when you make your appointment. When sufficient notice is not given to cancel or reschedule your appointment, it does not give us enough time to contact another patient who could come to the office during your assigned time. This results in other patients not getting the care they need, when they need it.

Because of the great need for our services we have implemented the following No-Show policy.

Arizona Urology Specialists, has implemented a No-Show policy. A NO-SHOW is when a patient fails to keep a scheduled appointment or without providing 24 hour's cancellation notice. A No-Show will generate a fee of $100.00 and with 3 or more no shows it may require you to seek medical care with another group. If your appointment is a surgery at the hospital/ Surgery Center or in office procedure such as a biopsy, our fee in the event you fail to show for your procedure is $250.00.

In the event that you have a special circumstance regarding your missed appointment, please contact our office. We understand that there may be issues beyond your control and we want to be understanding of special circumstances.

I have read and fully understand the Patient No-Show Policy.

____ ____________________

Patient Signature / (Parent or Guardian for Minor Date

Policy: Prior Authorization Fee
Date 6/9/2016

Dear Patient,

Arizona Urology Specialists providers make every effort to ensure that you receive the safest, most effective and reasonably priced prescription medications, treatments, laboratory tests and imaging studies we feel is best suited for your healthcare. We must also abide by regulations set by your insurance company and government agencies. Over the past year, many health insurance companies or plans are requiring prior authorization or approval for an increasing number of medications, imaging studies and laboratory testing.

As this is additional and labor intensive service that our providers and staff complete, effective July 1, 2016, Arizona Urology Specialists will begin charging a fee of $25.00 per authorization. This cost is an out-of-pocket expense to you and not covered by your insurance.

You can be assured that your provider will take every step necessary to provide you with a cost effective treatment and recommend testing or a medication that does not require prior authorization. In the event our office needs to perform an authorization, our office will reach out to you as soon as possible to see if you would like to proceed with the authorization and to collect the $25.00 fee in advance. Our office is unable to guarantee that your insurance carrier will approve the item(s) being authorized.

Please note that this fee does not apply to surgical authorizations performed in the office, a surgery center or hospital facility. In the event that your procedure is performed in the office and requires a medication such as Botox, your insurance carrier may require additional authorization for the medication and may be subject to this authorization fee.

If you have any questions, please contact the business office at 602-557-0007.

Patient Financial Policy

We are committed to providing the best possible medical care and patient experience to our patients. Patients knowing and understanding their financial responsibility is a key component to a positive care experience and a successful physician patient relationship.

Non-Covered Services: Patients are responsible for knowing their insurance coverage and bringing their insurance cards to their appointments. Please know your insurance benefits before each visit. You will be asked to pay for any services that are not covered by your insurance plan.

Correct Insurance Information: You are responsible for providing us with the most correct and update information about your health insurance. It is your responsibility to notify us immediately of a change to your health insurance plan or change in insurance status. If we have incorrect insurance information, outstanding balances will be billed to you directly.

Payment is required at the Time of Service: You are responsible for paying deductibles, copayments, coinsurance and other out of pocket expenses at time of service. If we are unable to verify your insurance coverage, you will be asked for payment. In addition to cash payments and checks, we also accept most major credit cards. Patients who are not covered by health insurance are required to pay for the provided services at the time of service.

Missed Appointments: Multiple missed or no show appointments will result in a $25 charge per occurrence and the patient may be subject to discharge from the practice.

Special Insurance Processing Requests: The Arizona State Constitution permits insured individuals to pay directly for health care services, if they so desire. If you choose to pay for health care services, your health care provider will not submit a claim to your health plan. It is your responsibility for notifying your provider's office when you do not wish a claim to be submitted on your behalf.

Related Facilities or Services: AUS Physicians may have a financial interest in where you are referred for treatment. This may include, but not limited to surgery centers, lithotripsy centers, pathology labs, oncology treatment centers, radiation facilities that perform CT and MRI scans and other medical and non-medical related entities.

Collection Agency Fees: When patient accounts become extremely delinquent, patients or patient guarantors agree to pay collection agency or attorney fees or not less than thirty five (35) percent. The collection agency fees will be added to the patient's outstanding balance and collected by the collection agency upon referral to the agency.

Administrative Charges: Patients may incur, and are responsible for, the payment of additional charges at the discretion of AUS. The charges may include but are not limited to (subject to change at any time).

- Charge for Returned Checks $25.00
- Charge for extensive phone consultations and/or after hour's phone calls requiring diagnosis, treatment, or prescriptions. $100.00
- Charge for copying and distribution of patient medical records. $50.00
- Charge for insurance authorization of prescription medications. $25.00
- Charge for forms completion, including but not limited to disability and FMLA forms. $35.00
- Charges for providing non-English speaking interpreters. Price varies based on language.

Patient Authorizations:

By my signature below, I hereby authorize AUS and the physicians, staff, labs, and hospitals associated with AUS to release ALL medical and other information acquired in the course of my examination and/ or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

I have read, understand, and agree to the provisions of this Policy.

____ ____
Printed Name of Patient Printed Name of Guardian (if Applicable)

____ ____
Signature of Patient or Guardian Date

Waiver of Patient Authorization
I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

____ ____
Signature of Patient or Guardian Date