Limestone Urology Associates

101 Fitness Way STE 2300, Athens, AL 35611
Phone 256-262-2170 Fax 256-216-1960

Dr. John Hinson
Dr. James Marshall
Zachary Curtis, CRNP

Thank you for choosing Limestone Urology Associates for your medical needs. Please complete the enclosed paperwork and bring it with you to your appointment.

Please arrive 20-30 minutes before your scheduled appointment time for new patients. If you arrive 15 minutes late for any appointment you may be asked to reschedule. Bring your driver's license and all insurance cards. Copays are due at check in. Please bring a list of medications that you are currently taking (prescription or over the counter) you do not need bring the actual bottles with you.

We look forward to seeing you!
Limestone Urology Associates

Limestone Urology Associates
101 Fitness Way STE 2300
Athens, Alabama 35611

WELCOME TO OUR PRACTICE!

We are so very pleased that you have selected our clinic as your health care provider. Please complete the enclosed forms with your signature where indicated and return them on or before your appointment day.

APPOINTMENTS: First time patients are asked to arrive at least 20-30 minutes early to allow adequate time for completing the initial registration. For purposes of maintaining continuity of care, we ask that you request that your latest, relevant records with the most recent test results and current medication list be faxed to us prior to your visit. Alternatively, you may bring those records with you to your first appointment. Your initial visit in establishing care with the doctor will consist of routine checking of vital signs and complete discussion of your medical history, medications you are currently taking, and health issues you may currently be experiencing.

WEB PORTAL: Most communications from the clinic will be sent through a secure online portal; so all patients are expected to register for the free service prior to their first appointment. You may submit refill requests, message clinic staff on non-urgent matters, and review your medical history including lab results through the portal. Registrations instructions are included with this packet.

INSURANCE: Our office participates in most insurance plans. If you are unsure about your insurance coverage, please call your insurance provider for clarification. Remember that your health coverage is a contract between you and your insurance company. We will assist you in getting full benefits from your insurance carrier. **Your co-payment must be collected at the time of your visit.** If you accrue an unpaid balance with no effort to pay, you will be denied medical treatment from our office. We accept cash, checks (payable to Limestone Urology Associates), Master Card, Visa, American Express, Discover and Debit Cards.

BILLING: Payment is expected at the time of service. If you do not have insurance coverage, please discuss financial options with the office staff prior to your visit. As a courtesy, if we accept your insurance, a statement will not be issued until after your insurance carrier has paid your allotted benefits. If your insurance carrier reimbursement is delinquent for 90 days, you may be asked to contact your insurance carrier. Please remember that any balance not covered by your insurance company is your responsibility to pay.

MEDICATIONS: We utilize electronic prescription writing for most medications and routine medication refills will be handled during scheduled appointments. Generally, when a routine prescription has no more refills remaining, this indicates that it is time for an appointment to review that particular condition for which the medication was prescribed. If a refill is necessary, please notify the clinic **at least 3 days prior to the need for refill** to allow time for the doctor to confirm the prescription details, review records and fill the medication appropriately and in a timely manner. Medication refills should preferentially be requested using the secure online portal. No antibiotics or narcotics will be prescribed without an examination; this is not considered good medical practice. An up-to-date list of all medications is sufficient if all necessary information is on the list, such as medications strength, and quantity.

HOURS: Our normal business hours are Monday-Thursday from 8:30am-4:30pm, excluding 12:00 to 1:00 for lunch each day and Friday from 8:30am-12pm.

Limestone Urology Associates
101 Fitness Way STE 2300
Athens, Alabama 35611

PATIENT INFORMATION:

Last Name_____ First Name_____ Middle_____

Date of Birth_____ Male/Female_____ SS#_____ Marital Status_____

Race_____ Ethnic Group_____ Primary Language Spoken_____

Street Address_____ City/State_____ Zip_____

Primary Phone_____ Alternate Phone_____

Email Address_____ Preferred Reminder Method: □ Phone Call □ Text Msg

Employer_____ Retired _____ Homemaker ____ Disabled____ Unemployed____

Preferred Pharmacy_____

Primary Care Provider _____

PRIMARY INSURANCE: _____ Contract # _____ Group # _____

Secondary Insurance _____ Contract # _____ Group # _____

Second Policy Holder Name _____ Date of Birth _____ SS# _____

EMERGENCY CONTACT:

Name_____ Phone_____ Relationship_____

RESPONSIBLE PARTY INFORMATION (If Not Self)

Full Name_____

Street Address_____ City/State_____ Zip_____

Home Phone_____ Cell Phone_____

Date of Birth_____ Marital Status _____SS#_____ Relationship_____

I hereby authorize and direct payment to Limestone Urology Associates for medical benefits, if any, otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for the charges not covered by this authorization. I understand that checks returned for non-payment will incur a $30.00 fee. I hereby authorize Limestone Urology Associates to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing claims for medical services. I understand that regardless of my insurance status, I am solely responsible for payment of any services rendered to me, or on my behalf, whether or not paid by my insurance company.

Patient/Responsible Party Signature_____ **Date**_____

Limestone Urology Associates
101 Fitness Way Ste. 2300
Athens, AL 35611
Ph.: 256-262-2170 Fax: 256-216-1960

Date: _____ Name: _____ **DOB**: _____

Reason for today's visit_____

ALLERGIES

Write Specific Allergy / Reaction

- **NO KNOWN DRUG ALLERGIES**
- MEDICATIONS:_____

MEDICATIONS CURRENTLY IN USE **Check here if NO MEDS____**

Medication Name	Dose	Frequency

Review Of Symptoms - Please indicate below if you are **CURRENTLY** experiencing any of these symptoms.

Constitutional

YES	NO	
□	□	Chills
□	□	Fever
□	□	Weight gain (unintentional)
□	□	Weight loss (unintentional)

Eyes

□	□	Glaucoma
□	□	Cataracts
□	□	Glasses/Contacts

Gastrointestinal

□	□	Abdominal Pain
□	□	Constipation
□	□	Diarrhea
□	□	Heartburn
□	□	Nausea
□	□	Vomiting

Cardiovascular

□	□	Irregular heart beat
□	□	Palpitations
□	□	High blood pressure
□	□	Varicose veins

Other _____

Endocrine

□	□	Diabetes: Type 1 ___ Type 2 ___
□	□	Thyroid Disorder
□	□	Infertility

Psychiatric

□	□	Anxiety
□	□	Sleep disturbance/Insomnia
□	□	Depression

Other _____

Musculoskeletal

YES	NO	
□	□	Joint pain
□	□	Back pain
□	□	Neck pain

Respiratory

□	□	COPD
□	□	Cough (acute)
□	□	Cough (chronic)
□	□	Shortness of breath

Other _____

Genitourinary

□	□	Difficulty urinating
□	□	Blood in urine
□	□	Unprotected intercourse
□	□	Urine retention
□	□	Impotence
□	□	Urinary frequency at night
□	□	Urinary frequency
□	□	Urinary incontinence
□	□	Urine Stream change
□	□	Frequent UTI's

Hematologic/Lymphatic

□	□	Easy bruising
□	□	Excessive bleeding
□	□	History of blood transfusion

Neurololgical

□	□	Fainting
□	□	Numbness/tingling
□	□	Seizures
□	□	Weakness

Patient Signature _____ **Date** _____

Smoking History:

Do you currently use nicotine? _____
If yes, what do you use?
(Cigarettes Pipe Cigar Smokeless tobacco nicotine gum/patch vape)

If past user, when did you quit? _____

Alcohol:

Do you currently drink alcohol?
(Non-Drinker Social Rarely)
If so, how much? _____ What kind? _____

Caffeine:

☐ None

☐ Coffee How much: _____ per day _____ / per week_____

☐ Tea How much: _____ per day _____/ per week_____

☐ Soda How much: _____ per day _____ /per week _____

Substance Abuse History: **Circle all that apply**

None Amphetamines Barbiturates Benzodiazepines Cocaine Ecstasy Hallucinogens Heroin Inhalants LSD Marijuana Mescaline Narcotics Opium PCP Psilocybin (mushrooms) Sedatives Other: _____

Mental Health History: **Circle all that apply**

None Mood Disorder Eating Disorder Sexual Disorder Sleep Disorder

Schizophrenia/Psychosis Depression Other: _____

Communicable Disease History: **Circle all that apply**

None Sexually Transmitted Diseases (STD) Common Reportable Diseases

Rare Reportable Diseases Environmental Exposure Other: _____

LUA - PAST MEDICAL HISTORY FORM

Name_____ Date of Birth _____

Check the box if the condition pertains to you and write comments if necessary.

Cardiovascular Comment

- ☐ Arrhythmia _____
- ☐ Angina _____
- ☐ Atrial Fibrillation _____
- ☐ CHF _____
- ☐ Heart Disease _____
- ☐ Heart Attack _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Pacemaker/Defibulator _____
- ☐ Vascular Disease _____
- ☐ Other _____

Gastrointestinal Comment

- ☐ Celiac Disease _____
- ☐ Constipation _____
- ☐ Diarrhea _____
- ☐ Diverticulitis _____
- ☐ Diverticulosis _____
- ☐ GERD _____
- ☐ Heartburn _____
- ☐ Hepatitis _____
- ☐ Hiatal Hernia _____
- ☐ IBS _____
- ☐ Other _____

Musculoskeletal Comment

- ☐ Arthritis _____
- ☐ Chronic Pain _____
- ☐ Fibromyalgia _____
- ☐ Gout _____
- ☐ Numbness/Weakness _____
- ☐ Osteoarthritis _____
- ☐ Osteoporosis _____
- ☐ RA _____
- ☐ Other _____

Respiratory Comment

- ☐ Asthma _____
- ☐ COPD _____
- ☐ Emphysema _____
- ☐ Sleep Apnea _____
- ☐ TB _____
- ☐ Other _____

Renal/Genitourinary Comment

- ☐ BPH _____
- ☐ Endometriosis _____
- ☐ Erectile Dysfunction _____
- ☐ Kidney Stones _____
- ☐ Polycystic Kidney Disease _____
- ☐ Renal Failure _____
- ☐ Urinary Incontinence _____
- ☐ UTI, Recurrent _____
- ☐ Other _____

Endocrine Comment

- ☐ Addison Disease _____
- ☐ Cushing Disease _____
- ☐ Type I Diabetes _____
- ☐ Type II Diabetes _____
- ☐ Hyperthyroidism _____
- ☐ Hypothyroidism _____
- ☐ Other _____

Neurological Comment

□ Alzheimer's Disease _____
□ ADD/ADHD _____
□ Dementia _____
□ Faint/Dizziness _____
□ Headache-Migraine _____
□ Headache-Tension _____
□ MS _____
□ Neuropathy _____
□ Seizures _____
□ Stroke _____
□ Cognitive Impairment _____
□ Other _____

Allergy/Immunology/Dermatology

Comment

□ Allergies _____
□ Chicken Pox _____
□ Eczema _____
□ Sinus, frequent _____
□ Other _____

Psychiatric Comment

□ Anxiety _____
□ Bipolar Disorder _____
□ Depression _____
□ Schizophrenia _____
□ Personality Disorder _____
□ Panic Attacks _____
□ PTSD _____
□ Eating Disorder _____

Hematologic Comment

□ Anemia _____
□ Hepatitis B _____
□ Hepatitis C _____
□ Iron Deficiency _____

Ears/Nose/Throat Comment

□ Vertigo/Dizziness _____
□ Hearing Loss _____
□ Otitis _____
□ Tinnitus _____
□ Other _____

Other Conditions Comment

□ Insomnia _____
□ AIDS/HIV _____
□ Cancer _____
□ Cataracts _____
□ Glaucoma _____
□ Other _____

Previous Surgeries

Surgery_____ Approximate Date: _____
Surgery_____ Approximate Date: _____
Surgery_____ Approximate Date: _____
Surgery_____ Approximate Date: _____

Please list all other Healthcare Providers you see:

Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____

Family History (Complete Health Information about your family)

Disease	Family Member (Circle one)				
Alzheimer's / Dementia	Father	Mother	Sibling	Grandparent	Other:
Asthma, Hay Fever	Father	Mother	Sibling	Grandparent	Other:
Cancer, Type:	Father	Mother	Sibling	Grandparent	Other:
Cancer, Type:	Father	Mother	Sibling	Grandparent	Other:
CHF	Father	Mother	Sibling	Grandparent	Other:
CVA / Stroke	Father	Mother	Sibling	Grandparent	Other:
COPD	Father	Mother	Sibling	Grandparent	Other:
Diabetes	Father	Mother	Sibling	Grandparent	Other:
GI Problems	Father	Mother	Sibling	Grandparent	Other:
Glaucoma	Father	Mother	Sibling	Grandparent	Other:
Heart Attack	Father	Mother	Sibling	Grandparent	Other:
Heart Bypass	Father	Mother	Sibling	Grandparent	Other:
Heart Disease	Father	Mother	Sibling	Grandparent	Other:
Heart Stent	Father	Mother	Sibling	Grandparent	Other:
Hyperlipidemia	Father	Mother	Sibling	Grandparent	Other:
Hypertension	Father	Mother	Sibling	Grandparent	Other:
Kidney Problems	Father	Mother	Sibling	Grandparent	Other:
Seizures	Father	Mother	Sibling	Grandparent	Other:
Thyroid Disease	Father	Mother	Sibling	Grandparent	Other:
Other:	Father	Mother	Sibling	Grandparent	Other:
Other:	Father	Mother	Sibling	Grandparent	Other:

Athens-Limestone Health Services, LLC

Patient Name: _____ **Date of Birth:** _____

DUE TO THE PRIVACY CONFIDENTIALITY ACT, please list the people that you approve to have access to your information as stated below:

BILLING INFORMATION:

_____ Relationship: _____ Phone # _____

_____ Relationship: _____ Phone # _____

MEDICAL INFORMATION:

_____ Relationship: _____ Phone # _____

_____ Relationship: _____ Phone # _____

AUTHORIZATION TO FILE INSURANCE

I authorize the release of medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Athens Limestone Health Services to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Athens Limestone Health Services or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct. I also acknowledge that I am responsible for payment of any services not covered by my insurance and that it is my responsibility to know what services may not be covered by my insurance policy.

Agree: ☐ Disagree: ☐

AUTHORIZATION FOR PHONE CONTACT

I hereby authorize clinic staff to leave messages regarding my medical condition, such as lab reports, other test results, medications, and appointment reminders on my home answering machine or cell phone. By providing us with your landline and/or cell phone numbers, you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This authorization applies to any landline or cell number you may acquire in the future. We may also contact you by sending text message or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. This authorization will be in effect until I have given written notice to the clinic.

Agree: ☐ Disagree: ☐

AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I hereby authorize the clinic staff to electronically obtain my prescription history via SureScripts. This authorization will be in effect until I have given written notice to the clinic.

Agree: ☐ Disagree: ☐

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES AND PATIENT RIGHTS

We are required by law to maintain the privacy of, and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices and agree to all information listed above. Signature below also indicates that you have received a copy of the Patient Rights & Responsibilities for Athens-Limestone Health Services Clinics.

Signature of patient or patient's representative: _____ **Date:** _____

Limestone Urology Associates

101 Fitness Way STE 2300 Athens, AL 35611
256-262-2170 Phone 256-216-1960 Fax

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature_____

Date_____

Limestone Urology Associates

101 Fitness Way STE 2300 Athens, AL 35611
256-262-2170 Phone 256-216-1960 Fax

Inclement Weather Policy

In the event of inclement weather, please call our office to confirm if open or closed.

Appointment No-Show / Same Day Cancellation Policy

Effective August 15th , 2016

It is the policy of Limestone Urology Associates to monitor and manage appointment no shows. Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least twenty-four (24) hours prior to the scheduled time is considered a "no show." The first time a patient is a no show; they will be reminded of the no-show policy with a letter. Once the patient has been a no show for the second time, the no-show fee will be charged and another letter will be sent. The no-show patient fee is **$25.00**, as set by Limestone Urology Associates, for failure to show, this fee is due prior to the next appointment. A patient who consistently fails to present themselves more than five (5) times will be dismissed from Limestone Urology Associates.

It is the policy of Limestone Urology Associates to monitor and manage appointments that are canceled the day of the appointment. The first 2 "Same Day Cancellations" fee will be waived, however, beginning with the 3rd occurrence a **$25.00** charge will be billed and a letter sent. Payment must be made before the next appointment can be scheduled.

_____**Please initial here**

Medication Refill Policy Effective August 15th, 2016

It is imperative to notify the nurse if there is a need for any refills **at the time of each visit**. Calling at a later time for refills may cause a delay in receiving your medications. Please allow at least **3 business days for medication refills that are requested by call in**.

_____**Please initial here**

Forms Requests There will be a $25 charge for certain forms that require the doctor to complete, such as FMLA and Short Term Disability. Please allow 5-7 business days to complete.

_____

Patient's Signature **Date**

Athens-Limestone Health Services

PATIENT RIGHTS

Welcome to Limestone Urology Associates. Our goal is to make your visit as pleasant as possible. We want to ensure that each patient at our clinic receives information regarding patient rights. We are committed to provide a standard of care that ensures our patients are safe from accidental injury. These rights are stated to publish our commitment that each patient will receive the best possible care that we can offer.

As a patient at Limestone Urology Associates your rights include the following:

- The right of access to treatment regardless of race, age, creed, sex or national origin in a safe setting, free from abuse or harassment.
- The right to reasonable access to care and acceptance for treatment within the clinic's capacity or referral to another facility when medically appropriate.
- The right to care that is considerate and respectful of your personal values, culture and beliefs.
- The right to personal privacy and confidentiality of your personal health
- The right to appropriate assessment and management of pain.
- The right to access information contained in your clinical record within a reasonable time frame.
- The right to participate in decisions regarding your care, to be involved in planning your care and treatment, and to receive information necessary to give informed consent.
- The right to accept medical care and refuse medical treatment, as permitted by law, and to be informed of the medical consequences if refused.
- The right to formulate an Advance Directive, such as a Living Will. Information will be provided to you upon your request.
- The right to legally designate a representative decision maker in the event you are incapable of understanding a proposed treatment or procedure or are unable to communicate your wishes regarding your care and to have effective communication.
- The right to receive an itemized, detailed explanation of your bill for services and explanation of benefits paid by insurance.
- The right to voice complaints concerning the quality of care you receive without fear of reprisal, to have those complaints reviewed, according to our Patient Grievance Resolution Policy, and, when possible, resolved.

If you have any concerns about the care you receive while you are a patient please ask to speak to the Office Manager at any time. If you have a patient safety or quality care concern you may also contact any one of the following:

1. **Joint Commission on Accreditation of Healthcare Organizations**
   Office of Quality Monitoring
   One Renaissance Boulevard
   Oakbrook Terrace, IL 60181
   (Fax) 630-792-5636
   (Email) complaint@jcaho.org

2. **State of Alabama Dept of Public Health Hotline**
   1-800-356-9595 Monday-Friday 8 a.m. to 5 p.m.

3. **Athens-Limestone Hospital Patient Safety Officer**
   Administration Telephone: 256-233-9119.

4. **Centers for Medicare and Medicaid Services**
   7500 Security Blvd., Mail Stop S2-12-25
   Baltimore, MD 21244-1850

PATIENT RESPONSIBILITIES

As a patient of Limestone urology associates, your responsibilities include:

- To provide, to the best of your knowledge, complete and accurate information about your present condition, past illnesses, hospitalizations, medications, and other matters relating to your health.
- To report unexpected changes in your condition.
- To follow instructions and adhere to your plan of care.
- To review all educational materials given to you.
- To report the presence of pain to your physicians and nurses.
- To ask appropriate questions when you don't understand.
- To cooperate with nurses, physicians, and others who participate in administering your care.
- To recognize that your own behavior and actions influence treatment outcomes.
- To recognize that other patients and clinic personnel also have rights.
- To act with consideration and respect toward other patients and clinic personnel.

Patient's Signature **Date**

Limestone Urology Associates

101 Fitness Way STE 2300 Athens, AL 35611
256-262-2170 Phone 256-216-1960 Fax

We would like to invite you to the Patient Portal. It is a secure online website that gives you convenient 24-hour access to your personal health information and medical records, such as lab results and appointments. We have attached a pamphlet with further details.

Please mark whether you would like to be invited to our patient portal.

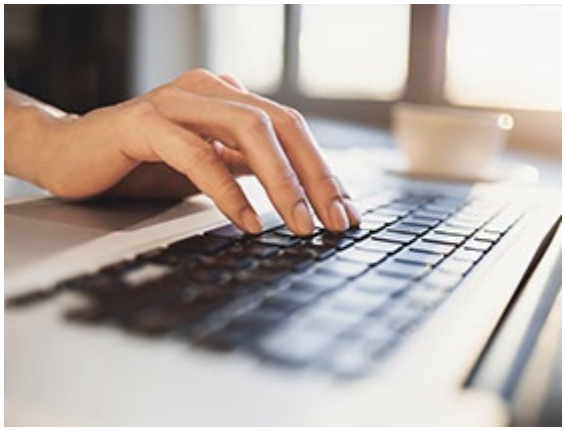
YES_____ NO_____

If yes, please provide an email address_____

Athens Limestone Health Services

Invites you to join

Our Patient Portal



Portal URL:
alhclinic@mymedaccess.com

How to Register

There are two ways to register for the Patient Portal.

Option 1

Provide your email address so you can be given access to the Patient Portal. You will receive an email containing a link to register for the Patient Portal. Click on the link and follow the instructions. Enter the supplied Username and Password. You will be prompted to create a new Password. You will then have to enter information to verify your identity.

Option 2

You can also be registered for the Patient Portal without providing your email address. We will print out a registration card with detailed instructions to follow. After accessing the website, enter the supplied Username and Password. You will be prompted to create a new Password. You will then have to enter information to verify your identity.

Patient Portal Frequently Asked Questions

Here are our answers to the most commonly asked questions about our Patient Portal.

What is a Patient Portal?

A Patient Portal is a secure online website that gives you convenient 24-hour access to your personal health information and medical records—from anywhere with an Internet connection.

Why Should I Use a Patient Portal?

Accessing your personal medical records through a Patient Portal can help you to be more actively involved in your own health care. Accessing your family members' health information can help you take care of them more easily.

Also, patient portals offer self-service options that can eliminate phone tag with your doctor and might even save a trip to the doctor's office.

Is My Information Safe?

Yes. Patient portals have privacy and security safeguards in place to protect your health information.
Always remember to protect your Username and Password from others and make sure to only log on to the Patient Portal from a personal or secure computer.

Can My Family Access My Patient Portal?

You may choose to give family members or healthcare proxies access to your Patient Portal. They will have their own login once you set this up in your Portal.

What Do I Do If...

I Don't Receive a Registration Email?

I Forgot My Password or Username?

Click on the link that says, "Forgot Password" or "Forgot Username" and follow the additional instructions. If you still need help, contact the office to reset your account.

I Have An Urgent Issue or Emergency?

DO NOT use the Patient Portal. Call the office if you need to speak with a staff member immediately. If you are experiencing an emergency, call 911 or go to the nearest emergency room.

Patient Portal Website

alhclinics@mymedaccess.com

Contact Us

Athens Limestone Health Services

Visit us on the Web:
www.athenslimestonehospital.com