SOUTH MISSISSIPPI Urology PLLC

Patient Information

FIRST NAME: _____ MIDDLE: _____ LAST NAME: _____

DATE OF BIRTH: ___/___/___ MARRIED: ____ WIDOWED: ____ DIVORCED: ____ SINGLE: ____ Spouses Name: _____

STREET ADDRESS: _____ APT/LOT: _____ CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS: _____ APT/LOT: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____ M: _____ F: _____ SOCIAL SECURITY #: _____

REFERRING PHYSICIAN: (First and Last Name): _____

CHOICE OF LANGUAGE: _____ RACE: _____ ETHNICITY: _____

EMPLOYER NAME: _____ EMPLOYER ADDRESS: _____ CITY: _____ STATE: ___ ZIPCODE: _____

Can we leave a message on your cell phone? Yes: _____ No: _____ N/A: _____

Can we leave a message on your home answering machine: Yes: _____ No: _____ N/A: _____

Can we leave a message at your place of employment Yes: _____ No: _____ N/A: _____

Can we send emails concerning appointments/medical condition? Yes: _____ No: _____ N/A: _____

Can we discuss your medical condition with any members of your household or family Yes: _____ No: _____

If YES please give the following information:

Name(s): _____ Relationship: _____ Name(s): _____ Relationship: _____

IF PATIENT IS A MINOR INDICATE RELATIONSHIP:

PARENT: _____ GUARDIAN: _____ OTHER: _____

PARENT/GUARDIAN FIRST NAME: _____MIDDLE: _____ LAST NAME: _____ DATE OF BIRTH: __/__/_____

SOCIAL SECURITY #: _____ HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company Name:	Group Name:	Policy Number:
Relationship to Policy Holder: Self ☐ Spouse ☐ Child ☐ Other ☐	Policy Holder FULL Name (if different)	Policy Holder's Date of Birth: Policy Holder's Social Security #

SECONDARY INSURANCE NAME:

Insurance Company Name:	Group Name:	Policy Number:
Relationship to Policy Holder: Self ☐ Spouse ☐ Child ☐ Other ☐	Policy Holder FULL Name (if different)	Policy Holder's Date of Birth: Policy Holder's Social Security #

EMERGENCY CONTACT: (That does not live with you): Name: _____ Relation: _____ PH#: _____

DATE: _____ **Signature:** _____

PLEASE ANSWER ALL QUESTIONS

Mark S. Lyell, M.D.
David L. Spencer Jr., M.D.
Alejandra Diaz, PA-C

CONSENT FOR TREATMENT

This consent is **not** to be used or considered an informed consent for operation or surgical procedures. This is to certify that the undersigned authorizes the examination and/or treatment as may be necessary or advisable completed within the office of South Mississippi Urology, PLLC (SMU).

I consent to my photograph to be taken by South Mississippi Urology, PLLC for identification purposes.

1. The undersigned as the patient or his/her authorized legal representative do hereby authorize South Mississippi Urology, PLLC to release to my insurance company or other appropriate agencies, information necessary to validate this claim for billing purposes.
2. South Mississippi Urology, PLLC is also hereby authorized to release to any other physicians or medical entity information as needed for treatment, care of the insured.
3. I hereby authorize any medical and/or health insurance company to pay the proceeds of any benefits due me directly to South Mississippi Urology, PLLC. A copy of this form can be considered as an original for insurance purposes. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or the indicated person for whom I am financially responsible. Although I have requested the doctors to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt payment of the bill.
4. **I have read this agreement and understand the contents.**

PATIENT'S NAME (print)	Date	PATIENT'S NAME (signature)

Responsible Party NAME	Relationship	Date	Responsible Party NAME (signature)

5. **STATEMENT TO PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO SOUTH MISSISSIPPI UROLOGY, PLLC**

Medicare#: _____ and/or Medicaid#: _____

BENEFICIARY: _____

I request that payment of authorized MEDICARE/MEDICAID benefits be made on my behalf to South Mississippi Urology, PLLC for services furnished me by physicians associated with South Mississippi Urology, PLLC. I authorize South Mississippi Urology, PLLC to release Health Care Financing Administration/ or Medicaid and its agents any information needed to determine these benefits or the benefits payable for related services.

_____
Patient/Responsible Party Signature

SOUTH MISSISSIPPI Urology PLLC

Mark S. Lyell, M.D.
David L. Spencer Jr., M.D.
Alejandra Diaz, PA-C

Authorization to Obtain Medication History

Patient Name: _____

DOB: _____

SSN: _____

Address: _____

By signing below, I hereby authorize South Mississippi Urology to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

_____

Date of Authorization

_____

Patient/Legal Representative or Parent/Legal Guardian Print Name

_____

Patient/Legal Representative or Parent/Legal Guardian Signature

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. South Mississippi Urology may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

SOUTH MISSISSIPPI Urology PLLC

Mark S. Lyell, M.D.
David L. Spencer Jr., M.D.
Alejandra Diaz, PA-C

FINANCIAL POLICY

Thank you for choosing South Mississippi Urology as your healthcare provider. We are committed to providing you the best possible service at the lowest possible price. Following is a statement of our financial policy which we require you to read and sign prior to treatment.

South Mississippi Urology accepts payment for professional services in the form of cash, check, credit card or patient financing. All patients will be required to establish a financial arrangement when services are rendered. In addition, we accept insurance from major insurance companies. ***PLEASE BE AWARE THAT FEW INSURANCE COMPANIES ATTEMPT TO COVER ALL MEDICAL COSTS. EACH PATIENT IS REQUIRED TO MAKE A DEPOSIT PRIOR TO SURGERY.*** Your insurance coverage is a contract between you and your insurance carrier. We will assist you in maximizing your insurance benefits and in obtaining necessary pre-certifications. As a courtesy we will review your insurance coverage, estimate your insurance payment, review your insurance form and file your claim with the carrier. To avoid any misunderstanding, we will require you to assign all insurance benefits for professional services directly to our office. If you request your insurance company to pay you directly, we will require full payment from you at the time of service. You will be notified when the insurance carrier remits payment to our practice. We will apply this payment to your account and refund any credit balance within 30 days.

If an insurance problem occurs you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problem. ***YOU WILL BE RESPONSIBLE FOR ANY PORTION OF YOUR BILL WHICH IS DENIED OR NOT PAID BY YOUR INSURANCE CARRIER.***

If this bill is not paid within the ninety (90) day period from demand or billing, South Mississippi Urology, PLLC may turn it over to a collection agency or attorney for payment of services rendered.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication. Our staff has been instructed to make every effort to clarify any misunderstandings you have concerning your balance. If you have any questions concerning our financial policy or need any assistance, please contact our practice immediately at 769-2069.

I have read, understand and agree to the financial policy.

_____ _____

Signature of Patient or Responsible Party Date

1124 Oakleigh Rd., Ocean Springs, MS 39564 228-875-3778
2525 Telephone Rd , Pascagoula, MS 39567 228-769-2069
147 Reynoir Street, Suite 306, Biloxi, MS 39531

Revised: 1/22/2015 sk Revised: 11/15/2016 jr Revised: 8/29/2017 jr Revised 10/17/2017 jr Revised 5/29/2018 jr

SMS MANAGEMENT, LLC

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

South Mississippi Healthcare ('SMS') is dedicated to protecting your health information. We understand that health information about your health is personal and we are committed to protecting health information about you. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will inform you of the ways in which we may use and disclose your health information. It describes your rights to the health information and certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to Health Information about you
- Follow the terms of the Notice Of Privacy Practices for the Protected Health Information

Permitted and required uses and disclosures:

- For treatment
- For Payment including but not limited to, your insurance, self-funded or third-party health plans
- For Health Care Operations
- For appointments, automated appointment reminders and referrals
- As required by Law
- To avert a serious threat to health and safety
- As required by Workers Compensation, Military or Veterans Affair
- Public health risks
- Health care oversight activities such as audits, investigations and inspections
- Lawsuits and disputes
- Law enforcement, National Security and intelligence activities
- Coroners, health examiners and funeral directors
- Security Officials for Inmates

You have certain rights regarding Health Information about you:

- Right to request restrictions
- Right to confidential communications
- Right to inspect and obtain paper copies. (SMS charges a reasonable cost-based fee for paper copies.)
- Right to amend
- Right to accounting of disclosure
- Right to copy of this Notice (full notice is available upon request)
- Right to receive notification of any breach

We reserve the right to change this notice. In the event of changes to this Notice, we will place a current Notice in our Facility with the changes and have you sign a new acknowledgement of receipt of the notice.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with us or to the Secretary of the U.S. Department of Health and Human services. All complaints must be in writing.

Acknowledgement of Receipt of this Notice:

SMS requires you to sign a separate form acknowledging you have received a copy of this Notice. This Acknowledgement becomes a part of your record.

SMS MANAGEMENT, LLC

ACKNOWLEDGEMENT FORM for: Notice of Privacy Practices for Protected Health Information

I HAVE READ AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS CONCERNING THIS NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

_____
Patient or Patient's Representative

_____
Date

SMS MANAGEMENT, LLC

POLICY ON USE OF RECORDING DEVICES BY PATIENTS IN OUR OFFICES

I. To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited within our offices at any of our locations. This includes any audio/video equipment or use of cell phones for recording purposes.

A. The Health Insurance Portability and Accountability Act (HIPAA) grants privacy protection to patients records. Once a recording is made, it may be hard to ensure that it remains private.

B. Electronic recording infringes on the privacy rights of the physician and employees.

C. If it is discovered that you have electronically recorded any of the SMS staff, or any other patients in our office, we will withdraw you from our care. You are expected to abide by our policy while you are on our premises. Your understanding and compliance to this policy will be greatly appreciated.

_____
Patient or Patient's Representative

_____
Date

FMLA/DISABILITY/LOAN FORM

Name: _____

DOB: _____

Doctor: _____

Surgery Date: _____

Place of Employment: _____

Type of Job: _____

FORMS WILL BE FAXED ONE TIME. It will be your responsibility to ensure your employer received the faxed forms.

FAXING FORMS

Fax Number: _____

Protected information: By signing this form I understand that medical information released will contain information related to my health.

I understand that by faxing this information there is no guarantee my privacy will be protected due to not knowing who is on the receiving end of the fax number. There is a chance of human error when dialing the fax number provided as well. I understand that medical health information is protected by federal law and I authorize SMS Healthcare to fax to the number I have given.

Signature: _____ Date: _____

Employee Initials: _____

PLEASE NOTE – FORMS CAN TAKE 7 to 10 BUSINESS DAYS TO COMPLETE AND THERE IS A $25.00 CHARGE.

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

Pharmacy: _____ **Primary Care Physician:** _____

Review of Systems

Constitutional Systems		
Appetite Changes	Yes	No
Chills	Yes	No
Fever	Yes	No
Headache	Yes	No
Weight Loss	Yes	No
Ears, Nose and Throat		
Sinus Congestion	Yes	No
Sore Throat	Yes	No
Ringing in the Ear(s)	Yes	No
Hearing Loss	Yes	No
Respiratory		
Chronic Cough	Yes	No
Shortness of Breath	Yes	No
Coughing up Blood	Yes	No
Cardiovascular		
Angina	Yes	No
Palpitations	Yes	No
Chest Pain	Yes	No
Ankle Edema	Yes	No
Gastrointestinal		
Abdominal Pain	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Nausea/Vomiting	Yes	No
Black Stools	Yes	No
Skin		
Persistent Itching	Yes	No
Unusual Lesions	Yes	No
Rash	Yes	No
Jaundice/Yellow Skin	Yes	No
Musculoskeletal		
Arthritis	Yes	No
Back Pain	Yes	No
Joint Pain	Yes	No

Genitourinary		
Blood in Urine	Yes	No
Frequent Urination	Yes	No
Urgency	Yes	No
Bladder not Emptying	Yes	No
Straining to Void	Yes	No
Leaking	Yes	No
- with Cough	Yes	No
- with Urgency	Yes	No
Pain with Intercourse	Yes	No
Male		
- Testicle Pain	Yes	No
- Poor Erections	Yes	No
- No Erections	Yes	No
- Testicle Mass/Lump	Yes	No
Female		
- Heavy Periods	Yes	No
- Painful Periods	Yes	No
- Vaginal Discharge	Yes	No
Endocrine		
Excessive Sweating	Yes	No
Excessive Thirst	Yes	No
Excessive Weight Gain	Yes	No
Excessive Weight Loss	Yes	No
Hematological		
Bleeding Problems	Yes	No
Swollen Glands	Yes	No
Easy Bruising	Yes	No
Neurological		
Dizziness	Yes	No
Numbness	Yes	No
Psychiatric		
Insomnia	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Eyes		
Blurred Vision	Yes	No
Eye Pain	Yes	No

Pain Level Today (*Circle One*):

0 No Hurt **1** **2** Hurts Little Bit **3** **4** Hurts Little More **5** **6** Hurts Even More **7** **8** Hurts Whole Lot **9** **10** Hurts Worst

Patient Signature: _____

Location of Pain _____

ER _____ Recent Labs _____ Urine _____

COVID-19: _____ Tested _____ S/S _____

Travel _____

Soda: _____ Tea: _____ Coffee: _____

Smoking: _____ Smokeless Tob Use: _____

Drug Use: _____

Patient instructed to wear mask _____