GULFSTREAM UROLOGY ASSOCIATES, P.A.

PATIENT FIRST NAME: _____ LAST NAME: _____ MI: _____

Reason for Visit: _____ Primary Care Physician: _____

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

Address: _____ City: _____State: _____ Zip: _____

Mailing address (if different)_____

Home Phone # (_____)_____ Cell Phone # (_____)_____

Email: _____ Primary Language:_____

Relationship (circle your choice) Married / Single / Divorced / Widowed/ Life Partner / Separated

Race (circle your choice): Caucasian / Black-African American / Hispanic / American Indian-Alaska Native /

Asian / Native Hawaiian- Pacific Islander / Other _____ / Refuse to State (as required by law)

Hispanic-Latino Ethnicity: _____ Yes _____ No _____ Refuse to State (as required by state law)

PHARMACY (Please provide as many details as possible)

PHARMACY NAME: _____ CITY: _____

PHARMACY CROSS-ROADS: _____ AND _____

EMERGENCY CONTACT

NAME: _____ PHONE# (_____)_____RELATIONSHIP_____

Can we release medical information to this person? ____ Yes ____ No

NOTICE OF HIPAA PRIVACY PRACTICE

A copy of this office Notices of Privacy Practices has been provided to me.

Signature _____ Date: _____

To whom it may we disclose your medical information (pathology, labs, instructions, or post-procedure results?)

Full name: _____ Phone # (_____)_____

Full name: _____ Phone # (_____)_____

The above information is true and accurate to the best of my knowledge. I understand that if you participate with my insurance, I am responsible for my co-payment and any unpaid balance as your patient. Insurance Prior-Authorization approval certification for office visits and / or procedures does not guarantee payment. If you do not participate with my insurance, I will be required to pay the entire visit charge ($300 first visit, and $100 each follow up visit). I understand that you accept cash, check, MasterCard, Visa, American Express, and Discover card as a form of payment.

Patient / Guardian Signature: _____ Date: _____

GULFSTREAM UROLOGY ASSOCIATES, P.A.

PATIENT NAME: _____ **DATE OF BIRTH:**_____

CURRENT MEDICATIONS WITH DOSAGES (Ask for additional paper if needed)					
#	**NAME OF MEDICATION**	**DOSAGE IN MG**	**#**	**NAME OF MEDICATION**	**DOSAGE IN MG**
1			**6**		
2			**7**		
3			**8**		
4			**9**		
5			**10**		

DRUG ALLERGIES: _____

(*You may write additional medications and drug allergies on the back of this sheet)*

Have you ever had any reaction to: **X-Ray dye?** _____ **If so what kind of reaction ?:**
Seafood? _____ _____
Iodine? _____ _____

List any serious illnesses, injuries, or disabilities you have or have had in the past:

_____
_____
_____

PAST MEDICAL HISTORY (Please check ALL that apply)					
Condition	**Self**	**Family**	**Condition**	**Self**	**Family**
Asthma			Kidney Stones		
Bedwetting			Mental / Nervous disorders		
Blood disorders			Sickle Cell Disease		
Cancer: Prostate					
Cancer: Other					
Change in Weight			Thyroid Dysfunction		
Constipation			Tuberculosis		
Diarrhea			Urinary Tract Infection		
Diabetes			Other:		
Hypertension			Other:		

GULFSTREAM UROLOGY ASSOCIATES, P.A.

PATIENT NAME: _____ **DATE OF BIRTH:**_____

PREVIOUS UROLOGIC PROCEDURES (Please indicate if you have had any of the following)				
Procedure	**Y**	**N**	**Location**	**Date**
Kidney X-ray (IVP, CT, U/S)				
Cystoscopic Exam				

UROLOGICAL HISTORY (Please answer Yes or No)			
1	Do you urinate frequently?	**YES**	**NO**
2	How many times a day?		
3	Do you awaken at night to urinate?	**YES**	**NO**
4	How many times a night?		
5	Do you experience pain or burning with urination?	**YES**	**NO**
6	Do you have blood in your urine?	**YES**	**NO**
7	Do you have a weak urinary stream?	**YES**	**NO**
8	Do you strain to urinate?	**YES**	**NO**
9	Have you had bladder or kidney infection?	**YES**	**NO**
10	Do you get sudden urges to urinate?	**YES**	**NO**
11	Do you leak urine at any time?	**YES**	**NO**
12	What causes you to leak?	**YES**	**NO**
	WOMEN		
1	How many children have you had?	**YES**	**NO**
2	How many times have you been pregnant?		
3	Do you have pain with intercourse?	**YES**	**NO**
4	Do you still menstruate?	**YES**	**NO**
5	If so last menstrual date?		
6	If no, are you on Estrogen replacement?	**YES**	**NO**
	MEN		
1	How many children do you have?		
2	Have you had a Vasectomy?	**YES**	**NO**
3	Do you have difficulty with erections?	**YES**	**NO**

GULFSTREAM UROLOGY ASSOCIATES, P.A.

PATIENT NAME: _____ **DATE OF BIRTH:**_____

PAST SURGICAL HISTORY (List of all Surgeries/Procedures and the year)		
Procedure	**Location**	**Date**

SOCIAL HISTORY (Check all that apply)		
☐ **Current Smoker** How often do you smoke? ☐ Everyday ☐ Some days How many cigarettes a day? ☐ 5 or less ☐ 6 to 10 ☐ 11 to 20 ☐ 21 to 30 ☐ 31 or more	☐ **Former Smoker** How long has it been since you quit? ☐ < 1month ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 to 12 months☐ 1 to 5 years ☐ 5 to 10 years ☐ > 10 years	☐ **Non-Smoker**
Do you drink Alcohol? ☐ YES ☐ NO ☐ SOCIALLY ☐ DAILY		

PHYSICIAN NOTES:

_____
_____
_____
_____

GULFSTREAM UROLOGY ASSOCIATES, P.A.

PATIENT NAME: _____ **DATE OF BIRTH:**_____

REVIEW OF SYSTEMS Do you now or have you ever had any problems related to the following systems? (circle Yes or No)					
CONSTITUTIONAL SYMPTOMS			**INTEGUMENTARY**		
Fever	**YES**	**NO**	Skin Rash	**YES**	**NO**
Chills	**YES**	**NO**	Boils	**YES**	**NO**
Headache	**YES**	**NO**	Persistent Itch	**YES**	**NO**
Other	**YES**	**NO**	Other	**YES**	**NO**
EYES			**MUSCULOSKELETAL**		
Blurred vision	**YES**	**NO**	Joint Pain	**YES**	**NO**
Double vision	**YES**	**NO**	Neck Pain	**YES**	**NO**
Pain	**YES**	**NO**	Back Pain	**YES**	**NO**
Other	**YES**	**NO**			
ALLERGIC/IMMUNOLOGIC			**EAR/NOSE/THROAT/MOUTH**		
Hay Fever	**YES**	**NO**	Ear Infection	**YES**	**NO**
Drug Allergies	**YES**	**NO**	Sore Throat	**YES**	**NO**
Other	**YES**	**NO**	Sinus Problems	**YES**	**NO**
			Other	**YES**	**NO**
NEUROLOGICAL			**GENITOURINARY**		
Tremors	**YES**	**NO**	Urine Retention	**YES**	**NO**
Dizzy Spells	**YES**	**NO**	Painful Urination	**YES**	**NO**
Numbness/Tingling	**YES**	**NO**	Urinary Frequency	**YES**	**NO**
Other	**YES**	**NO**			
ENDOCRINE			**RESPIRATORY**		
Excessive Thirst	**YES**	**NO**	Wheezing	**YES**	**NO**
Too Hot/Cold	**YES**	**NO**	Frequent Cough	**YES**	**NO**
Tired/Sluggish	**YES**	**NO**	Shortness of Breath	**YES**	**NO**
Other	**YES**	**NO**	Other	**YES**	**NO**
GASTROINTESTINAL			**HEMATOLOGICAL/LYMPHATIC**		
Abdominal Pain	**YES**	**NO**	Swollen Glands	**YES**	**NO**
Nausea/Vomiting	**YES**	**NO**	Blood Clotting Problems	**YES**	**NO**
Indigestion/Heartburn	**YES**	**NO**	Other	**YES**	**NO**
Other	**YES**	**NO**			
CARDIOVASCULAR					
Chest Pain	**YES**	**NO**			
Varicose Veins	**YES**	**NO**			
High Blood Pressure	**YES**	**NO**			
Other	**YES**	**NO**			

PHYSICAN USE ONLY: Comments/Notes:

_____

_____

_____

GULFSTREAM UROLOGY ASSOCIATES, P.A.

PATIENT NAME: _____ **DATE OF BIRTH:**_____

INCONTINENCE QUESTIONAIRE				
Do you experience any urinary incontinence?			**YES**	**NO**
Please circle the number that best describes what you are feeling. Use the following as your guide. **(0) Not at all** **(1) Slightly** **(2) Moderately** **(3) Greatly**				
Do you experience, and if so, how much are you bothered by:				
Frequent urination?	**0**	**1**	**2**	**3**
Urine leakage related to the feeling of urgency?	**0**	**1**	**2**	**3**
Urine leakage related to physical activity, coughing, or sneezing?	**0**	**1**	**2**	**3**
Small amounts of urine leakage?	**0**	**1**	**2**	**3**
Difficulty emptying your bladder?	**0**	**1**	**2**	**3**
Pain or discomfort in the lower abdomen or genital area?	**0**	**1**	**2**	**3**

FOR PHYSICIAN ONLY	
Timed Voiding	
Double Voiding	
Conservative Fluid Management	
Kegel Exercise Program	
Anti-cholinergic or Other Medical Therapy	
Urodynamic Evaluation Discussed	
Surgical Intervention Discussed	

PHYSCIAN SIGNATURE: _____ **DATE:**_____

GULFSTREAM UROLOGY ASSOCIATES, P.A.

FINANCIAL POLICIES & INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:**_____

This form is provided to help you understand the facility's policies regarding insurance filing and your financial responsibility to Gulfstream Urology Associates, P.A. The facility's services are provided directly to you and not your insurance company. Therefore, you are ultimately responsible for payment of the services rendered. **Please read and initial the following statements.**

_____ It is YOUR responsibility to know your insurance benefits. While our staff attempts to obtain your insurance benefits prior to your visit, the information we receive from your insurance company is NOT a guarantee of payment. If you question your insurance coverage for your service, please contact your insurance provider directly.

_____ It is YOUR responsibility to notify us of your correct and updated Primary and Secondary insurance information. Any coordination of benefits must be communicated directly to your insurance provider.

_____ Any financial responsibility quoted prior to the visit is an ESTIMATE. This amount is based on the information provided by your insurance portal. You will be billed if the amount collected is less than the amount your insurance company applies to your copay, co-insurance or deductible. ALL ESTIMATED amounts are due at the times of service.

_____ You may receive a separate bill if you have a procedure. Any payments made at the surgery center does not include the physician fees. Physician fee ESTIMATE will be collected no later than 1 day prior to surgery.

_____ As a courtesy we will bill your insurance. However, if the claim is not paid within 45 days, you will be billed for any balance and YOU will need to follow-up with your insurance provider.

_____ If we do not participate with your insurance, the physician fee will need to be paid in full at the time of service. A claim will be filed once on your behalf so that you may be reimbursed. All efforts will be made to collect account balances. Accounts unpaid after 3 bills or 90 days may be turned over to a collection agency. A collection charge may be added to any outstanding balance and will be your responsibility.

_____ A charge of $35 will be applied to your account if a check is returned for non-sufficient funds.

_____ Dr. Ball is affiliated with St. Lucie Surgery Center and North County Surgery Center.

_____ I understand that if I am unable to keep my appointment that I need to contact Dr. Ball's office to cancel twenty-four (24) hours in advance. I agree to pay **$50** for **no-show to a follow-up appointment** or **$100** for **no-show to any in office procedure appointment**.

_____ I request that payment of authorized Medicare and/or Commercial Insurance benefits be made on my behalf to Gulfstream Urology Associates, P.A. for any services furnished to me by the physician. I also authorize Gulfstream Urology Associates, P.A.to release to my insurance provider information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims benefits.

Patient Signature:_____ Date:_____

GULFSTREAM UROLOGY ASSOCIATES, P.A.

PATIENT NAME: _____ **DATE OF BIRTH:**_____

(Please read and initial each of the following)

Authorization for Treatment

_____ I hereby authorize Dr. Adam J. Ball, or a physician designated by him, or whomever he may designate as assistant to render medical care to me. I consent to care and treatment that may encompass laboratory, diagnosis, or medical treatment that Dr. Ball, his assistant, or a covering physician may deem necessary for my health and well-being.

Receipt of Notice of Gulfstream Urology Associates, P.A. Financial Policies

_____ I hereby acknowledge receipt of Gulfstream Urology Associates, P.A.'s Financial Policies. The "Notice" provides detailed information about how the practice processes your account. I understand that the practice has reserved the right to change its policies and procedures that are described in the "Notice". I also understand that a copy of any future revisions will be provided to me or made available.

Financial Disclosure

_____ Government regulations require that all patients having services provided must be notified prior to the service, the financial relationship between the referring provider and the treatment facility or modality. Adam J. Ball, MD, FACS is a physician investor and/or has financial interest in several companies and products. They are listed below for your convenience.

- **Theralogix, LLC**
- **United Medical Systems (UMS)**

_____ Please be advised: Any specimen taken during a biopsy, cystoscopy and urine sample done in our office are sent to an outside lab or pathology for processing. You may receive a bill after your insurance has processed their claim. Dr. Ball reserves the right to refer your specimen to a lab and or pathology company of his choosing. We are not responsible for any charges incurred for this processing. We are not responsible for knowledge of network and non-network benefits of your pathology. These companies include: Oncotype, Cx-Bladder, Informed Diagnostics, Realtox Diagnostics, MDX, ExoDx, Lyndx, Prolaris, Decipher, Diacarta and Quest Diagnostics.

Your signature below will also confirm that you have read and understand the above authorization for treatment, receipt notice and financial disclosure.

Patient Signature:_____ Date:_____

GULFSTREAM UROLOGY ASSOCIATES, PA

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at GULFSTREAM UROLOGY ASSOCIATES, PA, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis will not involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with GULFSTREAM UROLOGY ASSOCIATES, PA to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

_____

Signature of Patient

_____

Printed Name of Patient

_____

Date

GULFSTREAM UROLOGY ASSOCIATES, PA

PELVIC EXAMINATIONS CONSENT FORM

The 2022 Florida Statutes (including Special Session A)
Title XXXII
REGULATION OF PROFESSIONS AND OCCUPATIONS
Chapter 456
HEALTH PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS
456.51 Consent for pelvic examinations.—

Patient Name: _____

Date of Birth: _____

- **CONSENT:** I, the above listed Patient or as the legally authorized person for the Patient, hereby consent to receiving pelvic examinations being performed by my physician or other health care practitioner, any medical student or any student receiving training as a health care practitioner.

- **NATURE OF PELVIC EXAMINATIONS:** For the purposes of this Consent Form, a "pelvic examination" means the series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, external pelvic tissue, or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

- **VALIDITY OF CONSENT:** The Patient, or the Patient's legally authorized person, acknowledges that this consent will remain valid from the date the Patient, or the Patient's legally authorized person, dated this Consent Form below, unless otherwise revoked in writing by the Patient, or the Patient's legal authorized person.

I CONSENT TO RECEIVE PELVIC EXAMINATIONS AS DESCRIBED ABOVE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____
Patient's Signature Date

_____ _____
Legally Authorized Person Signature Relationship to Patient

_____ _____
Legally Authorized Person Printed Name Date

_____

Witness Signature

Witness Printed Name

Date

GULFSTREAM UROLOGY ASSOCIATES, PA

Please DO NOT use Patient Portal to communicate with your Practice for urgent or emergency medical issues. If you are experiencing an urgent medical need, please contact us by phone. For emergencies call 911

Patient Portal User Agreement and Consent Effective: October 9, 2015

The Patient Portal (defined below) is owned and operated by the practice to which you are seeking to online access (the "Practice"). The Practice has adopted this user agreement ("User Agreement" or "Agreement") to make you aware of the terms and conditions of your use of the Patient Portal and any derivative websites of the Patient Portal (collectively, the "Patient Portal"). In the event that you purport to be the agent of, represent, or otherwise act on behalf of any other person, references to "you," "your" or "User" shall include such entity or person in addition to such representative, and your acceptance of this Agreement shall constitute acceptance on behalf of such person.

The Practice uses reasonable efforts to maintain the Patient Portal, but the Practice is not responsible for any defects or failures associated with the Patient Portal, any part thereof or any damages (such as lost profits or other consequential damages) that may result from any such defects or failures. The Patient Portal may be inaccessible or inoperable for any reason, including, without limitation: (a) equipment malfunctions, (b) periodic maintenance procedures or repairs which the Practice may undertake from time to time or (c) causes beyond the control of the Practice or which are not foreseeable by the Practice. In addition, the Practice makes no guarantees as to the web sites and information located worldwide throughout the Internet that you may access as a result of your use of the Patient Portal, including as to the accuracy, content, or quality of any such sites and information or the privacy practices of any such site. The Practice is not a backup service for storing data you submit to the Patient Portal, and the Practice shall have no liability regarding any loss of such data. You are solely responsible for creating backups of any data you submit using the Patient Portal

The Patient Portal is a secure website that allows you to use a computer to interact with medical information via the internet. The Patient Portal also allows you to communicate with the Practice via secure messaging. Please note that all communication via the Patient Portal will be included in your permanent patient record.

Responsibilities, Risks and Benefits:

The Patient Portal is provided as a convenience to you at no cost and is only available in English at this time. We do not sell or give away any private information, including email addresses. We reserve the right to suspend or terminate the Patient Portal access at any time and for any reason. All messages sent to you will be electronically secure. Messages and emails from you to any staff member must be sent through the Patient Portal for security and confidentiality reasons. The Patient Portal messages will be handled by our staff in a manner similar to how phone communication is handled. Although we strive to reply to Patient Portal messages within one business day, we cannot guarantee that we will be able to address your messages in that timeframe. We encourage you to use the Patient Portal at any time but understand that we can only reply to messages during our office hours, excluding holidays recognized by the Practice. If

you do not receive a response within two business days, please feel free to call our office. You are responsible to provide us with your correct email address and inform us immediately of any change. You are also responsible for the protection of your login information and password. Please understand that all electronic communications carry some degree of risk, even in a secured environment. Even with all due precautions, online communications may be intercepted, forwarded or changed without a patient's or the healthcare provider's knowledge. By using or accessing the Patient Portal, you expressly accept these risks. Note that it is easier for a patient's identity to be stolen or for someone to try to impersonate a patient via online communication. Online communications are admissible as evidence in court just as medical records are in the event the physician-patient privilege is waived or if a court orders disclosure. Online communications may disrupt or damage a computer if a computer virus is transmitted via an attached file, hyperlink or other method. You assume liability for such disruptions or damages caused by such transmissions. Responses to online communications are limited by the information provided and your question may necessitate a follow-up phone call or a request to meet with you in person to gain further information. Electronic communications will be viewed by not only the physician, but the staff members assigned to handle such communications and any other provider covering for the patient's physician if the patient's physician is unavailable to respond. Applicable law may allow a health care professional to determine that a minor patient is "mature" to keep a portion of the

minor's medical information confidential. If the minor patient is determined "mature" by his or her physician, all Patient Portal communication will be with the minor directly and a new consent form with the minor's email address will be required. Applicable law may also permit confidential communication with a minor patient in regards to treatment and reporting of sexually transmitted diseases to the minor and communications with pregnant minors in regards to questions about the health of her fetus. In these

situations, all Patient Portal communications will be directly with the minor and a new consent form with the minor's email address will be required. The Practice will keep a copy of all medically important online communications in your medical record secure pursuant to applicable federal and state laws and regulations. Print or store in a secure place (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you. The Practice will not forward online communications with you to third parties except as authorized or required by law.

Please note that online communications should never be used for emergency communications or urgent requests. These should occur via telephone or using existing emergency communications tools as noted above. Follow-up is solely your responsibility. You are responsible for scheduling any necessary appointments and for determining if an online communication did not receive a response. You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. The Practice is not responsible for breaches of confidentiality caused by you or an independent third-party.

Guidelines for Safe Online Communications:

Take steps to keep your online communications to and from the Practice confidential, including:
Do not store messages on your employer-provided devices (e.g. computer, cell phone, tablet, etc.); otherwise personal information could be accessible or owned by your employer. Use a screen saver or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private. Do not allow other individuals or third parties access to the devices(s) upon which you store medical communications. Keep your login and password information secure and confidential. Do not use email for medical communications. Standard email lacks the necessary security and privacy features and may expose medical communications to employers or other unintended third-parties.

Access to Online Communications:

The following pertains to access to and use of online communications:

Online communications do not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement. The Practice may stop providing online communications with you or change the services provided online at any time without prior notification to you.

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All of my questions have been answered and I understand and concur with the information

Print Patient Name: _____ Date of Birth _____

Email address: _____

Signature: _____

Date: _____

I am over the age of 18 and have sole responsibility of my medical care

□ Yes
□ No

(We do not offer the Patient Portal to minors or those patients which do not make their own medical decisions at this time. We apologize for the inconvenience.)

I choose not to participate in Patient Portal at this time because:

□ I do not have an E-mail address
□ I do not wish to share my E-mail address
□ English is not my preferred language
□ Other