



ACKERMAN UROLOGY

Men's Health & Vitality

Patient Information

Last Name: _____ First Name: _____ MI: _____

DOB: _____ SSN: _____ Gender: _____

Home Phone: _____ Mobile Phone: _____

Preferred Phone: Home Mobile Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Occupation: _____ Part-Time Full-Time Retired

Employer: _____

If patient is not the policyholder, please provide their Social Security Number and Date of Birth for billing purposes.

Name: _____ DOB: _____ SSN: _____

Signature: _____

How did you find us? Check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Family/ Friend | <input type="checkbox"/> Print | <input type="checkbox"/> Billboard |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Radio | <input type="checkbox"/> Community Event |
| <input type="checkbox"/> Online Search | <input type="checkbox"/> Television | <input type="checkbox"/> Drive-By |
| <input type="checkbox"/> None Apply | <input type="checkbox"/> Insurance Company | Other: _____ |

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- Not Hispanic or Latino
- Hispanic or Latino
- Decline Response

Race:

- American-Indian or Alaska Native
- Black or African American
- Native Hawaiian or Pacific Islander
- White

- Asian
- Other
- Decline Response

Preferred Language: _____

Decline Response

Cancers and Blood Disorders:

Anemia	Colon Cancer	Malignant Melanoma	Uterine Cancer
Bladder Cancer	Kidney Cancer	Ovarian Cancer	Blood clots legs or lungs
Breast Cancer	Leukemia/Lymphoma	Prostate Cancer	Skin Cancer (_____)
Cervical Cancer	Lung Cancer	Testicular Cancer	HIV/AIDS
Other Cancers or Blood Disorders: _____			

Cardiovascular:

Atrial fibrillation	Coronary artery disease	Heart murmur	Peripheral vascular disease
Congestive heart failure	Heart attack	High blood pressure	Other: _____

Pulmonary:

Asthma	Emphysema	Pulmonary edema	Sleep Apnea
COPD	Pneumothorax	Pulmonary embolism	Other: _____

Endocrine:

Diabetes	Gout	Low Testosterone	Osteoporosis
Glaucoma	Hypothyroidism	Menopause	Other: _____

Gastrointestinal:

Colon Polyp	Diverticulitis	Hepatitis _____	Stomach Ulcer
Crohn's disease	GERD	Pancreatitis	Other: _____

Neurological:

Alzheimer's	Depression	Neuropathy _____	Seizures
Anxiety	Fibromyalgia	Parkinson's	Stroke
Dementia	Multiple Sclerosis	Schizophrenia	TIA
Other: _____			

Surgical History: *(Please list dates if possible)*

General:

Appendix (Appendectomy)	Breast Biopsy R / L	Gallbladder (Cholecystectomy)	Mastectomy R / L
Breast Augmentation	Colon _____	Hernia _____	Tonsils (Tonsillectomy)

Urology:

Bladder Surgery	Prostate Surgery
Kidney Stone Surgery	Urethral Surgery
Kidney Surgery	Vasectomy

Female:

C-Section	Rectocele repair
Cystocele repair	Tubal ligation
Hysterectomy	Urethral sling

Cardiopulmonary:

Heart stents
Heart valve surgery
Lung surgery
Open heart surgery
Pacemaker

Other Surgeries:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Exams & Vaccines:

Type	Approximate Date
Physical Exam	
Colonoscopy	
Mammogram	
Pap Smear	
Flu Vaccine	

Type	Approximate Date
HPV Vaccine	
Pneumonia Vaccine	
Shingles Vaccine	
COVID-19 Vaccine	
Other:	

Chief Complaint

What is the main reason for your visit today? (Describe your problem in detail)

Medications: *(Name and Strength)*

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Smoking Status: Never Current Everyday Smoker Some Days Former
Alcohol Use: None Social Occasional Light Heavy

**The CDC notes that for men, heavy drinking is typically defined as consuming 15 drinks or more per week. For Women, heavy drinking is typically defined as consuming 8 drinks or more per week.*

Family History:

Kidney cancer: _____ Prostate cancer: _____
 Bladder cancer: _____ Other: _____

Allergies:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Primary Care Provider (PCP): _____ PCP Phone: _____

Preferred Pharmacy: _____

Preferred Pharmacy Address: _____

Preferred Pharmacy Phone: _____ Referring Provider: _____

Have you been to the hospital or the emergency room in the last 6 months? Yes No

If yes, what hospital did you go to? _____

Please list ALL active treating physicians (i.e. Pulmonologist, Oncologist, Internist, Cardiologist, etc.)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____



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MEDICAL RECORD RELEASE

(Full Disclosure of Health Information for Treatment and Quality of Care)

Please read the entire form, both pages, before signing below

Patient (name and information of person whose health information is being disclosed):

Name: _____ DOB: _____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: All my health information including any information about sensitive conditions (if any)
[See page 8 for details]

FROM WHOM: All information sources [See page 8 for details]

TO WHOM: Ackerman Urology Phone: 904-490-7400
10232 San Jose Blvd. Fax: 904-490-7401
Jacksonville, FL 32257

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons. [See page 8 for details]
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

Print Name of Patient or Patient Legal Representative: _____

Signature of Patient or Patient Legal Representative: _____

Personal Representative (explain: _____)

Date Signed: _____

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.



Patient Name: _____

DOB: _____

Financial Responsibility Form

We are committed to providing our patients with the highest quality care. Please read and sign this form to acknowledge your understanding of our patient financial policies. This form is effective for the lifetime of the patient or until permission is withdrawn via written notice to Ackerman Cancer Center or Ackerman Urology.

I hereby authorize Ackerman Cancer Center and its associate healthcare entities to release any information necessary to insurance carriers regarding my health and treatments and process insurance claims generated in the course of examination or treatment on my behalf.

I hereby authorize assignment of financial benefits directly to Ackerman Cancer Center and its associate healthcare entities for medical services. I understand that if my insurance carrier denies or does not cover my claim for medical services provided to me, I acknowledge that I assume full financial responsibility for these services, given that I was notified of this prior to the services being rendered. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage. I understand that co-payments are due at time of service.

I understand that any services connected to an elective Total Body MRI scan is not covered by insurance and I assume full financial responsibility for these services.

I have read and understand this Financial Responsibility Form described above. I agree to pay on time and in full amounts due to Ackerman Cancer Center and/or Ackerman Urology for all items and services.

Patient/Representative Signature

Date

Representative Name if Applicable (*please print*)

Relationship to Patient



Patient Name: _____

DOB: _____

Consents

General Consent to Treatment and Right to Refuse Treatment

General Consent to Treatment

Having come to Ackerman Urology, for evaluation or treatment, I (or my authorized representative on my behalf) hereby consent to and authorize Drs. Robert G. Busch and Eric A. Ordinario, and other staff members involved in my care to administer such diagnostic procedures, treatment or both as they may consider advisable to maintain my health and to assess and to evaluate and treat my injury or illness. I understand that the provider responsible for my care has the responsibility to explain to me the purpose, the benefits and the most common risks involved in the diagnosis and treatment of my illness or injury, as well as alternative available courses of treatment, and I understand that I have the right to refuse any suggested examination, test or treatment.

Right to Refuse Treatment

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

I have read the consent form or it has been read to me and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Patient/Representative Name (Print): _____

Patient/Representative Signature: _____

Date: _____

Photography Consent

I consent that photographs, videotapes or other types of media to preserve images and/or sounds may be taken of me or parts of my body, under the following conditions:

1. May be taken only with the consent of my physician.
2. May be taken by my physician or by a competent photographer, approved by my physician.
3. Photographs shall be used for medical records only, unless in the judgement of my physician, medical research, education or science will be benefited by their use.

I hereby relinquish any property rights in any photographs, videotapes and/or images and sounds taken and/or published.

Patient/Representative Name (Print): _____

Patient/Representative Signature: _____

Date: _____



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Patient Name: _____

DOB: _____

Please initial next to each statement. Your initial indicates you give consent and acknowledge to having read the following:

Notice of Privacy Practices: HIPAA

I have reviewed the Notice of Privacy Practices from Ackerman Cancer Center.

As stated in the Ackerman Cancer Center Notice of Privacy Practices: We may disclose your health information to a member of your family, a relative, a close friend or any other person that you identify.

Print below, the people/persons that you give authorization to disclose your health information to.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have read and agree to Notice of Privacy Practices.

Patient/Representative Name (Print): _____

Date: _____

Patient/Representative Signature: _____



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EXPLANATION OF FORM FLORIDA

AHCA FC4200-004

"Universal Medical Record Release for Full Disclosure of Health Information for Treatment and Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

OF WHAT: Includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. All records and other information regarding your health history, treatment, hospitalization, tests and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:
 - a. Drug, alcohol, or substance abuse
 - b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes psychotherapy notes as defined in HIPAA at 45 CFR 164.501)
 - c. Sickle cell anemia
 - d. Birth control and family planning
 - e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
 - f. Genetic (inherited) diseases or tests
2. Copies of educational tests or evaluations, including individualized educational programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.
3. Information created before or after the date of this form.

FROM WHOM: Includes: All information sources including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

PURPOSE: Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

REVOCAION: You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

RE-DISCLOSURE INFORMATION: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful redisclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

LIMITATIONS OF THIS FORM: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your healthcare provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.