PATIENT INFORMATION

NAME: M ☐ F ☐ DOB:

ADDRESS:

IS ARIZONA YOUR PERMANENT RESIDENCE: YES / NO

ALT ADDRESS:

SOCIAL SECURITY: MARITAL STATUS:

CONTACT

HOME:

CELL:

WORK:

OTHER:

PREFERRED METHOD OF CONTACT

OK TO LEAVE MESSAGE? YES / NO

☐ HOME ☐ CELL ☐ WORK ☐ OTHER ☐ EMAIL

EMAIL:

ARE YOU CURRENTLY WORKING? YES / NO DISABLED? YES / NO RETIRED? YES / NO

CURRENT/FORMER OCCUPATION or EMPLOYER:

RESPONSIBLE PARTY

OTHER THAN PATIENT

NAME: RELATIONSHIP: PHONE:

ADDRESS:

PRIMARY CARE PHYSICIAN: PHONE:

REFERRING PHYSICIAN: PHONE:

INSURANCE INFORMATION

PRIMARY INSURANCE: PHONE:

INSURED NAME: DOB:

GROUP # POLICY #

SECONDARY INSURANCE: PHONE:

INSURED NAME: DOB:

GROUP # POLICY #

PATIENT SIGNATURE/RESPONSIBLE PARTY: DATE:

1495 W. Chandler Blvd,
Suite B-8, Chandler, AZ 85224

Phone: 480 899 1696
Fax: 480 963 6227

Uhaaz.com

Advance Directive
NOTIFICATION

Print name _____ Signature _____

☐ I have a health care power of attorney ☐ I have an advance directive

I have talked with my family and my doctor about the care I want. If I am unable to speak for myself, please contact:

Name _____ Number _____

(Additional names on back)

Name _____ Number _____

Name _____ Number _____

Name _____ Number _____

Your life. Your terms.

Anthony J. Dyer, MD
Shaw Mahre, PA-C

Consent to Release Protected Health Information
Contact List

Patient Name: _____ DOB: _____ Date: _____

Initials ☐	I authorize Ironwood Physicians, PC to use/disclose my personal health information *to* the individuals listed on this form.		
Initials ☐	I understand that Ironwood Physicians, PC staff may leave detailed messages on my voicemail.		
1. Contact Name: *(Emergency Contact)*			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐ Spouse	☐ Family (Describe) _____	☐ Friend	☐ Other (Describe) _____
2. Contact Name:			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐ Spouse	☐ Family (Describe) _____	☐ Friend	☐ Other (Describe) _____
3. Contact Name:			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐ Spouse	☐ Family (Describe) _____	☐ Friend	☐ Other (Describe) _____

I hereby authorize Ironwood Physicians, PC to use and disclose my personal health information *to* the individuals identified on this form. I understand this authorization does not expire unless written notice is mailed to *P.O.* Box 6423 Chandler AZ, 85245.

I understand *this* may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, and/or drug abuse treatment, and genetic testing information, if any records exist.

I understand that the individuals identified on this form will be treated by Ironwood Physicians PC as individuals involved directly in my care and as *such,* Ironwood Physicians, PC will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations.

I understand that I have a right to request and receive a Notice of Privacy Practices from Ironwood Physicians, PC.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original, I voluntarily sign this authorization, and I understand that my ability to obtain health care from Ironwood Physicians PC will not be affected if I refuse to sign this authorization.

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Date: _____

Relationship to Patient: _____

FINANCIAL POLICY/ASSIGNMENT OF BENEFITS FOR PATIENTS

- I understand that I have medical insurance which when billed on my behalf should pay for their portion of my office visits and treatment charges. _____ initials

- I will inform Ironwood Physicians, PC or Ironwood Cancer and Research Centers of a change in my insurance coverage. _____initials

- I understand the billing process may take 4-6 weeks at which time my insurance company will determine and pay for services per my contract. _____ initials

- I understand that it is my responsibility to pay all co-pay, deductible and estimated co-insurance amounts at the time of service rendered and remaining balance as determined by my insurance company. _____ initials

- I understand that I will leave my credit card information to be kept on file and that if I do not pay within 60 days after my insurance has paid, I acknowledge that Ironwood Physicians, PC and Ironwood Cancer and Research Centers will charge the balance to the credit card on file. _____ initials

- I understand that if for any reason my insurance company does not pay for the covered services within 90 days of the services provided, I shall assume responsibility for the total amount owed, which may be charged to the credit card on file. _____ initials

- I thereby assign all medical benefits directly to Ironwood Physicians, PC and Ironwood Cancer and Research Centers for services rendered at their facilities. _____ initials

- I understand if a CT or PET/CT scan is completed it will be necessary for a licensed Radiologist to interpret or read your scan results. You will be receiving two statements for your CT or PET/CT scan for their professional interpretation of the CT or PET/CT scan separate of Ironwood. _____ initials

- We may request proof of insurance premium payment. _____ initials

- I have read and received a copy, if desired, of this document. _____ initials

Patient Printed Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Urologic Health
Associates

1455 W. Chandler Blvd,
Suite B-8, Chandler, AZ 85224

Phone: 480 899 1696
Fax: 480 963 6227

Uhaaz.com

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Ironwood Physicians may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at PO Box 6423, Chandler, AZ 85246

With your consent, Ironwood Physicians may mail to your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent, Ironwood Physicians may mail to your home or office any items that assist the practice in carrying out any TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your Pill to carry out treatment, payment and healthcare operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound to our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment payment and healthcare operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

Patient Name:

_____

Signature of Patient or Legal Guardian _____

Print Legal Guardian Name (If applicable)

_____

Date: _____

Authorization to Release Protected Health Information (PHI)

To: Urologic Health Associates

Fax: (480) 963-6227

For the purpose of continuing patient care

Patient Name _____ Date of Birth ____/____/_____

Address _____

City, State, Zip Code _____

Day time Telephone Number _____

I hereby authorize the hospital or medical facility in receipt of this form to disclose the following Protected Health Information pertaining to the above referenced patient to:

Urologic Health Associates

☐ Please release all pertinent records from the dates of _____ to _____

OR

☐ Please release the following Information:

_____

_____

I understand that this authorization covers records relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), Human Immunodeficiency Virus ("HIV"), behavioral, and/or mental health, alcohol and/or drug abuse treatment genetic testing, if any such records exist.

I understand that at any time I have the right to revoke on this authorization to release medical records, except if the recipient has already taken action on this authorization. I understand that in order to revoke this authorization I must do so in writing, and send my revocation to the recipient. I also understand that the revocation only applies to records that have not been released in response to the authorization.

I understand that, once this information has been disclosed to a third party, that the information may not be protected by Federal Privacy Regulations and may be re-disclosed by the third party or entity that has the received this Information. I also understand that Urologic Health Associates will not re-disclose my protected health information without my written consent.

I understand that this authorization does; and will expire one (1) year from the date of signing unless an earlier date Is specified in writing.

_____
Expiration Date

_____ _____
Signature Date

_____ _____
Print Name Relationship to Patient (if not patient)

Urologic Health Associates

Code of Conduct for Patients and Visitors

In an effort to provide a safe and healthy environment for staff and patients, Ironwood Physicians PC expects patients, parents and accompanying family and friends to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are prohibited and may result in your immediate dismissal from the practice:

- Physical assault or threatening to inflict bodily harm.
- Rude behaviors in person or through written, verbal or electronic communication, including but not limited to the following: Profanity, harassment, offensive or intimidating statements or gestures and threats of violence.
- Racial or cultural slurs or other derogatory remarks associated with race, language, or sexual orientation.
- Requests that would constitute illegal or unethical behavior on the part of Ironwood.
- Possessing firearms or any weapon
- Making verbal threats to harm another individual or destroy property

As a patient visiting our practice, please consider the following:

- If you have any questions about the care or are unhappy with the service received in our office, please contact our practice manager before you leave our office so that any clarifications about your care or the services you received can be addressed.
- Please communicate all issues that you wish to discuss with the doctor at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all patients the time and quality of care they deserve.
- Questions about your billing can be addressed with our patient accounts team @ 480-245-6285.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

I agree to the Ironwood Physicians "Code of Conduct for Patients and Visitors"

_____ _____

Patient's Name Date of Birth

_____ _____

Caregiver's Name/Relationship to patient Date

Urologic Health Associates

FIRST NAME: _____ **LAST NAME:** _____ **DOB:** _____

POA/LEGAL SIGNER (if not patient): _____ **PHONE:** _____

REFERRED BY: _____ **PRIMARY CARE DOCTOR:** _____

PHARMACY: (Name, Address/Phone) _____

ALLERGIES: ☐ None ☐ PCN ☐ Sulfa ☐ Cipro ☐ Iodine/Contrast ☐ Other: _____

MEDICAL HISTORY: Height: _____ Weight: _____

Influenza Vaccine Date: _____ Pneumonia Vaccine Date: _____

Colonoscopy/Cologuard Date: _____ Last Period: _____ ☐ Pregnant ☐ Menopause

☐ Diabetes (Onset Date: _____) ☐ Emphysema ☐ Hernia ☐ Hepatitis ☐ Hypertension
☐ Cancer (List Type): _____) ☐ Parkinson's ☐ Stroke ☐ Heart Attack ☐ Heart Murmur
☐ Other: _____

MY MAIN PROBLEMS/SYMPTOMS: _____

Is condition result of Work or Auto Accident? ☐ No ☐ Yes (please notify receptionist)

MEDICATIONS: ☐ None _____

_____

_____

FAMILY HISTORY: ☐ Bladder Cancer ☐ Prostate Cancer ☐ Kidney Stones ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Other Cancer ☐ Unknown

Family Members: ☐ Mother ☐ Father ☐ Grandmother: (☐ Maternal / ☐ Paternal) ☐ Grandfather:(☐ Maternal / ☐ Paternal)

SOCIAL HISTORY: ☐ Retired Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Tobacco Use: ☐ None ☐ Smoking ☐ Other Tobacco

SURGICAL HISTORY: ☐ None ☐ Hysterectomy ☐ Childbirth: C-Section # _____ Vaginal Delivery # _____

☐ Cystoscopy ☐ Kidney Stone Surgery ☐ Prostate Surgery ☐ Bladder Tack ☐ Bladder Tack
☐ Appendectomy ☐ Back/Hip/Knee ☐ Gallbladder ☐ Heart Bypass ☐ Sling (TVT)
☐ Other: _____

SYSTEMS REVIEW:

General/Constitutional	☐ Fever	☐ Weight Loss	☐ Chills
Eyes	☐ Blurry Vision	☐ Double Vision	☐ Cataracts
Ears, Nose, Mouth, Throat	☐ Hearing Loss	☐ Nasal Stuffiness	☐ Sore Throat
Cardiovascular	☐ Chest Pains	☐ Swollen Ankles	☐ Irregular Heartbeat
Respiratory	☐ Wheezing	☐ Chronic Cough	☐ Shortness of Breath
Gastrointestinal	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels
Genitourinary	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine
Musculoskeletal	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles
Integumentary/Skin	☐ Rash	☐ Persistent Itching	☐ Skin Cancer History
Neurologic	☐ Numbness	☐ Tingling	☐ Dizziness
Hematologic/Lymphatic	☐ Swollen Glands	☐ Abnormal Bleeding	☐ Transfusion History

URINARY SYMPTOM(S):

☐ Frequency ☐ Urgency ☐ Leakage ☐ Straining ☐ Abdominal pain
☐ Bladder pain ☐ Pain in side: R / L ☐ Not emptying bladder ☐ Urinating at night (#)