PATIENT INFORMATION

Name_____ Soc. Sec#_____ Height_____

Address_____ Date of Birth_____ Age_____

City_____State_____Zip_____Gender: M____F____

Home#_____Work#_____Cell#_____

Email _____

Emergency Contact Name _____ Relationship_____ Phone_____

Race: White ☐ African American ☐ American-Indian ☐ Asian ☐ Hispanic ☐

Ethnicity: Hispanic or Latino ☐ **Not** Hispanic or Latino ☐ Employment Status _____

PHARMACY_____CITY_____PHONE#_____

Primary Doctor Name_____Phone#_____Fax#_____

PRIMARY INSURANCE

Subscriber Name_____

Relation to Patient_____Birthdate_____

Insurance company _____Subscriber ID# _____Group#_____

ADDITIONAL INSURANCE

Is patient covered by additional Insurance? _____ Yes _____No

Subscriber Name _____Relation to Patient _____Birthdate_____

Insurance company _____Subscriber ID# _____Group#_____

ASSIGNMENT AND RELEASE

I certified that, I, and/or my dependent(s), have insurance coverage with_____and

Assign directly to Dr. Al-Juburi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please print name of Patient, Parent, Guardian or Personal Representative Date

Al-Juburi Urology, PLLC

Financial Policy

Thank you for choosing us as your Healthcare provider. Please understand that payment of your bill is important for us to maintain the resources to continue providing medical treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Self -pay Payment is due at the time of service. You will be given a standard 20% discount. The same standard discount will be given to all patients regardless of their financial situation unless they can prove indigence, and then other arrangements may be made.

Insurance Information:

If we participate: We expect payment in full of any co-payments at the time of your visit. We will file the claim to your insurance company on your behalf, as a courtesy to you. You must pay any deductibles and/or co-insurances promptly upon receipt of our billing statement. Questions regarding insurance benefits and coverage should be directed to your employer or insurance company.

If a referral or pre-authorization is needed for your visit it is your responsibility to be aware of that and to obtain it prior to your visit. Remember this is your insurance policy. If you do not have a referral and/or pre-authorization you may choose to pay in full for that visit or may reschedule your visit for a future date.

If any services are deemed as "Non-covered" the bill is your responsibility. It is also your responsibility to know what your insurance does and does not cover.
****Please note that if you are being seen for erectile dysfunction many insurance companies do not cover this diagnosis. You will be responsible for payment of these services. Also for infertility some insurance require pre-authorization in addition to your referral. This again is your responsibility to acquire from your PCP prior to your appointment.****

General Information:

Your insurance policy is contract between you and your insurance company. We are not a party to that contract.
****Accounts over 90 days past due will be turned over for collections. You will be responsible for any and all collections/attorney's fees as well as interest that are incurred. ****

There will be a **charge** for all appointments which are not cancelled within 24 hours prior to the appointment. This charge will not be billed to your insurance company it is your responsibility to pay.

There is a **$25.00 fee for returned checks.

Signature of patient_____Date:_____

Appointment Policy

Our office is dedicated to providing all our patients with the most thorough and comfortable care available. We know that efficient scheduling is an important part of the office experience. We appreciate your respect for our daily schedule which allows our staff to be on time. We will always respect your time. To enable us to provide efficient care we ask for your cooperation with the following:

1) **ON TIME ARRIVAL**

Please arrive at or just before your appointment time. If you arrive too early you will have to wait for your appointment time if other patients are ahead of you.

2) **LATE ARRIVAL**

If you arrive late for your appointment we reserve the right to reschedule the appointment. Late arrivals will cause a delay in seeing patients who are on time for their appointments. If you find that your are running late we recommend you call our office to determine if we can hold your appointment for that day.

3) **RESCHEDULING**

Please contact our office 24 hours in advance to cancel or reschedule any appointment. We maintain a list of emergency patients waiting for treatment/appointments therefore if you cancel/reschedule we are able to appoint one of these patients in your time slot.

4) **BROKEN APPOINTMENTS**

If you do not notify our office within the requested time of 24 hours before our appointment time a fee of $50.00 will be added to your account.

Please fill out the information below to sign up for Email and Text Messaging communication from our office:

Your name: _____

Your email address: _____

Your cell phone: _____

Would you like to receive appointment text messages from our office? Yes / No

Patient signature: _____

Date: _____

Al-Juburi Urology, PLLC

10680 Main Street, Suite 100

Fairfax, Virginia 22030

(703) 691-4666

Date: _____

Name: _____ Date of Birth: _____

The following is confidential and will not be released to anyone without your signed consent.

Reason for today's visit: _____

How long have you had this problem: _____

Are your symptoms? Mild _____ Moderate _____ Severe _____

ALLERGIES: (Please list all medical and food allergies) _____None

1) _____ 2) _____ 3) _____4) _____ 5)_____

MEDICATIONS: (currently taking) _____None

1) _____ 2) _____ 3) _____ 4) _____ 5) _____

SURGERIES: (Please list type of surgery, place of surgery and date)

1) _____ 2) _____ 3) _____

SOCIAL HISTORY:

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Use of Alcohol: Never_____ Rarely _____ Moderate _____ Daily _____

Use of Tabaco: Never _____ Rarely _____ Moderate _____ Daily _____

FAMILY HISTORY:	**Age**	**Diseases**	**None**	**Deceased**
Father:	_____	_____	_____	_____
Mother:	_____	_____	_____	_____
Siblings:	_____	_____	_____	_____

Patient Name: _____

MEDICAL HISTORY

General: ___Chills ___Fever ___Weight Loss ___Fatigue

Head: ___ Dizziness ___Fainting

Respiratory: ____Asthma ____Shortness of Breath ___ Tuberculosis (TB) ___Cough ___Recent X-ray

Urinary: ___ Bed Wetting ___Blood in Urine ___Burning ____Incontinence ____Infections

___Urine Discoloration ____Back Pain ___ Frequent Urination ____ Kidney Problems
___Low Urine Output ___Nighttime Urination ____Passing Stones ____Urgent Urination
___Weak Stream

Cardiovascular: ___Chest Pain ___Heart Murmur ___History of Heart Attack ___Shortness of breath
___High Blood Pressure

Gastrointestinal: ___Abdominal Pain ____Heart Burn ____Rectal bleeding ____Hemorrhoids
___Laxative Use ____Constipation ___Hepatitis ____Nausea ____Vomiting ____Diarrhea
___Liver Disease ___Antacid Use ___Decrease in appetite ____Gall Bladder disease ___Rectal Pain

Muscular-Skeletal: ___ Arthritis ___Back Problems ____Muscle cramps ____Joint Pain ___Gout

Male Genital: ___Hernia ___Lesions ___Prostate Problems ____Sexual Problems ___Venereal Disease
___Blood in Ejaculate ____Decreased desire in sex ____Erectile Dysfunction ____Genital Herpes
____Infertility ____Penile Discharge ____Premature Ejaculation ___Scrotum/Testes Mass ___Testicular Pain

Psychiatric: ___Depression ___Fatigue ____Excessive Stress ___Weight Loss ___Memory Loss

Breast: ___Discharge ___Self-Esteem ___Lumps ____Tenderness ___Pain

Skin: ___ Hives ___Eczema ____Bruise easily ____Itching _____Dryness ___Increase in mole size
___Rash

Female Genitals: ___ Birth Control ____DES Exposure ____Lesions ____Menopause
____Change in menstrual period ___Pelvic Pain

Neurological: ___Headache ___Unsteady Gait ____Nervousness ____Psych Disorder
____Behavior Change ___Head Injury ___Mood Change
Endocrine: ___Thyroid Trouble ___Swollen Glands ___Excessive Urination ____Increase in thirst ___Anemia

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

---**YOU ARE ONLY REQUIRED TO FILL THIS FORM OUT IF YOU HAVE AN INDIVIDUAL PERSON THAT MAY CALL ON YOUR BEHALF, OTHERWISE THERE IS NO NEED TO FILL IT OUT--*I hereby authorize the use/disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization or person authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

I authorize Al-Juburi Urology to disclose the following information from the medical records of:

Patient name _____ Date of Birth _____

Address _____

Telephone _____

This information is to be disclosed to the following individual or entity:

Name of person/entity _____

Relationship to patient

_____

Address _____

Telephone _____

Information to be disclosed:

_____Complete health records including all images (x-rays, photographs, etc.)

_____Complete health records excluding all images

OR

Select from the following: (check all that apply)

___ Discharge summary

___Treatment for alcohol and/or drug abuse

___History and Physical Examination

___Photographs, videos or other images

___Consultation Report

___Progress Notes

___Laboratory tests

___X-ray reports

___Mental health care or services

___Psychotherapy note …continued on next page

The patient or the patient's representative must read and initial the following statements:

a) I understand that unless earlier revoked, this authorization will expire on ___/___/___ (if patient has set an expiration date.) ***IF NOT PLEASE LEAVE BLANK*** **Initials: _____**

b) I understand that I may revoke this authorization at any time by notifying Al-Juburi Urology in writing, but if I do not, it will not have any effect on any actions the said entity/person took before it received the revocation. **Initials: _____**

c) I understand that Al-Juburi Urology cannot force me to sign this authorization as a condition to receive treatment from Al-Juburi Urology except:
   (i) When/if Al-Juburi Urology provides me with research related treatment; or
   (ii) When/if Al-Juburi Urology provides me with healthcare solely for the purpose of creating protected health information for disclosure to someone else. **Initials _____**

Al-Juburi Urology, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

****FORM MUST BE INITIALED BEFORE SIGNING****

Patient signature _____ Date _____

Print name _____

Representative signature _____ Date _____

Print name _____

Relationship of representative to patient _____

Please describe the representative's authority to act on behalf of the patient:

_____

---**YOU ARE ONLY REQUIRED TO FILL THIS FORM OUT IF YOU HAVE AN INDIVIDUAL PERSON THAT MAY CALL ON YOUR BEHALF, OTHERWISE THERE IS NO NEED TO FILL IT OUT--**