Kenneth M. "Trey" Blue, III, MD
Kelly J. Boudreaux, Jr., MD
Robert T. Grissom, MD, FACS
David N. Hastings, MD, FACS

Louisiana Urology LLC

H. Andrew Hollier, MD
William S. Kubricht, III, MD, FACS
Anna R. Smither, MD
Robert S. Taylor, MD, FACS
Paul W. Walker, MD

8080 Bluebonnet Blvd., Suite 3000
Baton Rouge, LA 70810
766-8100 • Fax 408-6873

Account # _____ F/C _____

Resp. Party # _____ DR _____ LOC _____

PATIENT INFORMATION

Patient _____
First Middle Last Suffix:Jr./Sr./Other

Mailing Address _____
Street City State Zip

Social Security _____ Date of Birth _____ Marital Status _____ Sex M or F

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Emerg Contact Name & Number _____

Referring Doctor _____ Primary Care Doctor _____

Employer: _____ Employment Status: _____ Student: ☐ Full-Time ☐ Part-Time

How did you hear about our clinic? ☐ Friend ☐ Internet ☐ Physician ☐ Relative ☐ TV ☐ Yellow Pages ☐ Other _____

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race
☐ Two or More Races ☐ White Preferred Language : _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Pharmacy: _____

RESPONSIBLE PARTY INFORMATION

SEND STATEMENT TO

Responsible Party _____ Suffix: Jr./Sr./Other _____
Last First Middle

Mailing Address _____
City State Zip

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____ Sex M or F

DOB _____ Social Security # _____ Employer _____

Employment Status ☐ Full-Time ☐ Self-Employed ☐ Part-time ☐ Not Employed ☐ Unknown ☐ Retired ☐ Military Active

INSURANCE INFORMATION

PRIMARY	SECONDARY/SUPPLEMENTAL
Insurance Company _____	Insurance Company _____
Address _____	Address _____
City State Zip	City State Zip
Patient's Relation to Insured ☐ Self ☐ Child ☐ Mate ☐ Other	Patient's Relationship to Insured ☐ Self ☐ Child ☐ Mate ☐ Other
Group # _____ Policy # _____	Group # _____ Policy # _____
Insured's Name _____	Insured's Name _____
DOB _____ Social Security # _____	DOB _____ Social Security # _____

*** A clinical summary will be provided at the office within three days of your visit.

I hereby authorize Louisiana Urology, LLC to release information to my insurance company for payment of medical claims and assign benefit payment to Louisiana Urology, LLC. I understand I am responsible for all allowable amounts including deductibles and copays not covered by any of my insurances.

_____ _____
Signature Date

LOUISIANA UROLOGY, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Louisiana Urology, LLC, we are committed to treating and using health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective April 16, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Louisiana Urology, LLC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Louisiana Urology, LLC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request, at your expense,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that the action has already been taken.

Our Responsibilities

Louisiana Urology, LLC is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in this authorization.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the action they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from our care.

We will use health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team bay use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department, radiology and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation or transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund-raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA, health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Stacie Hancock at (225) 766-8100.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

LOUISIANA UROLOGY, LLC

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____ SOCIAL SECURITY # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have been presented with a copy of this provider's **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

_____

_____

_____

PATIENT:

𝒳 _____ _____ _____

Signature of Patient or Legal Representative | Date | Witness Signature

OFFICE USE ONLY:

❑ Accepted

❑ Denied _____ _____ _____

Signature | Title | Date

Louisiana Urology, LLC
Financial Policy

Patient Name:_____ DOB:_____

FOR PATIENTS WITH INSURANCE:

We are contracted with most insurance companies, but please check with your insurer to make sure that we are a participating provider for your plan. If so, we will file your claim for you if proper proof of coverage is provided to us at the time of your visit. Your insurance coverage is a contract between you and your insurer and, although we will make every reasonable effort to assist you in getting your claim paid, any charges incurred are ultimately your responsibility. Occasionally, your insurer may send you a questionnaire that must be answered before they will process your claim. Please respond to any correspondence promptly in order to expedite your claim payment.

- **Copayments:** Copayments are due at the time of service and are collected upon arrival.
- **Deductibles and Coinsurance:** Deductibles and coinsurance are due at the time of service and are collected upon arrival. We will estimate these amounts as closely as possible. Should an overpayment occur, it will be refunded to you once your insurance has paid your claim.
- **Outstanding Balances:** If you have an outstanding balance at the time of your appointment, please be prepared to pay it when you check in.

Wellness Visits: We **do not** perform the **Medicare Wellness Visit.** If you have another insurer that allows you to use you yearly prostate exam as your annual wellness visit, please let the doctor know that you are here for your wellness exam so that we can file your claim properly. We can only file for a wellness exam when the patient has no symptoms and is only being seen for their routine prostate exam and PSA. If you are having symptoms or chose to discuss other medical problems during your visit, your insurer will process your claim with the applicable copayment or deductible.

FOR PRIVATE PAY PATIENTS:

Payment is required at the time of service. For new patients, please be prepared to pay $200 for your first appointment. If additional testing or imaging is performed, this amount may be more.

FORMS OF PAYMENT ACCEPTED:

- **Cash or Money Order**
- **Checks**
- **Credit Cards:** Visa, Mastercard, Discover and American Express
- **Health Savings/Reimbursement Credit Cards:** If you have an HSA or HRA card from one of the above vendors, we can accept this just like a regular credit card as long as there are funds in the account for processing.
- **Care Credit**

CARE CREDIT INFORMATION:

Because we are seeing more and more patients with high deductible insurance plans, we now offer short-term financing for up to six months with no interest through Care Credit. Please ask to speak to a patient account representative in our office if you would like more information about this program.

Thank you for entrusting us with your medical care. Please let us know if you have any questions or concerns.

I have read and understand the above financial policy:

_____ _____

Signature of Patient of Responsible Party Date

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Office: (225) 766-8100 • (225) 767-1347 • (225) 769-0788 • Fax (225) 766-3240

Satellite Offices:
Gonzales • New Roads • Plaquemine • Zachary

NOTICE REGARDING CHARGE FOR MISSED APPOINTMENTS

If you are unable to keep your scheduled appointment, please notify our office at least 24 hours in advance. **Failure to notify the office at least 24 hours prior to the time of your appointment will result in a $75.00 charge,** which will be added to your account.

As a courtesy, you will receive a telephone call from our appointment reminder system at the phone number you provide as your "home telephone" number. We cannot guarantee that this reminder will be completed at least 24 hours prior to your appointment, therefore we recommend that you keep a record of your appointment time and, should you need to cancel or reschedule, contact us as soon as possible.

Your compliance with this policy will allow us to coordinate our schedule more efficiently and will allow us to schedule patients who may need to be seen urgently.

Thank you for your cooperation.

Office Staff of William S. Kubricht, III, M.D., FACS

_____
Patient Signature

_____
Date

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ALTERNATIVE CONTACTS FORM

In accordance with the Health Insurance and Portability and Accountability Act (HIPAA), Louisiana Urology, LLC makes every possible effort to ensure the confidentiality of your personal health record. We will not release your personal health information to anyone other than you without your written permission, except as permitted by HIPAA or required by law.

The authorization below allows our staff members to speak only with the individual(s) which you designate in the event that you are not available to receive phone calls or if you have an adult family member or friend who helps to coordinate your medical care. Please do not designate your doctor.

We will not leave written or verbal health information with any other person unless you specifically authorize below:

_____ I **do not** authorize anyone to receive information regarding my medical care.
_____ I **authorize** my physician and the employees of this clinic to speak with:

1. Name _____ Relationship _____
   Phone Number(s) _____
   ____ Appointments ____ Account ____ Lab/Test Results ____ Medical Care

2. Name _____ Relationship _____
   Phone Number(s) _____
   ____ Appointments ____ Account ____ Lab/Test Results ____ Medical Care

3. Name _____ Relationship_____
   Phone Number(s) _____
   ____ Appointments ____ Account ____ Lab/Test Results ____ Medical Care

Alternate means of contacting me are:

My answering machine/voice mail/pager_____
My email_____
My fax number_____
Other_____

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form.

I agree that, should I desire to revoke this authorization, I will give written notice.

Patient Signature _____
Witness Signature _____
Date _____

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PHYSICIAN INFORMATION

PLEASE MAKE SURE TO LIST FIRST AND LAST NAMES

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

Cardiologist _____ Phone _____

Pain Management _____ Phone _____

Gastroenterologist _____ Phone _____

Endocrinologist _____ Phone _____

OB-GYN_____ Phone _____

Nephrologist _____ Phone _____

Neurologist _____ Phone _____

Other:

_____ Phone _____

_____ Phone _____

_____ Phone _____

_____ Phone _____

Home Health _____ Phone _____

Pharmacy and Location _____

Pharmacy Phone Number _____

Patient Name _____ Today's Date _____
Date of Birth _____

Female Patient History & Physical
(Please complete the following)

Referring Physician _____
Primary Care Physician _____
OB/GYN _____

Informant: Patient / Family (Daughter, Son, Husband) / Medical Record / Translator / Aide / Friend
_____

Allergies: (Please list all medication allergies, including the reaction you had.)

_____ _____
_____ _____
_____ _____

Medications: (Please list medications you are currently taking, including vitamins & supplements.):

_____ _____
_____ _____
_____ _____
_____ _____

Chief Complaint: (Please state your reason for coming to the physician today. How long has this been present?)

_____
_____

Review of Systems:
Please indicate if you now have or have had any of the problems related to the following organ systems. Circle Yes (Y) or No (N). (Please explain any responses of "Yes".)

General

Fever	Y	N
Chills	Y	N
Weight Gain	Y	N
Weight Loss	Y	N
Other_____		

Neurological

Stroke	Y	N
Seizures	Y	N
Migraine Headaches	Y	N
Numbness	Y	N
Other_____		

Eyes

Blurry Vision	Y	N
Glaucoma	Y	N
Pain	Y	N
Glasses/Contacts	Y	N
Other_____		

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Heartburn	Y	N
Hernia	Y	N
Blood in Stool	Y	N
Other_____		

Cardiovascular

High Blood Pressure	Y	N
Chest Pain	Y	N
Rapid Heart Beat	Y	N
Heart Failure	Y	N
Heart Attack	Y	N
Other_____		

Ears / Nose / Throat

Sinus Problems	Y	N
Allergies	Y	N
Difficulty Swallowing	Y	N
Hearing Loss	Y	N
Other_____		

Respiratory

Shortness of Breath	Y	N
Emphysema	Y	N
Asthma	Y	N
Cough	Y	N
Other_____		

Musculoskeletal

Arthritis	Y	N
Gout	Y	N
Joint Pain	Y	N
Back Pain	Y	N
Other_____		

Obstetric / Gynecology

Total # pregnancies _____
Total # Deliveries_____
Vaginal _____
C-Section _____
Weight of largest baby_____lbs _____oz
Last menstrual period_____

Endometriosis	Y	N
Unusual Vaginal Bleeding	Y	N

Other_____

Hematologic / Lymphatic

Bleeding Disorder	Y	N
Swollen Glands	Y	N
Anemia	Y	N
Cancer	Y	N
Other_____		

Endocrine / Renal

Diabetes	Y	N
Thyroid Problem	Y	N
Tired/Sluggish	Y	N
Kidney Problems	Y	N
Other_____		

Miscellaneous

Have had a blood transfusion? Y N

Family History: Have any of your *blood relatives* had any of the following? (Please circle the appropriate illness.)

Diabetes	Heart Disease	Bleeding Disorder	Kidney Failure	Stroke _____
Kidney Stones	Prostate Cancer	Breast Cancer	Lung Cancer	Kidney Cancer _____
Bladder Cancer	Uterine Cancer	Ovarian Cancer	Lung Disease	Cervical Cancer _____

Patient Name _____ **Today's Date** _____

DOB _____

Social History (Do you do or have you done any of the following?)

Smoke Y N If yes, how long have you smoked? _____ years How many packs/day? _____ Quit when? _____
Drink Alcohol Y N
Married Y N Height _____ft _____in
Use illegal drugs Y N Weight _____
IV Drugs Y N Preferred Pharmacy _____
Occupation _____

Past Medical History (Please list any medical problems which you have or are currently being treated for.)

_____ _____
_____ _____
_____ _____
_____ _____

Past Surgical History (Please list any surgeries that you have had in the past.)

_____ _____
_____ _____
_____ _____
_____ _____

History of Present Illness (Please answer by circling the appropriate response.)

1.	Do you leak urine when you cough, strain, lift, run or jump?	Y N	How long? _____Months/Years
2.	Do you leak urine when you are unable to get to the restroom in time?	Y N	How long? _____Months/Years
3.	Do you leak urine without feeling it?	Y N	
4.	Which is worse, leakage related to #1 or #2?	1 2	Equally bothersome
5.	How many pads do you use in an average day for urine leakage?	_____	Pads/day
6.	Does your urine leakage keep you from certain activities?	Y N	
7.	How *many times* do you leak urine in an average day?	_____	Accidents/day
8.	How *often* do you urinate in an average day?	Every _____	hours
9.	Do you have *burning* when you urinate?	Y N	
10.	Do you have to *run to the restroom*?	Y N	
11.	Do you have to *push or strain* to urinate?	Y N	
12.	Do you have *trouble starting* to urinate?	Y N	
13.	Is your stream *weak*?	Y N	
14.	Does your stream *start and stop*?	Y N	
15.	How often do you *get up at night* to urinate?	_____	voids per night
16.	Do you *empty* your bladder when you urinate?	Y N	
17.	Is bladder *pain the major reason* that signals you to urinate?	Y N	
18.	Do you have *pain* in your back/abdomen/pelvis? Circle all that apply.	Y N	
19.	Are you sexually active?	Y N	
	Do you have pain with intercourse?	Y N	
	If yes, is it related to dryness, a "tender spot", deep thrust? (specify)	Y N	N/A
	Do you leak urine during sexual intercourse?	Y N	
20.	Do you experience "bedwetting"?	Y N	
21.	Have you ever had any of the following? (please specify)	Y N	

Urinary Tract Infections	Kidney Stones	Blood in Urine
Constipation	Leakage of Stool	Numbness in Vagina