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

Account # _____

Resp. Party # _____

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

F/C _____

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

Insurance Company _____

Address _____

City State Zip

Patient's Relation to Insured ☐ Self ☐ Child ☐ Mate ☐ Other

Group # _____ Policy # _____

Insured's Name _____

DOB _____ Social Security # _____

SECONDARY/SUPPLEMENTAL

Insurance Company _____

Address _____

City State Zip

Patient's Relationship to Insured ☐ Self ☐ Child ☐ Mate ☐ Other

Group # _____ Policy # _____

Insured's Name _____

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

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

Louisiana Urology LLC

H. Andrew Hollier, MD
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Robert S. Taylor, MD, FACS

8080 Bluebonnet Blvd., Suite 3000 • Baton Rouge, Louisiana 70810
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 $25.00 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 Anna R. Smither, M.D.

_____
Patient Signature

_____
Date

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Phone: _____

What bothers you the most about the way you pass urine? _____

_____

Circle the number in the column which best describes your symptoms OVER THE LAST MONTH	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. How often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
3. How often have you had a weak urinary stream?	0	1	2	3	4	5
4. How often have you had to push or strain to begin urination?	0	1	2	3	4	5
5. How often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
6. How often have you found it difficult to postpone urination?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	5 times
7. How many times do you most typically get up to urinate from the time you went to bed at night until the time you get up in the morning?	0	1	2	3	4	5

	Delighted	Pleased	Mostly satisfied	Mixed feelings	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

If you do urinate after you go to bed at night, are you (check one): _____ Awakened by the urge to urinate?
_____ Urinate because you're up already

Do you have a normal sensation of urinating?	Yes		No	
Is the amount of urine you usually pass (circle the appropriate answers):	During the day:	Large	Average	Small
	At night:	Large	Average	Small

Are your urinary symptoms bothersome enough that you would want (check one):
_____ to take medication _____ to have surgery _____ not that bothersome

Have you taken medication for your prostate?	No	Yes (which and when) _____
Have you ever experienced episodes when you were unable to pass urine at all?	No	Yes /Please explain _____ _____

Do you wet yourself (urinary incontinence)?	Yes	No (if no, skip to next section)
If yes, for how long?	_____ months	_____ years
Is it getting worse?	No	Yes
Did it start after an injury or surgery?	No	Yes (specify)_____

How often does leakage happen? (circle appropriate answer)

Several times a day Once a day A few times a week Once a week Once a month Rarely

Are you aware of when the leakage occurs? (circle appropriate answer)

Always Usually Sometimes Never (just realize that you're wet)

Does the leakage come in (circle appropriate answer)

Few drops at a time Spurts Gushes Continuous dripping

Is the leakage worse with activities such as (circle the appropriate answers)

Coughing Sneezing Running Heavy lifting Walking Not related to activity

Is the leakage associated with a sudden strong urge to urinate so that you can't get to the toilet in time?

Always Usually Sometimes Never

What seems to trigger the sudden urgency and leakage?

Sight, sound feel of running water	Yes	No
Changing your position (from lying to sitting or sitting to standing)	Yes	No
Putting the key in the door when you return home	Yes	No
Other _____		

Do you lose urine without any warning (without activity or any feeling of urgency to urinate)? Yes No

Do you wet yourself while asleep? Yes No

Does the urine leakage interfere with sexual activity? Yes No

Do you wear protection for the wetting? Yes No

If yes, what kind of protection, how wet does it get and how many times would you change it in a typical day?

Kind of protection (pads, diaper, penile clamp, etc.)_____

How wet? (circle) Soaked through Moderately wet Damp A few drops

Number of pads/diapers changed per day (circle one)	0-1	1-2	2-3	3-4	4-5	5-6	6-7	more
Number of pads/diapers changed at night (circle one)	0-1	1-2	2-3	3-4	4-5	5-6	6-7	more

What medication have you tried for the wetting and when? _____

_____

Did the medication help? (circle) A lot A little Not at all

Have you had any operations to correct the leakage? Yes No

What was done and when?_____

Did it help? _____

Has urine leakage affected you (circle):	Not at all	Slightly	Moderately	Greatly
Ability to do household chores	0	1	2	3
Physical activities/exercise	0	1	2	3
Entertainment activities (movies, concerts)	0	1	2	3
Ability to travel more than 30 minutes from your home	0	1	2	3
Participation in social activities outside your home	0	1	2	3
Emotional health (depression, anxiety, etc.)	0	1	2	3
Feeling frustrated	0	1	2	3

Do you experience pain in relation to your bladder? Yes No

If yes, is it (check appropriate ones):

_____ Burning in penis or lower abdomen with urination
_____ Pain in lower abdomen when bladder is full
_____ Pain in the rectum or testicles

Does the pain/burning get better once you finish urinating? Yes No

INFECTIONS:

How often do you get urinary infections (circle appropriate):

Never 1-2/year 3-4/year 5-6/year More (if never, skip to next section)

What symptoms do you get with a urine infection (circle appropriate ones):

Increased frequency of urination Urgency burning Wetting Cloudy urine Blood

Do you usually get a culture done? Yes No Are the cultures usually positive? Yes No

Do your symptoms usually improve with antibiotics (circle appropriate):

Always Sometimes Not really Which antibiotics? _____

Have you ever taken an antibiotic to prevent infections?

No Yes (which ones and for how long) _____

With a urine infection, do you ever experience (circle appropriate):

Back/side pain Chills Sweats Fever (how high) _____

SEXUAL FUNCTION:

Are you satisfied with your sexual function? Yes No (If yes, skip to the next section)

If not, are you interested in treatment? Yes No

Do you have normal sex drive / desire? Yes No

Do you have normal sensation in your penis? Yes No

How would you describe your erections (check appropriate):

_____ Firm erection on demand _____ Somewhat firm erection on demand

_____ Firm erections only at night while asleep _____ Lose erection too quickly

_____ No erections at all

Are you able to have intercourse? Usually Half the time Rarely Never

Have you tried any treatments for erection problems? Yes No

Provide details: _____

_____

Do you have curvature of the penis when it is erect? Yes No

If yes, When and how did it begin _____

Is the curvature Upwards Downwards Left Right

Has it been getting worse? Yes No

Is it painful for: You Your partner Not painful

Are you able to have intercourse? Yes No

Do you have normal orgasms? Yes No

Do you ejaculate normally? Yes No (specify) _____

Have you ever experienced trauma to your groin/testicles (e.g. kicked, fallen on bike, etc.)? Please provide details

_____

INTERNATIONAL PROSTATE SYMPTOM SCORE SHEET (I-PSS)

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

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. INCOMPLETE EMPTYING: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2.FREQUENCY: Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. INTERMITTENCY: Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. URGE TO URINATE: Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. WEAK STREAM: Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING: Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5+ times**
7. **URINATING AT NIGHT:** Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Symptom Score:
1-7 Mild, 8-19 Moderate, 20-35 Severe

Total: _____

BOTHERSOME SCORE DUE TO URINARY SYMPTOMS							
	Delighted	**Pleased**	**Mostly**	**Mixed**	**Mostly**	**Unhappy**	**Terrible**
BOTHERSOME OF URINARY SYMPTOMS: How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

The International Prostate Symptom Score (I-PSS) is based on the answers to 7 questions concerning urinary symptoms and 1 question concerning the effect of symptoms. Each question concerning urinary symptoms allows the patient to choose 1 of 6 answers indicating increasing severity of the particular symptom. The answers are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

The first 7 questions of the I-PSS are identical to the questions appearing on the American Urological Association (AUA) symptom Index, which currently categorizes symptoms as follows: Mild - (symptoms score less than or equal to 7), Moderate - (symptom score range 8-19), Severe - (symptom score range 20-35).

The International Scientific Committee (SCI), under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), recommends the use of the additional question to begin a discussion with patients about the effect of symptoms on their lives. The answers to this question range from "delighted" to "terrible" or 0 to 6.