URGENT

YAKIMA UROLOGY ASSOCIATES P L L C

Dear Patient:

Thank you for choosing Yakima Urology Associates, enclosed please find our patient registration packet. In order to provide the best possible medical care our providers need the enclosed forms filled out completely and accurately.

YOUR RESPONSIBILITY

Registration Forms: To minimize any delays in your care - please complete these forms and send back as soon as possible *BEFORE* your appointment. -*OR*- visit our website – www.yua.com to fill out and submit the same forms electronically. Failure to do this 7 days prior to your appointment will result in your appointment being rescheduled.

CURRENT LIST OF ALL MEDICATIONS: Please bring all your current medications or a complete list of all medications to each appointment.

CO-PAYS AND DEDUCTIBLES: All payment of deductibles and co-pays are due on the date of service.

ALL INSURANCE ID CARDS & 1 Photo ID: Please bring all of your insurance information with you to your appointment. A copy of your insurance cards and photo ID will be taken and kept on file.

If you do not have insurance, we will need to collect a $200.00 deposit at the time of service or reschedule your appointment. Financial questions should be directed to 509-249-3900 ext. 411551.

Thank you for your cooperation. If you have any questions, please feel free to call us at 509-249-3900 or 1-800-572-8357.

☐ Yakima Urology Associates, PLLC
2500 Racquet Lane, Ste. 100
Yakima, WA 98902

☐ Ellensburg Clinic
611 S Chestnut Unit C
Ellensburg, WA 98926

Please mail paperwork to: 2500 Racquet Lane, Ste. 100 Yakima WA, 98902

Appointment date_____ Time_____

Your appointment is with:

☐ Dr. Gaskill ☐ Dr. Thorner ☐ Dr. Cox ☐ Dr. Matt Uhlman ☐Dr. Lauer ☐ Dr. Meier
☐ Esther McCorkindale, PA-C ☐ Steven Mack, PA-C

Yakima Urology Associates, PLLC

Patient Demographic, Insurance & Signature for Assignment

Date_____

PATIENT INFORMATION	**Doctor:**	**ID #:**
Name Last: First: MI:		**Date of Birth:**
Address:		**Social Security #:**
City: **State:** **Zip:**		**Marital Status:** ☐ Single ☐ Widowed ☐ Married / Spouse's Name:
Home Phone #:	**Primary Physician:**	
Cell Phone #:	**Referring Physician:**	
☐ **Male** ☐ **Female**	**Interpreter Needed:** ☐ **Yes / Language:**	**E-Mail:**
Ethnicity: (OPTIONAL) _____ (i.e.: Hispanic/Latino/Non-Hispanic or Latino/Other)	**Race: (OPTIONAL)**_____ (i.e.: American Indian/Alaska Native/Black/Hispanic/White/ African-American/Native Hawaiian/Other)	

PATIENT EMPLOYMENT	**CONTACT (In Case Of Emergency)**
☐ Employed ☐ Retired ☐ Unemployed ☐ Disabled	**Name:**
Employer:	**Phone #:**
Phone #:	**Relationship To Patient:**

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name of Subscriber:	**Name of Subscriber:**
☐ **Patient** ☐ **Parent** ☐ **Spouse** ☐ **Guardian**	☐ **Patient** ☐ **Parent** ☐ **Spouse** ☐ **Guardian**
Birth date of Subscriber:	**Birth date of Subscriber:**
SS # of Subscriber:	**SS # of Subscriber:**
Employer of Subscriber:	**Employer of Subscriber:**
Insurance:	**Insurance:**
ID#:	**ID#:**
Group#:	**Group#:**

GUARANTOR (Responsible Party for minor child) ☐ **Parent** ☐ **Guardian**		
Name:	**Date of Birth:**	
Social Security #:	**Phone:**	
Address:	**City:** **State:** **ZIP:**	
Employer:		

*** ***Signer below also acknowledges that Yakima Urology or its agents may use all available phone numbers or email address to contact the patient for follow up appointment or to further conduct its business.***

Signature of Patient or Person filling out this form: _____

Please fill out all pages completely.

PAYMENT POLICY

All accounts are due and payable in-full within 60 days. If you need to set up a payment agreement, please contact our Financial Counselor. Regardless of your insurance, you are responsible for payment of all services rendered. As a courtesy to you, we bill Primary & Secondary insurances. However, we are not contracted with all insurance companies. Since most insurance companies pay less than 100% of actual charges, a payment may be required at time of service unless other financial arrangements are made with the Financial Counselor. If you are without insurance coverage, prior to your appointment, you will meet with a Financial Counselor to discuss payment options. The Financial Counselor can be reached at 509 -249-3900 ext. 411551.

We Accept Visa, MasterCard and Discover *All returned checks will be assessed a $ 35.00 fee.

CANCELLATION/NO SHOW POLICY

As a courtesy, we attempt to contact patients to remind them of appointments; however, it is the responsibility of the patient to arrive for their appointment on time. Our goal is to provide quality medical care in a timely manner. In order to do so, we have a "no show" and cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment: In order to be respectful of the medical needs of all our patients please be courteous and call our office promptly if you are unable to attend an appointment.
Late Cancellations: Appointments cancelled with less than a 24 hour notice will be considered a "no show."
No Show Policy: A "no show" is someone who misses an appointment without canceling it 24 hours in advance. "No Show" appointments are subject to dismissal from our practice.

⇒Signature: _____ Date: _____

INSURANCE COVERAGE & ASSIGNMENT OF INSURANCE PAYMENTS

I authorize the release of information to my Insurance Company for processing claims. For all services I receive, I authorize and request my Insurance Company to make reimbursements payable on my behalf to: **Yakima Urology Associates, PLLC**

Referrals: I understand that if my insurance requires a referral it is my responsibility to obtain the referral from my primary care physician. If there is not a current referral on file for any visit for which I am seen, I agree that the charges incurred will be billed to me privately instead of my insurance carrier.

⇒Signature: _____ Date _____

MEDICARE COVERAGE LIFETIME AUTHORIZATION

1. The Patient, if physically and mentally competent, must sign on his own behalf. If the patient cannot sign, a representative payee as designated by the Social Security Administration or a legally appointed guardian may sign. The source of the signatory's authority should be stated, i.e., Social Security-appointed Representative payee, court appointed-guardian, etc.
2. This form is used in lieu of the patient's signature on the "Request for Payment" form, HCFA 1500, and is therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction by law, be subjected to fine and imprisonment under Federal Law.

I request that payment of authorized MEDICARE benefits be made on my behalf to: **Yakima Urology Associates, PLLC**

I authorize any holder of medical information about me to release to the CENTER FOR MEDICARE & MEDICAID SERVICES, and its agents, any information needed to determine these benefits or the benefits payable for related services.

⇒Signature: _____ Date _____

The patient, or minor's parents or guardian is responsible for all charges.

Yakima Urology Associates, PLLC

Date: _____

Patient Name: _____ **Date of Birth**: _____

Family Doctor: _____ **Referring Doctor**: _____

Height _____ **Weight** _____

What is your reason for being seen? _____

Do you require **Antibiotics** (**SBE Prophylaxis)** prior to Dental or Surgical procedures? Circle **YES** or **NO**

Do you have **SLEEP APNEA?** Circle **YES** or **NO** **Do you currently use a C-Pap machine? **YES** or **NO**

CURRENT MEDICATIONS: Please include aspirin and any supplements. ☐ **NONE**- No current medications

Medication Name:	Strength:	How Often to take:

PHARMACY NAME & LOCATION: _____

ALLERGIES to Medications (and indicate type of reaction) ☐ **NO KNOWN ALLERGIES**

Medication Name:	Type of Reaction:

Other Allergies? (Seasonal, latex, betadine, etc.)_____

PREVIOUS SURGERIES ☐ **No previous surgeries**

Date:	Type of Surgery – specify left or right:	Surgeon:

FAMILY HISTORY

Note major medical issues of family members (such as heart disease, diabetes, high blood pressure, cancer, etc.) If deceased, give the age and cause of death.

FATHER:_____ MOTHER:_____

BROTHERS:_____ SISTERS:_____

Other major illness in the family:_____ Which member?_____

Patient Name_____

PAST MEDICAL HISTORY

Please **check** those conditions you currently **have** or **have had** below:

CARDIOVASCULAR:

__Anemia / __Sickle Cell Anemia
__Carditis **Date**: _____
__CAD
__Angina (chest pain)
__Deep Vein Thrombosis **Date**: _____
__Hemophilia Type: _____
__Arrhythmia (Irregular heartbeat)
__Congestive Heart Failure
__High blood pressure
__Heart Murmur
__Heart Attack **Date**: _____
__Heart Disease (specify) _____
__Leukemia
__Rheumatic Fever
__Bleeding disorder (specify) _____
__Stroke **Date:** _____
__Valve disorder Type: _____
__ **NONE OF THE ABOVE**
__OTHER: _____

ENDOCRINE/METABOLIC:

__Diabetes - Insulin **or** Oral Med
__ Gout
__Hyperthyroidism
__Hypothyroidism
__**NONE OF THE ABOVE**
__OTHER: _____

GENERAL:

__Chemical Exposure Specify: _____
__Hepatitis __A __B __C **Date**: _____
__Hypercholesterolemia
__Hyperlipidemia
__Paget's Disease
__PCKD
__ Raynaud's Syndrome
__Infectious Disease:_____
__**NONE OF THE ABOVE**
__OTHER: _____

TUMORS:

__CANCER Type: _____
Date Diagnosed: _____
Treatment dates: _____
Treatment types:_____
__**NONE**

GASTROINTESTINAL:

__Cholecystitis (Gallbladder)
__Colitis
__Constipation
__Crohn's Disease
__ Colon Polyps: Benign or Cancerous
__Diverticulosis
__GERD/Reflux
__Hemorrhoids / __Fissures
__Hiatal Hernia
__Irritable Bowel Disease
__Liver Disease Pancreatitis
__Ulcerative Colitis
__Ulcers (specify) _____
__**NONE OF THE ABOVE**
__OTHER: _____

GENITOURINARY:

__Acute Prostatitis
__AIDS **Date diagnosed**: _____
__Benign Prostatic Hypertrophy (BPH)
__Bladder Stone
__Bladder infection
__Chronic Prostatitis
__Elevated PSA
__Interstitial Cystitis
__Recurrent UTI
__Kidney Disease (specify) _____
__Kidney Stones
__Kidney failure
__Transplant Recipient **Date:** _____
Type of Transplant: _____
__**NONE OF THE ABOVE**
__OTHER: _____

GYN/OB (Females Only)

__Breast Cancer / __Breast Disease
__Endometriosis
__Menstrual problems
__Ovarian cyst
__Uterine fibroids
__Osteoporosis
__Postmenopausal - When: _____
__Pregnancies
__# births /__# miscarriages/abortions
__ Prior Abnormal Pap
__**Hysterectomy** Complete or Partial

HEENT:

__Cataracts
__Glaucoma Narrow/Closed OR Wide/Open
__Hay Fever / __Sinusitis
__Mumps
__Vertigo
__**NONE OF THE ABOVE**
__OTHER: _____

MUSCULOSKELETAL:

__Arthritis
__Back Pain
__Carpal Tunnel Syndrome
__Fibromyalgia
__Morton's Neuroma
__**NONE OF THE ABOVE**
__OTHER: _____

NEUROLOGICAL/PSYCHOLOGICAL:

__ADD / __ADHD
__ Alzheimer's Disease
__Anxiety Disorder
__Bi-polar Disorder
__Depression
__Alcoholism
__Epilepsy
__Seizure
__Disorder Migraines
__Multiple Sclerosis
__Parkinson's Disease
__Spinal Cord Injury **Date:** _____
__Suicide Attempt
__**NONE OF THE ABOVE**
__OTHER: _____

RESPIRATORY:

__Asthma
__Bronchitis
__COPD
__Emphysema
__Pneumonia
__Pulmonary Embolism **Date:** _____
__Tuberculosis
__**NONE OF THE ABOVE**
__OTHER: _____

Patient Name:_____

SOCIAL HISTORY/HABITS:

Sexual Activity: ☐ None ☐ Active, single partner ☐ Active, multiple partners ☐ Contraceptives: _____

Sexually Transmitted Diseases-TYPE: _____ Sterilization Type: _____ Date: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other (specify): _____

Number of children: _____ Occupation: _____ Hobbies:_____

Alcohol Consumption: ☐ Do not drink ☐ Occasional/Social ☐ Heavy - Number of Drinks/day _____

Tobacco use: ☐ Do not smoke ____ packs/day for ____ years ☐ smokeless

☐ Quit Smoking: When _____ How much? ____ packs/day for ____ years

Recreational Drugs: ☐ None If yes, please list: _____

Caffeinated beverages per day: ☐ NONE ☐ 1-2 ☐ 3-4 ☐ 5 or more

Recent Foreign Travel: ☐ None If yes, where_____

REVIEW OF SYSTEM

Are you **currently** experiencing any problems relating to the following systems? **Circle YES OR NO** below.

Constitutional

Fever	YES	NO
Chills	YES	NO
Insomnia	YES	NO

Other:_____

Eyes

Blurred Vision	YES	NO
Double Vision	YES	NO
Pain	YES	NO

Other: _____

Allergic / Immunologic

Seasonal Allergies	YES	NO
Animal Fur	YES	NO
Food	YES	NO

Other:_____

Neurological

Tremors	YES	NO
Dizzy Spells	YES	NO
Numbness / Tingling	YES	NO
Headache	YES	NO

Other _____

Endocrine

Excessive Thirst	YES	NO
Heat /Cold intolerance	YES	NO
AbnormallyTired/Sluggish	YES	NO

Other:_____

Gastrointestinal

Abdominal Pain	YES	NO
Nausea / Vomiting	YES	NO
Indigestion / Heartburn	YES	NO
Rectal bleeding	YES	NO

Other:_____

Cardiovascular

Chest Pain/Angina	YES	NO
Palpitations	YES	NO
High Blood Pressure	YES	NO

Other:_____

Integumentary

Skin Rash	YES	NO
Boils	YES	NO
Persistent Itch	YES	NO
Pigment changes	YES	NO

Other:_____

Musculoskeletal

Joint Pain	YES	NO
Neck Pain	YES	NO
Back Pain	YES	NO

Other:_____

Ear / Nose / Throat / Mouth

Ear Infection	YES	NO
Sore Throat	YES	NO
Sinus Problems	YES	NO

Other:_____

Genitourinary

Urine Retention	YES	NO
Painful Urination	YES	NO
Urinary Frequency	YES	NO

Other:_____

Respiratory

Wheezing	YES	NO
Frequent Cough	YES	NO
Shortness of Breath	YES	NO

Other:_____

Hematologic / Lymphatic

Swollen Glands	YES	NO
Blood Clotting Problem	YES	NO

Other:_____

Psychologic

Are you generally satisfied with life?

YES NO

Do you feel depressed?

Rarely

Occasionally

Most of the time

Other:_____

_____

_____

Yakima Urology Associates, PLLC
2500 Racquet Lane, Suite 100 * Yakima, WA 98902
(509)249-3900 Fax (509) 573-9539

Authorization to Release Medical Information with Designated Individuals

Do you give Yakima Urology Associates, PLLC permission to discuss and/or release your medical information with family members/caregiver?

□ **YES** □ **NO** If yes, please provide complete information below.

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____

I give permission to Yakima Urology Associates, PLLC to release copies of my medical records to myself (The patient).

If you have an answering machine may we leave messages containing medical information, such as scheduling and prescription issues?
□ **YES** □ **NO**

_____ _____

Signature of Patient/Legal Guardian Date and Time

_____

Print First and Last Name

This authorization may be revoked in writing at any time. However, a revocation would not affect any actions already taken by Yakima Urology Associates, PLLC based upon this authorization. Proof of identification will be needed for verification.

PATIENT PORTAL ACCESS AUTHORIZED USERS

If you would like to authorize anyone other than yourself to utilize our patient portal to access your medical records please provide the following information for that person.

Name: _____ Relationship: _____ Date of Birth: _____

Phone Number: _____ Their email address: _____

LIVING WILL

I have completed a living will.
□ **YES** □ **NO**

If you would like more information regarding living wills, including an easy to fill out version, called Five Wishes, please contact Memorial Spiritual Care Department @ 509-575-8035.