Dear New Patient:

Welcome to Mercy Clinic Urology Jefferson. Enclosed are forms for you to fill out in advance of your appointment to ensure we have all of the information necessary to provide you with quality care and treatment. Please fill out all of the forms in their entirety.

Please arrive 20 minutes early so all paperwork can be processed and you can be checked in for your appointment. If you cannot keep this appointment, please notify us within 48 hours of your appointment time.

Before your appointment on:_____

1. Please complete the new patient packet and bring all the forms with you to first visit. Please do not mail the new patient forms.
2. If you forget your paperwork and are not able to arrive early enough to complete the paperwork prior to you scheduled appointment, you may be asked to reschedule your appointment.
3. You are responsible for obtaining your medical records and/or recent test results from previous physicians that may pertain to your treatment.

Getting to your appointment:

Mercy Clinic Urology Jefferson is located at Mercy Hospital Jefferson. We are located at the Clinic Entrance. The physical address is 1390 Hwy 61 Festus, MO 63028.

Insurance Information:

To ensure your visit proceeds in a timely fashion, we ask for your assistance at the time of the first visit and all subsequent visits thereafter.

1. Please be prepared to provide our staff with your insurance card at every visit you have with us. If your insurance changes, prompt notification to the staff will be the patient's responsibility to ensure accurate billing.
2. If your insurance requires an **authorized referral** to a specialist, please secure this referral from our primary physician before your arrival at our office, failure to do so will result in your appointment being rescheduled.
3. You are responsible for your co-payment at the time of your visit.

We look forward to meeting you and strive to provide nothing but exceptional service to all of our patients. After your visit with us, you will receive a survey via email asking about the care and service you received. We appreciate all feedback, and review all comments to ensure our patient's healthcare needs are being met. Thank you for choosing Mercy for your Health Care needs.

Sincerely,

Mercy Clinic Urology Jefferson

New Patient Instructions

Mercy Clinic Urology

Clinic Entrance

1390 Hwy 61

Festus, MO 63028

Phone Number: 636-931-5080

Fax Number: 636-937-7321

Important documents to bring to your appointment:

***Completed new patient packet**

***Photo ID**

***Insurance Card**

***Co-pay if required**

***Any labs or testing from another doctor or facility**

***Updated medication list. We need to know the dosage and the medication instructions.**

***Please come with a full bladder**

***If your insurance requires a referral, it is the patient's responsibility to make sure your primary doctor faxes us the insurance referral prior to your appointment. If you are unsure if you require a referral for a specialty physician, please call the number on the back of your insurance care.**

Thank you,

Mercy Clinic Urology Jefferson

MERCY CLINIC UROLOGY
1400 Highway 61 South
Festus, MO 63028
Phone: 636-931-5080 Fax: 636-937-7321

Mercy

Name:_____DOB:_____Date:_____

Marital Status: ___Single ___ Partnered ___Married ___Separated ___Divorced___Widowed

Primary Care Physician: _____

Reason for being seen:

_____
_____
_____

Allergies:

_____
_____

Current medications and doses: (please list any additional medications on the back)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Past Medical History: __No Significant History

__Atrial Fibrillation	__Carotid Stenosis	__GERD	__Kidney Disease	__Stroke
__Atrial Flutter	__Cirrhosis	__Gout	__Kidney Stones	__Other:
__Anemia	__Colitis	__Heart Attack	__Migraines	_____
__Anxiety	__COPD	__Heart Failure	__Osteoarthritis	_____
__Asthma	__Dementia	__Hepatitis	__Osteoporosis	_____
__BPH	__Depression	__High Cholesterol	__Pancreatitis	_____
__Coronary Disease	__Diabetes	__HIV	__Peptic Ulcer	_____
__Cancer_____	__Epilepsy	__Hypertension	__Peripheral Vascular	_____
__Cardiomyopathy	__Gastritis	__Inflammatory Bowel	__Sleep Apnea/CPAP	_____

Past Surgical History: __No Significant History

__Appendectomy	__C-Section	__Hysterectomy	__Shoulder_____	_____
__AV Graft/Dialysis Cath	__Carotid Surgery	__Hernia_____	__Tubal Ligation	_____
__Breast_____	__Foot_____	__Hip_____	__Tonsillectomy	_____
__Back_____	__Fistula	__Knee_____	__Other_____	_____
__Coronary Bypass	__Gallbladder	__Pacemaker/AICD	_____	_____

Social History:

__Smoking_____pack/day __Alcohol_____ __Drug Use_____ __Other_____
Occupation_____ Marital Status_____ __Children_____(#)

MERCY CLINIC UROLOGY
1400 Highway 61 South
Festus, MO 63028
Phone: 636-931-5080 Fax: 636-937-7321

Mercy

Family History:

Mother: ___Alive ___ Deceased; Age and Cause of Death_____
Father: ___Alive ___ Deceased; Age and Cause of Death_____
Do your parents have or had any of the following:

	Mother	Father
Hypertension	___	___
High Cholesterol	___	___
Diabetes; Type _____	___	___
Heart Disease	___	___
Stroke	___	___
Peripheral Vascular Disease	___	___
Kidney Disease	___	___
Carotid Stenosis	___	___
Arthritis; Type _____	___	___

- Other pertinent family history:_____
  _____
- Adopted or Unknown Family History

Additional Information:

_____
_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I have a change in my health.

Signed: _____
Date: _____

Thank you for your time!!

WOMEN ONLY

Are you still menstruating?	☐ Yes	☐ No
Do you experience flank pain (mid back- near kidneys)?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Do you usually get up to urinate during the night?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No

Number of pregnancies: _____ Number of live births: _____

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times: _____		
Do you experience flank pain (mid back- near kidneys)?	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam? _____/_____/_____	☐ Never	☐ Unknown

Name:_____

Mercy Clinic Urology **Review of Symptoms:**

Please check ALL current problems.

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weight loss
- ☐ Weight gain

Males Only
- ☐ Difficulty with erection
- ☐ Scrotal pain
- ☐ Penile discharge

EARS

Please circle right, left, or both
- ☐ Hearing loss (R/L)
- ☐ Earache (R/L)

Gynecological (females only)
- ☐ Vaginal discharge
- ☐ Vaginal pain/itching
- ☐ Pain with intercourse

MOUTH AND THROAT
- ☐ Sores in Mouth
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Sore throat

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Swelling of hands or feet
- ☐ Abnormal heart rhythm

ENDOCRINE
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst or urination

HEMATOLOGICAL
- ☐ Abnormal bleeding
- ☐ Abnormal bruising
- ☐ Cancer

NEUROLOGICAL
- ☐ Headaches/Migraines
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness/Tingling

ALLERGY
- ☐ Seasonal Allergy

RESPIRATORY
- ☐ Cough
- ☐ Difficulty sleeping
- ☐ Wheezing
- ☐ Blood in sputum

GASTROINTESTIONAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Bloody stools
- ☐ Acid reflux

MUSCULOSKETAL
- ☐ Muscle cramps or aches
- ☐ Joint pain or swelling
- ☐ Back pain
- ☐ Neck pain

Genitourinary
- ☐ Difficulty Urinating
- ☐ Weak Stream
- ☐ Blood in Urine
- ☐ Frequent urination
- ☐ Urinary incontinence
- ☐ Difficulty emptying bladder
- ☐ Flank pain
- ☐ Recurrent UTI
- ☐ Nocturia
- ☐ Straining to urinate
- ☐ Bedwetting
- ☐ Painful urination

I have answered the above questions to the best of my ability.

Signed:_____ Date:____/____/____

Mercy

Mercy Clinic "No Show" Policy

Mercy Clinic has developed the following policy for "No Shows." A No Show is when a patient does not come in for their scheduled appointment, or cancels their appointment less than two (2) hours prior to the appointment. This policy was developed to improve access to our providers, as No Shows leave open appointment time slots in which another patient waiting for care could have been treated.

The following represent Mercy Clinic's guidelines on No-Shows:

- Established Patients: a total of three (3) No Shows in a twelve (12) month timeframe within a practice may be considered grounds for termination from the practice. However, the number of no-shows and timeframe may vary based on specialty.

- New Patients: a series of two (2) No Shows in a twelve (12) month timeframe within a practice will not be allowed any future appointments to be made with that provider. However, the number of no-shows and timeframe may vary based on specialty.

If you are having trouble remembering your appointments, please consider using our free text reminder service, Televox. You can receive appointment text reminders two days in advance by texting MERCY to 622622.

By signing below, you recognize the importance of keeping appointments, and understand Mercy Clinic's No Show Policy.

Name of Patient: _____ Date: _____

Signature of Patient or Patient Representative: _____

Mercy

Name:_____

DOB:_____ MR#:_____ CSN#: _____

Physician and Hospital Services Agreement

1. **Annual Consent for Services:** I agree to the services that may be performed by a Mercy physician or non-physician provider ("provider") or facility. I understand I can withdraw this agreement at any time. This agreement applies to any provider services I may obtain from Mercy providers at a clinic or physician's office and also to any hospital services I may obtain at a Mercy hospital or from a hospital-based clinic location. I understand that except in an emergency, no major procedure or treatment will be performed without providing me an opportunity to give informed consent, meaning the provider will first provide me with information including the nature of the procedure or treatment, risks, benefits, and alternatives.
2. **Telehealth Services:** I give my permission for consult-based services that may be provided to me from another location by live video technology ("telehealth"). I understand that I can withdraw this permission at any time by telling my provider when telehealth services are recommended to me and that if I choose to withdraw this permission, there may be certain services that I am not able to receive at a Mercy facility. I also understand and agree that: (i) I may refuse telehealth services at any time without affecting my right to future care or treatment and without risking any third party payor benefits to which I am entitled; (ii) I will be informed of the alternatives, if any, to the telehealth services that are available to me; (iii) I will have the right to access the medical record of the telehealth services as provided by law; (iv) I give my permission for the sharing, storage, and retention of identifiable images or other information from the telehealth service, with the understanding that like in-person care, any identifiable images or other information will not be shared except as required or permitted by law; (v) I have the right to know who will be present during the telehealth services and may exclude anyone from either location; and (vi) there will be no videotaping or recording of telehealth services.
3. **Financial Agreement:** I guarantee and agree to pay for all goods and services provided to me or the patient named below at the rates listed in Mercy's Charge Description Master as of the date of treatment, or a different amount as may be determined under my (or the patient's) insurance plan(s) or my (or the patient's) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. Mercy will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.
4. **Assignment of Insurance Benefits:** I assign to Mercy, my physician or other non-Mercy health care professionals involved in my (or the patient's) care my (or the patient's) rights under all insurance and benefit plan documents, and authorize direct payment to each health care provider of all insurance and plan benefits payments for services provided to me (or the patient) by these providers. By paying my providers directly, my insurance company or employer is fulfilling its obligations to me (or the patient) under the insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.
5. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my (or the patient's) behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Mercy to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

Mercy

Participation in the Health Information Network
Authorization and Consent Form

What are you agreeing to by signing this form?

- To give your permission to allow your health care providers to share your health records electronically, through their computers, to better care for you.
- That you have received information about sharing your health records through the Health Information Network.

Please read the statements below.

(If you are a patient's legal representative, "me", "my", or "I" refer to the Patient)

By signing this form, I understand and agree that Mercy participates in my state's Health Information Network. Mercy and other participants in my state's Health Information Network:

1. Will be able to see all of my health records from both before and after today's date.
2. May use or share my health data, but only as allowed by federal and state laws. This is the same as for my health records in paper form.
3. May share *all* of my health records with providers who are treating me; this includes but is not limited to:
   - Illnesses or injuries (like diabetes or a broken bone)
   - Test results (like X-rays or blood tests)
   - Medicines that I am taking or have taken

   This also may include, but is not limited to sensitive data:
   - Alcohol or substance abuse problems
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health and developmental disabilities
   - Head and spinal cord injuries
   - Family planning information (including abortions)
   - Sexually transmitted diseases
4. May copy or include my health information in their own medical records when caring for me. Even if I later cancel my consent, providers I've visited who have copied my records are not required to remove them. This is the current law.
5. Have penalties in place for anyone sharing my data in the wrong way.
6. The Health Information Network will keep track of who views my health records to make sure they are secure. I can ask my doctor or the Health Information Network for a list of who has looked at my records.

PHI Communication Form

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____ Last 4 digits of SSN: _____

_____ Telephone: _____

I, _____, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below.

Authorized person(s) to receive **verbal** information regarding the above patient's care:

_____	_____	_____
Printed Name	Relationship to Patient	Telephone
_____	_____	_____
Printed Name	Relationship to Patient	Telephone
_____	_____	_____
Printed Name	Relationship to Patient	Telephone

Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record.

Mercy will not release paper or electronic copies of your medical record to any one including those listed above unless an ***Authorization for Use and Disclosure of Protected Health Information*** form is completed or Mercy is already permitted by law to do so.

Mercy may still speak to other persons not listed on this form about your care if otherwise permitted by law.

I understand I may revoke this authorization at any time and Mercy will cease discussing my Protected Health Information with the above person(s) upon receipt, unless otherwise relied upon or if Mercy is not otherwise required by law to share information with the above person(s).

Patient or Legal Personal Representative: _____ Date: _____
Signature

Patient or Legal Personal Representative: _____
Printed Name

Authority of Personal Representative: _____

Patient Name:
MRN#:
Date of Birth:

Mercy

Mercy

Mercy Hospital Jefferson

Authorization To Obtain or Release Confidential Information

I Authorize and Request: _____

_____

_____

(name of hospital/individual/agent being directed to release medical information)

To Release to: _____

_____

_____

the following information contained in my medical record:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ X-ray Report
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Emergency Room Report
- ☐ Lab
- ☐ Other (*please specify*): _____

_____

Patient Name: _____ Date of Birth: _____
(*Print*)

Purpose of Disclosure: _____

_____

This authorization expires in 90 days and is subject to revocation at any time, except to the extent that action has already been taken in reliance thereon.

_____
Patient's Signature Date

_____
Signature of Parent or Authorized Individual Date

_____
Witness

AUA SYMPTOM SCORE (AUASS)

MALES ONLY

PATIENT NAME:

DATE:

(Circle One Number on Each Line)	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
Over the past month or so how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hopurs after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, 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 or More Times
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you go up in the morning?	0	1	2	3	4	5
Add the score for each number above and write the total in the space to the right.					**Total:**	
SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)						

QUALITY OF LIKE (QOL)							
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
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

Sexual Health Inventory For Men (SHIM)

Instructions

Each question has 5 possible responses. Circle the number that best describes your own situation. Select only 1 answer for each question.

Over the past 6 months:

1. How do you rate your confidence that you could keep an erection?

1	2	3	4	5
Very low	Low	Moderate	High	Very high

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

1	2	3	4	5
Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

Adapted with permission from: Rosen RC, Cappelleri JC, Smith MD, Lipsky J, Peña BM. Development and evaluation of an abridged, 5-item version of the International Index of Erectile Dysfunction (IIEF-5) as a diagnostic tool for erectile dysfunction. *Int J Impot Res.* 1999;11:319-326. http://www.nature.com.