UROLOGY ASSOCIATES

DR. MATTHEW ALLAWAY DR. VASIL PAROUSIS
DR. JASON RILEY AUDRA HOUSER, CRNP

12234 WILLIAMS ROAD
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PHONE: 301-724-0132
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NEW PATIENT PACKET

New Patient,

Welcome to our practice! We look forward to meeting with you.

To make your appointment run as smoothly as possible, we do have a few requirements:

- Please complete all forms in their entirety and bring them with you to your appointment along with a photo ID and insurance/prescription cards
- Insurance – Some insurance plans require a referral from your primary care physician. It is your responsibility to know if this applies to you and to obtain that referral prior to your appointment. If you were told by your physician's office that a referral was sent, you must call to verify with our office that it was received. All co-pays are due at the time of service. As of 5/1/2023 patients with Medicare only (no secondary) have a co-pay of $30
- It is **VERY IMPORTANT** that you provide us with your medical records prior to each visit. This includes any recent blood work, urine cultures, imaging, procedures, ER visits, hospitalizations etc. – we have included an "Authorization for Release of Medical Records" if needed.
- We understand that things come up. We do request a 24 hour notice if you cannot make your appointment. Failure to do so may result in a $50 No Show fee that will be due at the time of your next appointment.

We value and respect your time and strive to stay on schedule. Occasionally, a patient emergency arises and we may be running late for your visit. You will have the option to reschedule or stay to be seen as soon as possible. In extreme situations, we may need to reschedule your appointment and we greatly appreciate your understanding – we will contact you as soon possible to make you aware.

Office Hours: Monday-Thursday 7:30am – 5:00pm, Friday hours may vary
Phone Lines are on: Monday –Thursday 8:00am – 4:30pm, Friday 8:00am-Noon

We thank you for working with us in our endeavor to provide an excellent healthcare experience and look forward to your visit!

Sincerely,

Providers and Staff of Urology Associates

Allaway & Parousis Urology MD PA
Ambulatory Urology Surgical Center LLC

Dr. Matthew Allaway, Dr. Vasil Parousis, Dr. Jason Riley, Audra Houser CRNP

Name (First, MI, Last):_____ Soc. Sec. #:_____-_____-_____

Mailing Address:_____

City_____ST_____Zip_____

Date of Birth:_____/_____/_____ Family Physician:_____

Home #_____ Cell #_____ Work #_____

May we leave a message on voicemail/answering machine? YES NO E-Mail_____

Preferred contact for appointment reminders: Call Home, Call Cell, Text Cell (CIRCLE ONE)

[If Minor: Parent/Guardian Name:_____ Relationship:_____Date of Birth_____

HIPAA Notification (Contacts we are authorized to speak with)

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Insurance Information: Complete All Information to Ensure Proper Billing

Name of Primary Insurance:_____

Policy Holder's Info (If other than patient) Name_____ DOB_____

SSN_____

Secondary Insurance:_____

Policy Holder's Info (If other than patient): Name_____DOB_____

SSN_____

Billing Agreement

The patient is responsible for all fees for services rendered and is therefore responsible for proper insurance coverage information. Patients are responsible for all fees associated with their out of network policy, as all insurance companies are not contracted with Urology Associates. All self-pay patients are required to pay for services on the day services are rendered unless other arrangements are made with our office. Co-Pays, deductibles or any non-covered percentages are due by the patient. The patient and/or the patient's insurance carrier may receive a separate bill for the use of the Ambulatory Surgical Center. Patients with Managed Care Insurances are responsible for their referrals from their Primary Care Physician.

Notice of Privacy Practices

I have read and/or received a copy of Urology Associates Notice of Privacy Practices. I acknowledge that Urology Associates keeps medical record for 5 years. At that point, medical records are destroyed.

Patient Consent

I consent to the release of protected health information that is required to carry out treatment and payment for healthcare services performed on my behalf. I also consent to all treatments as deemed appropriate by the treating physician and agree to pay for all such services rendered and/or authorize my insurance company to pay Urology Associates directly. Patients with balances will receive monthly statements. Accounts that are not paid on within 90 days will be turned over to Collection Service Center.

I understand that the information given above is current and correct and that my signature in no way releases my responsibility for payment of charges and services rendered

Signature_____**Date** _____/_____/_____

Ambulatory Urological Surgery Center

Medication Reconciliation

Patient Name:_____ DOB:_____ MR#:_____

Allergies:

Allergen	Reaction

☐ See Patient Allergy Sheet for complete allergy list (if checked)

Medications (Currently Taking):

Medication	Dosage	How often do you take this medication?	Date Last Taken	Continue or Discontinue **(to be completed by physician)**	Resume Date **(to be completed by physician)**
				Continue Discontinue	
				Continue Discontinue	
				Continue Discontinue	
				Continue Discontinue	
				Continue Discontinue	
				Continue Discontinue	
				Continue Discontinue	
				Continue Discontinue	
				Continue Discontinue	
				Continue Discontinue	

Patient Signature: _____ Date: _____

Pre-Operative Nurse: _____ Date: _____

Post-Operative Nurse: _____ Date: _____

PRE-ANESTHESIA QUESTIONAIRE

Patient Name:_____

Date:_____ Patient ID:_____ DOB:_____ History Reviewed by Anesthesiologist _____

Age:_____ Height:_____" Weight:_____lbs. BMI:_____ Procedure:_____

YES	NO	
		Have you had a cold, cough, fever, or the flu in the last two weeks?
		Do you have a history of stroke, mini-stroke, or seizures? If yes, please provide details below.
		Do you have a heart condition? If yes, when was the last time you were seen by your cardiologist?
		Do you get chest pain? Last time you took Nitroglycerin_____
		Have you ever had a blood clot in your arms, legs or lungs?
		Do you have high blood pressure or are being treated for high blood pressure?
		Do you have high cholesterol?
		Do you ever experience shortness of breath?
		Do you have asthma, bronchitis, COPD, or emphysema? If yes, provide details below.
		Do you or did you smoke?
		If yes: Packs per day:_____ Number of years smoked:_____ Year Quit or Current:_____
		Do you have sleep apnea, been told that you snore, use a C-PAP/BiPAP? If yes, please provide details below.
		Do you have acid reflux or GERD?
		Do you take medication on a regular basis for acid reflex or GERD?
		Do you have diabetes? Blood Sugar Result this morning and time you checked it_____
		Do you take insulin?
		Have you had hepatitis or liver disease?
		Do you have a thyroid condition that you take medication for?
		Do you have kidney disease? Are you on dialysis? YES NO
		Do you have back or neck pain?
		Do you have a muscle or nerve disease?
		Have you or a blood relative had difficulties with anesthesia? If yes, please provide details below.
		MEN: Do you take any medications for erectile dysfunction?
		WOMEN: Are you pregnant or breast feeding?
		Do you drink alcohol? If yes, how much per week?_____
		Do you use street drugs or marijuana? How much per week?_____
		Do you have bleeding problems? Are you taking any blood thinners? YES NO
		Have you ever been diagnosed with any form of cancer? If yes, where?_____
		Have you been out of the country in the last month? If yes, where?_____

Additional Medical History: _____

_____

Previous Surgeries: _____

_____

Last time you ate or drank anything? _____

Responsible adult with you today and relationship to you_____

(This person must remain on the facility property and be easily accessible during your entire stay.)

Is it ok to share details about your procedure with them post-operatively? Please circle one. YES NO

Teeth: Please circle all that apply. OWN TEETH CAPS/CROWNS LOOSE TEETH BRIDGE/PARTIAL PLATE

DENTURES: UPPER LOWER

Patient Signature:_____ Date:_____

Urology Associates
12234 Williams Road, Cumberland, MD 21502
Phone: 301.724.0132
Fax: 301.759.5874

Authorization for Release of Medical Records

Patient Name:_____ Date of Birth _____

I hereby authorize the release of my Protected Health Information (PHI):

FROM:
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

TO:
Urology Associates
12234 Williams Road
Cumberland, MD 21502
Phone: 301-724-0132
Fax: 301-759-5874

Description of PHI to be released:
____Entire Medical Record Dates Requested: _____ to _____
____Other: _____
Include Information Relating To: ____ Alcohol/Drug Treatment
____Mental Health Information
____HIV/AIDS Related Information

I understand that this authorization will expire 1 year from the date of signature. I understand that I may revoke this authorization (except to the extent that action was already taken as a result of this signed authorization) at any time by notifying the doctor releasing the information in writing. I understand that this authorization is intended as a release from all legal liability that may arise from the disclosure of the information requested.

_____ _____
Patient Signature (or Representative) Date

_____ _____
Printed name of Representative Relationship to Patient