Northwest Urology LLC

Urology

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Daniel Janoff, MD
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Michael Lavelle, MD
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Pediatric Urology

Daniel Hirselj, MD
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Kelly Bartholomew, PA-C

Welcome to Northwest Urology! For more than 40 years, our board-certified physicians have provided the Portland area with the highest standard of comprehensive urologic care. We look forward to being partners with you in your child's urologic health.

To expedite your registration and check-in process, please complete the enclosed registration and medical history forms and bring them with you to your appointment. Please remember to also bring your insurance card and photo identification. Your appointment may need to be rescheduled if insurance information or photo identification is not provided.

Please review the enclosed financial policy for information about our policies on payment at time of service, self-pay patients, no-show/cancellation policy, and more. If you have healthcare insurance, we strongly encourage you to contact your insurance company prior to your appointment to verify coverage and understand your benefits for your upcoming visit.

Checklist for your upcoming appointment:

- ❒ *Completed* registration/medical history forms (enclosed)
- ❒ *Signed and dated* financial policy (enclosed)
- ❒ Insurance card, and copay/coinsurance (contact your insurance company to verify coverage)

If you have any questions on the contents of this packet or about your child's appointment, please contact us at 503-223-6223.

Thank you for choosing Northwest Urology.

Sincerely,
The Physicians and Staff of Northwest Urology

Northwest Urology LLC

Authorization for Use or Disclosure of Protected Health Information

This form allows us disclose your health information to family members/friends, physicians, and/or organizations you would like involved in your care.

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

I request and authorize **Northwest Urology, LLC** to release protected healthcare information of the above named patient to:

Name of Individual and/or Organization	Relationship to patient	Phone	Fax
Name of Individual and/or Organization	Relationship to patient	Phone	Fax
Name of Individual and/or Organization	Relationship to patient	Phone	Fax

Information to be used or disclosed:

- ☐ **Entire Medical Record**
- ☐ Pertinent Records (last 2 years)
- ☐ Radiology Report(s)
- ☐ Laboratory/Pathology Report(s)
- ☐ Other_____

SPECIALLY PROTECTED RECORDS

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that the information below will be disclosed if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS Information

_____ Mental Health Information

_____ Genetic Testing Information

_____ Drug/Alcohol Diagnosis, treatment, or referral information

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Note: Unless revoked, this authorization will expire one year from date of signing.

_____ _____

Patient/Legal Guardian Signature Date

_____

Printed Name

Northwest Urology LLC

Patient Registration

Patient Name: _____ **Preferred Name:** _____
Last First M.I.

Gender: M F **DOB:** _____/_____/_____ **SSN:** _____-_____-_____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Street Address (if different than mailing): _____

Home Phone: _____ **Mobile Phone:** _____

Work Phone: _____ **Email:** _____

Contact Preference: ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Mail

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Language: _____ **Race:** _____

Ethnicity: ☐ Hispanic or Latino/Spanish ☐ Not Hispanic or Latino ☐ Other

May we send emails possibly containing your private medical information to the email address you provided above? ***Yes No***

May we leave voice messages at your preferred phone number possibly containing your private medical information? ***Yes No***

Would you like to receive automated reminder calls? If you receive the calls via your mobile device, carrier rates may apply. ***Yes No***

Would you like to receive automated text message alerts regarding appointment reminders and more? ***Yes No***

Employer Name: _____

Employer Phone: _____ **Occupation:** _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Preferred Pharmacy Name: _____ **Location or Phone:** _____

How did you hear about us? ☐ Advertising ☐ PCP ☐ Specialist Dr. ☐ Word of Mouth ☐ Patient ☐ Hospital

☐ Insurance Company ☐ Other (please specify): _____

Emergency Contact Name: _____ **Relationship:** _____

Home Phone: _____ **Mobile Phone:** _____

Spouse (Next of Kin) Name: _____ **DOB:** _____/_____/_____

Home Phone: _____ **Mobile Phone:** _____

(continued on back)

Responsible Party for Minor Children (if applicable):

1) Parent/Guardian Name: _____ **DOB:** _____/_____/_____
Last First M.I.

Relationship to patient: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

SSN: _____-_____-_____ **Phone:** _____ **Email:** _____

2) Parent/Guardian Name: _____ **DOB:** _____/_____/_____
Last First M.I.

Relationship to patient: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

SSN: _____-_____-_____ **Phone:** _____ **Email:** _____

Insurance Information:

Primary Insurance: _____ **Effective Date:** _____/_____/_____

ID #: _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____/_____/_____ **Relationship to patient:** _____

Secondary Insurance: _____ **Effective Date:** _____/_____/_____

ID#: _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____/_____/_____ **Relationship to patient:** _____

ASSIGNMENT OF BENEFITS

I hereby assign any medical surgical insurance benefits to Northwest Urology, LLC to allow my provider to obtain payment for services I receive. A photocopy of this assignment is as valid as the original. I understand that I am financially responsible for all charges, whether or not paid in part by insurance. I further authorize Northwest Urology, LLC to release financial information to a health insurer in order to obtain payment for services.

RELEASE OF INFORMATION

It is sometimes necessary for Northwest Urology, LLC to provide information regarding a patient's medical or pharmaceutical history and treatment to other medical providers, hospitals, pharmacies, or medical facilities when required for the patient's medical needs, to facilitate treatment, or to verify benefits. It is also sometimes necessary for those providers to request similar information from Northwest Urology, LLC. I give my authorization for such sharing of information.

Patient/Responsible Party Signature: _____ **Date:** _____

Print Responsible Party Name (if other than patient): _____

Relationship Patient: _____

Northwest Urology LLC

Pediatric Medical History for Date: _____

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

_____

_____

_____

Urological Problems (Please circle answer. If **Y**es, please explain):

Bladder/Kidney/Urinary Tract Infections	N Y _____		How often: _____	
Was there a fever with the infection?	N Y _____		Highest temp: _____	
Pain when urinating?	N	Rarely	Occasionally	Frequently
Penile Infections?	N N/A	Rarely	Occasionally	Frequently
Blood in Urine?	N Y (on a urine test)		Y (visible)	
Toilet Trained?	N Y		What age: _____	
Daytime Urine Leakage?	N	Rarely	Occasionally	Frequently
Get up at night to urinate?	Never	Rarely	Occasionally	Frequently
Bed Wetting?	Never	Rarely	Occasionally	Frequently
Sudden urge to urinate?	N	Rarely	Occasionally	Frequently

How often during the day does he/she urinate?: _____

MEDICATIONS and **DOSAGES**:

_____

_____

ALLERGIES (dietary, medications, other): NO YES:

_____

_____

Past Medical History (Please circle all that apply):

Eyes:	Glaucoma		Other: _____
Neurological:	Seizures	ADD/Hyperactivity	Other: _____
Endocrine (Gland):	Diabetes	Adrenal Disease	Other: _____
Pulmonary (Breathing):	Asthma/Wheezing	Pneumonia	Other: _____
Cardiac (Heart):	High Blood Pressure	Congenital Heart Disease	Other: _____
Gastrointestinal:	Crohn's/UC	GE Reflux	Other: _____
Infections:	Hepatitis	Tuberculosis (TB)	Other: _____

Syndromes/Chromosomal/OTHER problems: _____

Are immunizations up to date? No Yes

Baby born at: _____ weeks **(40 is normal)** **Birth Weight:** _____

Did Mother have problems during pregnancy? No Yes: _____

Drugs or medications taken during pregnancy: _____

Problems at birth?_____

(continued on back)

Surgeries and Dates: _____
Hospitalizations and Dates: _____
Menstruation History: N/A Age of onset: _____ **Date of last period:** _____

Child lives: At Home Foster Home Facility: _____
Child lives with: Mother Father Guardian/Relative Siblings/Other Children: _____
Does child attend school? No Yes **If yes, what time does child get home?**_____

FAMILY Medical Problems (circle)? **Kidney Failure; Urine infection in children; Bleeding disorder; Kidney, Bladder, Genital Abnormalities in Children**

Other: _____

Are you **CURRENTLY** experiencing any of the following:

Constitutional Problems:
- Fevers/Chills No Yes
- Headaches No Yes
- Other: _____

Eye Problems:
- Needs glasses/contacts No Yes
- Blurry vision No Yes
- Other: _____

ENT Problems:
- Congestion/Sinus trouble No Yes
- Recurrent ear infections No Yes
- Sore throat No Yes
- Other: _____

Cardiac (Heart) Problems:
- Turning blue No Yes
- Irregular heartbeat No Yes
- Heart murmur No Yes
- Other: _____

Pulmonary (Breathing/Respiratory) Problems:
- Wheezing No Yes
- Chronic cough No Yes
- Other: _____

GI (Gastrointestinal) Problems:
- Constipation No Yes
- Diarrhea No Yes
- Nausea/Vomiting No Yes
- Abdominal Pain No Yes
- Other: _____

Muscle/Joint Problems:
- Chronic back pain No Yes
- Chronic leg pain No Yes
- Lower extremity coordination concerns No Yes
- Other: _____

Skin Problems:
- Frequent rashes No Yes
- Other: _____

Neurological Problems:
- Learning problems No Yes
- Seizures No Yes
- Developmental delay No Yes
- Other: _____

Psychological Problems:
- Depression No Yes
- Anxiety No Yes
- Other: _____

Endocrine (Gland) Problems:
- Excessive thirst No Yes
- Too hot/cold No Yes
- Other: _____

Heme/Lymph Problems:
- Swollen glands No Yes
- Blood transfusion No Yes
- Clotting problems No Yes
- Other: _____

Genitourinary Problems:
- Incontinence No Yes
- Painful urination No Yes
- Blood in urine No Yes
- Other: _____

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Financial Policy

Thank you for choosing Northwest Urology as your health care provider. As a specialist clinic, it is our policy that patients pay at the time of service for the minimum portion of their bill that is not covered by insurance. Patients who are not prepared to pay may be required to reschedule their appointment. *Patients may still receive a bill* for in-house labs, additional services ordered during their appointment, if the appointment took longer than expected, if their insurance company adjusts the bill, or if new information is acquired bringing about new charges. **These bills are non-negotiable.**

IF YOU ARE INSURED:

What an insurance company pays depends on their policies and the coverage purchased by the patient. It is the patient's responsibility to review their coverage with their insurance carrier prior to their appointment. In order for us to bill an insurance company, the patient must provide us with complete and current insurance information. However, regardless of coverage, the patient is still responsible for the balance of charges incurred. If the patient is a minor, all current insurances must be provided and the appropriate primary policy must be indicated. The responsible party for any supplemental payment must also be designated, as well as their current mailing address. If you request to use our **Card on File**, we will only collect your copayment, if applicable, at the time of service. The remaining balance will be billed to your Visa, Discover, American Express, or MasterCard once your claim is processed by your insurance.

IF YOU ARE NOT INSURED:

If you do not have insurance, are unable to provide proof of insurance in a timely manner, or are on a plan that we do not participate in, full payment is due at the time of service. If you were not already notified, feel free to contact us in advance to receive the estimated amount due for your appointment. As a courtesy for paying in full, you will receive non-elective services at a 20% discount.

FOR ALL PATIENTS:

- Missed appointments or cancellations made with less than 24 hour notice may incur a $55 fee. This fee may also be assessed if a patient is more than 15 minutes late for their appointment. If the physician is delayed in the operating room or running behind in the clinic, a patient is welcome to reschedule his/her appointment.
- Each returned check for stop payment or non-sufficient funds (NSF) will generate a $40 fee.
- Medical records can be downloaded instantly, and free of charge, on our portal at www.nwurology.com. We also offer a password protected CD containing your medical records via mail or pick up for a $5 fee. Printed record requests containing 10 pages or less can be provided for a $30 fee, and $0.25 for each additional page. An additional charge of $5 will be applied for records requests processed within 7 business days. A signed authorization from the patient may be required to release information.
- Accounts with balances exceeding 90 days that are released to a collection agency incur a late fee of $35.
- Additional payment options may be applied for by calling our billing office prior to your visit at 971-244-0798.

I have read, understand, and agree to these financial policies

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Printed Name of Patient or Responsible Party