



Dear Valued Patient,

I would like to take this opportunity to welcome you to the Vantage Urologic Institute and to thank you for choosing our organization for your healthcare needs. Our physicians and staff are committed to providing you with the highest quality healthcare in a comfortable environment. Our physicians are board certified and committed to promoting good health and guiding patients toward a healthy lifestyle.

In order to make your first visit as pleasurable and efficient as possible, please complete our new patient forms and questionnaires prior to your scheduled appointment. You may complete these forms either by using our secure online portal (Your Health File) or downloading and faxing or mailing the completed forms to our office.

Patient's electing to self-register using our secure online portal can email their request to [support@vantageurology.com](mailto:support@vantageurology.com). An invitation will be sent to the email address provided with instructions and a link to begin the registration process.

Alternatively, to view the forms listed below, you will need Adobe Reader. You may download Adobe Reader for free at <http://www.adobe.com/>. Please fax, mail or bring your completed forms with you to our office at the time of your visit.

#### **New Patient Forms**

- 1) New Patient Welcome Letter
- 2) Practice Policies
- 3) Patient Registration
- 4) Assignment of Benefits
- 5) Notice of Privacy Practices and Patients' Rights (Read)
- 6) Acknowledgement of Notice of Privacy Practices and Patient Consent

#### **Questionnaires**

- 1) Health History Questionnaire
- 2) AUA Symptom Score (AUASS) and Quality of Life (QOL) (Males Only)
- 3) Sexual Health Inventory for Men (SHIM) (Males Only)

#### **Medical Records Request**

- 1) Authorization for Use or Disclosure of Protected Health Information (If Applicable)

Please remember the following items for your first appointment:

- 1) Copies of your completed new patient forms and questionnaires
- 2) Insurance card(s)
- 3) Current medications
- 4) Pertinent medical records, operative reports, x-rays, and laboratory results

Also, we request you arrive at least 30 minutes prior to your initial visit so that you may be properly registered and acquainted with our facility and staff.

You are encouraged to view our web site at [www.vantageurology.com](http://www.vantageurology.com) as it will answer many questions you may have regarding the care and services available at the Vantage Urologic Institute.

Thank you again for choosing the Vantage Urologic Institute. We look forward to seeing you.

Sincerely,

D. Russell Locke, M.D., FACS  
Founder and Director

# **PRACTICE POLICIES**

## **Scheduling an Appointment**

Patients are seen by appointment Monday through Friday, 8:00 a.m. to 3:30 p.m. Our receptionists are available daily until 3:30 p.m. to assist with your appointment scheduling. To schedule a routine office appointment, call (352) 861-2115. Alternatively, you may request an appointment using our online health portal (Your Health File).

When scheduling an appointment, please be prepared to provide the following information:

- Patient's name
- Patient's date of birth
- Mailing address
- Daytime phone number
- Insurance information
- Name of the physician who referred you to the Vantage Urologic Institute, if applicable
- Reason for the appointment or a brief description of your symptoms or condition

If you are a new patient or have not visited us in more than one year, please complete our new patient forms and questionnaires prior to your scheduled appointment. You may complete these forms either by using our secure online portal (Your Health File) or downloading and faxing or mailing the completed forms to our office.

If you are not able to keep your appointment as scheduled or are going to be late, please contact our office as soon as possible. This courtesy allows us to be of service to other patients.

We try our very best to stay on schedule, although emergencies sometimes arise. If we are seriously delayed, we will attempt to notify you as soon as possible. Occasionally, we may call patients in the waiting room out of turn if they have an emergency. We ask your patience if you have to wait.

## **Telephone Assistance**

To save you the time and expense of some follow-up visits, we may request that you call us at the office to report on your condition. Our medical staff will take the information, review your medical record with the physician and return your call at the end of the day if it is not an emergency. Should you have questions regarding your condition, medication or treatment, please call our office during normal business hours when we have access to your medical records.

If you need to have your prescription refilled, it is helpful if you know the name and phone number of your pharmacy. If you have your prescription bottle, it is best to keep it handy when speaking with our office staff.

## **Urgent Care and Emergencies**

Should you have an urgent problem, please contact our office immediately at (352) 861-2115. Our phones are answered 24 hours a day.

In a true emergency, it is best to go to the Emergency Department of the nearest hospital where the physician on duty will initiate treatment immediately.

**Referrals**

If you have been referred to the Vantage Urologic Institute by another physician or have a primary care physician, please inform us. We will be able to keep your physician current on your diagnosis and condition.

**Confidentiality**

Your medical record is strictly private. We will not give out information regarding your condition to your employer, friends or relatives without your written authorization. The only exception to this is when required by law.

**Insurance and Billing**

The Vantage Urologic Institute is a provider for Medicare and most major insurance plans. We will do everything possible to ensure your insurance benefits are received by billing all primary and secondary insurances. However, your insurance is a contract between you and your carrier. To ensure that the billing process goes smoothly, please make sure our office has accurate and current insurance information. You are also responsible for any charges that are not covered by your insurance at the time of your appointment, including a co-pay, deductible or other out of pocket expenses. If necessary, our staff is happy to work with patients to set up a payment plan.

If you have questions regarding billing or which insurance plans we accept, please call us at (352) 861-2115. Questions regarding insurance coverage and benefits should be directed to your employer or insurance company.

Patients with HMO type medical insurances must contact their primary care physician to obtain authorization or referral before scheduling an appointment with a medical specialist such as a urologist. Patients with PPO type medical insurances are permitted to schedule appointments directly with a urologist or other medical specialist.

# REGISTRATION

PATIENT INFORMATION										
LAST NAME			FIRST				MI	<input type="checkbox"/> DR. <input type="checkbox"/> MR. <input type="checkbox"/> MS. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS		
DATE OF BIRTH	AGE	RACE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER			MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SEP			
STREET ADDRESS			CITY			STATE	ZIP CODE	HOME PHONE (   )		
EMAIL ADDRESS										
PATIENT'S OCCUPATION			EMPLOYER				EMPLOYER PHONE (   )			
SPOUSE'S LAST NAME			FIRST				MI	<input type="checkbox"/> DR. <input type="checkbox"/> MR. <input type="checkbox"/> MS. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS		
SPOUSE'S OCCUPATION			EMPLOYER				EMPLOYER PHONE (   )			
WHY DID YOU CHOOSE OUR PRACTICE? (PLEASE CHECK ALL THAT APPLY) <input type="checkbox"/> INSURANCE PLAN <input type="checkbox"/> FAMILY <input type="checkbox"/> FRIEND <input type="checkbox"/> INTERNET <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> OTHER										
INSURANCE INFORMATION										
PRIMARY INSURANCE				POLICY #			GROUP #			
SUBSCRIBER'S NAME		SOCIAL SECURITY #		DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER					
SECONDARY INSURANCE				POLICY #			GROUP #			
SUBSCRIBER'S NAME		SOCIAL SECURITY #		DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER					
PRIMARY CARE PHYSICIAN										
LAST NAME			FIRST				MI	SPECIALTY		
STREET ADDRESS			CITY			STATE	ZIP CODE	OFFICE PHONE (   )		
REFERRING PHYSICIAN										
LAST NAME			FIRST				MI	SPECIALTY		
STREET ADDRESS			CITY			STATE	ZIP CODE	OFFICE PHONE (   )		
IN CASE OF EMERGENCY										
NAME OF LOCAL FRIEND OR RELATIVE			RELATIONSHIP TO PATIENT			HOME PHONE (   )		WORK PHONE (   )		
PHARMACY										
PHARMACY NAME (FIRST CHOICE)			LOCATION				PHONE NUMBER (   )			
PHARMACY NAME (SECOND CHOICE)			LOCATION				PHONE NUMBER (   )			
CERTIFICATION										
The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Vantage Health, LLC or insurance company to release any information required to process my claims.										
<b>X</b>										
PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (SIGNATURE)					DATE OF SIGNATURE					
PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (PRINTED NAME)					RELATIONSHIP IF OTHER THAN PATIENT					

# ASSIGNMENT OF BENEFITS

## Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Vantage Health, LLC and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Vantage Health, LLC of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Vantage Health, LLC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

## Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Vantage Health, LLC for all covered medical services and supplies provided to me during all courses of treatment and care provided by Vantage Health, LLC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Vantage Health, LLC, and will constitute a continuing authorization, maintained on file with Vantage Health, LLC, which will authorize and allow for direct payment to Vantage Health, LLC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Vantage Health, LLC.

## Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Vantage Health, LLC. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity if requested. The original authorization will be kept on file by Vantage Health, LLC.

**X**

\_\_\_\_\_  
Patient/Legal Guardian/Authorized Person (Signature)

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Patient/Legal Guardian/Authorized Person (Printed Name)

\_\_\_\_\_  
Relationship If Other Than Patient

**X**

\_\_\_\_\_  
Witness (Signature)

\_\_\_\_\_  
Date of Signature

## **NOTICE OF PRIVACY PRACTICES AND PATIENTS' RIGHTS**

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND YOUR RIGHTS AS A PATIENT. PLEASE REVIEW IT CAREFULLY.**

**If you have any questions about our practices or your rights, please contact:**

**Privacy Officer  
P.O. Box 773730  
Ocala, Florida 34477-3730  
(352) 861-2115  
(352) 854-5726 (Fax)**

This Notice of Privacy Practices, effective September 1, 2018, describes how we may use and disclose your protected health information for treatment, payment or healthcare operations, and for other purposes that are required or permitted by law. It also provides your rights to access and control your protected health information. Protected health information (PHI) is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition, and related health care services.

We reserve our right to revise, make new policies, or change the terms of this notice. Any revisions to our privacy practices will apply to all protected health information that we maintain at that time. We will post a notice of any revised practices in a prominent place on our premises.

The following practice locations and departments comprise Vantage Health, LLC and are covered under this Notice of Privacy Practices and Patients' Rights:

**Vantage Urologic Institute**

**Carlyle Dermatology**

**Consilience, LLC**

**BioVantra, LLC**

### **USES AND DISCLOSURES OF YOUR HEALTH INFORMATION**

All departments and offices comprising our practice, will use, share and disclose your protected health information as necessary for quality health care, treatment, payment, and our health care operations. We will not ask you to sign a consent form for uses and disclosures that are allowed, as described in this notice. Otherwise, your written consent will be maintained on file; and you have the right to revoke your consent, unless we have taken action in reliance on your authorization. Your consent to and acceptance of our services will mean that you have consented to our use and disclosure of your protected health information, as provided in this notice.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, including your surgical procedures, drug study participation and/or eligibility, and all in-office ancillary healthcare services provided by our organization. This also includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We will also disclose your protected health information to other outside physicians who may be treating you when we have the necessary permission from you to disclose your protected health information.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your

health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits.

**Health Care Operations:** We will use and disclose your protected health information as necessary to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing activities, drug study/recruitment activities, clinical improvement, professional peer review, business management, accreditation/licensing, and conducting or arranging for other practice-related business activities.

Additionally, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. When your physician or other staff member is ready to see you, we may call you by name while you are in the waiting area. We may use or disclose your protected health information, as necessary, to contact you for appointment or other reminders or notifications.

**Business Associates:** At times it may be necessary for us to provide your protected health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, billing, legal services, etc. These business associates are required to properly safeguard the privacy of your information. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

**Appointments and Services:** Our office and associated health care operations may contact you to provide appointment reminders or information about treatment alternatives, drug studies, or other health-related benefits and services that may be of interest to you.

#### **OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT**

We may further use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In such case, only the protected health information that is relevant to your health care will be disclosed.

**Family and Friends:** With your written approval, and using our best judgment, your protected health information may be disclosed to designated family, friends, and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies:** We may use and disclose your protected health information in an emergency treatment situation. Should such an emergency arise, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If our physician is required by law to provide treatment and we have attempted, but have been unable, to obtain your consent, we may still use or disclose your protected health information in rendering treatment to you.

**Communication Barriers:** We may use and disclose your protected health information if your physician attempts to obtain your consent but is unable to do so due to substantial communication



barriers, and the physician determines, using professional judgment, that you intend to consent to such use or disclosure under the circumstances.

## **OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT**

We may use or disclose your protected health information in the following situations, without your consent or authorization:

**Required by Law/Public Health:** Releases required by law and/or public health activities (e.g. disease, injury, birth/death reporting) and public health investigations;

**Abuse or Neglect:** Releases required for suspected child abuse or neglect, or if you are suspected of being a victim of abuse, neglect, or domestic violence;

**Food and Drug Administration:** Releases to the Food and Drug Administration for reporting adverse events, product defects, or for product recalls;

**Employment:** Releases to your employer when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;

**Regulatory Agencies:** Releases legally required to a government oversight agency conducting audits, investigations, or civil/criminal proceedings;

**Legal Proceedings:** Releases pursuant to a court order, administrative ordered subpoena or discovery request; in most cases you will have notice of such releases;

**Law Enforcement:** Releases to law enforcement as legally required for reporting wounds, injuries, and crimes;

**Coroners and Funeral Directors:** Releases to coroners and/or funeral directors according to applicable laws;

**Organ Donation:** Releases for organ/tissue donation or transplantation, according to your written instructions, or other legal directives;

**Military Requirements:** Releases for military requirements, armed forces services, or if necessary for national security or intelligence activities;

**Workers' Compensation:** Releases to workers' compensation agencies, as applicable to your workers' compensation benefit determinations;

**Research:** Releases to researchers when their research has been approved by an institutional review board; and

**Inmates:** Releases if you are an inmate of a correctional facility and we created or received your protected health information in the course of providing care to you.

## **PATIENTS' RIGHTS NOTIFICATION**

You are entitled to certain rights that you may exercise as described below.

**Access to Protected Health Information:** You have the right to copy and/or inspect much of your protected health information that we retain on your behalf, and that is contained in a designated record set, for as long as we maintain such protected health information. A "designated record set" contains medical and billing records and any other records that your physician and our office used for making decisions about you. Your request to access your protected health information must in writing, dated, and signed by you or your legal

representative.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action, and protected health information that is subject to law that prohibits such access. In some circumstances, you may have a right to have reviewed any decision denying your request for such protected health information.

**Amendments to Protected Health Information:** You have the right to request in writing that your protected health information that we maintain in a designated record set, be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To qualify for consideration, your amendment request must be in writing, dated, and signed by you or your legal representative, and must state the reasons for the requested amendment/correction. Should we make an amendment/correction that you request, we may also notify others within our organization(s) for the amendment/correction of your records that they maintain.

**Accounting for Disclosures of Protected Health Information:** You have the right to receive an accounting of certain disclosures of your protected health information that we make, after September 1, 2018. Requests must be made in writing, dated, and signed by you or your legal representative.

**Restrictions on Use and Disclosure of Protected Health Information:** You have the right to request restrictions on certain of our uses and disclosures of your protected health information. We are not required to agree to your restriction request but will attempt to accommodate reasonable and legal requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe the termination is appropriate. Should we terminate a request, we will notify you. You also have the right to terminate any restriction you impose on us, by providing our organization with a written termination, dated, and signed by you or your legal representative.

**Alternative Means/Alternative Locations:** You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests for alternative means of communications and/or locations. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request to our Privacy Officer.

**Complaints:** If you believe your privacy rights have been violated, you can file a complaint with our Compliance Officer. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

**Access Fees:** We will impose reasonable cost-based fees for certain work and expenses that we incur at your request to provide you with access to information. Such access fees may be imposed for copying, including supplies and labor, postage, and labor in the preparation of explanations or summaries of your protected health information. Such fees will be billed to you as the result of your request for your information and you agree, herein, to pay such fees as charged.

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT

I acknowledge that I have received and reviewed the Notice of Privacy Practices and Patients' Rights pertaining to this office and its affiliated covered entities, and all my questions have been answered to my satisfaction.

Also, I consent to the use or disclosure of my protected health information by the Vantage Health, LLC, and all of its departments, operations, and locations for the purpose of diagnosing or providing treatment, obtaining payment for my healthcare services, or to conduct its healthcare operations that specifically includes all satellite locations, billing and administration, laboratory and pathology.

**X**

\_\_\_\_\_  
Patient/Legal Guardian/Authorized Person (Signature)

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Patient/Legal Guardian/Authorized Person (Printed Name)

\_\_\_\_\_  
Relationship If Other Than Patient

### AUTHORIZATION

In compliance with HIPAA's Privacy Rule, it is the policy of this office to allow properly authorized individuals to have access to your protected health information (PHI). This authorization will remain in force until revoked in writing by the Patient. Please list below the individuals you wish to have access to your protected health information.

1 \_\_\_\_\_  
Name Relationship to Patient

2 \_\_\_\_\_  
Name Relationship to Patient

3 \_\_\_\_\_  
Name Relationship to Patient

4 \_\_\_\_\_  
Name Relationship to Patient

5 \_\_\_\_\_  
Name Relationship to Patient

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**HEALTH HISTORY QUESTIONNAIRE**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: (Last, First, M.I.)

 M  F

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PRESENT UROLOGIC HEALTH CONCERN(S)**

Please describe your current urologic problem(s) and why you are seeking consultation.

**ILLNESSES (Check all that apply)**

Have you ever been diagnosed with any of the following illnesses or medical problems? If yes, include approximate date or year.

<input type="checkbox"/> Abdominal Aortic Aneurysm	Date/Yr:	<input type="checkbox"/> HIV/AIDS	Date/Yr:
<input type="checkbox"/> Alzheimer's Disease	Date/Yr:	<input type="checkbox"/> Hodgkin's Disease	Date/Yr:
<input type="checkbox"/> Anemia	Date/Yr:	<input type="checkbox"/> Kidney Cancer	Date/Yr:
<input type="checkbox"/> Angina	Date/Yr:	<input type="checkbox"/> Kidney Stones	Date/Yr:
<input type="checkbox"/> Asthma/Bronchitis	Date/Yr:	<input type="checkbox"/> Leukemia	Date/Yr:
<input type="checkbox"/> Bladder Cancer	Date/Yr:	<input type="checkbox"/> Lung Cancer	Date/Yr:
<input type="checkbox"/> Breast Cancer	Date/Yr:	<input type="checkbox"/> Malignant Lymphoma	Date/Yr:
<input type="checkbox"/> Cardiac Arrhythmia	Date/Yr:	<input type="checkbox"/> Mitral Valve Prolapse	Date/Yr:
<input type="checkbox"/> Cerebrovascular Accident (Stroke)	Date/Yr:	<input type="checkbox"/> Multiple Sclerosis	Date/Yr:
<input type="checkbox"/> Cervical Cancer	Date/Yr:	<input type="checkbox"/> Osteoarthritis	Date/Yr:
<input type="checkbox"/> Cholelithiasis	Date/Yr:	<input type="checkbox"/> Ovarian Cancer	Date/Yr:
<input type="checkbox"/> Colon Cancer	Date/Yr:	<input type="checkbox"/> Padgett's Disease	Date/Yr:
<input type="checkbox"/> Coronary Artery Disease	Date/Yr:	<input type="checkbox"/> Parkinson's Disease	Date/Yr:
<input type="checkbox"/> Cystocele/Rectocele	Date/Yr:	<input type="checkbox"/> Penile Cancer	Date/Yr:
<input type="checkbox"/> Deep Venous Thrombosis	Date/Yr:	<input type="checkbox"/> Prostate Cancer	Date/Yr:
<input type="checkbox"/> Depression	Date/Yr:	<input type="checkbox"/> Prostate Enlargement (BPH)	Date/Yr:
<input type="checkbox"/> Diabetes	Date/Yr:	<input type="checkbox"/> Prostatitis	Date/Yr:
<input type="checkbox"/> Diverticulosis/Diverticulitis	Date/Yr:	<input type="checkbox"/> Pulmonary Tuberculosis	Date/Yr:
<input type="checkbox"/> Emphysema	Date/Yr:	<input type="checkbox"/> Seizures	Date/Yr:
<input type="checkbox"/> Erectile Dysfunction (ED)	Date/Yr:	<input type="checkbox"/> Testis Cancer	Date/Yr:
<input type="checkbox"/> Genital Condyloma	Date/Yr:	<input type="checkbox"/> Transient Ischemic Attack (TIA)	Date/Yr:
<input type="checkbox"/> Genital Herpes	Date/Yr:	<input type="checkbox"/> Thyroid Disease	Date/Yr:
<input type="checkbox"/> Glaucoma	Date/Yr:	<input type="checkbox"/> Ulcerative Colitis	Date/Yr:
<input type="checkbox"/> Gout	Date/Yr:	<input type="checkbox"/> Urinary Incontinence	Date/Yr:
<input type="checkbox"/> Heart Attack	Date/Yr:	<input type="checkbox"/> Urinary Tract Infection	Date/Yr:
<input type="checkbox"/> Heart Failure	Date/Yr:	<input type="checkbox"/>	Date/Yr:
<input type="checkbox"/> Heart Murmur	Date/Yr:	<input type="checkbox"/>	Date/Yr:
<input type="checkbox"/> Hepatitis	Date/Yr:	<input type="checkbox"/>	Date/Yr:
<input type="checkbox"/> Hiatal Hernia	Date/Yr:	<input type="checkbox"/>	Date/Yr:
<input type="checkbox"/> High Blood Pressure	Date/Yr:	<input type="checkbox"/>	Date/Yr:

**OPERATIONS**

Please list all surgeries including approximate date or year.

Surgery	Diagnosis	Date/Yr.

**MEDICATIONS**

Please list your prescribed drugs and over-the-counter drugs, such as vitamins and nutritional supplements including approximate start date.

Name of Drug	Strength	Frequency Taken	Start Date/Yr.

**ALLERGIES**

Please list all drug allergies including type of reaction.

Drug	Type Reaction

**PERSONAL HISTORY AND HEALTH HABITS**

<b>Marital Status</b>	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow		
<b>Religion</b>			
<b>Occupation</b>			
<b>Physical Activity</b>	<input type="checkbox"/> Non-Ambulatory <input type="checkbox"/> Walking <input type="checkbox"/> Aerobic Training <input type="checkbox"/> Other	<input type="checkbox"/> Limited-Mobility <input type="checkbox"/> Running <input type="checkbox"/> Strength Training	<input type="checkbox"/> Inactive <input type="checkbox"/> Swimming <input type="checkbox"/> Recreational Activities
<b>Dietary</b>	<input type="checkbox"/> Regular <input type="checkbox"/> Low Fat <input type="checkbox"/> Vegetarian <input type="checkbox"/> Other	<input type="checkbox"/> Diabetic <input type="checkbox"/> Renal Failure <input type="checkbox"/> Gluten Free	<input type="checkbox"/> Weight Reduction <input type="checkbox"/> Weight Gain <input type="checkbox"/> Lactose Free

<b>Advance Directive</b>	<input type="checkbox"/> None	<input type="checkbox"/> Living Will	<input type="checkbox"/> Surrogate
<b>Alcohol</b>	<input type="checkbox"/> None		
	<input type="checkbox"/> Beer (drinks/wk): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Wine (drinks/wk): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Liquor (drinks/wk): _____	Duration: _____ years	Date Discontinued: _____
<b>Tobacco</b>	<input type="checkbox"/> None		
	<input type="checkbox"/> Cigarette (pks/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Cigar (#/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Pipe (#/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Chew (#/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Snuff (#/day): _____	Duration: _____ years	Date Discontinued: _____
<b>Drugs</b>	<input type="checkbox"/> None		
	<input type="checkbox"/> Marijuana (#/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Cocaine (#/day): _____	Duration: _____ years	Date Discontinued: _____
	<input type="checkbox"/> Other (#/day): _____	Duration: _____ years	Date Discontinued: _____

### FAMILY HEALTH HISTORY

No History of Familial Disease

Relative (i.e., Father, Mother, Uncle, Sister, etc.)	Illness (i.e., Diabetes, Heart Disease, Prostate Cancer, etc.)

### REVIEW OF SYSTEMS (Check all that apply)

<b>General</b>	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Chills	<input type="checkbox"/> Fatigue
	<input type="checkbox"/> Fever	<input type="checkbox"/> Malaise	<input type="checkbox"/> Sweats
	<input type="checkbox"/> Weight Loss		
<b>Eyes</b>	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Eye Pain
	<input type="checkbox"/> Eye Discharge	<input type="checkbox"/> Vision Loss	<input type="checkbox"/> Eye Irritation
<b>Ears, Nose, and Throat</b>	<input type="checkbox"/> Decreased Hearing	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Ear Pain
	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Pain with Swallowing	<input type="checkbox"/> Nose Bleeds
<b>Cardiovascular</b>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Peripheral Edema	
	<input type="checkbox"/> Palpitations		
<b>Respiratory</b>	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bloody Sputum
	<input type="checkbox"/> Shortness of Breath		
<b>Gastrointestinal</b>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tarry Stools
	<input type="checkbox"/> Bloody Stools		
<b>Genitourinary</b>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Sexual Dysfunction
	<input type="checkbox"/> Difficulty Voiding	<input type="checkbox"/> Urinary Incontinence	

<b>Musculoskeletal</b>	<input type="checkbox"/> Back Pain <input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Joint Swelling
<b>Skin</b>	<input type="checkbox"/> Dryness <input type="checkbox"/> Suspicious Lesion	<input type="checkbox"/> Itching	<input type="checkbox"/> Rash
<b>Neurological</b>	<input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures	<input type="checkbox"/> Weakness	<input type="checkbox"/> Tremors
<b>Psychiatric</b>	<input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Memory Loss
<b>Endocrine</b>	<input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Weight Change	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Increased Thirst
<b>Hematologic and Lymphatic</b>	<input type="checkbox"/> Abnormal Bruising	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Enlarged Lymph Nodes
<b>Allergic and Immunologic</b>	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Itching	<input type="checkbox"/> HIV Exposure
<b>CERTIFICATION</b>			
The above information is true to the best of my knowledge.			
<b>X</b>			
	Patient/Legal Guardian/Authorized Person (Signature)		Date of Signature

## AUA SYMPTOM SCORE (AUASS)

**PATIENT NAME:** \_\_\_\_\_ **TODAY'S 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 hours 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 got 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 LIFE (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)

**PATIENT NAME:** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_\_

## PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

## OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		VERY LOW	LOW	MODERATE	HIGH	VERY HIGH
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	NO SEXUAL ACTIVITY	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
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	DID NOT ATTEMPT INTERCOURSE	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
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	DID NOT ATTEMPT INTERCOURSE	EXTREMELY DIFFICULT	VERY DIFFICULT	DIFFICULT	SLIGHTLY DIFFICULT	NOT DIFFICULT
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	DID NOT ATTEMPT INTERCOURSE	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
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5.

**TOTAL:** \_\_\_\_\_

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED

8-11 Moderate ED

12-16 Mild to Moderate ED

17-21 Mild ED

# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

<b>I HEREBY AUTHORIZE THE VANTAGE HEALTH, LLC TO USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION AS INDICATED BELOW:</b>					
<b>PATIENT INFORMATION</b>					
LAST NAME		FIRST		MI	
DATE OF BIRTH		SOCIAL SECURITY NUMBER			
ADDRESS					
CITY		STATE		ZIP	
DAYTIME PHONE NUMBER (       )		EVENING PHONE NUMBER (       )			
<b>RECORD HOLDER</b>			<b>RECORDS MAY BE RELEASED TO</b>		
NAME			Vantage Health, LLC (dba Vantage Urologic Institute)		
ADDRESS			9401 SW highway 200, STE 502		
CITY		STATE	ZIP	Ocala	FL 34481-9650
PHONE (       )		FAX (       )		(352) 861-2115	(352) 854-5726 (Fax)
<b>INFORMATION TO BE RELEASED</b>					
DATES OF SERVICE		<input type="checkbox"/> ALL		<input type="checkbox"/> DATE RANGE FROM: ____/____/____ TO: ____/____/____	
TYPES OF INFORMATION		<input type="checkbox"/> ALL <input type="checkbox"/> HISTORY & PHYSICAL <input type="checkbox"/> PROGRESS NOTES		<input type="checkbox"/> CONSULTATION REPORTS <input type="checkbox"/> LABORATORY REPORTS <input type="checkbox"/> PATHOLOGY REPORTS <input type="checkbox"/> RADIOLOGY REPORTS <input type="checkbox"/> OP/PROCEDURE REPORTS <input type="checkbox"/> DISCHARGE SUMMARY <input type="checkbox"/> OTHER	
USE OF INFORMATION		<input type="checkbox"/> CONTINUING CARE <input type="checkbox"/> LEGAL		<input type="checkbox"/> SECOND OPINION <input type="checkbox"/> SCHOOL <input type="checkbox"/> PERSONAL <input type="checkbox"/> INSURANCE <input type="checkbox"/> OTHER	
<b>SPECIAL CATEGORIES OF INFORMATION</b>					
<b>YOU MUST SPECIFICALLY AUTHORIZE THE DISCLOSURE OF THE FOLLOWING TYPES OF INFORMATION. (PLEASE CHECK ALL THAT APPLY)</b>					
<input type="checkbox"/> HIV TESTING RESULTS/AIDS INFORMATION		<input type="checkbox"/> ALCOHOL AND/OR DRUG ABUSE TREATMENT		<input type="checkbox"/> PSYCHIATRIC/MENTAL HEALTH RECORDS	
				<input type="checkbox"/> SEXUALLY TRANSMISSIBLE DISEASES	
<b>X</b>					
SIGNATURE PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON				DATE OF SIGNATURE	
<b>I UNDERSTAND THAT:</b>					
1. This authorization may be revoked in writing at any time, according to the instructions in the Vantage Health, LLC Notice of Privacy Practices, except to the extent that action has been taken in reliance on this authorization. <b>Unless otherwise revoked, this authorization is valid for one year from the date signed below.</b> A photocopy of this form will be considered as valid as the original.					
2. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal regulations.					
3. I am under no obligation to sign this authorization. My health care and payment for my health care will not be conditioned on signing this authorization.					
4. I may inspect and obtain a copy of any information disclosed. I may be charged a fee of up to \$1.00 per page for every page copied.					
5. I will get a copy of this form after I sign it.					
<b>BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION.</b>					
<b>X</b>					
PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (SIGNATURE)				DATE OF SIGNATURE	
PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON (PRINTED NAME)			RELATIONSHIP IF OTHER THAN PATIENT		
<b>X</b>					
WITNESS (SIGNATURE)				DATE OF SIGNATURE	