NEW YORK UROLOGY SPECIALISTS
Better Science. Better Health.

New Patient Instructions

33 W. 46 St. 5th Floor New York, N.Y. 10036

Welcome!

It is our pleasure to welcome you to your first visit. We aim to make your experience smooth and efficient. We request that you actively participate in your care. We have outlined a few important requests below.

Please **bring completed forms** to your first appointment. This will help with the registration process.

1. **Patient Information form** - this includes your personal contact information and insurance information necessary to register you with our practice

2. **Medical History** form - this form helps us to learn more about your medical, social and surgical history that may impact your care. Please list all medications you take and your allergies.

3. **Patient Privacy, HIPAA and Assignment of Benefits Authorization** form - this explains our compliance policies with the HIPAA (Health Insurance Portability and Accountability Act) and how to view our Notice of Privacy Policies. This form explains our financial policies and allows you to assign benefits and payments.

4. **Consent for Treatment and Communications** - this provides us with your permission to provide care to you and specifies your communication preferences.

Please **bring the following documents** when you come as they are necessary for us to see you:

- **A valid photo ID**: Driver License, State Issued ID or Passport.
- Your **insurance card**
- If your insurance requires a specialist **referral** or you are an HMO patient, please contact your primary care physician for an insurance referral.

If you are unable to keep your scheduled appointment please give us at least a 24 hour notice of cancellation.

- Please be prepared to give us a urine specimen in the office. Do not bring one with you.
- Please bring all relevant past medical records and studies in particular those that are pertinent to your urological problems. We want to see your past pathology reports, surgery reports, treatment notes. This will help us help you.
- If you have an elevated PSA, please bring all prior PSA test results.
- If you have history of prostate, bladder or kidney cancer, bring all treatment records.
- Please bring X-RAY / MRI / CT / PET / Ultrasound images on CD, DVD or USB discs, and any REPORTS about any radiology testing you may have had

Sincerely,

New York Urology Specialists

Your Urology Health Team
New York Urology Specialists

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NEW YORK UROLOGY SPECIALISTS
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PATIENT INFORMATION

33 W. 46 St. 5th Floor New York, N.Y. 10036

Appointment Date: _____

Last Name	First Name and Middle	Date of Birth	Age	Sex

Initial Questions

How did you hear about New York Urology Specialists? _____

What is your reason for choosing New York Urology Specialists for your urological care? _____

What transportation did you use to arrive to our office?

◯ Walked ◯ Auto ◯ Bus ◯ Train ◯ Taxi ◯ Others _____

How long is your commute to our office? _____

Did you arrive from? ◯ Home ◯ Work ◯ School ◯ Others _____

Is our office most convenient to your: ◯ Home ◯ Work ◯ Others _____

What are your preferred days for medical appointments? _____

Preferred Time of the Day: _____

Personal Details

SS# _____ E-mail address: _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ Country: _____

Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Referring MD: _____ Phone: _____ Fax: _____

Referring MD Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Primary Care Physician Address: _____

City: _____ State: _____ Zip: _____ Country: _____ E-mail: _____

Please list any other doctors that you see:

Name: _____ Phone: _____ Specialty: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Employment: ◯ Full time ◯ Part time ◯ Not Employed ◯ Self Employed ◯ Retired ◯ Military Duty

Student: ◯ Full time ◯ Part time ◉ Not a Student

Preferred Pharmacy

Preferred Pharmacy: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip _____

Mail-in or Alternate Pharmacy: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip _____

Emergency Contact

Phone #: _____ Name: _____ Relationship to Patient: _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Primary Insurance Information

Effective Date: _____ Insurance Company: _____ Specialist Copay _____

Employer: _____ Patient's Relationship to subscriber: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID#: _____ Group # _____ Policy Phone # _____

Secondary/Additional Insurance Information

Effective Date: _____ Insurance Company: _____ Specialist Copay _____

Employer: _____ Patient's Relationship to subscriber: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID#: _____ Group # _____ Policy Phone # _____

Spouse/Partner/Next of Kin Information

Name: _____ Relationship to Patient: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Sex: ◯ Male ◯ Female Date of Birth: _____ E-mail: _____

Additional Information

Race: ◯ White ◯ Hispanic ◯ African American ◯ Asian ◯ Native American

◯ Pacific Islanders ◯ Other:

Language: _____ Preferred Contact Number: _____

Payment Method

We request the following information as a guarantee of payment for services provided if you are a self-pay patient or if services are not covered by your insurance plan or if your deductible has not been met or any copayments or coinsurance is past due. Outstanding balances that are past due 15 days from the date of the first statement will be automatically charged to your debit or credit card. We accept Visa, MasterCard, American Express and PayPal. NO CHARGES WILL BE PROCESSED WITHOUT PRIOR NOTIFICATION. Please contact us if you have any questions regarding your statements.

How will you be paying for services rendered? ◯ Cash ◯ Check ◯ Credit Card

MC/VISA/Discover Number: | | | | | | | | | | | | | | | | Expiration Date: | | – | |

Card Verification Number: | | | | | | (For Visa & MasterCard, 3 last digits on the back of the card; For AMEX, 4 digits on the front of the card)

Personal Health Information Release- Provider can release necessary information related to my course of treatment

Patient Affirmation

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance. I authorize treatment by the physicians at New York Urology Specialists.

_____ Signature

_____ Date

NEW YORK UROLOGY SPECIALISTS
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MEDICAL HISTORY

33 W. 46 St. 5th Floor New York, N.Y. 10036

Date: _____

Height: _____ Ft _____ In Weight (lb): _____

1 Your Details

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Primary Care Physician: _____ Last Seen: _____ Other Specialists: _____

Prior or Referring Urologist: _____ Last seen: _____

Main Reason for Today's Visit: _____

☐ No Known Drug or Medication Allergies (NKDA)

Allergy Caused by	Reaction	Allergy Caused by	Reaction

2 Medications, Vitamins & Supplements

Please list the medications and/or over-the-counter supplements, vitamins. Please include anti-coagulants (blood thinners) including aspirin, coumadin (warfarin), Plavix (clopidogrel), Xarelto (Rivaroxaban), ELIQUIS (apixaban), Pradaxa (dabigatran).

Name	Dose & Frequency	Name	Dose & Frequency

3 Past Medical History

☐ No prior illness or medical/health problems

Yes	No		Yes	No	
○	○	Kidney Stones	○	○	Prostate cancer _____
○	○	Kidney problems	○	○	Bladder cancer _____
○	○	Gout	○	○	Kidney cancer _____
○	○	Urine/kidney infections	○	○	High blood pressure _____ years
○	○	Low testosterone	○	○	High cholesterol _____
○	○	Enlarged prostate (BPH)	○	○	Chest pain / ischemia / angina _____
○	○	ED (erectile dysfunction)	○	○	Heart problems / Myocardial infarction _____
○	○	Premature ejaculation (PE)	○	○	Stroke / CVA / TIA _____
○	○	Infertility (male or female)	○	○	Diabetes How long: _____ HbA1C: _____
○	○	Thyroid problems	○	○	Blood clots / DVT / coagulation or bleeding
○	○	Liver problems or hepatitis	○	○	Alzheimers / Dementia
○	○	Lung problems (asthma, COPD)	○	○	Neurological problems
○	○	HIV / AIDS	○	○	Back problems / Pain
○	○	STD (Gonorrhea, chlamydia, herpes, warts etc)	○	○	Arthritis
○	○	Sleep problems / Sleep apnea	○	○	Chemotherapy
○	○	Snoring	○	○	Radiation therapy
○	○	Psychiatric problems			

List Other Medical Problems

Please list ALL prior surgeries/operations/procedures: ☐ No surgeries or procedures

Do you have any metal implants, a pacemaker or a defibrillator? ◯ Yes ◯ No Date_____

Have you had a colonoscopy? ◯ Yes ◯ No Date_____

Have you had Kidney Surgery or Lithotripsy? ◯ Yes ◯ No Date_____

Have you had hysterectomy or vaginal/uterine surgery? ◯ Yes ◯ No Date_____

Have you had Prostate Surgery, Biopsy or Procedures? ◯ Yes ◯ No Date_____

Have you had cystoscopy, urethral surgery or urinary bladder surgery or procedures? ◯ Yes ◯ No Date_____

Have you had Cardiac catheterization, stent or heart surgery (CABG)? ◯ Yes ◯ No Date_____

Have you had Spine or Back surgery? ◯ Yes ◯ No Date_____

Have you had Spine, Neck or Back surgery? ◯ Yes ◯ No Date_____

additional checkmarks: ☐ Appendectomy ☐ Colon or bowel surgery ☐ Gallbladder / Cholecystectomy

Have you had Hernia repair? ◯ Yes ◯ No

If yes, where ☐ Right inguinal ☐ Left inguinal ☐ Umbilical ☐ Other: _____

Other Surgeries and Procedures:

4 Family History

Family History (If anyone is deceased - list age and cause). Please list biological relations only.

Children (#):_____ ☐ Healthy Medical Problems?_____

Brothers (#):_____ ☐ Healthy Medical Problems?_____

Sisters (#):_____ ☐ Healthy Medical Problems?_____

Mother: Age_____ ☐ Healthy Medical Problems?_____

Father: Age_____ ☐ Healthy Medical Problems?_____

5 Social History

Occupation:_____ Country of Origin_____

Live Alone?_____ Husband or Wife?_____ Significant Other?_____ Parents?_____ Roommate?_____

Tobacco Use ☐ Never

Cigarettes: ☐ Quit_____ when_____ packs/day_____ # of years_____

☐ Current Smoker: packs/day_____ # of years_____

Other tobacco: ◯ Yes ◯ No type_____ amount_____

Alcohol Use

Do you drink alcohol? ◯ Yes ◯ No # drinks/week_____ ☐ Socially (fewer than 1-2 drinks a week)_____

Recreational Drugs

Cocaine / Heroin / Marijuana / LSD / Others: ◯ Yes ◯ No _____

6 Sexual History

Sexually Active?: ◯ Yes ◯ No Satisfied with sexual function? ◯ Yes ◯ No

Do you currently have sexual partner(s): ◯ Yes ◯ No How many (past 2 years): _____

Frequency: ◯ Daily ◯ Few Times a week ◯ Weekly ◯ Few times a month ◯ Monthly ◯ Less than monthly

Sexual Partner Preferences: ◯ Male ◯ Female ◯ Both Males and Females

History of STDs (Sexually Transmitted Diseases)?: _____ Last tested for STD (date): _____

Sexual Practices (Tick all that apply): Want to get tested? ◯ Yes ◯ No

◯ Vaginal Sex ◯ Anal Sex ◯ Oral Sex ◯ No Penetration ◯ Masturbation ◯ Other _____

Men

Difficulty with Erections?: ◯ Yes ◯ No How Long: _____ Prior Treatment? _____

Able to obtain erection? ◯ Yes ◯ No How Long: _____ Prior Treatment? _____

Able to maintain erection? ◯ Yes ◯ No How Long: _____ Prior Treatment? _____

Decreased hardness? ◯ Yes ◯ No How Long: _____ Prior Treatment? _____

Problems with sexual interest?: ◯ Yes ◯ No How Long: _____ Prior Treatment? _____

Problems with ejaculation?: ◯ Yes ◯ No How Long: _____ Prior Treatment? _____

Difficulty with orgasm?: ◯ Yes ◯ No How Long: _____ Prior Treatment? _____

Penile Curvature (bent or curved penis?) ◯ Yes ◯ No How Long: _____ Prior Treatment? _____

No symptoms ☐

Pain in Penis ◯ Yes ◯ No Penile shortening ◯ Yes ◯ No

Difficulty with intercourse ◯ Yes ◯ No Penile narrowing ◯ Yes ◯ No

Women

Are you pregnant: ◯ Yes ◯ No Nursing: ◯ Yes ◯ No

Date of Last Period: _____ Periods: ◯ Regular ◯ Irregular # of Pregnancies: _____

Date of Last delivery: _____ Vaginal Deliveries: _____ C-sections: _____

Pain during intercourse?: ◯ Yes ◯ No _____

Problems with libido/interest?: ◯ Yes ◯ No _____ Difficulty with orgasm? ◯ Yes ◯ No _____

7 REVIEW OF SYMPTOMS

Genitourinary ☐ No prior or current complaints or problems.

	Yes	No	How long?		Yes	No	How long?
Painful urination	◯	◯	_____	Discharge: penis or vagina	◯	◯	_____
Frequent urination (every ___ hrs)	◯	◯	_____	Recent prostate infections	◯	◯	_____
Slow urine stream	◯	◯	_____	Pelvic Pain	◯	◯	_____
Unexpected urinary urgency	◯	◯	_____	Blood in urine	◯	◯	_____
Difficulty emptying your bladder completely?	◯	◯	_____	Blood is visible to the eye	◯	◯	_____
Nighttime urination: # of times per night? _____	◯	◯	_____				
Leakage of urine	◯	◯	_____				

# of pads used per day _____

How Often ◯ 3-5 times/day ◯ Daily ◯ Weekly

Does it happen with cough/laugh/exercise? _____

Does it happen when unable to get to the bathroom on time? _____

Weight Loss or Gain over past 6 months? ◯ Yes ◯ No If yes, # of pounds? _____ ◯ Gained ◯ Lost

Change in appetite: ? ◯ Yes ◯ No _____ Fever? ◯ Yes ◯ No _____ Chills? ◯ Yes ◯ No _____

Skin ☐ No prior or current complaints or problems.

	Yes	No		Yes	No		Yes	No
Genital warts	◯	◯	Severe acne	◯	◯	Abnormal moles or growths	◯	◯
Genital irritation / itchiness	◯	◯	Skin cancer	◯	◯	Other: _____		

Head, neck, eyes, ears, nose and throat ☐ No prior or current complaints or problems.

	Yes	No		Yes	No		Yes	No
Loss of Hearing	◯	◯	Headaches	◯	◯	Loss of balance	◯	◯
Double Vision or Blurred Vision	◯	◯	Snoring at night	◯	◯	Other: _____		

Cardiovascular ☐ No prior or current complaints or problems.

	Yes	No		Yes	No		Yes	No
Chest pain	◯	◯	Palpitations	◯	◯	Heart Attack	◯	◯
Stroke/ TIA	◯	◯	Swelling in legs	◯	◯	Other: _____		

Respiratory ☐ No prior or current complaints or problems.

	Yes	No		Yes	No		Yes	No
Cough	◯	◯	Shortness of breath	◯	◯	TB (Tuberculosis)	◯	◯
Emphysema or Bronchitis	◯	◯	Asthma or wheezing	◯	◯	Other: _____		

Gastrointestinal ☐ No prior or current complaints or problems.

	Yes	No		Yes	No		Yes	No
Heartburn	◯	◯	Nausea	◯	◯	Difficulty swallowing	◯	◯
Constipation	◯	◯	Vomiting	◯	◯	Hemorrhoids	◯	◯
Diarrhea	◯	◯	Blood in stool	◯	◯	Other: _____	◯	◯

Musculoskeletal and Neurologic ☐ No prior or current complaints or problems.

	Yes	No		Yes	No		Yes	No
Muscle pain	◯	◯	Joint Pain	◯	◯	Back pain or problems	◯	◯
Neck pain or problems	◯	◯	Tremors	◯	◯	Muscle weakness	◯	◯
Numbness/Tingling	◯	◯	Convulsions/seizures	◯	◯	Confusion	◯	◯
Loss of consciousness/ Fainting	◯	◯	Other: _____					

Mobility

Yes	No	
◯	◯	Are you able to walk independently?
◯	◯	Do you use an assistive device? ☐ Cane ☐ Walker ☐ wheelchair ☐ Scooter

How far can you walk (blocks or miles) _____ What stops you (shortness of breath, knee pain, etc)? _____

Psychiatric ☐ No prior or current complaints or problems.

	Yes	No		Yes	No		Yes	No
Anxiety	◯	◯	Sleep problems	◯	◯	Stress	◯	◯
Depression	◯	◯	Go to sleep time: _____			Wake up time: _____	Hours of uninterrupted sleep: _____	

Endocrine, Hematologic and Lymphatic ☐ No prior or current complaints or problems.

	Yes	No		Yes	No		Yes	No
Excessive thirst	◯	◯	Lack of energy / Easily tired	◯	◯	Excessive hunger	◯	◯
Heat intolerance	◯	◯	Anemia	◯	◯	Easy bruising/bleeding	◯	◯

_____ _____

Signature Date

REVIEWED BY: Physician: _____ Date: _____

Medical Assistant: _____ Date: _____

NEW YORK UROLOGY SPECIALISTS
Better Science. Better Health.

American Urological Association (AUA) Urinary Symptom Score

33 W. 46th St. 5th Floor New York, N.Y. 10036

MEASURE YOUR SYMPTOMS

Patient Name: _____ **Age:** _____ **Todays Date:** _____

It's easy with the Symptom Calculator! Use this Symptom Calculator to help you evaluate and assess your urinary symptoms.

Do you have any problems when you urinate? We recommend that you talk with a health care provider if your total score on the first seven questions is 8 or greater or if you are bothered at all.

Have you noticed any of the following when you have gone to the bathroom to urinate over the past month? Circle the correct answer for you and write your score in the right-hand column.

	0	1	2	3	4	5
	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

1. Incomplete emptying

Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

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

2. Frequency

Over the past month, how often have you had to urinate again less than two hours after you finished urinating?

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

3. Intermittency

Over the past month, how often have you found you stopped and started again several times when you urinated?

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

4. Urgency

Over the past month, how often have you found it difficult to postpone urination?

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

5. Weak stream

Over the past month, how often have you had a weak urinary stream?

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

6. Straining

Over the past month, how often have you had to push or strain to begin urination?

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

7. Nocturia

Over the past month, how many times 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?

None | 1 time | 2 times | 3 times | 4 times | 5 or more times

Total score: 0-7 mild symptoms; 8-19 moderate symptoms; 20-35 severe symptoms **Total Score:** 0

8. Bother score

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

Delighted | Pleased | Mostly satisfied | Mixed | Mostly dissatisfied | Unhappy | Terrible

Sexual Health Inventory for Men (SHIM)

Patient Name: _____ Age: _____ Todays Date: _____

This questionnaire can help you and your doctor determine if you have symptoms of erectile dysfunction (ED). For each question, circle the number next to the response that best describes your experience. Then add these numbers together and refer to the table below to see what your score may mean. Remember, only your doctor can decide if you have ED.

In the past 6 months:

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

- ☐ 1. Very low
- ☐ 2. Low
- ☐ 3. Moderate
- ☐ 4. High
- ☐ 5. Very high

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

- ☐ 0. No sexual activity
- ☐ 1. Almost never or never
- ☐ 2. A few times (much less than half the time)
- ☐ 3. Sometimes (about half the time)
- ☐ 4. Most times (much more than half the time)
- ☐ 5. Almost always or always

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

- ☐ 0. Did not attempt intercourse
- ☐ 1. Almost never or never
- ☐ 2. A few times (much less than half the time)
- ☐ 3. Sometimes (about half the time)
- ☐ 4. Most times (much more than half the time)
- ☐ 5. Almost always or always

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

- ☐ 0. Did not attempt intercourse
- ☐ 1. Extremely difficult
- ☐ 2. Very difficult
- ☐ 3. Difficult
- ☐ 4. Slightly difficult
- ☐ 5. Not difficult

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

- ☐ 0. Did not attempt intercourse
- ☐ 1. Almost never or never
- ☐ 2. A few times (much less than half the time)
- ☐ 3. Sometimes (about half the time)
- ☐ 4. Most times (much more than half the time)
- ☐ 5. Almost always or always

0

Score	You may have signs of
1-7	Severe ED
8-11	Moderate ED
12-16	Mild to moderate ED
17-21	Mild ED
22-25	No signs of ED

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Pfizer

Patient Name: _____ Age: _____ Todays Date: _____

ERECTION HARDNESS SCORE

Please choose the option that best represents how hard your erection is on a scale 1-4.

☐ **GRADE 1**	Penis is larger but not hard
☐ **GRADE 2**	Penis is hard but not hard enough for penetration
☐ **GRADE 3**	Penis is hard enough for penetration but not completely hard
☐ **GRADE 4**	Penis is completely hard and fully rigid

Low Testosterone Questionnaire

ADAM Questionnaire (Androgen Deficiency in the Aging Male)

	Answer YES or NO to each of the following questions:	Yes	No
1.	Do you have a decrease in libido (sex drive)?	☐	☐
2.	Do you have a lack of energy?	☐	☐
3.	Do you have a decrease in strength and/or endurance?	☐	☐
4.	Have you lost height?	☐	☐
5.	Have you noticed a decreased "enjoyment of life?"	☐	☐
6.	Are you sad and/or grumpy?	☐	☐
7.	Are your erections less strong?	☐	☐
8.	Have you noticed a recent deterioration in your ability to play sports?	☐	☐
9.	Are you falling asleep after dinner?	☐	☐
10.	Has there been a recent deterioration in your work performance?	☐	☐

0

If you answer "Yes" to questions 1 or 7 , or any 3 other questions, ask your healthcare provider if you could have a medical condition caused by low T and if you should be tested.

NEW YORK UROLOGY SPECIALISTS
Better Science. Better Health.

Consent for Treatment and Communications

33 W. 46 St. 5th Floor New York, N.Y. 10036

AUTHORIZATION TO RELEASE LAB AND DIAGNOSTIC TEST RESULTS: I understand that **New York Urology Specialists** policy is to notify patients of any abnormal labs or diagnostic test results as soon as possible. I indicated below which results may be released, how and to whom that information may be released. (You may choose more than one option).

I give my permission to **New York Urology Specialists** to use my address, phone number, email and clinical information to contact me, and/or other physicians, with appointment changes, surgery scheduling, prescription messages, test results, laboratory results and/or other related health information.

- ☐ If New York Urology Specialists contacts me by phone, I give them permission to leave a phone message on my answering machine, voice mail or cellular phone containing protected medical information.
- ☐ Give my results to me personally. My daytime phone number is _____
  (If you are not available to speak to us, we will leave a message to call our office).

I give the following people permission to receive tests results by phone, pick up prescriptions, medical records, radiology discs, pathology slides, disability forms, work status forms, or school forms on my behalf regarding my health care condition that pertains to my treatment with New York Urology Specialists.

Name: _____ Relationship: _____

Daytime Phone #: _____ Work #: _____ Cell #: _____

Name: _____ Relationship: _____

Daytime Phone #: _____ Work #: _____ Cell #: _____

I have been made aware and understand that **New York Urology Specialists** office may use an electronic prescription system which allows prescriptions to be electronically sent between doctors and my pharmacy. I understand that my doctor will be able to see information about medications I am already taking, including those prescribed by other providers.

CONSENT FOR TREATMENT: I voluntarily consent to my treatment at this medical practice and authorize such treatments, examinations, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physician. I have read this consent, and I am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to me concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND VOLUNTARILY AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

_____	_____	_____
Patient's Name (PRINT)	**Patient's Signature**	**Date**

As required by the Health Portability Act of 1996, New York Urology Specialists may not use or disclose your health information without your authorization. Your signature on this form indicates you are giving permission for the uses herein.

NEW YORK UROLOGY SPECIALISTS
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Medical Records Release Authorization

33 W. 46 St. 5th Floor New York, N.Y. 10036

Instructions to Patients:

Please list all medical providers (physicians, hospitals, radiology, pathology, etc.) that have relevant medical records that you wish to release to New York Urology Specialists. Your complete medical, surgical and urological history is needed to provide you with outstanding urology care.

Medical Provider (Doctor, Hospital, etc.): _____
Address: _____
City, State, and Zip Code: _____
Phone Number: _____ Fax Number: _____

Medical Provider (Doctor, Hospital, etc.): _____
Address: _____
City, State, and Zip Code: _____
Phone Number: _____ Fax Number: _____

Medical Provider (Doctor, Hospital, etc.): _____
Address: _____
City, State, and Zip Code: _____
Phone Number: _____ Fax Number: _____

Please release my medical records in your possession concerning my treatment to

New York Urology Specialists
33 W. 46 St., 5th Floor
New York, N.Y. 10036
Phone: 646-663-5252
Fax: 718-285-8555

☐ Please include records from past 12 months
☐ Please include ALL records
☐ Please include the following: _____

Patient Information:

First Name: _____ Last Name: _____

Date of Birth: _____ Phone # _____

_____ _____
Patient's Signature (or Authorized Representative) Date

Please print the name of the Authorized Patient Representative (if any)