WINDHAM UROLOGY GROUP P.C.
Brian S. McLeod, M.D.
63 Canterbury Road
Brooklyn, Ct. 06234
Phone: 860-412-0491
Fax: 860-412-0496

Appointment Date:_____________________________________

Appointment Time: ____________________________________ AM/PM

WINDHAM UROLOGY APPOINTMENT PROTOCOL

It is essential that all paperwork mailed to you be filled out completely. **PRIOR** to your visit.

Please be prepared to urinate **at the time** of your appointment. **(DO NOT BRING A SAMPLE WITH YOU).**

Please bring a list of **all medications**, if taken daily. Include dosage and number of times taken per day.

Please be prepared to pay any co-payment required by your insurance company; or, payment in full if we do not participate with your insurance company or if you are a self pay patient.

It is the patient's responsibility to make sure that if a referral is required, we have it on file **PRIOR** to your visit.

If you had X-rays taken at any facility/hospital other than Windham Hospital or Day Kimball Hospital , it is your responsibility to pick them up and bring with you to your appointment. **(A report is not sufficient).**

The policy of this practice is that we will not fill, refill, or call in to any pharmacy any narcotic prescription after 5:00pm or on weekends.

THE ABOVE POLICIES AND PROCEDURES ARE DESIGNED TO IMPROVE PATIENT SERVICE AND MINIMIZE WAIT TIMES. ALL PATIENTS ARE EXPECTED TO **ARRIVE FULLY PREPARED.** IF NOT, DUE TO TIME CONSTRAINTS, IT MAY BE NECESSARY TO RE-SCHEDULE YOUR APPOINTMENT.

YOUR COOPERATION IS APPRECIATED.

WINDHAM UROLOGY GROUP, P.C. - PATIENT REGISTRATION & HISTORY FORM

ACCT.#________________ PATIENT NAME:______________________________________DATE:______________

Responsible Party **(if a minor):**____

HOME ADDRESS:____

MAILING ADDRESS:____

HOME PH.#__________________CELL PH. #:__________________ SEX: MALE / FEMALE SS#______________

DATE OF BIRTH:_________________ AGE:________ PRIMARY CARE DR. :_____________________________

EMPLOYER NAME:______________________DUTIES:______________________ WORK PH.#______________

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SPOUSE'S NAME:___________________________ DOB:_______________ SS #:___________________________

SPOUSE'S EMPLOYER:__________________________________ WORK PH. #:____________________________

****

(OTHER THAN PERSON LIVING WITH YOU) IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

NAME:________________________________RELATIONSHIP:_______________ PHONE#:____________________

****

INSURANCE COMPANY____________________________________ POLICY #______________________________

NAME POLICY HOLDER:___________________________________ RELATIONSHIP:__________________________

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I request that payment of authorized insurance benefits be made on my behalf to WINDHAM UROLOGY GROUP, P.C. ID#060972264, local hospital and/or its hospital-based physician for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the CMS or any insurance carrier and its agents any information needed to determine these benefits payable for related services. Also, I HAVE BEEN NOTIFIED OF THE *NOTICE OF INFORMATION PRACTICES* that provides a more complete description of information and disclosures.

SIGNATURE:____

****

PATIENT HISTORY FORM

List any past and present UROLOGIC problems - Including any Urologic Surgeries with dates.

____

____

____

List any past surgical procedures and when they occurred.

____

____

SOCIAL HISTORY: Marital Status: M/S/W/D Do you smoke? Y/N - If yes, how much?____________Ex-Smoker: Year______
Do you drink alcohol? Y/N - If yes, how much?____________Do you drink caffeine? Y/N - If yes, how much?______________

FAMILY HISTORY:

List all serious illnesses in your immediate family. (ie: diabetes, tuberculosis, breast cancer, heart disease, prostate cancer)

Father:____
Mother:____
Siblings:____

REVIEW OF SYSTEMS

Do you now have problems related to the following systems? Please check Y/N

Please explain any **YES** answers in the space provided.

Name:______________________________

Date:____________________

Constitutional Symptoms	**YES**	**NO**	**Musculoskeletal**	**YES**	**NO**
Fever & Chills			Hx of Arthritis		
Weight Loss			Back Pain		
Other:			Other:		
Allergic/Immunologic			**Ear/Nose/Throat/Mouth**		
Hay Fever			Sinus Problems		
Drug Allergies			Other:		
Other:			**Genitourinary**		
Neurological			Incontinence/Leaking Urine		
Dizzy Spells			Painful Urination		
Other:			Blood in Urine		
Endocrine			Male: Problems with erection?		
Fatigue			Female:		
Other:			Menopause		
Gastrointestinal			No. of pregnancies		
Abdominal Pain			Other:		
Nausea/vomiting			**Respiratory**		
Constipation			Problems Breathing		
Other:			Chronic Cough		
Cardiovascular			Other:		
Chest Pain			**Hematologic/Lymphatic**		
High Blood Pressure			Swollen Glands		
Other:			Blood Clotting Problem		
Integumentary			Other:		
Skin Rash			**Psychologic**		
Other:			Any New Stress		
			Other:		

1. **INCOMPLETE EMPTYING** Over the last month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	Not at all 0	Less than 1 time in 5 1	Less than ½ the time 2	About ½ the time 3	More than ½ the time 4	Almost always 5
2. **FREQUENCY** During the last month, how often have you had to urinate again less than 2 hours after you finished urinating?	Not at all 0	Less than 1 time in 5 1	Less than ½ the time 2	About ½ the time 3	More than ½ the time 4	Almost always 5
3. **INTERMITTENCY** During the last month, how often have you stopped and started again several times when you urinated?	Not at all 0	Less than 1 time in 5 1	Less than ½ the time 2	About ½ the time 3	More than ½ the time 4	Almost always 5
4. **URGENCY** During the last month, how often have you found it difficult to postpone urination?	Not at all 0	Less than 1 time in 5 1	Less than ½ the time 2	About ½ the time 3	More than ½ the time 4	Almost always 5
5. **WEAK STREAM** During the last month, how often have you had a weak urinary stream?	Not at all 0	Less than 1 time in 5 1	Less than ½ the time 2	About ½ the time 3	More than ½ the time 4	Almost always 5
6. **STRAINING** During the last month, how often have you had to push or strain to begin urination?	Not at all 0	Less than 1 time in 5 1	Less than ½ the time 2	About ½ the time 3	More than ½ the time 4	Almost always 5
7. **NOCTURIA** During the last 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?	Never 0	1 time a night 1	2 times a night 2	3 times a night 3	4 times a night 4	5 times or more a night 5

MEDICATION LIST

(Please include over-the-counter medications as well as any herbal medications)

NAME: ______________________ **D.O.B.** ____________ **DATE:** __________

PHARMACY NAME: __________________________ **PHONE #:** ____________

DRUG ______________ DOSAGE ________ X PER DAY ______ REASON ____________

DRUG ______________ DOSAGE ________ X PER DAY ______ REASON ____________

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DRUG ______________ DOSAGE ________ X PER DAY ______ REASON ____________

ALLERGIES TO MEDICATIONS

NAME: ______________________________ DOB: __________

Date: ______________________________

PATIENT INFORMATION CONSENT FORM

I hereby give WINDHAM UROLOGY GROUP, P.C. permission to discuss the nature of my condition/treatment and diagnosis with the people listed below:

NAME: ____________________ RELATIONSHIP: __________ UPDATED: __________
Date/Pt. Initials

NAME: ____________________ RELATIONSHIP: __________ UPDATED: __________
Date/Pt. Initials

NAME: ____________________ RELATIONSHIP: __________ UPDATED: __________
Date/Pt. Initials

NAME: ____________________ RELATIONSHIP: __________ UPDATED: __________
Date/Pt. Initials

NAME: ____________________ RELATIONSHIP: __________ UPDATED: __________
Date/Pt. Initials

NAME: ____________________ RELATIONSHIP: __________ UPDATED: __________
Date/Pt. Initials

I ALSO GIVE MY PERMISSION FOR THE DOCTOR'S NAME TO BE LEFT ON MY ANSWERING MACHINE/VOICE MAIL BUT NO MEDICAL INFORMATION IS TO BE LEFT OR DISCUSSED WITH ANYONE OTHER THAN THE NAMES MENTIONED ABOVE.

DO NOT SIGN THIS FORM UNTIL YOU ARRIVE AT THE OFFICE FOR YOUR APPOINTMENT.

Patient Signature: ______________________________ Date: ____________________

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IMPORTANT INFORMATION ABOUT OUR POLICIES

PAYMENT IS EXPECTED AT THE TIME OF SERVICE
Windham Urology Group accepts **CASH; PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER & DEBIT CARDS.** (a $25.00 fee will be charged for any returned checks).

Payment is required at the time of service unless other arrangements have been made in advance. This includes payment for any **DEDUCTIBLES; CO-PAYMENTS and/or CO-INSURANCE** amounts for participating insurance companies. If your co-payment is not paid @ your visit and we need to bill you for it there will be $10.00 billing fee added. (this is to cover our cost).

INSURANCE: If we participate with your insurance carrier, as a **courtesy** we will bill them for the services provided to you. Ultimately, however, you the patient are responsible for all charges. If your insurance carrier requires a **Pre-certification or Referral** for any services rendered it is the patient's responsibility to notify the carrier. Failure to do so will result in reduction or denial of benefit payment and the patient will become responsible for all balances.

UNINSURED PATIENTS: You are responsible for payment in full at the time of service unless other arrangements have been made in advance

SURGICAL CANDIDATES: All of our surgical procedures are **ELECTIVE**. Prior to scheduling a surgical procedure we may ask you for a **DEPOSIT, DEDUCTIBLE OR CO-PAYMENT**. This payment will be required **1 week in advance** of the procedure and must be **paid in CASH**. We will contact your insurance company to check for coverage and any monies owed before the procedure. Our billing specialist will contact you with this information.

I understand that any patient balances **must be paid** within 60 days of a billing statement to avoid late fees and collection activity.

APPOINTMENT PROTOCOL

As a **courtesy**, we make confirming calls 2 days in advance of your scheduled appointment.

We require a 48hour notice of cancellation or re-scheduling of your appointment. If not, you will incur a $45.00 no-show or late cancellation fee. Insurances do not cover this fee so you, the patient, will be responsible for payment. A future appointment will be at the discretion of W.U.G. If you incur 3 or more no-shows or late cancellations, you may be discharged from the practice.

Compliance: By becoming a patient of W.U.G., you the patient are ultimately responsible to follow through with the recommendations of your physician. i.e.: keeping/scheduling follow-up appointments; treatments and/or referrals. If you fail to keep/or comply with the above, you release W.U.G. from any potential complications/liability of non-compliance.

By reading and signing this document, I the undersigned patient (or authorized representative) have read and understand the above policies. **This is a lifetime authorization, unless revoked in writing.**

____ ________________________________
Patient's Name (printed) Date

____
Patient's Signature