TEXAS UROLOGY SPECIALISTS

Michael Wierschem, M.D. • Huong Hegde, M.D. • Ashley Ross, M.D.
Mitchell Moskowitz, M.D.

(Please Fill Out Completely)

Date_____ Home Phone#_____

Cell Phone # _____

Work Phone # _____

E-mail _____

Date of Birth _____ Age_____ Marital Status: M S D W Male Female

Last Name _____First_____Middle_____

Address:_____

City_____State_____ZIP_____

Patient Employer_____Occupation_____

Spouse Name_____ Ok to release Medical Information to spouse? Yes No

Emergency Contact_____Phone_____

Pharmacy Name / Location_____Phone_____

Primary Care Doctor_____Phone_____

PATIENT NAME: _____ DATE: ___/___/_____ MED REC #:_____

DATE OF BIRTH: ___/___/_____ AGE: _____ HEIGHT: _____FT _____IN WEIGHT: _____LBS

Referring Physician: _____ Referring Physician's Phone #:_____ Referring Physician's Address: _____

Primary Care Physician (if Different)_____ Phone #:_____

Race ☐ White ☐ Black ☐ Hispanic / Latin ☐ Asian Other: _____ Sex: ☐ Female ☐ Male

Marital/Family Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Previously widowed? ☐ Yes ☐ No Previous divorce? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No If so, number:_____

Reason for your visit today: _____

Pharmacy Name: _____ Address: _____ City:_____ Zip:_____

Pharmacy Phone #:_____ Pharmacy Fax #: _____

Drug Allergies: _____ Reaction: _____

Other Allergies: _____ Reaction: _____

Medical History

	Yes	No
Angina (chest pain related to heart disease)	☐	☐
Anxiety	☐	☐
Arteriosclerosis (Hardening of the Arteries)	☐	☐
Arthritic Joints	☐	☐
Asthma	☐	☐
COPD	☐	☐
Depression	☐	☐
Deep Vein Thrombosis	☐	☐
Diabetes	☐	☐
Elevated Cholesterol	☐	☐
Gout	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
If yes, do you take antibiotics for dental procedures?	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
HIV	☐	☐
Hypothyroid (Low Thyroid)	☐	☐
Kidney Stones	☐	☐
Pacemaker Placement	☐	☐
Parkinson's Disease	☐	☐
Pulmonary Emboli (Blood Clot in Lung)	☐	☐
Sickle Cell Trait/Disease	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Use of Coumadin	☐	☐
Valvular Heart Disease	☐	☐
Weight Loss	☐	☐

Other:

_____

_____

Medications: (continue on reverse side if more space is needed)

Name	Strength	Frequency
Daily use of aspirin? ☐ Yes ☐ No		

Family History

FAMILY HISTORY of kidney stones? ☐ Yes ☐ No

FEMALES ONLY

pregnancies _____ # children _____

Date of Last Menstrual Period? _____

Date of Last PAP Smear? _____

☐ Normal ☐ Abnormal

MALES ONLY

History of Prostate Infections ☐ Yes ☐ No

Family History of Prostate Cancer? ☐ Yes ☐ No

Date of your last prostate exam? _____

Date of your last PSA test? _____

Surgical History: (continue on reverse side if more space is needed)

Year	Operation	Hospital

Social History

Do you or have you smoked Cigarettes?
☐ Yes ☐ No ☐ Quit (Year_____) # packs per day?___

Do you or have you used alcohol?
☐ Yes ☐ No ☐ Quit (Year_____) # drinks per week? ___

Substance Abuse ☐ Yes ☐ No ☐ Quit (Year_____)

Coffee	Cups Per Day	0	1	2	3	4+
Tea	Cups Per Day	0	1	2	3	4+
Carbonated Drinks	Cans Per Day	0	1	2	3	4+
Water	Cups Per Day	0	1	2	3	4+

Exercise Activity:_____

Occupation:_____

Over the past month, how often have you:	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 had a sensation of not emptying your bladder completely after urinating?	0	1	2	3	4	5
2 had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3 found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
4 found it difficult to postpone urination?	0	1	2	3	4	5
5 had a weak urinary stream?	0	1	2	3	4	5
6 had to push or strain to begin urination?	0	1	2	3	4	5
7 most typically gotten up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	(number of times) 3	4	5

Total score _____

PATIENT REVIEW OF SYSTEMS: Please mark all yes or no

Constitutional--☐Neg

	Yes	No
chills	○	○
fever	○	○

Respiratory--☐Neg

	Yes	No
dyspnea (shortness of breath)	○	○

Gastrointestinal-☐Neg

	Yes	No
diarrhea	○	○

Metabolic/Endocrine--☐Neg

	Yes	No
goiter	○	○

Musculoskeletal-☐Neg

	Yes	No
back pain	○	○

Heent---☐Neg

	Yes	No
double vision	○	○

Cardiovascular--☐Neg

	Yes	No
chest pain	○	○

Integumentary--☐Neg

	Yes	No
rash	○	○

Neurological--☐Neg

	Yes	No
syncope/fainting	○	○

Hema/Lymphatic-☐Neg

	Yes	No
easy bleeding	○	○
petechiae/easy bruising	○	○

Psychiatric--☐Neg

	Yes	No
anxiety	○	○

Additional Information / Medications / Surgical History

_____

_____

_____

_____

11 System ROS

☐ All Negative

FOR DOCTORS ONLY:

CHIEF COMPLAINT

PRESENT ILLNESS

PHYSICAL EXAM

PROCEDURES

LAB

OUTSIDE RECORDS

ASSESSMENT

PLAN

TEXAS UROLOGY SPECIALISTS

AUTHORIZATION FOR RELEASE OF INFORMATION

DATE: _____

I, _____, give my permission for Texas Urology Specialists' physicians and/or staff to discuss my medical treatment, account information, and/or any test results with the following:

Individual's Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*****Note to patient:** We are not able to release records or discuss your care with your spouse or family without a written release.*****

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

_____

(Signature of Patient or Responsible Party) *(Patient Date of Birth)*

Michael Wierschem, M.D. • Huong Hegde, M.D • Ashley Ross, M.D • Mitchell Moskowitz, M.D.
5425 W. Spring Creek Pkwy, Suite 150 • Plano, TX 75024 • T: 972-403-5425
5236 W. University Dr, Suite 4500 • McKinney, TX 75071 • T: 972-596-6733
7777 Forest Lane, Bldg C724 • Dallas, TX 75230 • T: 972-566-5400
www.TexasUrologySpecialists.com

TEXAS UROLOGY SPECIALISTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Urology Specialists is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Urology Specialists.

Print Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

(TUS) Use Only

Date acknowledgement received: _____ by: _____

-OR-

Reason not obtained:

_____

_____

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Name: _____ **Patient Birth date**_____

Today's date _____

Why are we asking these questions? In 2009 Congress passed the HITECH Act to create uniformity among electronic health records. Asking for your language ensures you and your healthcare providers will be able to communicate clearly. We will be asking about race & ethnicity because some groups are at a higher risk of developing certain diseases. This information will be updated in your medical record and will remain confidential.

Preferred Language _____

Circle Ethnicity **HISPANIC OR LATINO** **NOT HISPANIC OR LATINO**

Circle Preferred Method of Contact Home phone Cell phone Work phone Email Mail Home Address

Phone number not previous provided _____ **H C W (circle type)**

Email address: _____

CIRCLE RACE

AFRICAN AMERICAN	HMONG	PACIFIC ISLANDER NOS
ASIAN INDIAN PAKISTANI SRI LANKAN	JAPANESE	POLYNESIAN NOS
CAUCASIAN	KAMPUCHEAN CAMBODIAN	SAMOAN
CHAMORRAN	KOREAN	TAHITIAN
CHINESE	LAOTIAN	THAI
FIJI ISLANDER	MELANESIAN NOS	TONGAN
FILIPINO	MICRONESIAN NOS	VIETNAMESE
GUAMANIAN NOS	NATIVE AMERICAN	UNKNOWN
HAWAIIAN	NEW GUINEAN	
HISPANIC	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS	

Options/Values were selected by HITECH Act and Texas State Tumor Registry.

TEXAS UROLOGY SPECIALISTS

Oncology Care Model Beneficiary Notification Letter

Texas Urology Specialists is participating in a Medicare initiative called the Oncology Care Model. You are receiving this letter because your health care provider has identified you as a patient who may receive care through this initiative. Oncology practices participating in the Oncology Care Model, including **Texas Urology Specialists**, will work with Medicare to improve cancer care for patients receiving chemotherapy.

Your Medicare rights have not been changed.

You still have all the same Medicare rights and protections, including the right to choose which health care provider you see. However, because **Texas Urology Specialists** chose to participate in the Oncology Care Model, all of **Texas Urology Specialists'** Medicare beneficiaries who meet the eligibility criteria of this initiative will receive care under the initiative, including access to patient-focused services (listed below). If you do not wish to receive care under the Oncology Care Model, you must choose a health care provider who does not participate in this initiative to receive care. Regardless of which health care provider you see, Medicare will continue to cover all of your medically necessary services.

The Oncology Care Model aims to improve cancer care.

The Oncology Care Model was designed to help ensure that you receive the right care at the right time by giving your health care provider extra resources to manage your cancer care. Your health care provider will use these resources to give you access to the patient-focused services listed below. Medicare will monitor **Texas Urology Specialists** to make sure you and other people with Medicare receive quality care. **Texas Urology Specialists** will regularly receive information from Medicare about its participation in the initiative.

You will receive access to patient-focused services.

As part of the Oncology Care Model, **Texas Urology Specialists** will give you access to patient-focused services aimed at meeting your individual needs while you are receiving chemotherapy or hormonal therapy. Under the initiative, you can:

- Contact a health care provider who has access to your medical records 24 hours a day, 7 days a week

- Work with your health care provider to create a detailed care plan that meets your needs
- Work with your health care provider to access other patient-focused supportive services

Talk to your health care provider to learn more about these patient-focused services.

These patient-focused services are called Enhanced Services, and Medicare pays for these services via the Monthly Enhanced Oncology Services (MEOS) payment (G9678). Claims for the MEOS payment will appear on your Medicare Summary Notice (MSN) (Medicare billing statement) as "Oncology Care Model {OCM) Monthly Enhanced Oncology Services {MEOS) payment for enhanced care manage {G9678)." Note that the date of service on the MSN may be different from the date on which you actually received services and a health care provider in the practice—other than the health care provider you actually saw—may bill for that service. As shown under the "Maximum You May Be Billed" section of the MSN for the MEOS claim, you will not be responsible for paying for any portion of these patient-focused services; Medicare will cover the full amount of these services.

Your feedback is important.

Medicare may also ask you to answer a survey about the services and care you received from **Texas Urology Specialists**. The survey will be mailed to you. Your feedback will help improve care for all people with Medicare who receive chemotherapy or hormonal therapy.

Find more information.

For more information about the Oncology Care Model, you can:

- Visit www.innovation.cms.gov/initiatives/oncology-care/
- Call_____ at _____
- Call 1-800-MEDICARE (1-800-663-4227). TTY users can call 1-877-486-2048

If you have concerns or complaints about your care, talk to your health care provider, or contact your Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO). To get your BFCC-QIO's phone number, visit Medicare.gov/contacts or call 1-800-MEDICARE.

To find a different health care provider, visit www.Medicare.gov/physiciancompare, or call 1-800-MEDICARE.