Dear Valued Patient,

On behalf of the physicians, associate practitioners, nurses and staff of USMD Physician Services, I want to welcome you to our organization and thank you for choosing a USMD physician to care for you and/or your loved ones.

At USMD, our physicians put their patients' needs first. We are committed to providing you and your family with the highest-quality care and exceptional customer service. Our physicians are board certified and committed to promoting good health and guiding patients toward a healthy lifestyle.

With nearly 70 locations and more than 250 physicians and associate practitioners in just under 20 different specialties, USMD offers convenient locations all across the Dallas-Fort Worth metroplex to care for everyone in your family at every stage of life.

One of the unique features that USMD offers is NextMD for MCNT patients and Follow My Health for UANT patients. Through NextMD and Follow My Health, patients have communication with their physician's office through a protected, online portal. NextMD and Follow My Health also give patients the ability to access and review lab results and request appointments and prescription refills. Please talk with a staff member if you have questions or would like more information.

To learn more about USMD, please visit our website at www.usmd.com.

Again, thank you for choosing USMD for your healthcare needs.

Sincerely,

Richard C. Johnston MD, FACP
Chief Executive Officer and Chief Physician Officer
USMD Health System

USMD Health System

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____ State:_____ Zip Code: _____ Email: _____

Main Contact#: _____ Alternate#:_____ Work#: _____

Date of Birth: _____/_____/_____ Sex: ○ Male ○ Female SS# (optional): _____

Marital Status : ○ Single ○ Married ○ Divorced ○ Widowed Occupation: _____

Patient Referred By: _____ Spouse's Name: _____

Spouse's Date of Birth: _____/_____/_____ Main Contact#: _____ Alternate#: _____

Emergency Contact:_____ Relationship: _____ Phone#: _____

Primary Care Physician: _____ Phone#:_____

Referring Physician: _____ Phone#:_____

Other Patient Information

Which racial category does the patient most closely identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: _____(Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other: _____(Please Specify)

Insurance Information

Primary Insurance:_____ Policy/ID# _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Secondary Insurance: _____ Policy/ID#: _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Complete – Only if Patient is a Minor

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Name: _____ Relationship: _____

Siblings:_____ DOB: _____/_____/_____ Other Siblings:_____ DOB: _____/_____/_____

USMD Health System

GENERAL CONSENT FORM

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

Assignment of Benefits. I authorize USMD Physician Services, ("USMD") to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that USMD will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment. I consent for USMD to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, USMD may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at USMD's expense.

Patient Initials: _____

Electronic Prescription. I understand USMD utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Phone Calls. By providing contact information, I authorize USMD, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of Others in Care. I authorize USMD to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** _____

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone #: _____ Secondary Phone #: _____

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

Patient Financial Policy

I acknowledge receipt of the "Patient Financial Policy." **Patient Initials:** _____

Notice of Privacy Practices

I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** _____

Minor Patient Photograph (when applicable)

I consent for USMD to photograph the minor patient for identification purposes only. **Patient Initials:** _____

_____

Print Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

USMD Health System

FINANCIAL POLICY

Patient Name: _____ Patient Date of Birth:_____/_____/_____

Please read prior to receiving services.

USMD Physician Services ("USMD") recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

- **PAYMENT: Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, USMD will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

- **SELF PAYMENT (PRIVATE, CASH PAYMENT):** If you have no insurance coverage we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

- **MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service.** If your insurance plan requires a referral authorization from a primary care physician please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as **"out of network" or "non covered" treatment**, and you will be responsible for a larger amount or all of the charges. The patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan.

- **MEDICARE:** USMD providers are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

- **AUTOMOBILE ACCIDENT PATIENTS:** We do treat automobile accident patients. However, we are unable to monitor long-term accounts and require payment as a self-paying patient. We will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.

- **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of USMD.

USMD Health System

FINANCIAL POLICY

- **SECONDARY INSURANCE:** The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information. Patient agrees to immediately notify provider of any future additions, changes or deletions in primary or secondary insurance coverage.

- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage will result in full financial responsibility for services rendered.

- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call **(817) 514-5200**.

- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

USMD firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (817) 514-5200.

USMD Health System

HISTORY OF PRESENT ILLNESS

Today's Date: _____

_____ _____ _____ _____/_____/_____
Last Name First Name M.I. D.O.B.

Whom may we thank for referring you to USMD | UANT? ☐ Self ☐ Friend ☐ Physician: _____

Primary Care Physician: _____ Previous Urologist: _____

What is the main reason for your visit:

☐ Elevated PSA
☐ Erectile dysfunction
☐ History of bladder cancer
☐ Vasectomy
☐ Kidney stones
☐ History of kidney cancer
☐ Urinary tract infections
☐ Infertility
☐ History of prostate cancer
☐ Abdominal or flank pain
Blood in urine: ☐ Visible ☐ Invisible
☐ BPH or male voiding symptoms or Incontinence or female voiding symptoms
☐ Other Specify _____

What is the approximate date when the symptoms started or you first became aware of the problem?

Date: _____/_____/_____ or _____ ☐ days ☐ weeks ☐ months ☐ years ago

Describe any previous treatment (medicines, surgery, etc) prior to this visit for the problem:

_____

_____

Complete the following section if the reason for today's visit is for voiding problems (male or female):

How many times during the day do you typically void in the toilet or urinal? _____

How many times do you typically get out of bed at night to urinate? _____

Do you have difficulty starting your urinary stream?	☐ Yes	☐ No
Do you have decreased force in your stream?	☐ Yes	☐ No
Do you have to strain or push to void?	☐ Yes	☐ No
Do you still feel full when you have finished voiding?	☐ Yes	☐ No
Does your stream typically stop and start during voiding?	☐ Yes	☐ No
Do you typically have pain during voiding?	☐ Yes	☐ No
Have you seen blood in your urine?	☐ Yes	☐ No

Complete the following section if the reason for today's visit is for incontinence (male or female):

How many episodes of incontinence do you have in a typical daytime period? _____

How many episodes of incontinence do you have in a typical nighttime period? _____

Are you incontinent with...

Coughing?	☐ Yes	☐ No
Sneezing?	☐ Yes	☐ No
Walking?	☐ Yes	☐ No
Physical activity?	☐ Yes	☐ No

Are you bothered by a need to hurry to get to the bathroom?	☐ Yes	☐ No
Are you incontinent because you cannot get to the bathroom in time?	☐ Yes	☐ No
Do you wear pads to manage incontinence?	☐ Yes	☐ No

If **yes**, type of pad _____ # pads per day _____ # pads per night _____

Last treatment date for a urinary tract infection..... _____/_____/_____

Do you have...

Diabetes?	☐ Yes	☐ No
Stroke or head injury?	☐ Yes	☐ No
Back injury or surgery?	☐ Yes	☐ No
Past radiation therapy?	☐ Yes	☐ No
Weak or numb legs?	☐ Yes	☐ No
Incontinence of stool?	☐ Yes	☐ No

(WOMEN ONLY) Number of pregnancies/deliveries? _____/ _____

USMD Health System

HISTORY OF PRESENT ILLNESS

Patient Name: _____ Date of Birth: _____ /_____ / _____

CURRENT MEDICATIONS

(include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ **NONE**

Name of Medication	Dose (mg)	How often is the medication taken	Reason for taking medication	Physician prescribing
1				
2				
3				
4				
5				
6				
7				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State/Zip:_____

ALLERGIES (include medications, foods, x-ray dyes) or ☐ NONE KNOWN

Name of allergen	Type of reaction	Approximate date
1		
2		
3		
4		

PAST SURGERIES (include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ NONE

Type of Surgery	Date (approximate)	Hospital or City if known
1		
2		
3		
4		
5		
6		
7		
8		

OTHER HOSPITALIZATIONS (include all non surgical hospitalizations) or ☐ NONE

Reasons for Hospital Stay	Date (approximate)	Hospital or City if known
1		
2		
3		
4		
5		
6		
7		

USMD Health System

HISTORY OF PRESENT ILLNESS

Patient Name: _____ Date of Birth: _____ /_____ / _____

MEDICAL CONDITIONS (include past and present medical conditions, check appropriate box)

Condition	NO	Past (Resolved)	Now Active	Date Onset	Specialist MD if applicable
High Blood pressure (hypertension)					
Elevated cholesterol					
Heart attack					
Irregular heart beat (cardiac arrhythmia)					
Congestive heart failure					
Stroke or TIAs					
Ulcers of the stomach or intestine					
Emphysema, COPD, or lung problems					
Asthma					
Diabetes					
Bleeding problems					
HIV/AIDS					
Kidney disease (renal failure)					
Liver disease (hepatitis B or C)					
Seizures					
Thyroid disease					
Psychological or psychiatric disease					
Cancer of any organ (specify)					
Kidney stones					
Glaucoma					
List other conditions					

FAMILY HISTORY

Is there a history in your family of:	No	Yes	Affected relative(s)
Heart attack			
Diabetes			
Prostate cancer			
Kidney cancer			
Kidney stones			
Other significant disease			

TOBACCO HISTORY

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

* If yes, I smoked an average of _____ packs/day for _____ years. I quit in _____(year)

Do you use other tobacco products? ☐ Yes ☐ No

* If yes, please specify _____

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____

Have you ever used intravenous drugs? ☐ Yes ☐ No

OCCUPATION AND MARITAL STATUS

I am currently: ☐ single ☐ married ☐ divorced ☐ widowed

I am: ☐ retired ☐ employed full time ☐ employed part time ☐ unemployed ☐ student

My occupation is/was: _____

USMD Health System

HISTORY OF PRESENT ILLNESS

Patient Name: _____ Date of Birth: _____ /_____ / _____

REVIEW OF SYSTEMS

(Current or Recent Symptoms)

Constitutional

Fever	☐Yes	☐No
Chills	☐Yes	☐No
Headache	☐Yes	☐No
Weight gain over 10 lbs	☐Yes	☐No
Weight loss over 10 lbs	☐Yes	☐No

Neurological (nervous system)

Seizures	☐Yes	☐No
Dizziness	☐Yes	☐No
Numbness in extremity	☐Yes	☐No
Weakness in extremity	☐Yes	☐No
Loss of balance	☐Yes	☐No
Frequent falls	☐Yes	☐No
Tremors	☐Yes	☐No

Endocrine (internal glands)

Excessive thirst	☐Yes	☐No
Cold or heat intolerance	☐Yes	☐No
Excessive fatigue	☐Yes	☐No
Thyroid disease	☐Yes	☐No

Gastrointestinal

Abdominal pain	☐Yes	☐No
Nausea vomiting	☐Yes	☐No
Indigestion/Heartburn	☐Yes	☐No
Diarrhea	☐Yes	☐No
Constipation	☐Yes	☐No
Blood in stools	☐Yes	☐No

Cardiovascular

Chest pain, pressure	☐Yes	☐No
Palpitations	☐Yes	☐No
Calf pain with exercise	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Wake up breathless	☐Yes	☐No
Swelling in legs/ankles	☐Yes	☐No

Integumentary (skin problems)

Unexplained rash	☐Yes	☐No
Frequent boils	☐Yes	☐No

Musculoskeletal

Joint pain	☐Yes	☐No
Which joint_____		
Neck pain	☐Yes	☐No
Back pain	☐Yes	☐No
Recent or chronic		
Muscle weakness	☐Yes	☐No

Respiratory (lungs)

Wheezing	☐Yes	☐No
Frequent coughing	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Coughing up blood	☐Yes	☐No

Hematologic/Lymphatic

Swollen lymph glands	☐Yes	☐No
Bleeding tendency	☐Yes	☐No

Genitourinary (urinary and genital)
(Complete only if not reason for visit)

Painful urination	☐Yes	☐No
Frequent urination	☐Yes	☐No
Urgent urination	☐Yes	☐No
Blood in urine	☐Yes	☐No
Weak urine stream	☐Yes	☐No
Straining to urinate	☐Yes	☐No
Interrupted urine flow	☐Yes	☐No
Incontinence	☐Yes	☐No
Incomplete emptying	☐Yes	☐No
Erectile dysfunction	☐Yes	☐No

Eyes

Blurred vision	☐Yes	☐No
Double vision	☐Yes	☐No
Eye pain	☐Yes	☐No
History glaucoma	☐Yes	☐No
Untreated cataracts	☐Yes	☐No
Retinal disease	☐Yes	☐No

Ear/Nose/Throat/Mouth

Ear infections	☐Yes	☐No
Sore throat	☐Yes	☐No
Hearing loss	☐Yes	☐No
Sinus allergies	☐Yes	☐No
Difficulty swallowing	☐Yes	☐No
Nose bleeds	☐Yes	☐No
Hoarseness	☐Yes	☐No

Psychological

Depression	☐Yes	☐No
Loss of general interest	☐Yes	☐No
Severe anxiety	☐Yes	☐No

Height (inches) _____

Weight (lbs) _____

_____
Patient Name

_____
Date of Birth

_____
Signature

_____
Date