

Fort Bend Urology

Henry T. Pham, M.D.

Adult & Pediatric Urology

16659 SW Freeway, Suite 141 Sugar Land, Tex

Phone: (281)494-8333 Fax: (281)494-8334

New Patient Checklist

- Please fill out the New Patient Demographic and Patient History forms.
(If possible, please fax the completed packet to (281) 494-8334 before your appointment)
- Please bring your Picture ID or Drivers License
- Please bring all of your insurance cards and referral forms required by your insurance company
- Please bring a list of ALL the medications you are currently taking
- Please bring medical records for the reason of your visit. This includes films from recent X-Rays, imaging studies, and recent lab work done.)
- Male Patients- Please fill out an AUA symptom score sheet
- Please be ready to produce a urine specimen in the office

Location

We are located in Medical Office Building 2 of the Methodist Sugar Land Hospital. This is at the corner of Highway 59 and Sweetwater Blvd. Our address is 16659 SW Freeway, Suite 141 Sugar Land, Texas 77479. Our phone number is (281) 494-8333.

Payment

Payment is due at the time of service. This includes any copay, coinsurance, or deductibles. **For payment we accept Visa, Master Card, Cash.**

Please note that we do not accept Check, American Express or Discover cards.

If you would like to know what your responsibility would be for your visit, please call the office and ask for assistance.

We look forward to seeing you in the office!

Welcome !

Henry T. Pham, M.D.

Name: (First) _____ (MI) _____ (Last) _____

DOB: _____ Sex: M F Marital Status: S M D W SS#: _____

Address: (Street) _____ City: _____ State: _____ Zip : _____

Home Tel #: _____ Work #: _____ Cell #: _____

How may we contact you regarding appointments or results? Home Work Cell

May we leave messages on your voice mail? Yes No Email Address: _____

Preferred Language: _____ Ethnicity: Hispanic or Latino (a person of Cuban, Mexican,

Puerto Rican, South or Central American or other Spanish culture/origin) Non Hispanic or Latino

Race: White Black African American American Indian/Alaska Native Pacific Islander Asian Other

Emergency Contact: _____ Relationship: _____

Home Tel #: _____ Work #: _____ Cell #: _____

Employer : _____ Who referred you to our office? Doctor: _____ Other: _____

Pharmacy Name: _____ Pharmacy Phone: (_____) _____

PRIMARY INSURANCE: _____ Phone # _____

Policy Holder: _____ ID #: _____ Group #: _____

Relation to Patient: _____ Date of Birth: _____

SECONDARY INSURANCE: _____ Phone # _____

Policy Holder: _____ ID: _____ Group #: _____

Relation to Patient: _____ Date of Birth: _____

Method of Payment: Visa MasterCard Discover Cash **(NO CHECKS/AMEX ACCEPTED)**

Release of Information: Health information Henry T. Pham, M.D. collects or receives about you may be disclosed to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have reviewed the Notice of Privacy Policies and Practices. I authorize the person(s) listed above to receive all health information about appointments, treatments and/or other information pertinent to my healthcare provided by Henry T. Pham, M.D. I authorize the release of any medical information needed to determine my medical reimbursement benefits under my insurance policy. This includes authorization to obtain medical information from the insurance carrier and pharmacy. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. The insurance may deny coverage for infertility, sexual dysfunction, and pre-existing medical condition. The office has no way of knowing all the terms of the policy.

Patient's Signature: _____ **Date:** _____

Important

There will be a charge of \$50 for missed appointments. We ask that you kindly give 24-hour notice to cancel or reschedule an appointment. _____ **Initials**

We reserve the right to charge patients a \$25 prescription reprinting fee for “lost” or “misplaced” prescriptions or for a request for prescription outside of an office visit. _____ **Initials**

Our office may be able to pull your prescription, lab and claim history from your insurance carrier. I authorize this office to review my prescription, lab, and medical history if available electronically. _____ **Initials**

Dr. Henry Pham is pleased to offer you the opportunity to communicate with him via e-mail. There is no guarantee that e-mail messages will be secure once they are sent. This practice will not release confidential information about you without your written consent. I CONSENT I REFUSE I understand that e-mail messages I send will not be answered. _____ **Initials**

Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance we are committed to help you receive the maximum allowable benefits. **In order to achieve these goals we need your assistance and your understanding of our payment policy.**

Payment for all office services and supplies is due at the time service is rendered. This includes any copay, deductible or co-insurance determined by your insurance company.

We accept cash, MasterCard, Discover and Visa only. We **DO NOT** accept any checks, unless approved in advance through the Business Office. (Returned checks are subject to an additional fee of \$50.00 and will terminate your privilege to pay by check).

We are happy to process your insurance form for reimbursement, but must be provided with appropriate proof of insurance and identification. This is a courtesy we extend to you, but ultimately payment for all charges for care provided is your responsibility.

Please inform us of any changes in your insurance policy. If such information is not provided, you will be responsible for the charges associated with your visit.

Surgical procedures may require a deposit, including deductible and or co-pay. Remaining balances are to be paid within one month of settlement with your insurance company. We pre-approve the surgical procedure with individual insurance carriers to determine benefits, but it is ultimately the patient’s responsibility to pre-approve all surgical procedures and to be aware of conditions of approval, such as obtaining 2nd opinion, etc.

Important- Some insurance plans require patients to obtain referrals and/or preauthorization for services provided with a Specialist (i.e. Urologist). Ultimately it is the patient’s responsibility to obtain the necessary referral or preauthorization from their Primary Care Physician (PCP). If we are not notified and subsequently unable to obtain preauthorization, you will be responsible for the bill.

We emphasize that as a medical care provider, our relationship is with you and not your insurance company. We cannot be responsible for any loss of benefits. It is your responsibility to know your policy. If you have any questions concerning the above information, please do not hesitate to ask us. We are here to help you.

By signing below I acknowledge that I have read and agree with the policy listed above.

Signature of Patient or Guarantor

Date

Last Name: _____ First: _____ Date of Birth: _____

Reason for your visit today: _____

MEDICATIONS LIST: None

ALLERGIES: No known drug allergies
 IV contrast Levaquin Ciprofloxacin
 Aspirin Codeine Penicillin
 Iodine Sulfa Drugs Demerol
 Morphine Latex other _____

FOR FEMALES: Are you currently pregnant? : YES NO Date last menstrual period began: _____

FOR MALES: Are you currently taking Viagra Levitra Cialis

PAST UROLOGICAL HISTORY: None Difficulty starting urination Difficulty stopping urination
 Bed wetting Blood in urine Frequent urination Kidney stones Pain in testis
 Prostate trouble Urgent urination Bladder Infections Burning urination Kidney infections
 Leaking urine Painful urination Swelling of testicles Urinating at night Venereal disease
 Bladder Cancer Kidney Cancer Prostate Cancer Urine infections Incontinence
 Problems with sexual function

PAST MEDICAL HISTORY: None Diabetes High blood pressure High Cholesterol
 Asthma Lung Disorder Heart attack Hemorrhoids Stroke Bleeding Disorder
 Glaucoma Gout Hepatitis Depression Seizures Thyroid Disorder
 Liver disease Other: _____

FAMILY HISTORY: Cancer (Type: _____) Diabetes Heart disease Kidney disease

PREVIOUS SURGERIES: _____

SOCIAL HISTORY:

Are you a smoker? Yes No Secondary smoking exposure
If you are a smoker, please check off: 1/4 pack/day 1/3 pack/day 1/2 pack/day 3/4 pack/day
 1 pack/day 1.25 pack/day 1.5 pack/day less than 1/4 pack/day occasionally Former smoker
 Social smoker Smoking onset date: _____ Quit date _____

Do you drink alcohol? Yes No
If you drink, please check off: Rare Socially Occasionally Former drinker Alcohol dependency
 Recovering alcoholic

Exercise history: Walking Running Cardio Weights Aerobic Cycling Swimming
 Hiking Yoga Active lifestyle, but no organized exercise No exercise

Nutrition history: Poor diet Average diet Good diet Excellent diet Vegetarian

Occupation history: Retired Unemployed Student Full-time Part-time Homemaker

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

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security # _____

I authorize the following individual or organization to disclose the above named individual's health information:

_____ Address: _____

This information may be disclosed TO and used by the following individual or organization:

Henry T. Pham, M.D. Phone: (281)494-8333 Fax: (281)494-8334
16659 S.W. Freeway, Suite 141 Sugar Land, Texas 77479

For the purpose of: _____

Please release the following:

- Progress Notes
- X-Ray Films
- History/Physical Exam
- Medication List
- EKG Reports
- Complete Record from _____ to _____
- Laboratory Results-from _____ to _____
- X-Ray/Imaging Reports-from _____ to _____
- Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Yes, I consent to the release of this information. **No, I do not consent to the release of this information.**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Henry T. Pham, M.D. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness

Information Needed

Name: _____ Date of birth: _____

Email address: _____

Password reset question (30 character limit, **PICK ONE and ANSWER**)

What is your first pet's name?	What is your favorite color?	What is your mother's maiden name?

Form Instructions:

1. Print out the form. Fill in the information. Make sure you give us an email address that you check regularly. Please also review the security information and sign the form indicating that you wish to enroll in the service.
2. If you forget your password, you will have to call the office to have your password reset OR answer your security question above.
3. Send the form back to the office:
Fax: (281)494-8334
Mail: 16659 Southwest Freeway, Suite 141 Sugar Land, Texas 77479
4. The office will set you up for viewing your records online and send you an email with your login name.

I the Patient understand that the Web View portal is **NOT** to be used for urgent or emergency situations. **In the event of an emergency I will call emergency medical services or 911, or go directly to the emergency room.**

I understand that it may take 48 hours to receive a response to an email request. IF I do NOT receive a response within 48 hours I will contact the office at (281) 494-8333.

I the Patient understand that I must notify the office of any changes in email addresses or other circumstances that would affect my access to Web View or access others may have to my health information.

I understand that providers and staff at Fort Bend Urology, the office of Dr. Henry Pham may use Web View to communicate lab and test results to me and I agree to accept this method of communication.

I the Patient understand that I should remember to log out and close my browser when I am finished accessing password protected WebView Portal services. This prevents someone else from accessing my personal information if I leave, share, or use a public computer (i.e. an internet cafe).

Patient Signature and Date: _____