



Dr. Ricky Bare, F.A.C.S.  
Dr. J.G. Cargill III  
Dr. James Brien  
Dr. Michael Burris  
Dr. H. Brooks Hooper  
Kimberly Bullock, FNP

## PATIENT INFORMATION SHEET

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
FIRST MI LAST

SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SEX:  MALE  FEMALE

ADDRESS: \_\_\_\_\_  
STREET  
CITY STATE ZIP

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE: \_\_\_\_\_

MARITAL STATUS (CHECK ONE):  SINGLE  MARRIED  WIDOWED  DIVORCED  SEPARATED  DOMESTIC PARTNER

RACE: \_\_\_\_\_ ETHNICITY:  HISPANIC/LATINO  NON-HISPANIC

HOME PHONE#: (\_\_\_\_) \_\_\_\_\_ CELL PHONE#: (\_\_\_\_) \_\_\_\_\_

EMPLOYMENT STATUS:  FULL-TIME  PART-TIME  UNEMPLOYED  RETIRED  STUDENT

EMPLOYER: \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ PATIENT PORTAL:  YES  NO

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE#: (\_\_\_\_) \_\_\_\_\_

WHO REFERRED YOU TO US? REFERRING PHYSICIAN: \_\_\_\_\_

ADVERTISMENT  FAMILY MEMBER/FRIEND  HEALTH FAIR  HOSPITAL  INTERNET

INSURANCE REFERRAL  YELLOW PAGES  OTHER: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE#: (\_\_\_\_) \_\_\_\_\_

IF PATIENT IS A MINOR, PLEASE PROVIDE NAME OF PARENT(S) OR LEGAL GUARDIANS: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ PHONE#: (\_\_\_\_) \_\_\_\_\_

WE ARE DEDICATED TO PROVIDING THE BEST CARE POSSIBLE TO OUR PATIENTS. WE CAN BETTER ACCOMPLISH THIS GOAL BY OBTAINING YOUR OPINION ON HOW WE ARE DOING. MAY WE CONTACT YOU BY MAIL, E-MAIL, TEXT, OR TELEPHONE FOR OUR SURVEY?  YES  NO

A Division of RTA of WNC

Address: 1 Doctors Park – Asheville, NC 28801 Phone: (828) 253-5314 Fax: (828) 253-0434 Web: [www.ashevilleurological.com](http://www.ashevilleurological.com)



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## Patient Questionnaire

**AUA Admin.**  
 MRN # \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

1. What is the main reason you are seeing the doctor today? \_\_\_\_\_  
 \_\_\_\_\_

2. Was this consultation requested by a Physician?  Yes  No  
 If so, by whom? \_\_\_\_\_

3. Have you seen a Urologist before?  Yes  No  
 If so, which Urologist have you seen? \_\_\_\_\_

4. What pharmacy do you prefer to use? Name \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

5. Please list any medications that you are ALLERGIC to:  **No Known Drug Allergies**


6. List the Names (and Dose, if known) of any prescription or over the counter medications you take  
*\*\*If you have a medication list, please give it to the medical staff\*\**  
 **No Medications**

Medications	Strength	Times taken per day

7. Do you take any of the following blood thinners? (Check those that apply)  **No Blood Thinners**

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Coumadin/Warfarin	<input type="checkbox"/> NSAIDS
<input type="checkbox"/> Plavix	<input type="checkbox"/> Xarelto	<input type="checkbox"/> Pradaxa
<input type="checkbox"/> Other _____		

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

## Patient Questionnaire Continued

**AUA Admin.**  
MRN # \_\_\_\_\_

8. Please list all operations you have ever had (if known, list the date).  **No Operations**


9. Please list ALL medical problems (check all that apply)  **No Medical Problems**

- Blood Pressure – High or Low (circle one)   
  High Cholesterol   
  Diabetes – Type I or Type II (circle one)  
 Thyroid - High or Low (circle one)   
  COPD   
  Heart Disease

Please list any additional medical problems


10. Do you leak urine?     **Yes**     **No**

11. Do you have a family history of any of the following? Place a  in all boxes that apply.

	Father	Mother	Brother	Sister	Children
<b>Bladder Cancer</b>					
<b>Kidney Stones</b>					
<b>Prostate Cancer</b>					
<b>Colon Cancer</b>					
<b>Diabetes</b>					
<b>Heart Disease</b>					
<b>High Blood Pressure</b>					
<b>Kidney Cancer</b>					
<b>Kidney Dialysis</b>					
<b>Lung Cancer</b>					

**Family History Unknown**

12. What is your occupation? \_\_\_\_\_

13. Do you smoke?     Current Every day Smoker     Current Some Day Smoker     Former Smoker

Never Smoked                      Packs smoked per day \_\_\_\_\_

Smoking Duration:     1-5 years     6-10 years     11-20 years     over 20 years

Smokeless Tobacco     Yes             No

14. How many caffeinated drinks do you have each day? \_\_\_\_\_

15. Do you drink alcohol?     Yes     No     Former    How much? \_\_\_\_\_

16. How much do you weigh? \_\_\_\_\_              How tall are you? \_\_\_\_\_ ft    \_\_\_\_\_ inches

A Division of RTA of WNC

## Patient Questionnaire Continued

**AUA Admin.**  
MRN # \_\_\_\_\_

17. Have you ever had a serious problem or been treated for any of the following?  
(Please check *Yes* or *No* for each symptom)

<p><b>Constitutional Symptoms</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 25%;">Yes</th> <th style="width: 25%;">No</th> </tr> </thead> <tbody> <tr><td>Change in appetite</td><td></td><td></td></tr> <tr><td>Weight Change</td><td></td><td></td></tr> <tr><td>Chills</td><td></td><td></td></tr> <tr><td>Fever</td><td></td><td></td></tr> </tbody> </table> <p><b>Eyes</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Glaucoma</td><td></td><td></td></tr> <tr><td>Cataracts</td><td></td><td></td></tr> </tbody> </table> <p><b>ENT</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Nose Bleed</td><td></td><td></td></tr> <tr><td>Difficulty Swallowing</td><td></td><td></td></tr> <tr><td>Hoarseness</td><td></td><td></td></tr> <tr><td>Hearing Loss</td><td></td><td></td></tr> </tbody> </table> <p><b>Respiratory</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Shortness of Breath</td><td></td><td></td></tr> <tr><td>Cough</td><td></td><td></td></tr> <tr><td>Coughing up Blood</td><td></td><td></td></tr> </tbody> </table> <p><b>Cardiac</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Chest Pain</td><td></td><td></td></tr> <tr><td>Heart Attack</td><td></td><td></td></tr> <tr><td>Palpitations</td><td></td><td></td></tr> <tr><td>High Blood Pressure</td><td></td><td></td></tr> </tbody> </table> <p><b>GI</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Abdominal Pain</td><td></td><td></td></tr> <tr><td>Nausea</td><td></td><td></td></tr> <tr><td>Vomiting</td><td></td><td></td></tr> <tr><td>Diarrhea</td><td></td><td></td></tr> <tr><td>Constipation</td><td></td><td></td></tr> </tbody> </table> <p><b>Musculoskeletal</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Arthritis</td><td></td><td></td></tr> <tr><td>Joint Pain</td><td></td><td></td></tr> <tr><td>Joint Replacement</td><td></td><td></td></tr> <tr><td>Back Pain</td><td></td><td></td></tr> </tbody> </table>		Yes	No	Change in appetite			Weight Change			Chills			Fever			Glaucoma			Cataracts			Nose Bleed			Difficulty Swallowing			Hoarseness			Hearing Loss			Shortness of Breath			Cough			Coughing up Blood			Chest Pain			Heart Attack			Palpitations			High Blood Pressure			Abdominal Pain			Nausea			Vomiting			Diarrhea			Constipation			Arthritis			Joint Pain			Joint Replacement			Back Pain			<p><b>Neurological</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 25%;">Yes</th> <th style="width: 25%;">No</th> </tr> </thead> <tbody> <tr><td>Dizziness</td><td></td><td></td></tr> <tr><td>Seizure</td><td></td><td></td></tr> <tr><td>Headache</td><td></td><td></td></tr> <tr><td>Loss of Consciousness</td><td></td><td></td></tr> </tbody> </table> <p><b>Skin</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Rashes</td><td></td><td></td></tr> <tr><td>Non-Healing Lesions</td><td></td><td></td></tr> </tbody> </table> <p><b>Psychiatric</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Nervousness</td><td></td><td></td></tr> <tr><td>Mood Changes</td><td></td><td></td></tr> <tr><td>Depression</td><td></td><td></td></tr> </tbody> </table> <p><b>Endocrine</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Thyroid Trouble</td><td></td><td></td></tr> <tr><td>Diabetes</td><td></td><td></td></tr> </tbody> </table> <p><b>Hematology</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Anemia</td><td></td><td></td></tr> <tr><td>Easy Bruising</td><td></td><td></td></tr> <tr><td>Swollen Glands</td><td></td><td></td></tr> </tbody> </table> <p><b>Genito-Urinary</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Kidney Disease</td><td></td><td></td></tr> <tr><td>Kidney Stones</td><td></td><td></td></tr> <tr><td>Bladder Trouble</td><td></td><td></td></tr> <tr><td>Blood in Urine</td><td></td><td></td></tr> <tr><td>Urinary Infection</td><td></td><td></td></tr> <tr><td>Prostate Gland</td><td></td><td></td></tr> <tr><td>Urinary Incontinence</td><td></td><td></td></tr> <tr><td>Urinary Frequency</td><td></td><td></td></tr> </tbody> </table>		Yes	No	Dizziness			Seizure			Headache			Loss of Consciousness			Rashes			Non-Healing Lesions			Nervousness			Mood Changes			Depression			Thyroid Trouble			Diabetes			Anemia			Easy Bruising			Swollen Glands			Kidney Disease			Kidney Stones			Bladder Trouble			Blood in Urine			Urinary Infection			Prostate Gland			Urinary Incontinence			Urinary Frequency		
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## WHAT IS YOUR Enlarged Prostate (EP) Symptom Score?

Use this scorecard of symptoms. Circle one number in each line. Add the 7 circled numbers to get a total score, then talk to your doctor.

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
had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
stopped and started again several times when you urinated?	0	1	2	3	4	5
found it difficult to postpone urination?	0	1	2	3	4	5
had a weak urinary stream?	0	1	2	3	4	5
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 did you 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

Your score:

Symptom Score:  1-7 Mild  8-19 Moderate  20-35 Severe

Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

## Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Medical Record Number
Address (Street, City, State, ZIP Code)		Telephone Number

I request that my health information or medical billing record be disclosed or restricted, as follows:

**I authorize** the names listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

**\*DO NOT** discuss or provide information to the following individuals or entities:

Authorized Name	Relationship to Patient

Restricted Name/Entity	Relationship to Patient

\*I request the use of **ONLY** the following address and/or phone number(s) to contact me regarding my health or billing information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Patient Rights:** Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

**Physician Office Responsibilities:** Your physician office is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	Date
--	------

If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_

### THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY

**DISPOSITION of PATIENT REQUEST:** The above request for restriction of health information by the above-named patient has been:

\*Granted \_\_\_\_\_ Denied \_\_\_\_\_

\*If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s).

Reason(s) for Denial, if Applicable \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Office Representative: \_\_\_\_\_ Date: \_\_\_\_\_



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## **FINANCIAL POLICY**

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient’s healthcare and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, your insurance coverage, and your financial responsibilities.

**Professional Fees:** Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor’s education/training , and support costs associated with providing and coordinating your care. We will be happy to provide you with detailed fee information at any time.

**Patient Payments:** Co-pays, deductibles, services not covered by your insurance plan, and outstanding balances are due at the time of your appointment. Payments may be made with cash, check or credit card. Returned checks will be subject to the fee allowed by state regulations. Please let us know if you are having a particular financial problem and we will try our best to be understanding. Please feel free to discuss mutually acceptable payment arrangements with our in house Financial Coordinator or our Central Billing Office.

**Insurance Payments:** We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays. If your insurance company has not responded to us within 60 days of a filed insurance claim, the charges will be sent to you directly and you will be responsible for their payment as well as for payment of any other charges incurred consistent with this financial policy.

**Restricted Service:** While we always see patients for emergency care, routine care will only be given to the patients whose accounts are current or who have made financial arrangements with us and are maintaining the conditions thereof.

**Medical Forms:** The completion of disability forms, FMLA forms, and other supplemental insurance forms all require physician and staff time to complete. Accordingly, a fee of \$25.00 will be charged to complete these forms. The fee must be paid by cash or check prior to the completion of the forms.

**Nurse Visit:** Please note that if a patient comes in with an appointment or has a walk in appointment on the clinical staff schedule, charges will be filed with your insurance for services provided during your visit. As a result of charges being filed with your insurance, it is possible that your insurance may apply a co-payment or coinsurance for the visit.

***Acknowledged, agreed, and accepted:***

<b>AUA Admin.</b> MRN # _____
----------------------------------

\_\_\_\_\_  
*Patient Name (Please Print)*

\_\_\_\_\_  
*Patient Date of Birth*

\_\_\_\_\_  
*Patient Signature or Authorized Person*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Relationship to Patient*

**Radiation Therapy Associates of Western North Carolina, PA  
Asheville Urological Associates**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**I hereby acknowledge:** A copy of the Notice of Privacy Practices was given to me.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Patient Date of Birth

\*\*\*\*\*  
**FOR OFFICE USE ONLY**

If an acknowledgment is not obtained, please complete the information below:

Patient's name: \_\_\_\_\_

Date of attempt to obtain acknowledgment: \_\_\_\_\_

Reason acknowledgment was not obtained:

- Patient/family member received notice but refused to sign acknowledgment
- Emergency treatment situation
- Patient was incapacitated and no family member was present
- Unable to communicate due to language barriers
- Other (please describe below)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date



**Assignment of Benefits/Right to Payment, Patient Responsibility  
and Release of Information Form**

AUA Admin. MRN # _____
---------------------------

**Radiation Therapy Associates of Western North Carolina, PA  
Asheville Urological Associates  
PO BOX 60914 CHARLOTTE, NC 28260-0914**

I, the undersigned, irrevocably assign to the provider/entity referenced above (“Provider”), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a “Plan”) in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

**Patient Responsibility**

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

**Release of Information**

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of Patient/Person Legally Responsible

Date: \_\_\_\_\_

\_\_\_\_\_  
Print Name of Patient/Person Legally Responsible

\_\_\_\_\_  
Relationship to Patient  
(If signed by Person Legally Responsible)

\_\_\_\_\_  
Patient Date of Birth