

# LONGWOOD UROLOGICAL ASSOCIATES, PC

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Tel: (617) 277-0100

## PATIENT INFORMATION

SS# \_\_\_\_\_

Your Name \_\_\_\_\_

Your Address \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Home Telephone Number \_\_\_\_\_ Work Telephone \_\_\_\_\_

Sex (M) (F)      Date of Birth \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_

E-Mail address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Referring Physician Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Primary Care Physician Address: \_\_\_\_\_

Marital Status (M) (S) (W) (D) (Other) \_\_\_\_\_ Status: (Employed- Full Time)

(Employed- Part Time) (Not-employed) (Self-Employed (Retired) (Military)

(Full-Time Student) (Part-Time Student) (Not a Student)

Person to Notify in Case of Emergency \_\_\_\_\_ Telephone \_\_\_\_\_

Who May We Thank For Referring You? \_\_\_\_\_

## GUARANTOR INFORMATION

Is the Patient Responsible for the Bill (Y) (N) If no, Guarantor name \_\_\_\_\_

Guarantor Address \_\_\_\_\_ Telephone \_\_\_\_\_

Guarantor's SS# \_\_\_\_\_ Guarantor's Date of Birth \_\_\_\_\_

Guarantor's Employer \_\_\_\_\_

Guarantor's Business Address \_\_\_\_\_ Telephone: \_\_\_\_\_

E-Mail address: \_\_\_\_\_

## INSURANCE INFORMATION

*Please provide your insurance card(s) with this form, and/or complete below:*

Subscriber Name \_\_\_\_\_ Subscriber SS# \_\_\_\_\_

Name of Insurance \_\_\_\_\_ CoPay Amount \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Contact \_\_\_\_\_

Effective Date \_\_\_\_\_ Certificate # \_\_\_\_\_

Group Name \_\_\_\_\_ Group # \_\_\_\_\_

**Please read and sign the statements on the reverse side of this form before returning to check-in.  
We will be pleased to answer any questions that you may have.**



# Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

## Constitutional Symptoms

Fever Y N  
 Chills Y N  
 Headache Y N  
 Other \_\_\_\_\_

## Eyes

Blurred vision Y N  
 Double vision Y N  
 Pain Y N  
 Other \_\_\_\_\_

## Allergic/Immunologic

Hay Fever Y N  
 Drug allergies Y N  
 Other \_\_\_\_\_

## Neurological

Tremors Y N  
 Dizzy spells Y N  
 Numbness/tingling Y N  
 Other \_\_\_\_\_

## Endocrine

Excessive thirst Y N  
 Too hot/cold Y N  
 Tired/sluggish Y N  
 Other \_\_\_\_\_

## Gastrointestinal

Abdominal pain Y N  
 Nausea/vomiting Y N  
 Indigestion/heartburn Y N  
 Other \_\_\_\_\_

## Cardiovascular

Chest pain Y N  
 Varicose veins Y N  
 High blood pressure Y N  
 Other \_\_\_\_\_

## Integumentary

Skin rash Y N  
 Boils Y N  
 Persistent itch Y N  
 Other \_\_\_\_\_

## Musculoskeletal

Joint pain Y N  
 Neck pain Y N  
 Back pain Y N  
 Other \_\_\_\_\_

## Ear/Nose/Throat/Mouth

Ear infection Y N  
 Sore throat Y N  
 Sinus problems Y N  
 Other \_\_\_\_\_

## Genitourinary

Urine retention Y N  
 Painful urination Y N  
 Urinary frequency Y N  
 Other \_\_\_\_\_

## Respiratory

Wheezing Y N  
 Frequent cough Y N  
 Shortness of breath Y N  
 Other \_\_\_\_\_

## Hematologic/Lymphatic

Swollen glands Y N  
 Blood clotting problem Y N  
 Other \_\_\_\_\_

## Psychologic

Are you generally satisfied with your life? Y N  
 Do you feel severely depressed? Y N  
 Have you considered suicide? Y N  
 Other \_\_\_\_\_

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: \_\_\_\_\_

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

# International Prostate Symptom Score (I-PSS)<sup>1,2</sup>

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date Completed \_\_\_\_\_

	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		
<b>1. Incomplete Emptying</b> Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5		
<b>2. Frequency</b> Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5		
<b>3. Intermittency</b> Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5		
<b>4. Urgency</b> Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5		
<b>5. Weak Stream</b> Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5		
<b>6. Straining</b> Over the past month, 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 times or more		
<b>7. Nocturia</b> Over the past 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?	0	1	2	3	4	5		
<b>Total I-PSS Score</b>								
	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible	
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6	

Adapted with permission from Chatelain C et al, eds.<sup>3</sup>

The International Prostate Symptom Score (I-PSS) is based on the answers to 7 questions concerning urinary symptoms. Each question allows the patient to choose 1 of 6 answers indicating increasing severity of the particular symptom. The answers are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

The International Scientific Committee notes that physicians who counsel men with lower urinary tract symptoms (LUTS) use these measures not only during the initial interview but also during and after treatment in order to monitor treatment response.

The International Scientific Committee, under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (IACC), has agreed to use the symptom index for BPH, which has been developed by the American Urological Association (AUA) Measurement Committee, as the symptoms assessment tool for patients.<sup>4</sup>

**Medicare Lifetime Signature on File:**

I request that payment of authorized Medicare benefits be made on my behalf to Longwood Urological Associates, PC for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Private Insurance Authorization for Assignment of Benefits/Information Release:**

I, the undersigned authorize payment of medical benefits to Longwood Urological Associates, PC for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

\_\_\_\_\_  
Patient, Parent or Guardian Signature (if child is under 18 years old)

\_\_\_\_\_  
Date

**Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (HIPAA):**

I, the undersigned understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address that I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restriction to use or disclosure of my health information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I fully understand and accept/decline the terms of this consent.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

LONGWOOD UROLOGICAL ASSOCIATES  
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## Managed Care Patients

Your office visit today requires a Referral from your Primary Care Physician

Your claim will be submitted to your insurance carrier, but if your Referral has not been received by that time, you will assume financial responsibility for the charges incurred.

Signature: \_\_\_\_\_

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