



Welcome to our practice. In order to facilitate your office visit, please complete the enclosed forms and bring them to your appointment. By doing this prior to your office visit, you will help us stay on time and make your visit as efficient as possible.

Unless submitting your forms online, please bring them to your appointment along with the following:

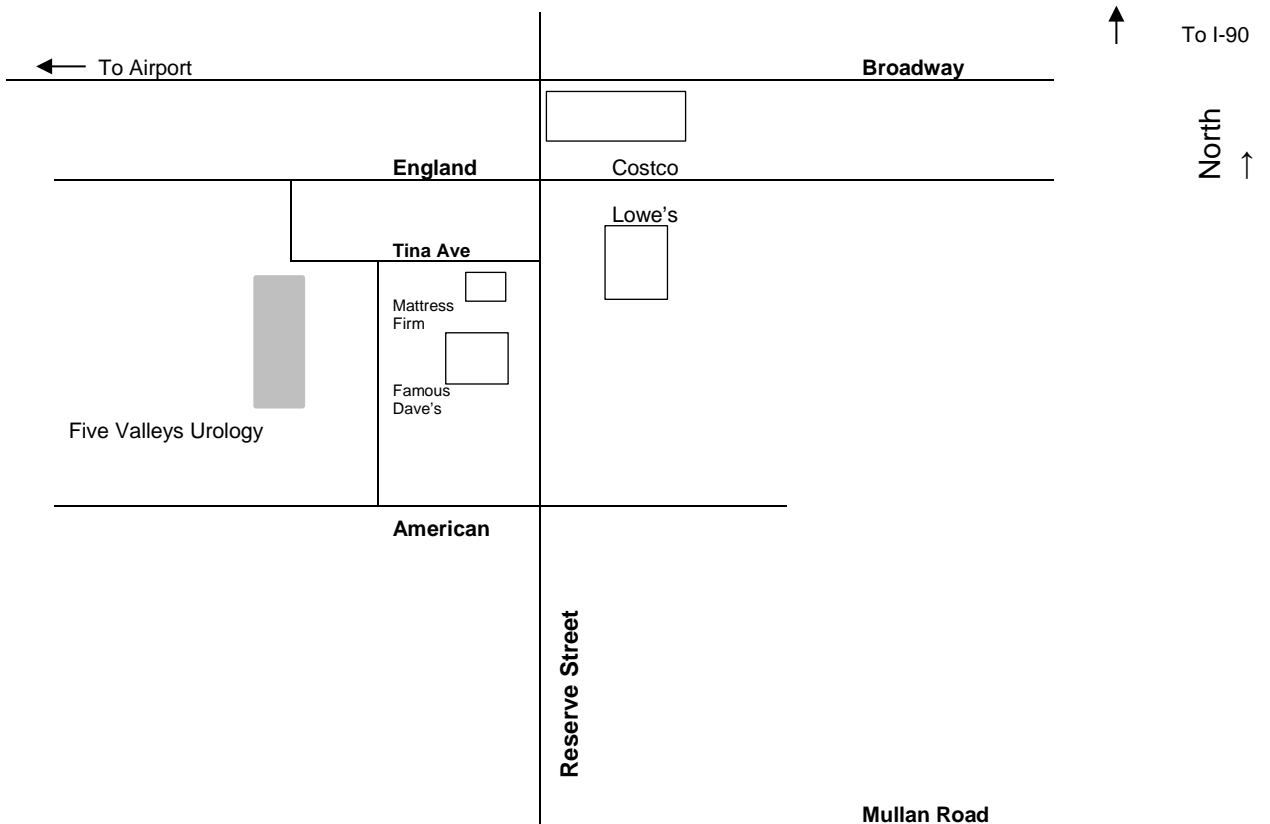
- Insurance card & driver's license or photo ID
- Insurance co-pay for specialist (amount usually found on your insurance card)

Your Appointment details: Appt. date: _____ Check-in Time: _____

- Provider:
- Karl R Westenfelder, MD Garrick R Simmons, MD Kevin M Kronner, MD
- Christopher G Wicher, MD Jeffrey D. Redshaw, M.D.
- Whitney C Martin, PA-C Richard Wiesemann, PA-C

- Urine specimens are requested from most patients so please come prepared to leave a specimen.

If you have questions, call our office at the 728-3366. Our hours are 8 a.m. to 5 p.m., Monday through Friday, or look on our website for more information. www.fivevalleysurology.com



Our Location: 2875 Tina Avenue, Suite 101 Missoula, MT 59808 Phone: (406)728-3366 Fax: (406-728-0651)
Over

Care Provisions Policies

Five Valleys Urology

We appreciate the opportunity to serve you and pledge to provide you our best medical care, with compassion, in a safe environment. In order to make our relationship with you the best it can possibly be, please be familiar with and agree to the following policies:

Administrative Policies

- We promise to treat you with respect & dignity in a professional and caring manner and we will inform you at check-in if your doctor is running late or has been called to surgery. In return we expect you to refrain from using verbally abusive language, threatening any employee or provider, or otherwise hostile behavior. Using such is cause for immediate termination from this practice.
- Many appointments require collection of a urine sample so please check with the front desk upon arrival before going to the bathroom.
- To respect other patients, we ask that cell phones be turned on vibrate mode while in our office.
- In-office procedures require extra supplies and time. Canceling a vasectomy, MonaLisa, or Urolift within 24 hours of appt. will result in a \$75.00 fee. Canceling Urodynamics or SpaceOAR within 72 hours will result in a \$100.00 fee.
- Missing or no-showing your appointment creates an undue burden and increases the cost of care to other patients. Missing three appointments without notice will result in dismissal from this practice.

Insurance & Billing Policies

- If you have insurance, please bring your card to every appointment; without it we cannot bill your carrier. We are required to collect co-payments and co-insurance and reserve the right to re-schedule or cancel appointments to comply with insurance company agreements.
- Your health insurance policy is an agreement between you and your insurance carrier. You are responsible for understanding your own coverage. Your insurance company makes the determination of your eligibility. You authorize your insurance benefits to be transferred directly to the rendering provider and acknowledge you are financially responsible for paying any co-insurance amounts. You agree to pay for services rendered within the limits of this care provisions policy.
- If you do not have insurance, wish not to provide your social security number, or choose not to file a visit with your insurance, a minimum payment of \$100 at time of service is required. The remaining balance for services received will be addressed in our billing statement.
- Many insurance companies have lists of approved drugs they cover. Your provider will prescribe the medication they feel will best address your needs. We will do our best to respond to prior-authorization requests from your insurance company, but this process may delay your prescription. You are responsible for contacting your insurance provider with any questions or requests concerning approved medications.
- Disability, FMLA, and other form completion requests will be processed after a form fee of \$25.00 is received.
- We accept cash, check, credit card, and Care Credit. Payment in full is due within 30 days of your first statement unless other arrangements have been made. We send two statements at 30-day intervals. You understand and agree that if we send your account to collections for non-payment, a fee of 35% of the unpaid balance will be added. This amount shall be in addition to any other cost incurred directly or indirectly to collect amounts owed under this agreement. We offer a financial aid program to patients who meet the criteria.
- If you need a surgical procedure, our surgery coordinator will assist you in scheduling. Although we seek prior authorizations, insurance carriers state they are not a guarantee of payment. You must call your insurance carrier to verify they will cover your procedure.
- If you get lab or imaging tests as part of your appointment remember some tests/labs are performed by outside parties; in such cases they bill separately. If you know your insurance carrier only covers certain labs or facilities, please notify our office in advance.

By signing below you agree to the terms of service provided herein.

Signature (patient or guardian)

Date

Karl R. Westenfelder, M.D., Garrick R. Simmons, M.D. Kevin M. Kronner, M.D., Christopher G. Wicher, M.D.
Jeffrey D. Redshaw, M.D., Richard L. Wiesemann, PA-C, Whitney C. Martin, PA-C
2875 Tina Ave STE 101 Missoula, MT 59808
(406) 728-3366 Fax (406) 728-0651

**Registration
Form**

FIVE VALLEYS UROLOGY

rev. 11/2015

PATIENT INFORMATION

NAME (Last,First, Middle) _____ AGE _____ DOB _____ SEX _____ SOC. SEC. # _____
BILLING ADDRESS _____ PHYSICAL ADDRESS (If Applicable) _____
CITY, STATE, ZIP _____ CITY, STATE, ZIP _____
HOME PHONE _____ CELL PHONE _____ MARITAL STATUS _____
EMAIL ADDRESS _____ SPOUSE/PARTNER NAME _____
OCCUPATION _____ EMERGENCY CONTACT _____
EMPLOYER _____ EMERGENCY PHONE _____
WORK PHONE _____ EMERGENCY CONTACT RELATIONSHIP TO PATIENT _____

PARENT/GUARDIAN INFORMATION IF PATIENT IS A MINOR

FATHER NAME _____ SSN# _____ DOB _____
ADDRESS (IF DIFFERENT FROM PATIENT) _____ CITY, STATE, ZIP _____
HOME PHONE _____ CELL PHONE _____ EMPLOYER/WORK PHONE _____
MOTHER NAME _____ SSN# _____ DOB _____
ADDRESS (IF DIFFERENT FROM PATIENT) _____ CITY, STATE, ZIP _____
HOME PHONE _____ CELL PHONE _____ EMPLOYER/WORK PHONE _____

HEALTH INSURANCE INFORMATION (PLEASE PRESENT YOUR CARD TO FRONT DESK AT CHECK IN)

CO-PAYS OR SELF-PAY DEPOSITS ARE DUE AT TIME OF SERVICE. WE REQUIRE 24 HR NOTIFICATION OF CANCELLATIONS OR REQUESTS TO RESCHEDULE. WE CHARGE NO SHOW FEES FOR MOST APPOINTMENT TYPES.

PRIMARY INSURANCE

ADDRESS _____ POLICY # _____
CITY, STATE, ZIP _____ GROUP # _____
NAME OF INSURED _____ SSN# _____ DOB _____

SECONDARY INSURANCE

ADDRESS _____ POLICY # _____
CITY, STATE, ZIP _____ GROUP # _____
NAME OF INSURED _____ SSN# _____ DOB _____

SOME INSURANCE COMPANIES REQUIRE LABS, IMAGING, TEST, PROCEDURES, AND/OR SURGERIES TO BE PERFORMED AT SPECIFIC FACILITIES AND WILL DENY PAYMENT OTHERWISE. PLEASE INFORM OUR OFFICE IF YOUR POLICY HAS SUCH LIMITATIONS. YOU MUST NOTIFY OUR OFFICE IF YOUR INSURANCE COMPANY REQUIRES PRE-AUTHORIZATION FOR SERVICES.

ASSIGNMENT AND RELEASE OF INFORMATION

To the best of my knowledge, all of this is true and complete. I authorize payment of insurance benefits directly to Five Valleys Urology. I understand that I am responsible to pay for all services rendered to me. I am willing to make specific arrangements to pay the portion that is not covered by insurance. I authorize Five Valleys Urology to mutually exchange medical information with my referring physician(s) and/or associates. To the extent necessary to determine liability for payment and to obtain reimbursement. I authorize disclosure of my medical information to my insurance carrier and/or any attorney assigned.

CONSENT TO TREAT

I hereby request and consent to treatment and services reasonable and proper by today's standards provided by a provider of Five Valleys Urology and any employee acting under my providers orders.

SIGNATURE OF RESPONSIBLE PARTY:

DATE:

over 

**Privacy
& Confidentiality Notice**

FIVE VALLEYS UROLOGY

(Reference Federal Register 45 C.F.R. § Part 164.506)

I understand that protected health information (PHI) may be used and disclosed to perform treatment, payment and/or healthcare operations. I acknowledge I've been given the opportunity to read and review a complete copy of the Five Valleys Urology Privacy Notice with a complete description of such uses and understand I had a right to review the privacy notice before signing below. I understand I have a right to request this office restrict how my information is used, but this office may not agree with the requested restrictions. I have a right to revoke this authorization and consent, in writing, at any time. This office reserves the right to amend the privacy policy, whether required by law or otherwise, and a revised notice may be obtained by calling our office or physically coming to our office.

Printed Name

Signature

Date

~~~~~  
**Additional Privacy & Communication Considerations**

Some patients want other individuals, such as family members, to have access to their PHI. In order to comply with strict legal standards, a written release is required to allow another person access to your medical record, even if that other person is your spouse or partner. This release grants permission to the individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication and will be in effect unless I notify this office of any changes or revocations.

1. Designated Party: \_\_\_\_\_ Tel: \_\_\_\_\_ Relation: \_\_\_\_\_

Is this person also authorized to discuss financial matters?  Yes  No

2. Designated Party: \_\_\_\_\_ Tel: \_\_\_\_\_ Relation: \_\_\_\_\_

Is this person also authorized to discuss financial matters?  Yes  No

3. Designated Party: \_\_\_\_\_ Tel: \_\_\_\_\_ Relation: \_\_\_\_\_

Is this person also authorized to discuss financial matters?  Yes  No

May we leave messages or voice mails that might contain PHI?  Yes  No

May we send text messages that might contain PHI?  Yes  No cell: \_\_\_\_\_

May we send email that might contain PHI?  Yes  No email: \_\_\_\_\_

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Check if "C" for Current or "P" for Past to any urological problems below**

|                          |                                                 | Gender specific – female |   | Gender specific – male   |                                       |   |   |
|--------------------------|-------------------------------------------------|--------------------------|---|--------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> | Blood in your urine                             | C                        | P | <input type="checkbox"/> | Undescended Testicles                 | C | P |
| <input type="checkbox"/> | Urinary Tract Infection                         | C                        | P | <input type="checkbox"/> | Curvature of the penis                | C | P |
| <input type="checkbox"/> | Loss of urine when you cough, sneeze, or strain | C                        | P | <input type="checkbox"/> | Varicocele                            | C | P |
| <input type="checkbox"/> | Kidney or Bladder Stones                        | C                        | P | <input type="checkbox"/> | Epididymitis                          | C | P |
| <input type="checkbox"/> | Bedwetting or daytime wetting of clothes        | C                        | P | <input type="checkbox"/> | Problems with sex drive               | C | P |
| <input type="checkbox"/> | Skin problems in genital or groin area          | C                        | P | <input type="checkbox"/> | Problems with ejaculation             | C | P |
| <input type="checkbox"/> | Pain with sexual intercourse                    | C                        | P | <input type="checkbox"/> | Problems getting or keeping erections | C | P |
| <input type="checkbox"/> | History of sexually transmitted disease         | C                        | P |                          |                                       |   |   |
| <input type="checkbox"/> | Bowel Incontinence                              | C                        | P |                          |                                       |   |   |

**SURGICAL HISTORY**

**Check any past surgical history**

|                          | date                  | Gender specific - female | date               | Gender specific - male   | date                 |
|--------------------------|-----------------------|--------------------------|--------------------|--------------------------|----------------------|
| <input type="checkbox"/> | Appendectomy          | <input type="checkbox"/> | Bladder Suspension | <input type="checkbox"/> | Prostate Surgery     |
| <input type="checkbox"/> | Back Surgery          | <input type="checkbox"/> | Breast Biopsy      | <input type="checkbox"/> | Penile Prosthesis    |
| <input type="checkbox"/> | Heart Bypass          | <input type="checkbox"/> | C-Section          | <input type="checkbox"/> | Prostate Biopsy      |
| <input type="checkbox"/> | Colon Surgery         | <input type="checkbox"/> | Hysterectomy       | <input type="checkbox"/> | Scrotal Area Surgery |
| <input type="checkbox"/> | Heart Stent           | <input type="checkbox"/> | Mastectomy R / L   | <input type="checkbox"/> | Testicle Removal     |
| <input type="checkbox"/> | Gallbladder           | <input type="checkbox"/> | Pubovaginal Sling  | <input type="checkbox"/> | Varicocele Surgery   |
| <input type="checkbox"/> | Gastric Bypass        | <input type="checkbox"/> | Tubal Ligation     | <input type="checkbox"/> | Vasectomy            |
| <input type="checkbox"/> | Hernia repair         | <input type="checkbox"/> | Vaginal Delivery   | <input type="checkbox"/> | Other: _____         |
| <input type="checkbox"/> | Hip Replacement R / L | <input type="checkbox"/> | Kidney Stones      | <input type="checkbox"/> | Pacemaker            |
| <input type="checkbox"/> | Kidney Removal R / L  | <input type="checkbox"/> | Knee Replacement   | <input type="checkbox"/> | Tonsillectomy        |

Other: \_\_\_\_\_

**FAMILY HISTORY**

**Check any family history of illness**

|                          | Adopted? Y N             | Father | Mother | Brother | Sister | Grandparent | Son | Daughter | Runs in Family |
|--------------------------|--------------------------|--------|--------|---------|--------|-------------|-----|----------|----------------|
| <input type="checkbox"/> | Diabetes                 |        |        |         |        |             |     |          |                |
| <input type="checkbox"/> | Enlarged Prostate        |        |        |         |        |             |     |          |                |
| <input type="checkbox"/> | High Blood Pressure      |        |        |         |        |             |     |          |                |
| <input type="checkbox"/> | Kidney Stones            |        |        |         |        |             |     |          |                |
| <input type="checkbox"/> | Kidney Failure           |        |        |         |        |             |     |          |                |
| <input type="checkbox"/> | Prostate Cancer          |        |        |         |        |             |     |          |                |
| <input type="checkbox"/> | Stroke                   |        |        |         |        |             |     |          |                |
| <input type="checkbox"/> | Urinary Tract Infections |        |        |         |        |             |     |          |                |
| <input type="checkbox"/> | Cancer: Other _____      |        |        |         |        |             |     |          |                |

**SOCIAL HISTORY**

**MARITAL STATUS:** S M D W

Children? N Y

# of sons: \_\_\_\_\_ # of

daughters: \_\_\_\_\_

**TOBACCO USE** (please circle): Current Former Never Passive Smoke Exposure If quit, year: \_\_\_\_\_

If yes, Type: \_\_\_\_\_ Have you tried to quit? N Y

**ALCOHOL:** Do you drink? N Y If yes, type \_\_\_\_\_ frequency \_\_\_\_\_ amount \_\_\_\_\_ last drink \_\_\_\_\_

If no, former drinker? N Y Have you ever undergone alcohol abuse treatment? N Y

**CAFFEINE:** N Y If yes, type: \_\_\_\_\_ Amount of caffeine per day: \_\_\_\_\_

**DRUGS:** Do you use drugs? N Y If yes, what kind and how often? \_\_\_\_\_ Have you been treated for drug abuse? \_\_\_\_\_

**FAMILY:** Mother Living? N Y If no, list cause of death & age \_\_\_\_\_ How many brothers do you have?

Father Living? N Y If no, list cause of death & age \_\_\_\_\_ How many sisters do you have?

## CHIEF COMPLAINT & PRESENT ILLNESS

What is the main reason for your visit today? \_\_\_\_\_

### Location of the problem

Abdomen      Back      Leg      Flank  
Pelvis      Rectum      Bladder      Genitalia  
Other \_\_\_\_\_

**On a Scale of 1-10, with 10 being the most severe, which number best describes the problem?**

1   2   3   4   5   6   7   8   9   10

**When did you first notice the problem?**

2 days ago                      2 weeks ago                      1 month ago  
Other \_\_\_\_\_

**Does anything help or make the problem worse?**

Moving around                      Standing Up                      Lying on my side  
Other \_\_\_\_\_

### How long does the problem last?

30 minutes                      1 hour                      It is always there  
Other \_\_\_\_\_

**Is anything else occurring at the same time?      Yes      No**

(If yes, explain) \_\_\_\_\_

**Do you have**                      Nausea                      Rash                      Headaches  
Other? \_\_\_\_\_

**Is the problem constant or variable?**

Constant      Variable      Dull then Sharp      Very sharp then leaves  
Other \_\_\_\_\_

**Does the problem interfere with your normal functions?**

**Yes      No**

Explain \_\_\_\_\_

**What testing have you had to evaluate your urological problem? (Please circle)**

X-Ray  
CT Scan  
MRI  
IVP  
Blood tests

Ultrasound  
Nuclear bone scan  
Nuclear renal scan  
Urine Specimen  
Cystoscopy

Urodynamic Testing  
Other: \_\_\_\_\_  
Unsure

Where were tests performed? \_\_\_\_\_

### Urinary Questionnaire

Do you leak urine?      Yes      No      If yes, is your leakage associated with the urge to urinate?      Yes      No  
If yes, do you wear protective pads / protective liners / diapers      Yes      No      #pads/day \_\_\_\_\_  
Does your urine smell?      Yes      No      Is your urine discolored?      Yes      No

### Sexual Health Questionnaire

Are you satisfied with your sexual life?      Yes      No      Do you have decreased libido/desire?      Yes      No

**(Men only)** Have you tried any medications for erectile dysfunction?      Yes      No      If yes, which? \_\_\_\_\_

**(Women only)** Have you tried any treatments for vaginal tissue rejuvenation?      Yes      No      If yes, which? \_\_\_\_\_

Over 

KARL WESTENFELDER, MD  
GARRICK SIMMONS, MD  
KEVIN KRONNER, MD  
CHRISTOPHER WICHER, MD  
JEFFREY REDSHAW, MD



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PATIENT LABEL

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

**REVIEW OF SYSTEMS**

In the past month, have you had any of the following problems? Please check those that apply.

**GENERAL**

- Fever
- Headache
- Fatigue

**HEART/CARDIOVASCULAR**

- Chest pain
- Swollen legs or feet
- Palpitations

**BLOOD/LYMPH**

- Swollen Glands
- Blood Clotting Issues
- Transfusion History

**GENITOURINARY**

- Painful Urination
- Urine Retention
- Urinary Frequency
- Incontinence

**ENDOCRINE**

- Excessive Thirst
- Tired/Sluggish
- Too hot/cold

**LUNGS**

- Shortness of breath
- Cough

**STOMACH AND INTESTINES**

- Abdominal pain
- Heartburn/Indigestion
- Nausea/Vomiting

**NERVOUS SYSTEM**

- Numbness or tingling
- Dizziness
- Memory loss

**Women Only**

- Abnormal Pap smear
- Irregular periods

**Male Only**

- Erectile Dysfunction
- Penile Discharge

**EARS, NOSE, THROAT, MOUTH**

- Ear Infection
- Sore Throat
- Loss of Hearing

**SKIN**

- Rash
- Hair loss
- Nodules/bumps

**EYES**

- Dryness
- Double or blurred vision
- Pain

**MUSCLE/JOINTS/BONES**

- Numbness
- Joint pain
- Weakness

**PSYCHIATRIC**

- Depression
- Irritability
- Anxiety