FIVE VALLEYS UROLOGY
WESTENFELDER • SIMMONS • KRONNER • WICHER

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.

Please bring the following to your appointment:

- Completed forms (please use a pen and sign all forms)
- 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:_____

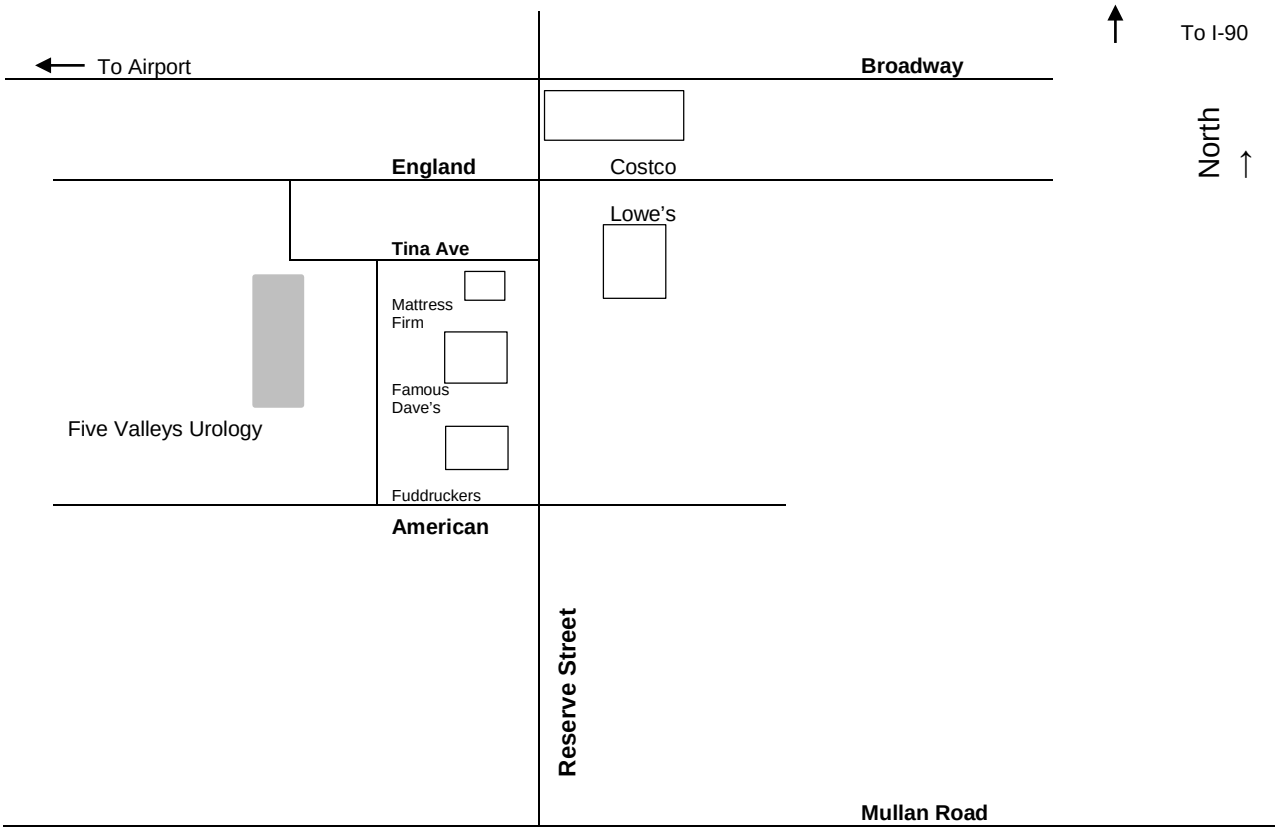
Provider: ☐ Karl R Westenfelder, MD ☐ Garrick R Simmons, MD

☐ Kevin M Kronner, MD ☐ Christopher G Wicher, MD

☐ Richard Wiesemann PA-C ☐ Whitney C Martin PA-C

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

If you have questions please 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)

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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 the following policies:

Administrative Policies

- We promise to inform you at check-in if your doctor is running late or has been called to surgery.
- 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 such as vasectomy require extra supplies. Canceling a vasectomy within 24 hours of appt. will result in a $75.00 sterile tray fee. Canceling Urodynamics within 72 hours will result in a $100.00 fee. By scheduling an in-office procedure you agree to these terms.
- Missing or no-showing your appointment creates an undue burden and increases the cost of care to other patients. Should you miss three appointments without notice, you will be dismissed from this practice.
- We promise to treat you with respect & dignity in a professional and caring manner. 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.
- When you are placed in an exam room, we will partially shut the door to protect everyone's privacy.

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 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 or credit card. We send two statements at 30-day intervals; afterwards delinquent accounts are turned to collections. You understand and agree that if we are forced to send your account to collections, 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

Over ⟶

Karl R. Westenfelder, M.D., Garrick R. Simmons, M.D. Kevin M. Kronner, M.D., Christopher G. Wicher, 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.

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_____ _____

SIGNATURE OF RESPONSIBLE PARTY: ***DATE:***

Privacy
& Confidentiality Notice **FIVE VALLEYS UROLGOY**

(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

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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 email that might contain PHI? □ Yes □ No email:________________________

May we send text messages that might contain PHI? □ Yes □ No cell:____________________

____________________ ____________________ ________
Printed Name Signature Date
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UROLOGIC HISTORY FORM

FIVE VALLEYS UROLOGY
WESTENFELDER · SIMMONS · KRONNER · WICHER

Today's Date:_____

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

Please Circle Race:
African American Asian
American Indian Black
Alaskan Native Hispanic
Native Hawaiian Other

Age:_____ Weight:_____ Height:_____ Gender:_____

Primary Doctor:_____ Referring Doctor:_____

Have you been seen by us in the past? Yes No If yes, when?_____ By whom?_____

Occupation:_____ Do you have an Advanced Care Directive? Yes No (please bring copy)

MEDICATIONS/ALLERGIES/IMMUNIZATIONS LIST

ALLERGIES: None Codeine IVP Dye Latex Mycins Penicillin Sulfa Cipro/Levaquin

OTHER ALLERGIES:_____

PHARMACY NAME & ADDRESS:_____

PHARMACY PHONE & FAX:_____ **MAIL ORDER?** Yes No

BLOOD THINNERS: Aspirin Plavix Warfarin Coumadin Ibuprofen Aleve Motrin Celebrex Other:_____

IMMUNIZATIONS: Influenza Immunization? N Y date _____ Pneumococcal Vaccination? N Y date_____

Medications: Please list all prescription & OTC medications and supplements	**Dose**	**How Often**

MEDICAL HISTORY

Check any past & ongoing medical problems

- □ Acid Reflux
- □ Anemia
- □ Angina
- □ Arthritis
- □ Asthma
- □ Cancer: type_____
- □ Chronic UTIs
- □ Congestive Heart Failure
- □ COPD
- □ Coronary Artery Disease
- □ Chron's Disease
- □ Dementia
- □ Depression
- □ Diabetes: # of years___
- □ Diverticulitis
- □ Enlarged Prostate
- □ Glaucoma
- □ Gout
- □ Heart Attack
- □ Hepatitis C
- □ High Blood Pressure
- □ High Cholesterol
- □ HIV
- □ IBS
- □ Kidney Disease
- □ Kidney Stones
- □ Liver Disease
- □ Lupus
- □ Migraines
- □ Multiple Sclerosis
- □ Neurologic
- □ Osteoarthritis
- □ Osteoporosis
- □ Parkinson's
- □ Peptic Ulcer
- □ Peripheral Vasc. Disease
- □ Rheumatoid Arthritis
- □ Seizure Disorder
- □ Stroke
- □ Thyroid Disease

Other (please explain)_____ Hearing loss? Yes No Hearing Aids? Yes No

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

			Gender specific – female			Gender specific – male		
□	Blood in your urine	C P	□	Pregnant	C P	□	Undescended Testicles	C P
□	Urinary Tract Infection	C P	□	Trying to become pregnant	C P	□	Curvature of the penis	C P
□	Loss of urine when you cough, sneeze, or strain	C P	□	Cysts	C P	□	Varicocele	C P
□	Kidney or Bladder Stones	C P	□	Menstrual pain	C P	□	Epididymitis	C P
□	Bedwetting or daytime wetting of clothes	C P	□	Organ prolapse	C P	□	Problems with sex drive	C P
□	Skin problems in genital or groin area	C P	□	Endometrioses	C P	□	Problems with ejaculation	C P
□	Pain with sexual intercourse	C P	□	Vaginal dryness	C P	□	Problems getting or keeping erections	C P
□	History of sexually transmitted disease	C P						
□	Bowel Incontinence	C P						

SURGICAL HISTORY

Check any past surgical history

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

Other:_____

FAMILY HISTORY

Check any family history of illness

	Adopted? Y N	Father	Mother	Brother	Sister	Grandparent	Son	Daughter	Runs in Family
□	Diabetes								
□	Enlarged Prostate								
□	High Blood Pressure								
□	Kidney Stones								
□	Kidney Failure								
□	Prostate Cancer								
□	Stroke								
□	Urinary Tract Infections								
□	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?_____

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Review of Systems

FIVE VALLEYS UROLOGY

Today's Date___/___/_____

Please check any problems you have or have had in the past month

Constitutional Symptoms — Explain any Current
- Fever ☐
- Chills ☐
- Headaches ☐
- Other ☐

Eyes
- Blurred Vision ☐
- Double Vision ☐
- Pain ☐
- Other ☐

Ear/Nose/Throat/Mouth
- Ear Infection ☐
- Sore Throat ☐
- Sinus Problems ☐
- Other ☐

Cardiovascular
- Chest Pain ☐
- Varicose Veins ☐
- High Blood Pressure ☐
- Other ☐

Respiratory
- Wheezing ☐
- Frequent Cough ☐
- Shortness of Breath ☐
- Other ☐

Gastrointestinal
- Abdomen Pain ☐
- Nausea/Vomiting ☐
- Indigestion/Heartburn ☐
- Other ☐

Genitourinary
- Urine Retention ☐
- Painful Urination ☐
- Urinary Frequency ☐
- Other ☐

Reproductive - Female
- Breast Lumps/Pain ☐
- Vaginal Discharge ☐
- Other_____ ☐

Integumentary — Explain any Current
- Skin Rash ☐
- Boils ☐
- Persistent Itch ☐
- Other ☐

Neurological
- Tremors ☐
- Dizzy Spells ☐
- Numbness/Tingling ☐
- Other ☐

Musculoskeletal
- Joint Pain ☐
- Neck Pain ☐
- Back Pain ☐
- Other ☐

Endocrine
- Excessive Thirst ☐
- Too hot/cold ☐
- Tired/Sluggish ☐
- Other ☐

Psychologic

Are you satisfied with your life? Yes No

Explain if no_____

Do you feel depressed? Yes No

Explain if yes_____

Hematological/Lymphatic
- Swollen Glands ☐
- Blood Clotting ☐
- Other ☐

Allergic/Immunologic
- Hay Fever ☐
- Drug Allergies ☐
- Other ☐
- Other ☐

Reproductive - Male
- Penile Discharge ☐
- Erectile Dysfunction ☐
- Other_____ ☐

Physician Use Only:

Physician:_____ Date:_____

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