WEST TEXAS UROLOGY

John B. Staub, MD
Michael J. Dragun, MD
Aaron B. Stike, MD
Jonathan S. Nelson, MD
Christopher P. Slayden, MD

To All of Our Patients

Patient Care Coverage: We strive for the best patient care possible at all times. Our doctors have been practicing together for over 10 years and they are familiar with each other's patient practices. They have full faith in each other to care for their patients if they are unavailable.

Please be aware that from time to time, our doctors may be unavailable at the same time and it may be necessary to have another Midland urologist cover our patients. In the event that you need emergent care and our doctors are unavailable, you will be able to get care through the emergency room at Midland Memorial Hospital or Medical Center Hospital and Dr. Staub, Dr. Dragun, Dr. Stike, Dr. Nelson, or Dr. Slayden will resume your care as soon as they return. The other urologist will only cover for emergencies.

Prescription Refills: Please allow at least 48 to 72 hours for us to process all prescription refill requests. Due to surgery schedules and emergencies, we can't always turn around your request the same day it is made.

Office Hours: While our normal office hours are 8:30 to 5:00, there are days that we leave early or close for lunch depending on our patient schedule for the day. For your convenience, you may call our office to check staff availability.

Missed Appointments: A scheduled appointment means that this time is reserved only for you. We request that if you cannot make your appointment that you give us 24 hours advanced notice. As a courtesy, we will remind you of your appointment the business day before.

2706 W. Cuthbert, Bldg C, Midland, Texas 79701, (432) 687-0311
540 W. 5th Street, Suite 420, Odessa, Texas 79761

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Weather Policy

As of 2/26/2015, West Texas Urology will follow the lead of MISD in regards to the weather policy. If MISD closes due to inclement weather, our office will also close. If MISD announces a 2 hour delay, we will also have a 2 hour delay. This will allow our patients as well as our staff to stay safe.

If you have an appointment on a day that MISD announces a delay or closure, you will need to call the office the next business day to reschedule. For example if you have an appointment on Tuesday morning at 9:00 and MISD announces there is a 2 hour delay to school which means we will not open until 10:30 (2 hours after our normal 8:30), you will need to call to reschedule your appointment. A second example is if you have an appointment on Tuesday and MISD cancels the day, you will need to call on Wednesday to reschedule that appointment.

The Odessa office will also follow the MISD guidelines so that our providers can safely make it to Odessa. If for some reason ECISD delays start time or has a closure, we will then follow the ECISD guidelines for the Odessa office.

If you have questions in regards to this policy, please contact our office at 432-687-0311.

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New Patient Registration

Registro Para Paciente Nuevo

REFFERING PHYSICIAN NAME _____ PATIENT EMAIL ADDRESS _____
MEDICO QUE LO REFIRIO — CORREO ELECTRONICO DEL PACIENTE

PATIENT LAST NAME_____ FIRST_____ M.I_____ SEX _____
APELLIDO — NOMBRE PERSONAL — INICIAL — SEXO

DATE OF BIRTH_____ PREFERRED LANGUAGE_____ HOME PHONE #_____
FECHA DE NACIMENTO — IDIOMA PREFERIDO — # DE TELEFONO DE CASA

MARITAL STATUS: (circle one) Married Single Divorced Widowed Legally Separated Life Partner
ESTATUS MARITAL: (circule uno) Casado Soltero Divorciado Viudo Separado Legalmente Pareja de vida

ADDRESS _____ CITY _____ STATE_____ ZIP _____
DIRECCION — CIUDAD — ESTADO — CODIGO POSTAL

SOCIAL SECURITY #_____ TX DRIVERS LICENSE _____
DE SEGURO SOCIAL — # DE LICENSIA DEL ESTADO DE TX

PATIENT'S EMPLOYER _____ OCCUPATION _____ WORK PHONE #_____
PATRON DEL PACIENTE — OCUPACION — # DE TELEFONO DEL TRABAJO

EMPLOYER ADDRESS_____ CITY, STATE, ZIP_____
DIRECCION DEL PATRON — CIUDAD, ESTADO, CODIGO POSTAL

CELL PHONE # _____ BEST DAYTIME NUMBER: (circle one) HOME WORK CELL
DE SU CELULAR — MEJOR # PARA HABLARLE EN EL DIA — CASA TRABAJO CELULAR

PREFERRED REMINDERS SENT BY: (circle one) PHONE MAIL EMAIL SECURED PORTAL MESSAGE DON'T SEND
RECORDATORIOS PREFERIDO ENVIADAS POR: TELEFONO CORREO CORREO ELECTRONICO MENSAJE PORTAL GARANTIZADO NO ENVIAR

RACE: (circle one) Native American/Alaskan African American Native Hawaiian/Islander Asian White Decline
RAZA: (circule uno) Americano Nativo/Alaskanio Americano Africano Nativo Hawaiano/Islandero Asiatico Blanco Declinar

ETHNICITY: (circle one) Not Hispanic or Latino Hispanic or Latino Decline to Specify Unknown
ETNICIDAD: (circule uno) No Hispano o Latino Hispano o Latino Decline para Especificar Desconocido

SPOUSE NAME_____ EMPLOYER _____ SOCIAL SECURITY #_____
NOMBRE DE SU ESPOSO(A) — PATRON — # DE SEGURO SOCIAL

SPOUSE DATE OF BIRTH_____ SPOUSE WORK PHONE _____ SPOUSE CELL #_____
FECHA DE NACIMIENTO DE SU ESPOSO(A) — # DE TELEFONO DEL TRABAJO DE SU ESPOSO(A) — # DE CELULAR DE SU ESPOSO(A)

IF PATIENT IS A MINOR (SI EL PACIENTE ES MENOR DE EDAD)

FATHER NAME _____ EMPLOYER _____ PHONE _____
NOMBRE DEL PADRE — PATRON — # DE TELEFONO

MOTHER NAME _____ EMPLOYER _____ PHONE _____
NOMBRE DE LA MADRE — PATRON — # DE TELEFONO

RESPONSBILE PARTY (circle one) BOTH FATHER MOTHER OTHER_____
RESPONSABLES — LOS DOS — PADRE — MADRE — OTRO

FATHER SOCIAL SECURITY # _____ MOTHER SOCIAL SECURITY # _____
DE SEGURO SOCIAL DEL PADRE — # DE SEGURO SOCIAL DE LA MADRE

FATHER DATE OF BIRTH _____ MOTHER DATE OF BIRTH _____
FECHA DE NACIMIENT DEL PADRE — FECHA DE NACIMIENTO DE LA MADRE

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN FOR SERVICE PROVIDED.
YO AUTORIZO EL PAGO AL MEDICO POR LOS SERVICIOS RECIBIDOS.

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.
YO AUTORIZO QUE SE DE LA INFORMACION MEDICA NECESARIA PARA PROCESAR ESTA COBRANZA.

SIGNED: _____ **DATE:** _____
FIRMA — **FECHA**

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FINANCIAL POLICY

Filing Your Insurance Claim:

We will file your claims for all office visits and surgical procedures if you have ***Medicare, Medicaid, pre-approved government assistance,*** or if we participate in your PPO network (call the number on your insurance card to verify). ***It is the responsibility of the patient to verify network participation as well as coverage for any procedures or conditions for which the patient is being seen prior to services being rendered. This includes obtaining any required insurance authorizations or referrals from your PCP for HMO insurances.*** If we are not listed as a participating provider and are considered "out of network", payment is due in full at the time service is rendered. As a courtesy to you, we will still be happy to file your claim with your insurance company if you so desire. Credit balances will be promptly refunded.

Co-pays/Coinsurances/Deductibles/Deposits*:*

Payment for all visits will be due at check in. We will make every effort to verify your insurance and notify you of an estimate that will be due at the time of your visit. If we cannot verify your insurance, you will be considered self pay and your visit will be due in full. Exceptions will be made for emergent patients only. A deposit, or advance payment, may be required if you are scheduled for a surgical procedure. Payment terms will be discussed with you prior to your scheduled procedure date.

Patient Balances*:*

Any balance due after your insurance claim is either paid or denied is your responsibility. Patient Statements are generated monthly and balances are due upon receipt of your statement. If you are unable to pay the balance due, you must contact the office to make payment arrangements and sign a payment agreement. Patient balances that are not kept current according to payment agreements are considered delinquent and will be referred to an outside agency for collection.

Missed Appointments*:*

A scheduled appointment means that this time is reserved only for you. We request that if you cannot make your appointment that you give us 24 hours advanced notice. As a courtesy, we will remind you of your appointment the business day before. We also request 24 hours advanced notice to reschedule an appointment.

Additional Fees Not Covered By Insurance:

Additional fees may be charged for prior authorizations of medications, filling out of forms such as FMLA, missed appointment fees, and other administrative duties. The patient is responsible for these fees.

Should you have any further questions, please contact our office prior to your appointment or surgery.

I have read and understand the above Financial Policy.

Date: _____ Signed: _____

Patient or Parent (if minor)

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Acknowledgement of Receipt of Notice of Privacy Practices

West Texas Urology, P.A. reserves the right to modify the privacy practices outlined in the notice.

Signature

The Notice of Privacy Practices for West Texas Urology, P.A. is posted in the lobby and also on our website. I acknowledge that I can ask for a copy and it will be provided to me if I so desire.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

I give permission to disclose my protected health information with my family and/or caregivers.

_____ Yes _____ No

PRE-APPOINTMENT INFORMATION

Please fill out this form as thoroughly as possible and bring it with you to your appointment. **All questions must be answered**, if you are unsure of an answer, please put "don't know", if question doesn't apply, please put "N/A".

Last Name		First Name	
Date Of Birth		Today's Date	
Referring Doctor		Family Doctor	
Pharmacy Name & Location			

ALLERGIES

Medication	Reaction
Are you allergic to radiation contrast? Y / N	

MEDICATIONS (Please bring medicines to your appointment) (Attach list if necessary)

Medication	Dosage	How many times a day?

PAST SURGICAL HISTORY

√	Surgery	Date	√	Surgery	Date	√	Surgery	Date
	Appendix Removal			Eye Surgery			Rectal Surgery	
	Back Surgery			Heart Surgery			Shoulder Surgery	
	Bladder Suspension			Hernia Repair			Thyroid Surgery	
	Brain Surgery			Hip Replacement			Tonsillectomy	
	Cesarean Delivery			Hysterectomy			TURP	
	Gallbladder Removal			Knee Surgery			Vaginal Delivery	
	Colon Resection			Neck Surgery			Weight Loss Surgery	
Other:								

Age 51-75	Have you had a colonoscopy?	Y / N	When?
Age 65 +	Have you had the Pneumonia Vaccine?	Y / N	When?

PAST MEDICAL HISTORY

√	Problem	√	Problem	√	Problem	√	Problem
	Asthma		Diabetes Type I		Heart Failure		Osteoarthritis
	Atrial Fibrillation		Diabetes Type II		Hepatitis		Parkinson's Disease
	Breast Cancer		Glaucoma		HIV		Sleep Apnea
	Chest Pain		Heart Attack		Hypertension		Stroke
	Chronic Kidney Failure		Heart Disease (with chest pain)		Kidney Stones		Thyroid Disorder
	COPD		Heart Disease (no chest pain)		Multiple Sclerosis		Prostate Cancer
Other:							

FAMILY HISTORY

Problem	Family Member	Problem	Family Member	Problem	Family Member
Prostate Cancer		Diabetes		Kidney Stones	
Bladder Cancer		Heart Attack		Kidney Cancer	
Colon Cancer		Hypertension		Breast Cancer	
Other:					

SOCIAL HISTORY

Smoking Status:	Current Every Day User	Current Some Day User	Former Smoker	Never Smoked

Do you drink alcohol?	Yes	Not Anymore	Never	Do you use recreational Drugs?	Yes	No

REVIEW OF SYSTEMS

√	General	√	Cardiovascular	√	ENT	√	Respiratory
	fever/chills		leg swelling		bleeding gums		asthma
	fatigue/weakness		exercise intolerance		hearing loss		pneumonia
	weight gain		irregular heart beat		nose bleeds		shortness of breath
	weight loss		palpitations		dizziness		cough
√	Eyes	√	Integumentary	√	GU (Male)	√	Hematologic
	blurred vision		changing moles		blood in urine		easy bleeding/bruising
	double vision		hair loss		painful urination		swollen glands
	dry eyes		itching		urinary incontinence		anemia
	glasses/contacts		skin rash		erectile dysfunction		HIV
√	Gastrointestinal	√	Musculoskeletal	√	GU (Female)	√	Psych
	constipation		muscle cramps		blood in urine		anxiety
	diarrhea		joint pain		painful urination		depression
	nausea/vomiting		back pain		urinary incontinence		hallucinations
	rectal bleeding		neck pain/stiffness		vaginal discharge		difficulty sleeping

MEN ONLY

If you are being seen for prostate problems and related difficulty urinating, please complete the following:

Over the Past 1 Month:	Not at all	< 20% of the time	< 50% of the time	50% of the time	> 50% of the time	Almost always
How often have you had a sensation of not emptying your bladder completely?	0	1	2	3	4	5
How often did you urinate more than once within a 2-hour period?	0	1	2	3	4	5
How often have you stopped and started several times while urinating?	0	1	2	3	4	5
How often have you had difficulty postponing urination?	0	1	2	3	4	5
How often have you had a weak urinary stream?	0	1	2	3	4	5
How often did you strain to begin to urination?	0	1	2	3	4	5
How many times did you get up during the night to urinate?	0 Times	1 Time	2 Times	3 Times	4 Times	5 Times

Total Score: _____