VITALITY UROLOGY
INSTITUTE

Patient Registration- **(Please print clearly)**

Patient Name: ____ Date of Birth: _______________
First Middle Last Name

Patient Address: ____
Street Apt. /Suite City State Zip

Sex: ☐ Male ☐ Female Age: _________ Name of Spouse: _________________________________

Home Phone: _______________________________ Alternate Contact/Cell: ________________________

Social Security #: ________________________ Email: ____

Employer: _______________________________________ Occupation: ___________________________

Primary Care Doctor: ____

Office Phone #: ________________________ Fax Number: ________________________

Preferred Pharmacy: ____

Phone Number: ________________________ Fax Number: ________________________

Insurance Information

☐ **SELF-PAY** (I have no insurance / my insurance is not accepted)

Primary Insurance: ____ ☐ Self ☐ Spouse ☐ Parent

Subscriber Name: ____ Subscriber Birthdate: ____________

Member ID #: ____ Group #: _________________________

Secondary Insurance: ____ ☐ Self ☐ Spouse ☐ Parent

Subscriber Name: ____ Subscriber Birthdate: ____________

Member ID #: ____ Group #: _________________________

In case of emergency, please call: Name: ____

Phone #: ___________________________ Relationship to Patient: __________________________________

I understand that my insurance(s) will be filed, as a courtesy, but I remain solely responsible to Jonathan Clavell, M.D. F.A.C.S for all charges incurred. I hereby authorize Jonathan Clavell, M.D. F.A.C.S and/or its representative to release any and all information necessary to process my insurance claim(s). I hereby authorize my insurance company(s) to pay benefits directly to Jonathan Clavell, M.D. F.A.C.S. I hereby authorize Jonathan Clavell, M.D. F.A.C.S to release my medical records to other physicians who may also provide medical care to me.

Signature: ____ Date: ________________________

JONATHAN CLAVELL, M.D, F.A.C.S
UROLOGY AND MEN'S SEXUAL HEALTH SPECIALIST
12727 Kimberley Ln, Suite 303 | Houston, TX 77024 | p (713) 424-4030 | f (713) 424-9030
www.houstonmenshealth.com

Patient's Medical History

Patient Name: ____ Date: ____________________

Sex: ☐Male ☐Female Age: _________ Marital Status: ________________________________

How did you hear about our office? ____

Work Status: ☐Presently working ☐Retired ☐Disabled

Reason for visit today: ____

Height: __________ Weight: __________

Do you smoke: ☐No ☐Yes If yes, how long? _______ Number of packs per day? ________

Do you drink Alcohol: ☐No ☐Yes If yes, How much? ____________________________

Ongoing medical illnesses (include diagnosis): ____

____

Prior Surgeries (including Month/Year): ____

____

____

Other Hospitalizations (including Month/Year): ____

____

List current Medications you are taking (including dosage): ____________________________

____

____

____

List Allergies to Medicines: ____

____

Family History/Diseases: ____

____

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Patient Name: ____ Date______________________

*****Males Only*****

Erectile Dysfunction: ___No ___Yes When was your last Pneumococcal Vaccine? ______________

Urinary Leakage: ___No ___Yes When was your last colonoscopy done? _________________

Number of times awakened to urinate at night: _________________

*****Females Only*****

Urinary Leakage: ___No ___Yes Urinary Frequency: ___No ___Yes

Are you pregnant? ___No ___Yes # of Pregnancies _____ # of Children: _______

<u>Please check if you have now or have had in the past any of the following:</u>

___Anemia
___Anesthesia Issues
___Arthritis
___Asthma
___Back Problems
___Bladder Infections
___Blood in Urine
___Bleeding Disorders
___Bronchitis
___Cancer
___Diabetes
___Gastritis
___Diverticulitis
___Emphysema
___Eye Disorder
___Gout
___Heart Attack
___HIV/AIDS
___Hypertension
___Heart Murmur
___Hepatitis
___Liver Disorders
___Kidney Disorders
___Kidney Stones
___Leg/Foot Disorder
___Leukemia
___Paralysis
___Mental Illness
___Nerve Disorder
___Osteomyelitis
___Prostate Disorder
___Phlebitis
___Polio
___Poor Circulation
___Sickle Cell
___Rash
___Rheumatic Fever
___Shingles
___Thyroid Condition
___Skin Disorders
___Ulcers
___Stroke
___Venereal Disease
___Tuberculosis
___Vein Clot

Other conditions not listed: ____

This information is correct to the best of my knowledge.

Patient Signature: ____ Date: ______________________

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Patient Acknowledgment and Consent for Use and Disclosure of Protected Health Information

1. Purpose of Consent

I understand that as part of my health care, Vitality Urology Institute obtains, uses, and may disclose my protected health information (PHI) to carry out treatment, payment, and health care operations. This consent is required by the Health Insurance Portability and Accountability Act (HIPAA).

2. Information Sharing

I consent to Vitality Urology Institute using my PHI for the following purposes:

- **Treatment**: To provide, coordinate, or manage my health care and related services.
- **Payment**: To obtain payment for my health care services from insurance companies or other payers.
- **Health Care Operations**: To conduct quality assessment and improvement activities, case management, accreditation, and other administrative activities.

3. Authorization for Disclosure

I authorize Vitality Urology Institute to disclose my PHI to:

- **Healthcare Providers**: As necessary to coordinate my care and treatment.
- **Insurance Companies**: To process claims and determine benefits.
- **Other Entities**: As required by law or for the purposes of public health, research, or legal obligations.

4. Privacy Practices

I have been provided with a copy of Vitality Urology Institute Notice of Privacy Practices, which describes how my PHI may be used and disclosed, and my rights regarding my PHI. I understand that I have the right to review this notice prior to signing this consent.

5. Right to Revoke Consent

I understand that I may revoke this consent at any time by providing a written notice to Vitality Urology Institute. However, I acknowledge that any revocation will not affect actions already taken in reliance on this consent.

6. Contact Information

If I have any questions about this consent or Vitality Urology Institute's privacy practices, I can contact the office at 713-424-4030.

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Acknowledgement of Privacy Policies

I have reviewed this office's Notice of Privacy practices, which explain how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____________________________________ ____________________________________

Signature of Patient or Personal Representative | Date

Lab Notification

Laboratory testing of certain important clinical variables will be offered on site if it is believed that your insurance is contracted to reimburse the practice for these services. Should your insurance deny this coverage or request a refund of payment for this service, you will be responsible for an amount determined by the practice as fair and reasonable compensation.

You are free to inquire about this price at any time before your services are rendered and to choose an outside lab for the same testing, also potentially at your expense.

____________________________________ ____________________________________

Patient Signature | Date

Cancellation Policy

Please understand that we request a 24-hour cancellation notice. Failure to notify us within 24 hours of a scheduled appointment will result in a $50.00 fee due on or before your next visit. Please speak to an office representative for clarification of any concerns.

____________________________________ ____________________________________

Patient Signature | Date

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Assignment of Benefits

I hereby authorize payment of benefits directly to the physician for the surgical and/or medical services herein specified. I am aware of my responsibility to pay any non-covered service, as well as any co-pay, coinsurance; and/or deductible due at the time of treatment.

________________________________ ________________________________

Patient Signature | Date

Release of Information

Insurance: I hereby authorize the physician to release any information acquired in the course of my examination, treatment, or surgery for billing and treatment purposes only.

________________________________ ________________________________

Patient Signature | Date

Individuals: I authorize the physician to release my personal health information to the following people (i.e. spouse, relatives, friends, **primary care doctor and other specialists**)

____

____

____

☐ If you do not want your information disclosed to others, please check this box.

________________________________ ________________________________

Patient Signature | Date

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International Prostate Symptom Score (I-PSS)

Patient Name: ______________________________ Date: ______________

	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	Your Score
1. Incomplete Emptying: 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	
2. Frequency: Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency: 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	
4. Urgency: Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream: Over the past month, how often have you had a \weak urinary stream?	0	1	2	3	4	5	
6. Straining: 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	
7. Nocturia: 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	
Total I-PSS Score							
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
Quality of Life Due to Urinary Symptoms If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel?	0	1	2	3	4	5	6

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SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

Patients Name: ____ Today's Date: ________________

Sexual Health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you, and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

PATIENT INSTRUCTIONS
Each question has several possible responses. Circle the number of the response that best describes your own situation. Please be sure that you select one and only one response for each question.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		VERY LOW	LOW	MODERATE	HIGH	VERY HIGH
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	NO SEXUAL ACTIVITY	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	DO NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	DO NOT ATTEMPT INTERCOURSE	EXTREMELY DIFFICULT	VERY DIFFICULT	DIFFICULT	SLIGHTLY DIFFICULT	NOT DIFFICULT
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	DO NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. **TOTAL:** ____________

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TELEMEDICINE CONSENT FORM

Patient Name: ____ DOB: ______________________

I understand that Telemedicine requires me and my healthcare provider to communicate information interactively through video equipment, about my health, including prior health history, present symptoms, laboratory and diagnostic tests.

- Details of your medical history, examinations, x-ray, and tests may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.

- Visual and physical examination of you may take place.

- Nonmedical technical personnel may be requested to enter the area where telemedicine is being performed.

- Video, audio, and/or photo recordings may be taken of the encounter(s).

- On the benefits and risks of telemedicine (174.5.b Regulation) telemedicine allows to provide quality services without having to travel long distances, but in turn presents some risks as described below.
  a. There is a risk despite our best efforts to protect the privacy of patient information, that the security protocol may fail causing a violation of the privacy of personal medical information.
  b. There is a risk of a delay in diagnosis and medical treatment due to unexpected failures of electronic equipment for this service.
  c. I understand that if telemedicine consultation cannot be done, I will be referred to another health professional for a consultation or query will be scheduled in person (174.5.c of the Regulation).

- I understand that I can withdraw my consent at any time to participate in this therapeutic means and then refer me to another health professional.

- Any dissemination of patient-identifiable images or information and certain necessary administrative and operational activities supporting your care shall not occur without your authorization.

By signing below, I understand the written information provided above and voluntarily and freely agree give my consent to take part in the telemedicine be it via video conference, phone or text message with the doctor and his team for evaluation, assessment, and diagnosis for my current medical condition.

Patient Signature: ____ Date: ____________________

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