COASTAL
UROLOGY

VICTOR E. ABRAHAM, MD., FACS
SARA TENNANT, PA - C

Patient – Healthcare Provider Acknowledgement Form

PATIENT NAME _____ **DOB**_____

This list is an example of medications that should be discontinued, 5-10 days before your procedure, specified by one of our providers or staff. This is not a complete list, so if you are unsure about a certain medication, please make our staff aware.

medications with this symbol may require clearance from your cardiologist

ADVIL	BAYER	*COUMADIN	FENOPROFEN	NUPRIN
ALEVE	BC POWDER/TABLETS	DARVON	FISH OIL	NYQUIL
ALKA	BUFFERIN	DISALCID	FLORINAL	PAMPRIN
SELTZER	CAMA ARTHRITIS PAIN	DOAN'S	IBUPROFEN	PHENTERMINE
ASPIRIN	RELIEVER	DRISTAN	INDOCIN	*PLAVIX
ANACIN	CLINORIL	DURAGESIC	LODINE	PROPOXYPHEN
ANAPROX	CONGESPRIN	ECOTRIN	LOVENOX	ROBAXISAL
ASCRIPTIN	CHEWABLE TABLETS	EMPIRIN	MIDOL	VITAMIN E
ASPERGUM	CORICIDIN	EXCEDRIN	MOTRIN	*WARFARIN
BAYER	CORICIDIN-D	FELDENE	NAPROSYN	ZORPHIN
BC POWDER OR TABLETS	*CLOPIDOGREL		NORGESIC	

Procedures that require the discontinuation of these medications include:

ACCULOBE/ CALYPSO MARKERS	PROSTATE BIOPSY	TESTOPEL	VANTAS	VASECTOMY	BCG	UDS	CYSTO

- **Patients taking Coumadin may stop taking medications 5 days before any <u>IN OFFICE PROCEDURES ONLY OR AS DIRECTED.</u>**
- **Patients may take Tylenol or Celebrex up to a few hours before the <u>IN OFFICE PROCEDURE ONLY.</u>**

Your signature is required indicating you have received example list of medication. For any questions and/or concerns please call our office.
☐ Prescription ☐ Medication List ☐ Procedure Description Reviewed with Patient (if applicable)

****Prescriptions are provided to be taken prior to or day of procedures listed above. Additional prescriptions will not be disbursed due to the reschedule or cancellation of a procedure.****

Patient Signature _____ Date _____

Staff Signature _____ Date _____

Victor E. Abraham, MD **Coastal Urology** Sara Tennant, PA-C
1099 Medical Center Drive Suite #101
Wilmington, NC 28401

VASECTOMY INSTRUCTIONS

BEFORE

- **ON THE DAY OF YOUR PROCEDURE YOU MUST HAVE A DRIVER.**
- IF YOU ARE TAKING ANY OF THE MEDICATIONS ON THE BLOOD THINNERS SHEET (SEE ATTACHED), STOP THEM 7-10 DAYS PRIOR TO YOUR PROCEDURE.
- TAKE YOUR ANTIBIOTICS (1ST DOSE 2 HOURS BEFORE THE VASECTOMY).
- TAKE YOUR VALIUM 1 HOUR BEFORE WITH FOOD.
- **SHAVE THE FRONT OF THE SCROTUM THE NIGHT BEFORE OR THE MORNING OF THE VASECTOMY.**
- **YOU WILL NEED TO WEAR SNUG-FITTING UNDERWEAR THE DAY OF YOUR VASECTOMY.**

AFTER

- TAKE IT EASY FOR THE REST OF THE DAY.
- APPLY ICE OR A BAG OF PEAS FOR 4 HOURS AFTER THE VASECTOMY.
- TAKE YOUR PAIN MEDICATION AND THE REST OF YOUR ANTIBIOTICS AS PRESCRIBED.
- YOU MAY NEED TO TAKE A STOOL SOFTNER TWICE A DAY TO AVOID CONSTIPATION FROM THE PAIN MEDICATION. (COLACE IS AN OVER THE COUNTER OPTION)
- YOU MAY SHOWER 24 HOURS AFTER THE VASECTOMY. (AVOID BATHS AND POOLS FOR 1 WEEK)
- NO HEAVY LIFTING FOR THREE TO FIVE DAYS.
- NO INTERCOURSE DURING THE FIRST WEEK.
- EJACULATE AT LEAST TWICE PER WEEK, STARTING ON WEEK #2.
- BRING A FRESH SPECIMEN INTO THE OFFICE ON WEEK #8.
- CONTINUE TO USE ANOTHER FORM OF BIRTH CONTROL UNTIL WE HAVE NOTIFED YOU OF YOUR SPECIMEN RESULTS.

COASTAL UROLOGY

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PATIENT REGISTRATION

NAME_____ BIRTH DATE_____ ☐ MALE ☐ FEMALE

SS#_____ ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE: HOME_____ WORK_____ CELL_____

E-MAIL ADDRESSS _____ MAY WE CONTACT YOU THROUGH E-MAIL ? ☐ YES ☐ NO

MAY WE SEND NORMAL LAB RESULTS TO THIS SECURED E-MAIL? ☐ YES ☐ NO

WOULD YOU LIKE TO ENROLL IN OUR ONLINE PATIENT PORTAL? ☐ YES ☐ NO

EMPLOYER_____ ADDRESS_____

PRIMARY MEDICAL DOCTOR _____ PRIMARY PHONE_____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

HEALTH INSURANCE CO._____ INSURED NAME_____ DOB_____

PERSON RESPONSIBLE FOR PAYMENT ☐ PATIENT ☐ OTHER: _____

I UNDERSTAND THAT CO-PAYMENTS AND CO-INSURANCE PAYMENTS IS DUE IN FULL AT TIME OF SERVICE. COASTAL UROLOGY WILL SUBMIT YOUR CLAIMS TO THE INSURANCE COMPANY PROVIDED.

THERE WILL BE A $25 CHARGE FOR MISSED APPOINTMENTS OR LATE CANCELLATIONS. CANCELLATIONS MUST BE MADE AT LEAST 24 HOURS PRIOR TO SCHEDULED APPOINTMENT.

HOW DID YOU HEAR ABOUT US? ☐ INTERNET ☐ FAMILY/FRIEND ☐ PHYSICIAN

☐ OTHER: (PLEASE EXPLAIN)_____

With whom, other than yourself, may we discuss your medical and billing information?

1. Name _____ PHONE _____ 2. NAME _____ PHONE _____

*A current Notice of Privacy Practices for Coastal Urology is available to you at the check-in counter.

I acknowledge that I have been offered a Notice of Privacy Practices from Coastal Urology and allow the release of my medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Coastal Urology for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services of medical treatment. I understand that Coastal Urology does not participate with all insurance plans and I may be responsible for any out of network services not covered by my plan. I understand it is my responsibility to verify coverage with my insurance carrier. Overpayments on any Coastal Urology accounts may be applied to your patient balance within the network. The information on this page and the medical history are correct to the best of my knowledge and I agree to abide by the guidelines of the above payment policy.

X_____ DATE_____

SIGNATURE OF PATIENT OR REPRESENTATIVE

COASTAL UROLOGY

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PATIENT REGISTRATION

NAME_____ BIRTH DATE_____

WHAT IT IS YOUR UROLOGICAL PROBLEM?_____

MEDICAL HISTORY

DRUG ALLERGIES: ☐PENICILLIN ☐CIPRO ☐IV CONTRAST DYE/ IODINE ☐NONE ☐SEAFOOD

☐OTHER:_____

PREFERRED PHARMACY _____ **PHONE** _____

PLEASE LIST ***ALL*** **MEDICATIONS** OR PROVIDE DETAILED LIST : _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

PAST MEDICAL HISTORY (CHECK **ALL** THAT APPLY):

☐ ASTHMA ☐STROKE (CVA) ☐CANCER:_____ ☐ CONGESTIVE HEART FAILURE

☐COPD ☐ DIABETES ☐ GASTROESOPHOGEAL REFLUX ☐ HIGH CHOLESTEROL

☐HYPERTENSION ☐HYPOTHYROIDISM ☐ HEART ATTACK ☐ ANGINA (HEART PAIN)

☐ARTIFICIAL HEART VALVES, #_____ ☐KIDNEY STONES ☐ CLOT IN LEGS

☐ATRIFICIAL JOINTS ☐ STOMACH ULCERS ☐ HEPATITIS ☐ HIV/AIDS

☐ CHRONIC BRONCHITIS ☐ OTHERS:_____

PAST SURGERIES (INCLUDE YEAR): _____ _____ _____

_____ _____ _____ _____

FAMILY HISTORY: ☐ PROSTATE CANCER ☐ BLADDER CANCER ☐ KIDNEY CANCER ☐KIDNEY STONES
☐ URINARY INFECTIONS ☐OTHER_____

SMOKING: ☐ YES NUMBER OF PACKER PER DAY _____ NUMBER OF YEARS SMOKING_____

☐QUIT LAST SMOKED_____ ☐NEVER

ALCOHOL: ☐NEVER ☐RARE ☐WEEKENDS ☐SOCIALLY ☐DAILY ☐RECOVERING ALCOHOLIC

Male Symptom Questionaire

Patient Name: _____ DOB: _____

In the past month:

Nocturia: How many times did you get up per night to urinate?	None	1 time	2 times	3 times	4 times	more than 4
	Not at all	Less than 1 in 5 Times	Less than Half the Time	Half the Time	More than Half	Almost Always
Incomplete Emptying: How often have you had the sensation of not emptying your baldder?						
Frequency: How often have you had to urinate every 2 hours or less?						
Intermittency: How often has your stream stopped and started while urinating?						
Urgency: How often have you found it difficult to postpone urination?						
Weak Stream: How often have you had a weak urinary stream?						
Straining: How often have you had to strain to start urination?						

Quality of life due to Urinary Symptoms	Perfect	Pleased	Mostly Statisfied	Mixed	Unhappy	Terrible

Have you had or still have:	YES	NO
Urge Incontinence: Strong need to urinate followed by leaking		
Stress Incontinence: Leaking with a cough, sneeze or laugh		
Urinary Retention: Unable to urinate requiring a catheter		
Blood in the urine		
Kidney Stones		
Testicular Pain		
Elevated PSA		
An abnormal prostate exam		
Biopsy of the prostate		
Chronic Prostatitis		
Kidney, Bladder or Urinary Infections		
Surgery or Radiation of the prostate, kidneys, bladder, testicles, penis or colon?		
Have you seen a Urologist before?		

CLINCAL USE ONLY

IPSS Score: _____

Do you have Erectile Dystfunction?	YES	NO		
If yes, please continue...				
Which drugs have you tried?	None	Cialis	Viagra	Levitra
Which one worked without significant side effects?	None	Cialis	Viagra	Levitra
Select any other treatments tried-	Vacuum Device	Muse	Penile Injection	Penile Prosthesis
Have you had your testosterone checked?	No	Low	Normal	Unsure

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Patient Portal Authorization Agreement

Name: _____

Email: _____

Coastal Urology, PLLC offers secure electronic access to your medical record and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks we have imposed some terms and conditions of participation. Your signature on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works
A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the Portal site. Using the connection channel between your computer and the Web site, you can read, view, or send information on or from your computer. It is automatically encrypted in transmission between the Web site and your computer.

How to Participate
You may compose, pick up, and reply to secure messages or view information sent to you through the Patient Portal. Once you have reviewed, agreed to, and signed our policies and procedures regarding use of the Patient Portal, we will assign you a username and password. You may then login to the Patient Portal through our website at www.gotomyclinic.com/cu.

Protecting Your Private Health Information and Risks
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no

transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes. Protect your username and password information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information.

If you believe someone has learned your password, you should immediately go to the Web site and change it. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times. Access to the Patient Portal is a free service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential. Please read our Notice of Privacy Practices for additional information on uses and disclosures.

Conditions of Participating in the Patient Portal
Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service we will notify you as promptly as we reasonably can. You agree to not hold Coastal Urology PLLC or any of its staff or physicians liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this agreement and do not request a username and password.

If you have questions we will gladly provide more information.

Patient Acknowledgement
Signature: _____

Date: _____

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www.coastalurology.net

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Phone Number: _____ Address: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name/Facility :	Phone Number:
Address:	Fax Number:
City: State:	Zip Code:

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ I understand this information will be used for: _____

☐ I understand this authorization will expire 1 year from the date indicated below, and that I may revoke this authorization at any time as explained in Coastal Urology's Notice of Privacy Practices

☐ I have the right to receive a copy of this authorization

☐ The requestor should not re-disclose my medical records to another party without further written consent

Patient or Legal Representative's Signature: _____ Date Signed: _____

Print Name: _____ If Not Patient, State Relationship: _____