

# COMMONWEALTH UROLOGY

## Patient Registration Welcome!

### Patient Information

Please Print Clearly

Appointment Scheduled with:  Dr. Basile  Dr. Patel

Today's Date: \_\_\_\_\_

New Patient

Update Info

Name: \_\_\_\_\_ Sex: Male Female  
First MI Last

Address: \_\_\_\_\_  
City State Zip Code

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Marital Status: M S D W

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care/Referring Physician: \_\_\_\_\_ Doctor #: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy #: \_\_\_\_\_

Drug Reactions/Allergies: \_\_\_\_\_

### Spouse Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
First MI Last

Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Employer: \_\_\_\_\_

### Insurance Information

PRIMARY: \_\_\_\_\_ Copay/Deductible: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip Code

Policy ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Type of Insurance: PPO HMO POS MC Referral /Authorization Required: Yes No

SECONDARY: \_\_\_\_\_ Copay/Deductible: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip Code

Policy ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

**JOHN J. BASILE, MD, PC**  
**SUNIL V. PATEL, MD**  
**Adult and Pediatric Urology**

**AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS**

I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to my dependent or me during the period of such care to third party payers and/or healthcare practitioners. I also authorize and request my insurance company to pay directly to the doctor or to John J. Basile, M.D., P.C. benefits otherwise payable to me.

I understand that if my insurance plan requires a referral from my primary care physician, **that it is my responsibility** to obtain it; otherwise, I agree that I am responsible for payment at the time of visit. I certify that the information I have reported with regard to my insurance coverage is correct and that if my insurance plan changes, that I will properly notify the doctor's office of such change. I also agree to pay for services rendered which are not covered under my insurance plan. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient, Parent or Guardian)

**Adult and Pediatric Urology**  
**JOHN J. BASILE, MD, PC**  
**SUNIL V. PATEL, MD**  
3020 Hamaker Court, Suite B-111  
Fairfax, Virginia 22031-2220  
Tel: 703.876.0288  
Fax: 703.876.0290

**PATIENT HISTORY FORM**

**Patient Name:** \_\_\_\_\_

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

**CHIEF COMPLAINT**

State, as clearly as possible, the main reason for your visit.

\_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

Elaborate on your chief complaint.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please Specify if you have had any of the following:**

Urinary Tract Infections  
Specify: \_\_\_\_\_

Kidney Stones  
Specify: \_\_\_\_\_

Sexually Transmitted Disease  
Specify: \_\_\_\_\_

Cancer of the Urinary Tract (kidney, bladder, prostate, or testicle)  
Specify: \_\_\_\_\_

Prostatitis  
Specify: \_\_\_\_\_

Incontinence  
Specify: \_\_\_\_\_

Erectile Dysfunction  
Specify: \_\_\_\_\_

Infertility  
Specify: \_\_\_\_\_

**PAST MEDICAL HISTORY**

List all personal past illnesses with dates of diagnosis.

<b>Illness:</b>	<b>Date:</b>	<b>Illness:</b>	<b>Date:</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PAST SURGICAL HISTORY**

List all surgical procedures you have undergone with dates.

<b>Surgery:</b>	<b>Date:</b>	<b>Surgery:</b>	<b>Date:</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**MEDICATIONS**

List all medications you are currently taking with doses.

<b>Medication:</b>	<b>Date:</b>	<b>Medication:</b>	<b>Date:</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take aspirin, Ibuprofen, or any product that contains them?  Yes  No  
If yes, when was the last time you took it? \_\_\_\_\_

Do you take Coumadin or any other type of blood thinner?  Yes  No  
If yes, when was the last time you took it? \_\_\_\_\_

**ALLERGIES**

List all drugs to which you are allergic and your specific reaction to them.

<b>Drug:</b>	<b>Reaction:</b>	<b>Drug:</b>	<b>Reaction:</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to Iodine?  Yes  No  
If yes, how do you react to it? \_\_\_\_\_

Are you allergic to shellfish?  Yes  No  
If yes, how do you react to it? \_\_\_\_\_

**SOCIAL HISTORY**

What is your occupation? \_\_\_\_\_

Do you smoke?  Yes  No  
If yes, how much, and for how long? \_\_\_\_\_

Do you drink alcohol?  Yes  No  
If yes, what type, how much, and for how long? \_\_\_\_\_

**FAMILY HISTORY**

List all serious illnesses in your immediate family, and the family member affected.

<b>Illness:</b>	<b>Family Member:</b>	<b>Illness:</b>	<b>Family Member:</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## **REVIEW OF SYSTEMS**

Please indicate if you have had any problems related to the following systems:

### Constitutional Symptoms

Fever  Yes  No  
Chills  Yes  No  
Headache  Yes  No  
Other: \_\_\_\_\_

### Integumentary

Skin Rash  Yes  No  
Boils  Yes  No  
Persistent Itch  Yes  No  
Other: \_\_\_\_\_

### Eyes

Blurred Vision  Yes  No  
Double Vision  Yes  No  
Pain  Yes  No  
Other: \_\_\_\_\_

### Musculoskeletal

Joint Pain  Yes  No  
Neck Pain  Yes  No  
Back Pain  Yes  No  
Other: \_\_\_\_\_

### Allergic/Immunologic

Hay Fever  Yes  No  
Drug Allergies  Yes  No  
Other: \_\_\_\_\_

### Ear/Nose/Throat/Mouth

Ear Infection  Yes  No  
Sore Throat  Yes  No  
Sinus Problems  Yes  No  
Other: \_\_\_\_\_

### Neurological

Tremors  Yes  No  
Dizzy Spells  Yes  No  
Numbness/Tingling  Yes  No  
Other: \_\_\_\_\_

### Genitourinary

Urine Retention  Yes  No  
Painful Urination  Yes  No  
Urinary Frequency  Yes  No  
Other: \_\_\_\_\_

### Endocrine

Excessive Thirst  Yes  No  
Too hot/cold  Yes  No  
Tired/sluggish  Yes  No  
Other: \_\_\_\_\_

### Respiratory

Wheezing  Yes  No  
Frequent Cough  Yes  No  
Shortness of Breath  Yes  No  
Other: \_\_\_\_\_

### Gastrointestinal

Abdominal Pain  Yes  No  
Nausea/Vomiting  Yes  No  
Indigestion/Heartburn  Yes  No  
Other: \_\_\_\_\_

### Hematologic/Lymphatic

Swollen Glands  Yes  No  
Blood Clotting Prob.  Yes  No  
Other: \_\_\_\_\_

### Cardiovascular

Chest Pain  Yes  No  
Varicose Veins  Yes  No  
High Blood Pressure  Yes  No  
Other: \_\_\_\_\_

### Psychologic

Satisfied with Life  Yes  No  
Feel Depressed  Yes  No  
Considered Suicide?  Yes  No  
Other: \_\_\_\_\_

.....  
*If you are a male patient and have difficulty urinating, please complete the questionnaire on the next page.*  
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# COMMONWEALTH UROLOGY

**John J. Basile, M.D., P.C.**

**Sunil V. Patel, M.D.**

## NOTICE OF INFORMATION PRACTICES

Effective Date: April 14, 2003

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

A new federal regulation, known as the "Health Insurance Portability & Accountability Act (HIPAA)", requires that we provide notice in writing of our privacy practices. These privacy practices are in place to maintain the privacy of your protected health information (PHI).

John J. Basile, M.D. and Sunil V. Patel, M.D., may disclose PHI for the purposes of treatment, payment, and to operate the practice. The following are some examples, and do not imply an exclusive list.

Examples of uses and disclosures for treatment:

- If the doctor refers you to another physician for continuation of treatment, the doctor may give your name and the reason for your referral to the doctor's office.
- The doctor or his staff may call you to advise you of treatment alternatives or recommendations for treatment.

Examples of uses and disclosures to obtain payment:

- Our billing office may submit a claim form that contains your name, address, social security number, diagnosis, and procedure(s) performed by our physicians to your insurance company.

Examples of uses and disclosures to operate the practice:

- Our staff may call with reminders about upcoming appointments.
- Our staff may leave messages for you on your telephone and ask you to return the call.
- The physicians may audit (read and comment upon) your chart to track and improve our performance in assuring that we perform screening test on time.

John J Basile, M.D. and/or Sunil V. Patel, M.D., are permitted or required to use or disclose PHI without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements and court orders.

John J Basile, M.D. and/or Sunil V. Patel, M.D., will not make any other disclosure of your PHI, other than for the aforementioned purposes of treatment, payment, or practice operation, without the individual's written authorization. Such authorization may be revoked by you at any time. Revocation must be in writing.

You have the following rights regarding your PHI, and the practice must act on your request within 60 days:

- You may request restrictions on certain uses and disclosures of PHI, but we are not required to agree to a requested restriction.
- You may request to inspect and copy your own PHI.
- You may request that your information be amended.
- You may request a paper copy of this notice.

See Reverse

Requested copies of your medical records will be available to you within 15 days of written request, as per Virginia State Law. The law requires the practice to abide by the terms of this notice and to provide individuals with notice revisions. Copies of this notice are available at any time during normal business hours and on our website.

You may file a complaint with the practice or the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. File a complaint with the practice in writing at the address listed below. You will not be penalized for filing a complaint.

I acknowledge that I have read and understand the HIPAA notice of information practices set forth in this office.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

**If you wish anyone other than you to have access to your PHI, please indicate this permission in writing below; otherwise, please leave blank.**

**I authorize the following person(s) to obtain information about me and my health condition.**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

**Privacy Officer  
c/o Commonwealth Urology  
3020 Hamaker Court  
Suite B-111  
Fairfax, VA 22031  
Phone 703-876-0288 / Fax 703-876-0290**

**JOHN J. BASILE, MD, PC  
SUNIL V. PATEL, MD  
Adult and Pediatric Urology**

**AGREEMENT**

**THIS AGREEMENT** is made by and between \_\_\_\_\_ ("Patient"), Social Security Number \_\_\_\_\_, and JOHN J. BASILE, M.D., P.C., ADULT AND PEDIATRIC UROLOGY, 3020 Hamaker Court, Suite B-111, Fairfax, Virginia 22031 ("Physician").

WHEREAS, Patient is interested in employing Physician for his professional services and expertise; and

WHEREAS, Physician agrees to handle Patient's medical issues with the skill, expertise and common knowledge of physicians trained in the same medical field and areas of expertise.

NOW, THEREFORE, the parties do hereby agree as follows:

1. **Purpose:** Patient agrees to employ Physician for the purpose of medical diagnosis and treatment.
2. **Services:** Patient understands that it is difficult and impossible at this time to specify the exact nature and extent of treatment, procedures, and Physician's time involved. Physician hereby warrants that he shall exert all of his efforts and skills in resolving Patient's complaints. Due to the nature of medical treatment, Physician cannot and does not guarantee the outcome of any procedure.
3. **Financial Agreement:** As a courtesy, Physician shall file Patient's medical claim with Patient's insurance company. Patient agrees that if insurance plan requires a referral from their primary care physician, then it is the **Patient's responsibility** to obtain the referral and further that if Patient does not obtain the referral, then the Patient shall make payment in full at the time of the scheduled appointment. Patient further agrees to make all co-payments at the scheduled appointment time. Patients unable to make payment immediately upon demand shall make payment arrangements with the Physician's business office. Patient certifies that the information reported with regard to insurance coverage is correct. Patient agrees that if any or all of the information concerning insurance coverage changes, Patient will immediately inform Physician's business office and provide the updated information. **Patient agrees to pay for any and all services rendered which are not covered under Patient's insurance plan, or which are not billed correctly due to information improperly provided to the Physician's office by the Patient. All unpaid balances which are overdue thirty (30) or more days shall accrued interest at ten percent (10%) per annum.**
4. **Cancellation:** Any appointment cancelled within 48 hours of the scheduled time will be charged a \$25.00 administrative fee. Any procedure cancelled within 48 hours of the scheduled time will be charged a \$100.00 administrative fee. Exceptions may be made on a case by case basis at the discretion of John J. Basile, M.D., or Sunil V. Patel, M.D.
5. **Collection:** In the event Patient's bill becomes delinquent and is sent for collection, then in that event Patient agrees to pay all cost of collection which include, but are not limited to, court costs, filing fees, subpoena costs, deposition costs, long-distance calls, transportation costs, reasonable attorney's fees defined as thirty three percent (33%) of the principal collection amount, as well as any other cost incurred attempting to collect the delinquent amount.
6. **Law and Binding Effect:** This Agreement shall be construed according to Virginia laws and courts, and shall be binding upon each of the parties, their heirs, successors and assigns.
7. **Venue/Jurisdiction:** The parties agree and consent to venue and jurisdiction as being Fairfax County in the Commonwealth of Virginia.

IN WITNESS WHEREOF, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

JOHN J. BASILE, M.D., P.C.,  
SUNIL V. PATEL, M.D.,  
ADULT AND PEDIATRIC UROLOGY

\_\_\_\_\_  
Patient (print name)

By: \_\_\_\_\_  
\*John J. Basile, MD/\*Sunil V. Patel, MD  
Office 703.876.0288  
Billing 703.876.1744

\_\_\_\_\_  
Patient (signature)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Credit Card Payment:

Visa: \_\_\_\_\_ Expire date: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
MasterCard: \_\_\_\_\_ Expire date: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

# COMMONWEALTH UROLOGY

John J. Basile, M.D., P.C.

Sunil V. Patel, M.D.

3020 Hamaker Court, Suite B-111 ~ Fairfax, VA 22031

Phone 703-876-0288 / Fax 703-876-0290

## NO SHOW, NO CALL POLICY

Dear Sir or Madam:

You have an appointment scheduled with Dr. John Basile or Dr. Sunil Patel. We realize that your time is valuable and hope that you realize the time of our doctors and our staff is valuable too.

If you are unable to keep your scheduled appointment with Dr. Basile or Dr. Patel, we request that you provide us notification at least two full business days (no less than 48 hours) in advance so that we may provide an opportunity for another patient to seek our urologic services. If you **do not** notify us of your intent to cancel a scheduled appointment at least 48 hours prior to the appointment/procedure, then you will be responsible for an out-of-pocket "no show, no call" cancellation fee of \$25 for appointments and \$100 for office procedures and \$250 for hospital/ Fairfax surgical center procedures. This fee must be paid in full within ten business days upon receipt of our bill.

For example, if your appointment falls on a Monday at 3 pm, we must have your notification of intent to cancel this appointment no later than 3 pm on the Thursday prior to the appointment. If your appointment falls on a Tuesday at 10 am, we must have notification of intent to cancel by no later than 10 am on the Friday prior to the appointment. If Monday is a holiday then notification of a Tuesday appointment must be made by 10 am the prior Thursday.

We realize that extenuating circumstances do occur and the final decision to assess for this fee is left to the discretion of the doctor.

Yours sincerely,

John J. Basile, M.D.

Sunil V. Patel, M.D.

I have read the above policy and agree to its terms and acknowledge that I will be legally responsible for the prompt payment of the assessed fee.

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Patient's Signature

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Date