NORTH IDAHO urology

# Patient Registration Form

Referring Physician: _____ Primary Care Physician: _____

Patient Name: _____ Male_____ Female_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone :(___) _____ Cell :(____) _____ Okay to leave a detailed message: Y ☐ N☐

Social Security #: _____ Date of Birth: _____ Age: _____

Email: _____ PREFERRED PHARMACY: _____

Spouse's Name: _____ Spouse's DOB: _____

Spouse's Phone Number: _____ ☐ HIPAA okay

Preferred Language _____ Race: _____

Please list below your emergency and HIPAA contacts. We can only speak to HIPAA contacts regarding your personal information including scheduling appointments and medical information.

Name: _____ Phone: (___) _____ Relationship: _____ ☐ HIPAA okay

Name: _____ Phone: (___) _____ Relationship: _____ ☐ HIPAA okay

Name: _____ Phone: (___) _____ Relationship: _____ ☐ HIPAA okay

Name: _____ Phone: (___) _____ Relationship: _____ ☐ HIPAA okay

Do you have insurance? Yes: _____ No: _____ If no, Self pay ($383 new patient or $293 per follow up)

Primary Insurance Plan Name: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Plan Name: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Name of person responsible for this account: _____ Relationship: _____

I have been given the opportunity to obtain a copy of the HIPAA Privacy Rules and the Patient Rights and Responsibilities from this provider (available online at www.niurology.com and at North Idaho Urology). I hereby authorize North Idaho Urology to apply for benefits for services rendered.

Signature: _____ Date: _____

# North Idaho Urology PLLC — Financial Policy

*Please review carefully. Questions? Ask staff prior to your appointment.*

## INSURANCE & PATIENT RESPONSIBILITIES

- Provide accurate insurance info at registration; understand your copays, deductibles, and coverage.
- Copayments are due at check-in. Non-payment may result in rescheduling. A $10.00 fee will be charged for non-payment of copayments.
- We submit claims on your behalf, but you are responsible for ensuring timely payment by your insurer.
- Some lab specimens may go to out-of-network labs — we do not bill or authorize for those services.
- Services deemed "not covered" by your insurer are your financial responsibility.

## SELF-PAY / UNINSURED / OUT-OF-NETWORK

- New patients: $383.00 due at time of service.
- Established patients: $293.00 due at time of service.
- Elective procedures must be paid in full before service.
- Any balance after initial payment will be billed; overpayments refunded after insurance pays.

**Accepted: Cash, Visa, MasterCard, CareCredit.**

## BILLING & PAYMENT PLANS

- Itemized statements sent by mail or email per your preference.
- Payment plans available — contact billing to arrange.
- Defaulted plans are sent to collections and may be reported to credit bureaus or result in legal action.

## ADMINISTRATIVE FEES

- Disability, FMLA, life insurance & related forms: $25.00/packet.
- Insurance pre-authorization for uncovered medications: $25.00/authorization. Coverage not guaranteed.

## CANCELLATION & NO-SHOW POLICY

- Notify us as soon as possible if canceling or rescheduling.
- Procedures/Surgeries: Cancellations <24 business hours in advance: $200.00 fee per occurrence.
- Office Visits: No-show without 24-hour notice: $50.00 fee.
- 3 No-shows may result in dismissal from practice

## AI SCRIBE — RECORDING CONSENT

- North Idaho Urology uses an AI-assisted medical scribe to improve documentation accuracy.
- Your visit may be recorded (audio/transcription) solely for generating clinical notes.
- Recordings are stored securely in compliance with HIPAA regulations.
- AI-generated notes are reviewed and approved by your provider before entering your medical record.
- Signing below indicates consent to recording for AI-assisted documentation.

## PATIENT ACKNOWLEDGMENT & CONSENT

I have read and understand the Financial Policy of North Idaho Urology PLLC and agree to its terms, which may be amended without notice. I also consent to recording of my visit for AI-assisted medical scribe documentation.

Patient Name (Print): _____

Date of Birth: _____

Patient / Guardian Signature:

_____ Date: _____

Relationship (if Guardian):

_____

*Accreditation Commission for Health Care: (855) 937-2242*

UPDATED 8.19.26

**North Idaho Urology Patient History Form**

Name: _____ Today's Date: _____

Date of Birth: _____ / _____ / _____ Age: _____ Were you referred by a physician? Yes / No

Height _____ If yes, name _____

Weight _____

## CURRENT PROBLEM

**What is the main problem that brings you to the office today? (Describe your symptoms in detail)**

_____ _____

_____ _____

## PAST MEDICAL HISTORY

Please list all illnesses requiring medical treatment, surgery, or hospitalization:

_____

_____

_____

_____

_____

_____

## MEDICATIONS

Please list current/recent medications: (Include dose, how often and date began)

_____

_____

_____

_____

_____

_____

**ALLERGIES (Please list reaction)** _____

_____

_____

_____

**Do you take aspirin?**_____

**Do you take Coumadin?** _____

**Do you take Plavix?** _____

## FAMILY MEDICAL HISTORY

Please list any major illnesses in family members, parents' age or age at death, siblings' age or age at death:

Father_____ Mother_____

Brothers/Sisters_____

Grandparents_____

## SOCIAL HISTORY

What is your occupation? _____ Do you smoke currently? Yes/No Years/Amount? _____

Marital Status? _____ Did you smoke in the past? Yes/No Dates

How much alcohol do you drink per day? _____

Female only:

Number of children: _____

## Urologic Symptoms/History

**Name**_____

Have you had any of the following recently? Please check any that apply.

**General**

☐Y N☐ fevers
☐Y N☐ chills
☐Y N☐ sweats
☐Y N☐ anorexia
☐Y N☐ fatigue
☐Y N☐ malaise
☐Y N☐ weight loss

**Eyes**

☐Y N☐ blurring
☐Y N☐ double vision
☐Y N☐ irritation
☐Y N☐ discharge
☐Y N☐ vision loss
☐Y N☐ eye pain
☐Y N☐ light sensitivity

**Ears/Nose/Throat**

☐Y N☐ earache
☐Y N☐ ear discharge
☐Y N☐ ringing
☐Y N☐ hearing loss
☐Y N☐ nasal congestion
☐Y N☐ nosebleeds
☐Y N☐ sore throat
☐Y N☐ hoarseness
☐Y N☐ painful swallowing

**Breast**

☐Y N☐ swelling
☐Y N☐ masses
☐Y N☐ nipple discharge
☐Y N☐ skin changes

**Cardiovascular**

☐Y N☐ chest pain
☐Y N☐ palpitations
☐Y N☐ dizziness/syncope
☐Y N☐ shortness of breath
☐Y N☐ short of breath lying down
☐Y N☐ sudden nighttime breathlessness
☐Y N☐ ankle swelling

**Respiratory**

☐Y N☐ cough
☐Y N☐ shortness of breath
☐Y N☐ excessive sputum
☐Y N☐ bloody sputum
☐Y N☐ wheezing

**Gastrointestinal**

☐Y N☐ nausea
☐Y N☐ vomiting
☐Y N☐ diarrhea
☐Y N☐ constipation
☐Y N☐ change in bowel habits
☐Y N☐ abdominal pain
☐Y N☐ black or tarry stools
☐Y N☐ red blood in the stools
☐Y N☐ jaundice

**Genitourinary**

☐Y N☐ urethral pain on voiding
☐Y N☐ frequent urination
☐Y N☐ urgent need to urinate
☐Y N☐ hesitancy/straining with stream
☐Y N☐ slowing of urine stream
☐Y N☐ intermittent urine stream
☐Y N☐ feeling bladder doesn't empty completely
☐Y N☐ urine leak with laugh, cough or strain
☐Y N☐ inability to get to the bathroom before leaking urine
☐Y N☐ getting up at night to urinate
☐Y N☐ blood in the urine
☐Y N☐ incontinence

**Male only:**

☐Y N☐ urethral discharge
☐Y N☐ testicular pain
☐Y N☐ difficulty with erections
☐Y N☐ decreased libido
☐Y N☐ history of vasectomy/kidney stones/STD's/urinary tract infections

**Female only:**

☐Y N☐ pelvic pain
☐Y N☐ vaginal discharge
☐Y N☐ vaginal bleeding (non-menstrual)
☐Y N☐ labial soreness
☐Y N☐ bladder dropping

**Musculoskeletal**

☐Y N☐ back pain
☐Y N☐ joint pain
☐Y N☐ joint swelling
☐Y N☐ muscle cramps
☐Y N☐ muscle weakness
☐Y N☐ stiffness
☐Y N☐ arthritis

**Skin**

☐Y N☐ rash
☐Y N☐ itching
☐Y N☐ dryness
☐Y N☐ suspicious lesions

**Neurologic**

☐Y N☐ transient paralysis
☐Y N☐ weakness
☐Y N☐ tingling numbness
☐Y N☐ seizures
☐Y N☐ dizziness
☐Y N☐ tremors
☐Y N☐ room spinning

**Psychiatric**

☐Y N☐ depression
☐Y N☐ anxiety
☐Y N☐ memory loss
☐Y N☐ mental disturbance
☐Y N☐ thoughts of suicide
☐Y N☐ hallucinations
☐Y N☐ paranoia

**Endocrine**

☐Y N☐ cold intolerance
☐Y N☐ heat intolerance
☐Y N☐ constant thirst
☐Y N☐ constant hunger
☐Y N☐ frequent urination
☐Y N☐ weight gain

**Heme/Lymphatic**

☐Y N☐ abnormal bruising
☐Y N☐ bleeding
☐Y N☐ low blood count
☐Y N☐ enlarged lymph nodes

**Allergic/Immunologic**

☐Y N☐ hives
☐Y N☐ hay fever
☐Y N☐ persistent infections
☐Y N☐ HIV exposure

NORTH IDAHO
urology


| P:(208)667-0621 | F: (208)664-1709 | E: info@niurology.com |
|---|---|---|
| 980 W Ironwood Drive<br>Suite 104<br>Coeur d'Alene, ID 83814 | 151 W 3rd Avenue<br>Suite 200<br>Post Falls, ID 83854 | 420 2nd Avenue<br>Sandpoint, ID 83864 |


## PATIENT RIGHTS AND RESPONSIBILITIES

North Idaho Urology recognizes the need to ensure that every patient is informed of his or her rights as a patient of our practice along with the associated responsibilities of each patient of our practice. Therefore, North Idaho Urology is informing you or your rights and responsibilities when seeking care from our providers at any of our locations.

You have the right to:

- Be treated with respect, consideration, and dignity.
- Be free of all forms of abuse, neglect, and harassment.
- Receive care in a safe setting.
- Be provided with appropriate personal privacy.
- Expect privacy of health information: all disclosures and records to be treated confidentially, and, except when required by law, be given the opportunity to approve or refuse their release.
- Be provided, to the degree known, complete information concerning your diagnosis, evaluation, and treatment, alternative treatments, and appropriate preventative measures, risks and benefits of treatment, and your prognosis, in appropriate understandable language.
- Be given the opportunity to have all your questions answered promptly to your satisfaction in appropriate understandable language.
- Be informed of:
  - These patient rights.
  - Expected conduct and responsibilities.
  - Services available from our organization.
  - Provisions for after-hours and emergency care.
  - Fees for services and payment policies.
  - The credentials of your healthcare providers upon request.
  - Any facility advance directives.
- To voice grievances regarding treatment and to have all grievances reported immediately to the administrator relating to, but not limited to, mistreatment, neglect, or verbal, mental, sexual, or physical abuse.
- Know by name the physician responsible for your care.
- Receive from your physician full information necessary to give informed consent prior to the start of any treatment plan, procedure, or surgery.

- Have all North Idaho Urology services made available to persons with disabilities.
- Decline treatment after being informed of the possible side effects and risks, and the possible consequences of such a decision. Your decision will be respected to the extent permissible by law.
- Receive an explanation of your bill.
- To express suggestions, complaints, exercise rights, and/or grievances without being subjected to discrimination or reprisal.

You have the responsibility to:

- Inform North Idah Urology of your need for interpretation services prior to your appointment, allowing time for us to find these services and get them scheduled.
- Arrive as scheduled for appointments and notify North Idaho Urology in advance of cancelled appointments. Provide accurate and complete information, to the best for your ability, about your personal contact information, insurance, medical history, medications (including over the counter products and dietary supplements), any allergies or sensitivities to medications and other items, and current health concerns.
- Ask sufficient questions to ensure understanding of your illness or problem, as well as your provider's recommendations for continuing care.
- Follow the agreed-upon treatment plans prescribed by our doctors and other health professionals working under your doctor's direction and participate in your care.
- Either carry out treatment and educational recommendations or accept responsibility for the outcome.
- Question any and all instructions you do not understand.
- Communicate with your health care provider if your condition does not follow the expected outcome.
- Inform North Idaho Urology of any medical power of attorney, living will, or other directive that could affect your care.
- Become informed of service costs and the requirements of your medical insurance coverage such as: required referrals, co-payments, deductibles, and your out-of-pocket responsibility.
- Make payment or arrange for payment of services accepting personal financial responsibility for any charges not covered by your insurance.
- Behave respectfully toward all North Idaho Urology healthcare professionals and staff, as well as other patients and visitors of our organization.

**If you have concerns or grievances, you may contact:**

- North Idaho Urology Administrator – Michelle Froehlich
- Front Office Manager – Shalae Shaw
- Clinical Manager – Nicole Fox
- Billing Manager – Christine Chatfield
- Accreditation Commission for Health Care - Toll-Free: (855) 937-2242