

We would like to take this opportunity to welcome you to The Hubbard Clinic. Since opening the clinic in 2000, we have helped thousands of men and women regain their quality of life.

The Prostate Center at The Hubbard Clinic specializes in the treatment of males with symptoms related to prostate disease, and all types of voiding dysfunctions, including urinary leakage.

The Women's Care Center at The Hubbard Clinic specializes in the treatment of urological conditions in females, including: urinary leakage (incontinence), urinary voiding problems, frequent urinary tract infections, and interstitial cystitis (IC). New female patients of The Hubbard Clinic are worked-up and examined by a female nurse practitioner or physician assistant.

The attached new patient packet includes all the paperwork that needs to be completed before you arrive at our office. **Please make sure that ALL paperwork is filled out completely before arriving at our office.**

If you are not ambulatory (unable to move or lift on your own) it would be helpful to bring an assistant to help accommodate you.

Please arrive **thirty minutes** before your appointment with your insurance cards and a full bladder. **If you arrive late for your appointment or your paperwork is not complete upon checking in, there may be a possibility that your appointment will be rescheduled.**

If you must bring your children, please make sure they wait in the designated waiting area with adult supervision.

If you would like further information about our clinic, please visit our website at www.hubbardclinic.com.

Sincerely,

The Hubbard Clinic Staff

THE HUBBARD CLINIC
John G. Hubbard, M.D.

DATE: _____

Patient Name: _____ DOB: _____ AGE: _____

Ref Dr: _____ Medical Dr. _____ Patient SSN: _____ - _____ - _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

State the reason for your visit: _____

When did you first notice the problem?

Few days ago 2 weeks ago 1 month ago

Other _____

Is anything else occurring at the same time?

YES NO If YES please explain

Nausea Rash Headaches

Other _____

Does anything help or make the problem worse?

Moving around - Standing up - Lying on my side

Other _____

Is the problem constant or variable?

Dull then sharp - Very sharp then leaves - Always there

Other _____

How long does the problem last?

30 mins 1 hr always there

Does the problem interfere with normal functions?

YES NO If yes explain: _____

PAST MEDICAL HISTORY

Do you have a history of:

Diabetes Y N

Weight Loss Y N

Cancer Y N

High Blood Pressure Y N

Kidney Stones Y N

Other _____

LIST ALL SURGERIES AND DATES

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

Does your family have a history of:

Diabetes Y N

Prostate Cancer Y N

Bladder Cancer Y N

Kidney Cancer Y N

Circulation Problems Y N

Heart Disease Y N

Mother Living? Y N

Cause of Death _____

Father Living? Y N

Cause of Death _____

LIST ALL MEDICATIONS AND DOSES

Drug _____ Dose _____

Drug _____ Dose _____

Drug _____ Dose _____

Drug _____ Dose _____

Drug _____ Dose _____

Drug _____ Dose _____

Drug _____ Dose _____

Drug _____ Dose _____

Drug _____ Dose _____

Drug _____ Dose _____

List any medical allergies _____

Do you smoke? Y N How much? _____ If you quit smoking, please give date _____

Do you drink alcohol? Y N If yes, circle answers that apply Daily Weekly Social Only

Marital Status -- Married Single Widowed Number of children _____

Additional Comments _____

Review of Systems

Do you now or have you recently (in the past 6 months) had any problems related to the following systems?

CONSTITUTIONAL

Fever Y N
 Chills Y N
 Headache Y N
 Weight Gain Y N
 Weight Loss Y N
 Height Loss Y N
 Other _____

EYES

Blurred Vision Y N
 Double Vision Y N
 Glaucoma Y N
 Other _____

EAR/NOSE/THROAT/MOUTH

Ear Infection Y N
 Sore Throat Y N
 Sinus Problems Y N
 Other _____

BREASTS-(FEMALES ONLY)

Lumps Y N
 Tenderness Y N
 Swelling Y N
 Nipple Discharge Y N
 Abnormal Changes
 In Breast Size Y N
 Last Mammogram
 Date _____
 Where _____
 Findings _____

CARDIOVASCULAR

Chest Pain Y N
 Varicose Veins Y N
 ↑ Blood Pressure Y N
 Other _____

RESPIRATORY

Wheezing Y N
 Shortness Breath Y N
 Chronic Cough Y N
 Lung Conditions Y N
 Other _____

GASTROINTESTINAL

Abdominal Pain Y N
 Nausea / Vomiting Y N
 Indigestion Y N
 Heartburn Y N
 Change in bowel habits? Y N
 Colonoscopy Y N
 When? _____ Findings? _____

GENITOURINARY

Urine Retention Y N
 Painful Urination Y N
 Blood in Urine Y N
 Urinary Frequency Y N
 Urinary Leakage Y N
 Urinary Urgency Y N
 Kidney Stones Y N
 Sexually Active Y N
 Urinating at Night Y N
 Other _____

GYNECOLOGICAL-(FEMALES)

Hot Flashes Y N
 Vaginal D/C Y N
 Unexplained Vaginal
 Bleeding Y N
 # of Pregnancies _____
 # of Vag Deliveries _____
 Last Menstrual Period _____
 Last Pap _____
 Do you use hormone
 replacements? Y N

INTEGUMENTARY

Skin Rash Y N
 Boils Y N
 Persistent Itch Y N
 Skin Discoloration Y N
 Other _____

NEUROLOGICAL

Tremors Y N
 Dizzy Spells Y N
 Numbness Y N
 Tingling Y N
 Other _____

MUSCULOSKELETAL

Joint Pain Y N
 Neck Pain Y N
 Back Pain Y N
 Other _____

ENDOCRINE

Decreased Libido Y N
 Other _____

PSYCHOLOGIC

Are you satisfied with your life?
 Y N
 Do you feel anxious?
 Y N
 Do you feel depressed?
 Y N
 Ever considered suicide?
 Y N
 Other _____

HEMATOLOGIC

Swollen Glands Y N
 Blood Clot Problems Y N
 Other _____

ALLERGIC/IMMUNOLOGIC

Hay Fever Y N
 Drug Allergies Y N
 Other _____

HUBBARD CLINIC

Patient's Full Name:				
Patient's Full Address: Street Address, City, State, Zip Code:				
Home Phone:	SSN#:	Sex:	Marital Status:	Spouse's Name:
Date of Birth:	Age:	Family Doctor:		
Employer/School:	Work Phone:	Cell Phone:	Email Address:	
Emergency Contact (not living with you)		Relationship to Contact:		Contact Phone:
How did you hear of The Hubbard Clinic?	Friend / Family	TV Commercial	Physician Referral	Other
Do we have your permission to reach you by phone - Yes / No		May we fax your records to other providers? Yes / No (with your permission)		
Do you have an Advanced Directive (living will) - Yes / No		If so, where is this document located?		
I give my permission to The Hubbard Clinic to release information regarding appointments, medical treatment, and/or billing to the following designated individuals:				

Primary Insurance Company:	Policy Holder ID#:
Policy Holder's Name:	Group #:
Relationship to Policy Holder:	Policy Holder's DOB:

Secondary Insurance Company:	Policy Holder ID#:
Policy Holder's Name:	Group #:
Relationship to Policy Holder:	Policy Holder's DOB:

- We do accept Medicare Assignment. You are responsible for the 20% co-insurance and the annual Medicare deductible.
- Pharmacological treatment for organic impotence IS NOT INCLUDED in the Medicare assignment policy since Medicare does not pay for these drugs.
- We file insurance claims electronically and via computer. Your signature at the bottom of this page gives us permission to do so.
- We automatically file all insurance as a courtesy to you the patient. However, our office cannot accept responsibility for negotiation of claims with insurance companies or other parties. If you have any questions concerning your particular coverage and/or covered services, please contact your personnel office or insurance agent. We can't determine what your particular plan coverage involves. It is the patient's responsibility to find out if our office participates with your particular insurance plan and policy.
- We DO NOT file claims to third party insurance carriers.
- **CONTRACT TO PAY FOR MEDICAL SERVICES:** I have read and I understand the above office policy concerning my insurance. I understand that I am fully responsible for payment of professional services rendered to me by The Hubbard Clinic. If insurance is filed for me, I authorize release of information to my insurance carrier, as well as direct payment or benefits to The Hubbard Clinic for services described.
- I authorize release of my medical records to other physicians and hospitals that are involved in my medical care.

Date: ____ / ____ / ____ Guarantor (Patient) Signature: _____

FINANCIAL POLICIES

COPAYS - All copays are due at the time of service. If you are unable to pay your copay at the time of service, then your appointment will be rescheduled.
PATIENT BALANCES - As a patient, you are expected to pay any patient due balances before being seen for an appointment. If you are unable to pay the balance in full, you will be required to set up a payment plan.

INSURANCE CLAIMS - The patient will become responsible for the charges if the insurance information given to our office at the time of service does not result in payment within 60 days.
COLLECTIONS - If your account becomes delinquent with our office, our billing department will make several attempts to secure the balance in full or set up a payment arrangement. If the attempts to secure balance in full or a payment arrangement fail, we will be forced to forward your account to an outside collection agency. If your account is forwarded to an outside collection agency, then we will add a 35% collection fee, and you will be dismissed as a patient from our practice.

APPOINTMENTS - Our office will call two business days prior to your appointment date to remind you of the appointment. It is the patient's responsibility to remember your appointment, and to supply this office with a 24-hour notice if you must cancel the appointment. Our office does extend a \$30.00 charge for all missed appointments. Surgeries cancelled without 5 days notice will be charged \$100. Urodynamics testing cancelled without 24-hour notice will be charged \$75.

MEDICAL RECORDS - There will be a \$25.00 charge for medical records after the first copy. Should you request your first free copy of medical records and then not pick it up within a 90-day time frame, we will shred those and you will be charged for the next copy.

Completion of disability, life insurance and other miscellaneous forms will be subject to a \$25.00 charge.

RETURNED CHECKS - There will be a \$50.00 charge for any check returned to our office for insufficient funds. Cash, credit card, or money order must then pay the balance.

SELF PAY - As a courtesy, The Hubbard Clinic will discount services to patients without insurance. Payment of these services is expected in full the day of the service; \$100 prior to being seen, and the remaining balance (if any) after the visit.

SURGERY - Patients will be responsible for paying their estimated amount due for their surgery **IN FULL** on the day of the procedure. We will call the insurance company prior to the pre-op appointment to determine this amount.

I, the undersigned, hereby agree that I have read and understand all of the Financial Policies of The Hubbard Clinic. If I have any financial questions or concerns, I will contact the billing department. Otherwise, I agree to be financially responsible for the full treatment I will receive by The Hubbard Clinic.

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights: You have the right to:

- Be treated with respect, consideration, and dignity.
- Be provided with information about The Hubbard Clinic, its services, and the names, specialties, and qualifications of its physicians, nurse practitioners, and medical assistants.
- Participate in decisions regarding your health care and treatment plan, including the right to refuse any medical procedure or treatment (to the extent permitted by law.)
- Be provided with complete information about your diagnosis and the treatment plans that are available to you. With this information, be involved with decisions regarding your healthcare. (Except when such participation is contraindicated for medical reasons.)
- Be provided with full privacy and confidentiality of all information and records regarding your care. This policy is outlined in "Notice of Privacy Policy and Practices" distributed to our patients by the front desk.
- Receive prompt and reasonable responses to questions, requests, and concerns.
- Voice your opinion about the care provided.
- Be provided with information regarding The Hubbard Clinic's Financial Policy.
- Change to another Urology/Gynecology physician by choice at any time during treatment. A form will be provided to you to initiate this change.
- To express suggestions and/or grievance, and the manager will provide the information needed to file an external appeal to CMS, insurance commissioner, or ERISA.
- Refuse to participate in experimental research.

Patient Responsibilities:

- Treat the staff of The Hubbard Clinic with respect, consideration, and dignity.
- Know the benefits and exclusions of your insurance coverage.
- Provide the healthcare provider with complete and accurate health information.
- Follow the treatment plan agreed upon by you and your healthcare provider.
- Have a voice in decisions regarding your healthcare and ask for further information if you are unsure.
- When necessary, contact the healthcare provider for any care needed after hours or for any urgent questions regarding your care.
- Know how to access healthcare services in routine, urgent, and emergency situations.
- To supply The Hubbard Clinic with any changes concerning demographical information and insurance coverage.
- To read and understand The Hubbard Clinic's Financial Policy. If you do not understand the policy, it is your responsibility to contact our billing department.

Patient Signature

Date

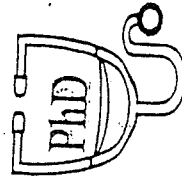
Witness/Office Personnel

I HAVE RECEIVED A COPY OF THE NOTICE
OF Privacy Practices Act THAT IS
ADHERED TO BY THE HUBBARD CLINIC.

Signature _____

Date _____

Provided By:



Notice of
Privacy Policy
and
Practices

Hubbard Clinic
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