



CONSULTATION BY APPOINTMENT

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Dear New Patient:

Welcome to our office. We have enclosed several materials to help facilitate your first visit to our office. Your appointment card has also been included. Please check it carefully. If this date and time are not convenient, please let us know as soon as possible and we will try to arrange a new one.

Please be sure and read over all the materials. We have enclosed a copy of our office policy as well as an updated explanation of our insurance participation and your payment responsibilities. Should you have any questions, please call our office.

We have enclosed a patient information sheet. Please complete this and bring it with you. Insurance information is important so please be accurate as possible. It is also very important that you bring any insurance cards at the time of your appointment. If your insurance requires you to have a referral to see a specialist, you will be required to bring this with you. If you do not have your referral at the time of your visit, we may be forced to reschedule you. **If you do not have your new patient paperwork filled out and mailed in ahead of time, we will be forced to reschedule you.**

We make every effort to see our patients as close to their appointment time as possible. Please understand that we are a surgical practice and therefore subject to emergency room and operating room circumstance that are unplanned. We ask your indulgence should a delay occur.

Sincerely,

Drs. DeMarco, Genvert, Maull, and Edney

**Arrival time for your appointment:**

\_\_\_\_\_

**PENINSULA UROLOGY ASSOCIATES, PA**  
New Patient Form

|                            |                                      |                          |  |                          |
|----------------------------|--------------------------------------|--------------------------|--|--------------------------|
| Name (First, Middle, Last) |                                      | Race                     | Age                                    | Date of Birth            |
| Social Security #          | Marital Status<br>M S D W            | Gender:<br>Male / Female |  | Spouse or Parent's Name: |
| Address                    |                                      | City                     | State                                  | Zip Code                 |
| Home Phone<br>( ) -        | Work Phone<br>( ) -                  | Emergency Contact        |  | Phone #<br>( ) -         |
| Cell Phone<br>( ) -        | Other Phone<br>( ) -                 | Other Contact            |  | Phone #<br>( ) -         |
| Employer                   |                                      | Employer address         |  |                          |
| Primary Care Physician     | How Were You Referred to Our Office? |                          | Method of Payment<br>Cash Check Credit |                          |

**PRIMARY INSURANCE**

|                                       |                          |                    |                   |  |
|---------------------------------------|--------------------------|--------------------|-------------------|--|
| Name of Insurance Company             |                          | Policy Number      | Group Number/Name |  |
| Address                               | City                     | State              | Zip Code          |  |
| Name of Insured                       | Relationship to Patient: | Insured Soc. Sec # | Effective Date    |  |
| Date of Birth (of Insured)            |                          |                    |                   |  |
| Do you have a copay? If so, how much? |                          |                    |                   |  |

**SECONDARY INSURANCE**

|                                       |                         |                    |                   |  |
|---------------------------------------|-------------------------|--------------------|-------------------|--|
| Name of Insurance Company             |                         | Policy Number      | Group Number/Name |  |
| Address                               | City                    | State              | Zip Code          |  |
| Name of Insured                       | Relationship to Patient | Insured Soc. Sec # | Effective Date    |  |
| Date of Birth (of Insured)            |                         |                    |                   |  |
| Do you have a copay? If so, how much? |                         |                    |                   |  |

**PENINSULA UROLOGY ASSOCIATES, P.A.**

**Patient History Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
SS# \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_  
Primary physician: \_\_\_\_\_ Is this who referred you to us? Yes \_\_\_ No \_\_\_  
If no, then who? \_\_\_\_\_ Other physicians: \_\_\_\_\_

Reason for coming to this office: \_\_\_\_\_  
\_\_\_\_\_

Have you ever seen a urologist before? Yes \_\_\_ No \_\_\_ If so, who? \_\_\_\_\_

Have you ever had any of the following?

|                              | <u>Yes</u> | <u>No</u> |                     | <u>Yes</u> | <u>No</u> |
|------------------------------|------------|-----------|---------------------|------------|-----------|
| Asthma                       | ___        | ___       | Hepatitis           | ___        | ___       |
| Emphysema/COPD               | ___        | ___       | Hypertension        | ___        | ___       |
| Heart disease                | ___        | ___       | Tuberculosis        | ___        | ___       |
| Diabetes                     | ___        | ___       | HIV                 | ___        | ___       |
| Cancer                       | ___        | ___       | Venereal disease    | ___        | ___       |
| If so, what type? _____      |            |           | Glaucoma            | ___        | ___       |
| _____                        |            |           | Parkinson's disease | ___        | ___       |
| Any other medical illnesses? |            |           | Multiple Sclerosis  | ___        | ___       |

List prior operations and approximate dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all medication and doses (including over the counter and herbal drugs, etc)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you take any of the following on a regular basis?

|          | <u>Yes</u> | <u>No</u> |                  | <u>Yes</u> | <u>No</u> |
|----------|------------|-----------|------------------|------------|-----------|
| Coumadin | ___        | ___       | Ibuprofen/NSAIDS | ___        | ___       |
| Plavix   | ___        | ___       | Vitamin E        | ___        | ___       |
| Aspirin  | ___        | ___       | Nitrates         | ___        | ___       |

Are you allergic to any medications?

If yes, please list: \_\_\_\_\_

Have you ever had an allergic reaction to contrast dye? Yes \_\_\_ No \_\_\_

PLEASE FLIP OVER SHEET ----->

**PENINSULA UROLOGY ASSOCIATES, P.A.**

Social History

Do you smoke? Yes \_\_\_ No \_\_\_ If yes, amount: \_\_\_\_\_  
 Previously smoked? Yes \_\_\_ No \_\_\_ If yes, amount: \_\_\_\_\_  
 Do you drink alcohol? Yes \_\_\_ No \_\_\_ If yes, amount: \_\_\_\_\_

Marital status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Occupation: \_\_\_\_\_ Highest level of education: \_\_\_\_\_

Family History

Has anyone in your family had any kidney, bladder or prostate problems? Yes \_\_\_ No \_\_\_  
 If yes, what? \_\_\_\_\_

Review of systems

Have you had any recent problems with the following?

| <u>Constitutional</u>             | <u>Yes</u> | <u>No</u> | <u>Musculoskeletal</u>      | <u>Yes</u> | <u>No</u> |
|-----------------------------------|------------|-----------|-----------------------------|------------|-----------|
| Fatigue                           | ___        | ___       | Arthritis                   | ___        | ___       |
| Night Sweats                      | ___        | ___       | Back pain                   | ___        | ___       |
| Unexplained weight loss           | ___        | ___       | Joint pain                  | ___        | ___       |
|                                   |            |           | Muscle weakness             | ___        | ___       |
| <u>HEENT</u>                      |            |           | <u>Genitourinary</u>        |            |           |
| Change in vision                  | ___        | ___       | Blood in urine              | ___        | ___       |
| Change in hearing                 | ___        | ___       | Burning on urination        | ___        | ___       |
| Sore Throat                       | ___        | ___       | Erection problems           | ___        | ___       |
| <u>Neurological</u>               |            |           | Kidney stones               | ___        | ___       |
| Dizzy Spells                      | ___        | ___       | Urinary frequency           | ___        | ___       |
| Headache                          | ___        | ___       | Urinary hesitancy           | ___        | ___       |
| Numbness/Tingling                 | ___        | ___       | Urinary tract infections    | ___        | ___       |
| Stroke                            | ___        | ___       | <u>Hematologic</u>          |            |           |
| <u>Gastrointestinal</u>           |            |           | Bleeding problem            | ___        | ___       |
| Abdominal pain                    | ___        | ___       | Swollen Glands              | ___        | ___       |
| Blood in stool                    | ___        | ___       | <u>Psychiatric</u>          |            |           |
| Change in bowel habits            | ___        | ___       | Anxiety                     | ___        | ___       |
| Nausea/vomiting                   | ___        | ___       | Depression                  | ___        | ___       |
| Rectal Bleeding                   | ___        | ___       | <u>Skin</u>                 |            |           |
| <u>Cardiovascular/Respiratory</u> |            |           | Skin Rashes                 | ___        | ___       |
| Blood in sputum                   | ___        | ___       | <u>Endocrine</u>            |            |           |
| Chest, Arm pain with exertion     | ___        | ___       | Excess Thirst or Hunger     | ___        | ___       |
| Frequent coughing                 | ___        | ___       | Intolerance to Heat or Cold | ___        | ___       |
| High Blood Pressure               | ___        | ___       |                             |            |           |
| Shortness of breath               | ___        | ___       |                             |            |           |

## Notice of Privacy Practices

### **UNDERSTANDING YOUR HEALTH RECORD / INFORMATION:**

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment, a means of communication among the many health professionals who contribute to your care, a legal document describing the care you received, a means by which you or a third party payer can verify that services billed were actually provided. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, and to better understand who, what, when, where and why others may access your health information, make more informed decisions when authorizing disclosure to others.

### **YOUR HEALTH INFORMATION RIGHTS:**

Although your health record is the physical property of Peninsula Urology Associates, P.A., the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a copy of your health record for a fee of \$25.00. You also have the right to inspect your record. Record inspection is to be scheduled by appointment only as directed by management. You may obtain an accounting of disclosures of your health information and / or request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

### **OUR RESPONSIBILITIES:**

This organization is required to maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

### **FOR MORE INFORMATION OR TO REPORT A PROBLEM:**

If you have questions and would like additional information, you may contact the Business Office at (410) 546-2133. If you believe your privacy rights have been violated, you can file a complaint with the Business Office or with the Secretary of Health and Human Services.

### **DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:**

We will use your health information for treatment and for payment. We will also use it as needed for business associates such as other physicians, labs and billing companies. To protect your health information, however, we require the business associate to appropriately safeguard your information. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement with your care or payment related to your care. We will also provide your health information as required by law to Worker's Compensation, public health officials, correctional institutions, and law enforcement officials.

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Patient Signature

Date Signed

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Other authorized Person(s) for Disclosure / relationship / telephone number

Date Effective

## PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between patients and the staff, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

We require a 24 hour cancellation notice, especially if we have scheduled a procedure for you. Failure to let us know within 24 hours may result in a \$25.00 service fee.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience, we will accept VISA and MasterCard.

As a courtesy, if you have a service performed other than an office visit, we will file your insurance claim for you if you assign the benefits to the doctor – in other words, you agree to have your insurance company pay the doctor directly. If your insurance does not pay the practice within a reasonable length of time we will look to you for payment.

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for whom we have an agreement and will only require you to pay the authorized co-payment at the time of service. We will collect the co-payment when you arrive for your appointment.

If your insurance company requires a referral from your primary care physician, it is recommended that you call your primary physician at least 7 days in advance so that your referral is in the office before you arrive for your appointment. If the referral is not here we have been advised from the insurance companies that we cannot see the patient unless the patient signs a waiver stating that he or she will be responsible for the bill. In that situation, payment will be expected at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of statement from our office.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parents or guardian with custody for payment.

In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print the Name of the Responsible Party

**DIRECTIONS TO THE SALISBURY OFFICE OF  
DRS. DEMARCO, GENVERT, MAULL, AND EDNEY**

**DIRECTIONS FROM UPPER MARYLAND AND DELAWARE**

Head south on Business Rt. 13. You will turn left just before the light at Pine Bluff Road onto Milford Street which is 0.7 mile south of Salisbury University at College Avenue. Go all the way to the end to South Division Street. Make a right onto South Division Street and take the second right into the medical complex. Our office is the second one on the right, two stories, # 401.

**DIRECTIONS FROM LOWER MARYLAND AND VIRGINIA**

Head north on Business Rt. 13. You will turn right just after the light at Pine Bluff Road onto Milford Street which is 0.8 mile north of the traffic light on Cedar Lane Road in Fruitland (by 84 Lumber). Go all the way to the end to South Division Street. Make a right onto South Division Street and take the second right into the medical complex. Our office is the second on the right, two stories, #401.

**DIRECTIONS TO BERLIN OFFICE**

The office is in the Berlin Professional Center on Franklin Avenue, Suite 107. Head south from Atlantic General Hospital on 113 for about 0.5 mile. Franklin Avenue will be a right hand turn. The office building is across from the Berlin Middle School.

**DIRECTIONS TO THE SALISBURY OFFICE FROM RT. 50 WESTBOUND**

Turn left on Beaglin Park Drive. Continue straight until you get to the traffic light on South Division Street. Turn left onto South Division Street and go just beyond Mitchell's Martial Arts (formerly Skateland) which in on the left. Take the second right after Milford Street on the right into the medical complex. Our office is the second on the right, two stories, # 401.

