Dear Patient:

We would like to welcome you to the Urologic Associates of Western Pennsylvania, LTD practice and thank you for scheduling your appointment. We will do everything we can to make your visit comfortable and beneficial.

If we are seeing you for the first time or have not seen you in several years, you will need to register at the reception desk upon your arrival. Please arrive at least 15 minutes before your scheduled appointment in order to complete the registration process.

In order to make your registration as smooth as possible, please bring the following items to your appointment:

- Photo ID
- Insurance cards
- Referral if required by your insurance plan
- Completed and signed forms in this packet
- Co-Pay (if required by your insurance company)
  - Our office accepts cash, personal checks, Mastercard, Visa and Discover cards.
  - If your Medicare or insurance plan requires an annual deductible that has not been met by your appointment, you will be responsible for this payment. You may be asked for this prior to your appointment.
  - If you do not have insurance or have a plan that is not accepted, you may be asked for a fee during the registration and/or check-out process. Please have cash, check or credit card available for payment.

Your doctor will see you after you have completed the registration process and have been brought back to the examination room. A Physician Assistant or Nurse Practitioner may assist your doctor during your evaluation. In order to help your doctor, please bring the following information to your appointment:

- Completed and signed medical history forms included in this packet
- Any tests or medical records related to this appointment
  - If they are supposed to be sent, please contact us prior to your appointment to make sure we received them
- Any related x-rays not done at the hospital affiliated with the specific office location of your appointment
  - X-rays may be on CD or as traditional x-ray films
  - Bring the report of the x-rays from the radiologist
  - A list of your current medications and allergies.
  - If you are not sure about this material, please call us

You will be asked for a urine specimen during your evaluation. We request that you come to your appointment with a full bladder. If you have to urinate prior to being brought back to the examination room, please ask us for assistance in obtaining your specimen before your evaluation.
In order to provide the best appointment availability for all our patients, we would ask that you keep your scheduled appointment. If you cannot keep your appointment, please notify us at your earliest opportunity — at least two days notice is greatly appreciated. In the event of illness or unforeseen circumstance, please call to inform us and to reschedule your appointment. Patients with ‘no show’ appointments may reschedule on a next-available appointment basis. Patients who fail to keep appointments without notice (‘no shows’) will be assessed a $25.00 administrative fee (not covered by insurance) due at the time of their rescheduled appointment.

Our office recognizes that many times, our patients need their providers to fill out or complete forms related to their medical status. While we are happy to assist you with your forms, this process is also very time consuming, so we need your help to make this process as fair and equitable as possible. Effective January 1, 2012 we will assess a $25.00 administrative fee (not covered by insurance) for FMLA, disability and life insurance forms, due at the time of your request.

Locations:

St. Margaret Office
200 Delafield Road
Suite 3060
Pittsburgh, PA 15215
(412) 781-6448
(412) 781-1350 FAX
Directions:
http://stmargaret.upmc.com/Locations.htm

Daniel Gup, MD
Kevin Traub, MD
Wendy Wolfe, PA-C
Mabry Beebe, PA-C

Butler Office
104 Technology Drive
Suite 204
Butler, PA 16001
(724) 482-4257
(724) 482-4785 FAX
Directions:
Call for assistance

Stephen Campanella, MD
Mark Musmanno, MD
Matt Goldinger, CRNP
Hailey Spirko, PA-C

Your appointment is scheduled for

__________________________, 2015 at __________________________ am / pm

With ____________________________.

Thank you.
PLEASE COMPLETE

SOCIAL SECURITY # ________________  SEX: MALE / FEMALE

BIRTHDATE _______________ AGE _____

LAST NAME _______________ FIRST NAME ____________  MI ______

ADDRESS ________________________________________________

CITY ____________________  STATE ______  ZIP CODE __________

HOME # ___________  WORK# ___________  CELL# ____________

EMPLOYER ____________________  OCCUPATION ____________________

MARITAL STATUS ___________  SPOUSE NAME ____________________

NEAREST RELATIVE _______________  PHONE# _______________

RELATIONSHIP ____________________

PRIMARY CARE PHYSICIAN _______________
UROLOGIC ASSOCIATES OF WESTERN PENNSYLVANIA, LTD.
PLEASE COMPLETE THE MEDICAL HISTORY FORM

NAME ___________________________ DATE OF BIRTH ___________ DATE ________

ADDRESS ___________________________ PHONE NUMBER ___________ CELL NUMBER ___________

EMERGENCY CONTACT NAME ___________________________ RELATIONSHIP TO PATIENT ________

EMERGENCY CONTACT PHONE NUMBER ___________________________

PCP AND/OR PHYSICIAN WHO SENT YOU: ___________________________

IN YOUR OWN WORDS, EXPLAIN REASON FOR YOUR VISIT ___________________________

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? YES OR NO ____________________
CUSTODIAN OF THE DOCUMENT: ___________________________

PHARMACY: ___________________________ PHARMACY PHONE NUMBER: _______
MAIL ORDER PHARMACY: ___________________________ PHARMACY PHONE NUMBER: _______

MEDICATIONS: (If more lines are needed, continue on reverse)

<table>
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<tr>
<th>Name of medicine (brand or generic)</th>
<th>Strength (# mg)</th>
<th>Dose (# pills)</th>
<th>Frequency (times/day)</th>
<th>Timing (when taken)</th>
</tr>
</thead>
</table>

Have you received:

Pneumonia Vaccine: Yes or No
Flu Vaccine: Yes or No
Month_____ Year______

DRUG ALLERGIES: ___________________________ NO DRUG ALLERGIES ________

MEDICAL PROBLEMS (PLEASE CIRCLE YES IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING)

Yes ANEMIA
Yes BLEEDING DISORDER
Yes HEART ATTACK
Yes ANGINA
Yes CANCER
Yes HIGH BLOOD PRESSURE
Yes ANTIBIOTIC PROPHYLAXIS
Yes DIABETES
Yes SEIZURE DISORDER
Yes ATRIAL Fibrillation
Yes GLAUCOMA
Yes STROKE
OTHER PROBLEMS: ___________________________

GYN History: ___________________________
Number of Pregnancies ________

SURGERIES: ___________________________

FAMILY HISTORY (CIRCLE THOSE THAT APPLY)

DIABETES KIDNEY DISEASE KIDNEY STONES
HEART DISEASE CANCER DIALYSIS
OTHER: ___________________________

PROSTATE CANCER: NO YES - WHO? ___________________________

SOCIAL HISTORY

SMOKER YES ______ NO ________ Quit ______ Never ______

ALCOHOL YES ______ NO ________ How much ______

CAFFEINE YES ______ NO ________ How much ______

REVIEW OF SYSTEMS (PLEASE CIRCLE YES ONLY IF YOU ARE CURRENTLY EXPERIENCING THE FOLLOWING)

Yes FEVER
Yes CONSTIPATION
Yes BLURRED VISION
Yes INCONTINENCE
Yes HEARING LOSS
Yes BACK PAIN
Yes CHEST PAIN
IF YES PAIN SCALE LEVEL 1-10 ______

Yes SHORTNESS OF BREATH
Yes RASH
Yes SLEEP APNEA
Yes DIZZINESS

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I, the undersigned, authorize payment of medical benefits to Urologic Associates of Western Pennsylvania for any services furnished to me by the physicians or their extenders. I understand that I am financially responsible for any amount not covered by my contract.

SIGNATURE ___________________________ DATE ________

MEDICARE LIFETIME SIGNATURE ON FILE

I request that authorized Medicare payment be made either to me or on my behalf to Urologic Associates of Western Pennsylvania for any services furnished to me by the physicians or their extenders.

SIGNATURE ___________________________ DATE ________
Medication List

Name: ___________________________ DOB: ___________________________

Pharmacy: ___________________________ Pharmacy Phone #: ___________________________
Mail Order Pharmacy: ___________________________ Pharmacy Phone #: ___________________________

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Patient: ____________________________  ____________________________  ____________________________  ____________________________
  Last Name                        First Name                      M.I.                           Date of Birth

UROLOGIC ASSOCIATES OF WESTERN PENNSYLVANIA, LTD.
Acknowledgement of Receipt of Notice of Privacy Practices

In general, any information that is about your health care, the care that you receive, or payment for that care is considered confidential and protected by our Company. We may need to use your protected health information to carry out treatment, payment, healthcare operations and other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures. (Copy provided upon request)

Signature of patient or patient’s representative  ____________________________

Date: ____________________________

Printed name of patient or patient’s representative: ____________________________

Relationship to the patient: ____________________________

For use ONLY by a representative of the Company

A good faith effort was made to obtain a written acknowledgement for receipt of our Notice of Privacy Practices was made available to (circle one) the patient/the patient’s representative on:

A signature on the acknowledgement was not obtained for the following reason(s)

Signature of Company representative: ____________________________
Patient Instructions Regarding Personal Health Information

I authorize my Physician, Physician Group or Staff member employed by the Practice to release any and all medical test results or other medical information relating to my treatment to: (Initial all choices that apply)

_____ May leave a message at work to call the physician’s office.

_____ May leave a message with a family member for me to call the physician’s office.

_____ May give test results/instructions to:

Designee’s Name: ________________________________

Relationship: ________________________________

_____ May only release test results to the patient

_____ Other: ________________________________

I understand this information will be used and these instructions will be in effect unless changed or revoked by me either in writing or by completing a new instruction form.

______________________________________________
Date

______________________________________________
Patient (legal representative) Signature

______________________________________________
Date of Birth
CONSENT FOR TREATMENT

Patient Name: __________________________ Date of Birth: ______________

Urologic Associates of Western Pennsylvania, Physician Name: ______________

I request those physicians and other healthcare professionals who care for me to perform routine diagnostic procedures, and therapeutic treatments, which in their judgment, become necessary while I am being treated by the Physician Practice named above. Routine diagnostic procedures and medical treatments include but are not limited to blood work, Radiological testing, administration of medications and procedures.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize the Physician Practice named above to retain, preserve and use for scientific, or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body during the visit. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS.

______________________________     __________________________
Patient Signature                Witness Signature

______________________________
Substitute Decision Maker

______________________________  Date/Time
If Substitute Decision Maker, state relationship
Urologic Associates of Western Pennsylvania
Financial Policy

THANK YOU for your trust in choosing us to serve your urologic needs. In order to serve you, all new patients must complete our “Medical History Form” before seeing the doctor. As we enter this doctor-patient relationship, we agree to provide quality urologic service at a fair and reasonable price, and you in turn, agree it is your obligation to be prepared to pay at the time of service and to understand the benefits of your insurance for physician office visits. We want to explain our Financial Policy to you so there are no unpleasant surprises.

Regarding Insurance: Your insurance policy is a contract between you and your insurance carrier. Urologic Associates of Western Pennsylvania is not a party to that contract. Not all services are a covered benefit in all contracts. It is your responsibility to be aware of your insurance company’s provision for payment of office visits and procedures.

If your insurance requires a co-payment, it is due at the time of service. The insurance companies require that a co-payment be made at every office visit, with few exceptions for some plans.

For the convenience of our patients, we accept cash, checks, Visa/MasterCard/Discover.

Our policy is to charge $25.00 for missed appointments, unless canceled 24 hours in advance. Please help us serve you better by keeping scheduled appointments. An additional $22.00 fee will be charged for any returned checks from the bank. There will also be a $25.00 administrative fee for the filling out and completion of FMLA, Disability and Life insurance forms, due at the time of request.

Our Billing Office is available during office hours to discuss our charges, insurance questions, the status of your account, and to help you with any billing or insurance questions. You may call the Billing Office at (412) 781-6448. Thank you for understanding our financial policy and please keep our records current with any changes in address, phone number, or insurance information.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO THE TERMS LISTED ABOVE.

Signature of Patient ____________________________ Date ______

Date of Birth ____________________________