MICAELA ALEMAN, M.D.

2911 Medical Arts Square
Suite 1A
Austin, TX 78705
Telephone: (512) 476-9850
Fax: (512) 236-8867

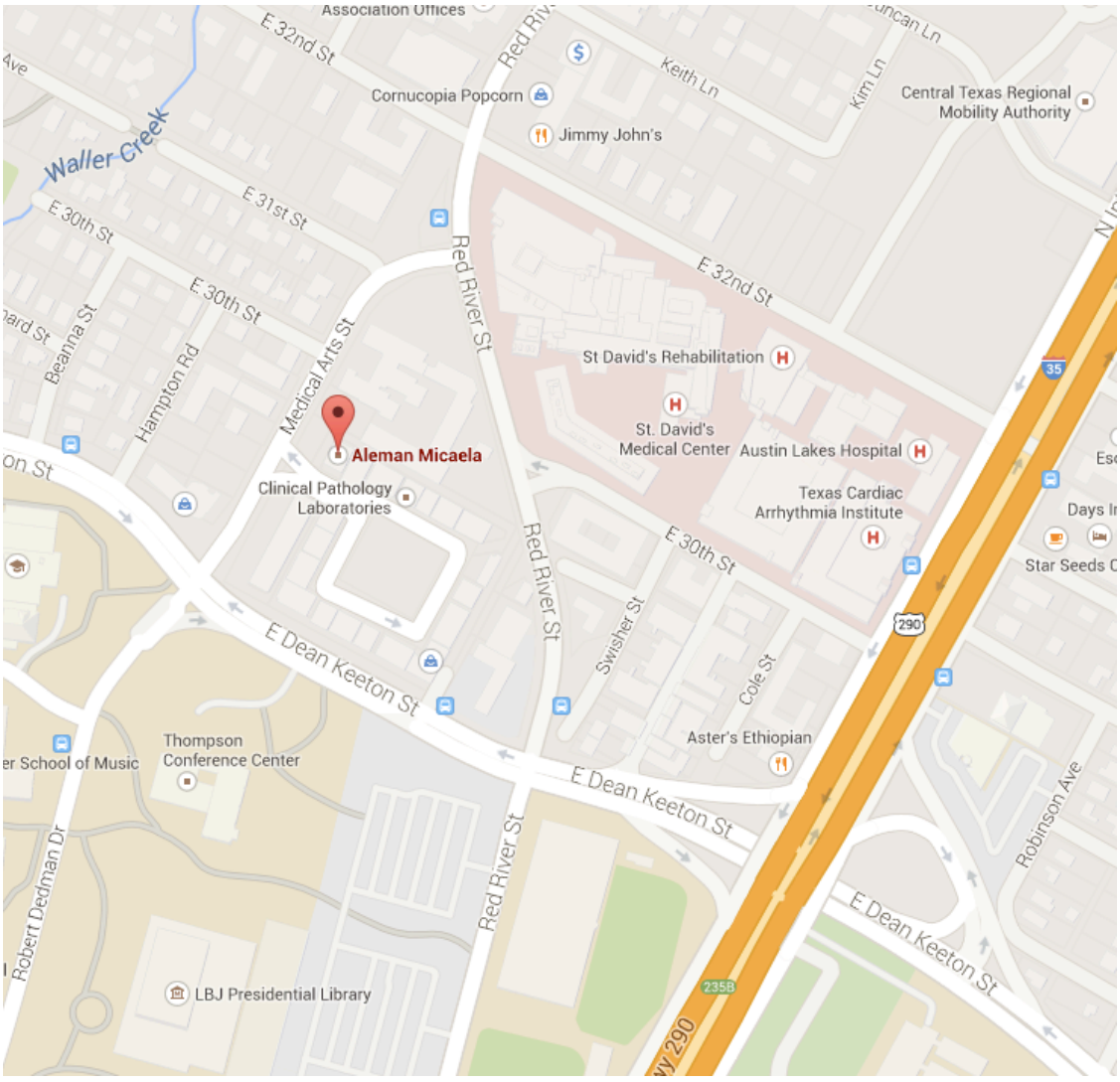
Dear Patient:

We are glad you have chosen Dr. Micaela Aleman to meet your urologic needs. To make the most of your visit with the doctor, we would like to request that you take time to fill out the enclosed forms completely. If you need clarification, we can help you. Please call us between 3:00 and 4:00 pm. At the time of your visit, we need the following documentation in addition to your forms: your insurance card, your driver's license, and a referral if applicable.

We ask that you arrive 15 minutes early for your appointment. We do the best to run on time. Our physician is a surgeon and at times delays are unavoidable. If you have any concerns, please call us before you come in.

We have also provided the map below so you can find us easier.

Dr. Aleman and staff



MICAELA ALEMAN, M.D.

Adult & Pediatric Urology

Today's Date: _____ Home Phone:_____

Email address: _____ Cell Phone: _____

Patient:_____Soc.Sec.#: _____
(Last Name) (First Name) (Initial)

Responsible Party (if a minor):_____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Sex: ☐ M ☐ F

Birthdate: _____ Age:____ Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Race: _____ Ethnicity: ☐Hispanic ☐NonHispanic Preferred language: _____

Patient's Employer: _____ Business Phone: _____

Employer's Address: _____
(City) (ST) (Zip)

Spouse's Name:_____

Primary Insurance: _____

Secondary Insurance: _____

Insurance Holder's Name: _____Soc.Sec.#: _____

Insurance Holder's Employer: _____ Business Phone:_____

Insurance holder's DOB: _____

Emergency Contact:_____Phone #: _____
(NAME and RELATIONSHIP)

Drugstore Name: _____Phone #: _____

Mail Order Pharmacy: _____Phone #: _____

Primary Care Physician: _____Phone #: _____

Whom may we thank for referring you? _____

We are pleased that you have chosen Micaela Aleman, M.D. for your urologic healthcare needs. Dr. Aleman and her staff are committed to providing you with the best possible care. Please take a brief moment to review the following office policies. If you have any questions, please see our front office staff.

OFFICE POLICIES

- Requests for refills of prescription medication should be made directly with your pharmacy. The pharmacy will contact us with the information needed to process your request. All requests will be completed within 24 hours; however**, we recommend you call your pharmacy 2-3 days before you run out of medication** to ensure you continue to receive your medicine as needed.

- All checks returned to our office for insufficient funds (NSF) are subject to a $30.00 returned check fee. Payment for NSF checks must be made by **cash, credit card or money order only**.

- A $45.00 fee is incurred for appointments that are missed or cancelled less than 24 hours in advance.

- Outstanding balances are turned over to a collection agency and in turn to credit bureaus. When you are unable to meet your responsibility, let us know so that we may work with you on this matter.

- We will do our best to see you when your health changes acutely (kidney stone, infection, blood in the urine, inability to urinate, etc). Please understand that some delays are unavoidable as are surgical emergencies when the doctor gets called to the operating room to assist a colleague.

- You have a right to a copy of any tests (laboratory, radiology, pathology) that were ordered. We encourage you to activate your patient portal so that this information can be communicated to you in a timely fashion. The portal is also a secure method of communication with us when your healthcare needs change.

- Our promise to you is to treat you with respect and compassion. We value your time and we strive daily to be punctual.

_____

Initials: patient/legal guardian

Micaela Aleman, M.D.

2911 MEDICAL ARTS SQUARE, #1A
Austin, TX 78705

Office (512) 476-9850
FAX (512) 236-8867

CONFIDENTIALITY

Occasionally, Dr. Aleman has to conduct some business over a cellular phone. In those instances, there exists a risk that others may overhear these conversations. Use of the cell phone is generally limited to returning pages, which usually are emergencies.

- If we need to reach you, may we leave a message for you:

☐ with someone at your home?
☐ on your home answering machine?
☐ with someone at your workplace?
☐ on your office voicemail?
☐ on your e-mail?

- I give permission for Dr. Aleman or her office to discuss my medical treatment with:

☐ my spouse or partner (name) _____
☐ my parent(s) (name) _____
☐ my employer (name) _____
☐ other _____

- I authorize Dr. Aleman to import my medication and medical history when available.

My signature below indicates that I have read and understand the above office policies.

_____ _____
Patient or Legal Guardian Date

INSURANCE AUTHORIZATION

I authorize Micaela Aleman, M.D. to release any medical or other information necessary to process claims with my insurance carrier. I also authorize the use of this signature on all claim submissions. I authorize payment of medical benefits to Micaela Aleman, M.D. I understand that I am financially responsible for all charges incurred whether or not my insurance carrier covers them. I certify that I have provided all insurance carrier information (i.e. primary, secondary, and/or tertiary carriers).

_____ _____
Patient or Legal Guardian Date

RECEIPT OF PRIVACY PRACTICES

I have reviewed a copy of LONE STAR UROLOGY/Dr. Micaela Aleman's Notice of Privacy Practices and I understand that a copy can be found on the website or in writing at my request.

_____ _____
Patient or Legal Guardian Date

MICAELA ALEMAN, MD

Health History

Name _____ Date _____

Purpose of Visit _____

ALLERGIES (to medications and reaction)

_____

_____

_____

_____

_____

_____

MEDICATIONS (prescription and over-the-counter)

_____

_____

_____

_____

_____

_____

MEDICAL CONDITIONS **
(Past and Present)

_____

_____

_____

_____

_____

_____

_____

_____

_____

SURGICAL HISTORY
(include dates)

_____

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY **
(Health conditions)

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Tobacco use ☐Never ☐Former smoker

☐Current smoker _____ppd

Alcohol use ☐Never

If yes: _____ glasses ☐day ☐week ☐month

Type: ☐Beer ☐Liquor ☐Wine

Caffeine use: _____ drinks per day

Blood transfusion history: ☐yes ☐no

Occupation: _____

Number of children: _____

Are you sexually active? ☐Yes ☐No

Living arrangement: ☐home ☐apartment

☐nursing home ☐dormitory

** HEALTH Conditions

___Cancer ___Heart disease ___Lupus

___Leukemia ___Gout ___Kidney Disease

___Diabetes ___Allergies ___Bleeding Problems

___Aneurysm ___Anemia ___Parkinson's

___Glaucoma ___Arthritis ___Dementia

___Asthma ___Blood clots/pulmonary clots

___COPD/emphysema ___High cholesterol

___High Blood Pressure ___Hepatitis A/B/C

___Stroke ___Anxiety ___HIV

___Acid reflux ___Sleep apnea ___Depression

___Migraines ___Multiple sclerosis ___Diverticulosis

___Thyroid disease ___Osteoporosis

Review of Systems

Have you had any problems related to the following systems **in the past year**? Circle the **positive** symptom.

GENERAL: Unusual weight gain/loss, weakness, fatigue, fever or night sweats.

SKIN: Rashes, lumps, itching, dryness, changes in the hair or nails.

HEAD: Headaches or head trauma.

EYES: Visual changes, blurred vision, pain, redness, double vision, glaucoma.

EARS: Hearing loss, pain, tinnitus, vertigo, or discharge.

NOSE/SINUSES: Frequent colds, nasal stuffiness, chronic allergies, nosebleeds.

OROPHARYNX: Teeth/ gum problems, sore tongue, sore throats, or hoarseness.

NECK: Lumps in the neck, swollen glands, or generalized neck pain.

RESPIRATORY: Cough, sputum, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis, pleurisy.

CARDIAC: Heart trouble, rheumatic fever, heart murmurs; dyspnea, orthopnea, chest pain, or palpitations.

GI: Difficulty swallowing, heartburn, changes in appetite, nausea, vomiting, vomiting of blood, indigestion, change in bowel movements, rectal bleeding or black tarry stools. Abdominal pain, jaundice, or hepatitis.

MUSCULOSKELETAL: Joint pains or stiffness, arthritis, gout, or back ache.

NEURO: Fainting, blackouts, seizures, paralysis, local weakness, numbness, tingling, tremors, or memory loss.

ENDOCRINE: Thyroid trouble, heat/cold intolerance, excessive sweating, diabetes, thirst, changes in hunger or urination.

HEME: Anemia, easy bruising or bleeding, as transfusion or possible reactions.

PERIPHERAL VASCULAR: Intermittent claudication, cramps, varicose veins, warts, or thrombophlebitis.

PSYCH: Depression, stress, anxiety, or generally satisfied with life.