Dear Patient,

Thank you for scheduling an appointment with our practice.

Please contact your insurance company as soon as you receive this letter to confirm if your insurance policy requires a referral for a specialist office visit.

If an insurance referral is required, please notify your primary care physician's office. Please note **most primary care physician offices require a minimum of 72 business hours to produce a referral.**

Valid referrals can be **faxed to our office at 973-726-7230** or brought to the office at the time of your appointment.

If your insurance policy requires a referral and one is not obtained in time for your appointment, you will be asked to pay our self-pay new patient fee of $200.

We look forward to seeing you at your appointment.

Regards,

Skylands Urology Group, P.A.
Primary Care Physician__________________________ Telephone:__________________________

Referring Physician__________________________ Telephone:__________________________

First Name ___________________ MI Last Name ___________________ Marital Status (S/M/D/W) __

Address 1 __________________________________________________________ Address 2 __________________________________________________________

City _____________________ State _______ Zip _____________________

Date of Birth ____________ SS# ____________ Drivers Lic# ____________ Sex [ ] Male [ ] Female

Home phone ____________ work phone ____________ cell phone ____________

E-Mail __________________________________________________________________________

Emergency Contact ____________________ Tel # ____________________ Relationship ________________

(Other than Spouse) ____________________ (Other than home number)

Emergency address: _______________________________________________________________________

Pharmacy: ______________________________________________________________________________

Tel # ________________________________________________________________________________

Employer name and address: ___________________________________________________________________________

Telephone: ________________________________________________________________________________

What do you do for a living? ___________________________________________________________________

SPouse’S INFORMATION

Name ___________________ Date of Birth ____________ Social Security ____________

Employer’s Name ___________________ Employer’s Phone # ____________

Employer’s Address City ___________________ State _______ Zip ___________________

PRIMARY INSURANCE CARRIER:

Ins Co ___________________ Ins Id # ____________ Group Id# ____________

Ins Address City ___________________ State _______ Zip ___________________

Ins Co Telephone # __________________________________________________________________________

POLICY HOLDER (IF NOT THE PATIENT)

Name ___________________ Date of Birth ____________ Social Security ____________

SECONDARY INSURANCE CARRIER:

Ins Co ___________________ Ins Id # ____________ Group Id# ____________

Ins Address City ___________________ State _______ Zip ___________________

Ins Co Telephone # __________________________________________________________________________

POLICY HOLDER (IF NOT THE PATIENT)

Name ___________________ Date of Birth ____________ Social Security ____________

ASSIGNMENT OF BENEFITS

I hereby authorize Skylands Urology Group, PA (SUG, PA) to apply for benefits to my insurance carrier on my behalf for services rendered by the Drs. I understand that I am financially responsible for any balances not covered by my insurance carrier. I request that payment from my insurance carrier be made directly to SUG, PA. I consent to medical care from SUG, PA I have received the HIPPA notice of privacy acknowledgement. I certify that the above is correct.

____________________________________________________________________________________

Patient or Guardian’s Signature ___________________ Date 10-04-2013 FRONT DESK

FRONT DESK
MEDICAL PHOTOGRAPHY CONSENT FORM

I ____________________________ DOB __________________________

Due hereby give my consent for Dr. Frank Salvatore, Dr. James Matteson, Dr. Donald Mykulak and Dr. Matthew Hall to have my image taken by the staff of Skylands Urology Group to be placed in my medical records ONLY for the purpose of identifying me for treatment.

By consenting to this medical photograph I understand that I will not receive payment from any party.

If I have any questions or wish to withdraw my consent in the future I may do so.

By signing this form below I confirm that this consent form has been explained to me in terms I understand.

Signature of patient ____________________________ Signature of witness ____________________________

05-28-2014 FRONT DESK PHOTOGRAPHY CONSENT
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations:

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment alternatives or other health related services. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the revised notice from this office.

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.
ACKNOWLEDGEMENT

DATE________________________________________

1. I __________________________________________ HAVE RECEIVED THE NOTICE OF PRIVACY ACKNOWLEDGEMENT GIVEN TO ME BY:

SKYLANDS UROLOGY GROUP, PA.

2. THE SAID PATIENT __________________________ REFUSED TO TAKE THE NOTICE OF PRIVACY ACKNOWLEDGEMENT GIVEN TO THEM BY:

SKYLANDS UROLOGY GROUP, PA.

3. I HEREBY GRANT PERMISSION TO ________________________________ (SPOUSE, RELATIVE, ETC.) PHONE __________________________ TO HAVE ACCESS TO MY MEDICAL RECORDS AND FILES.

______________________________________________
PATIENT/GUARDIAN SIGNATURE

______________________________________________
WITNESS

10-30-2013 FRONT DESK
MEDICARE FINANCIAL POLICY

It is our sincere desire to provide you with the best possible medical care. This involves mutual understanding among the patients, doctors and the staff. We encourage you, our patient, to discuss any questions you may have regarding our professional fees, this financial policy and your responsibility.

You will be financially responsible for your annual $147 deductible and for coinsurance representing 20% of the allowable Medicare fee for service. We do not waive the annual $147 deductible or coinsurance. Payment in the form of cash, check, Visa, MasterCard is required at the time of services. This is a federal law, with which we must comply.

The Medicare program specifically excludes payment for certain items and/or services. Medical procedure(s) recommended by the doctor that are not covered by Medicare require payment in advance. You will be asked to sign an Advance Beneficiary Notice (ABN) prior to the delivery of a non-covered service.

If you fail to inform this office of your secondary coverage at the time you complete your insurance paperwork, we will not be able to bill your secondary carrier. You will be responsible for any unpaid charges for deductibles and/or co-insurance.

If you neglect to report to Medicare who is primary and who is secondary regarding your coverage, known as “Coordination of Benefits”, you will automatically be responsible for all unpaid medical charges filed with Medicare.

All returned checks will be subject to $30.00 return fee.

Name of Beneficiary ___________________________  Medicare # ___________________________

“I request that payment of authorized Medicare benefits be made on my behalf to Skylands Urology Group, PA for any services furnished to me by my physician. I authorize any holder of medical information about me to be released to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.”

☐ I have been presented with a copy of the Skylands Urology Group, PA Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law.

Patient Signature ___________________________  Date ___________________________

Print Patient name ___________________________
Pt Name: __________________________ Date: ______________

What is your reason for seeing the doctor today? __________________________

PAST GU HISTORY: Have you ever had any of the following (If yes, please check box)

- Kidney Stones [ ]
- Bladder Infections [ ]
- Impotence [ ]
- Kidney Infection [ ]
- Bladder Polyps [ ]
- Incontinence [ ]
- Kidney Failure [ ]
- Blood in Urine [ ]
- Prostate Infection [ ]

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Less than 1 time in 5</th>
<th>Less than half the time</th>
<th>About half the time</th>
<th>More than half the time</th>
<th>Almost always</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you had to urinate again less than two hours after you finished urinating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Intermittency:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you found you stopped and started again several times when you urinated?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Urgency:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the last month, how difficult have you found it to postpone urination?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Weak Stream:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you had a weak urinary stream?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Straining?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you had to push or strain to urinate?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Nocturia:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the past month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?</td>
<td>none</td>
<td>1 time</td>
<td>2x’s</td>
<td>3x’s</td>
<td>4x’s</td>
<td>5+’s</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL IPSS SCORE

Quality of life due to urinary symptoms

Delighted | Pleased | Mostly Satisfied | Mixed | Mostly Dissatisfied | Unhappy | Terrible

If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?
# New Patient Questionnaire

**Pt Name:** __________________________  **Date:** ____________

**PLACE A CHECK MARK IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:**

<table>
<thead>
<tr>
<th>Constitutional:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever [ ] Chills [ ] Fatigue [ ] Weight loss [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ophthalmologic:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Blurry Vision [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENT:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dry Mouth [ ] Ringing in the Ears [ ] Sore throat [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Endocrine:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cold intolerance [ ] Excessive thirst [ ] Heat intolerance [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain [ ] Cough [ ] Shortness of breath at rest [ ] Wheezing [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiovascular:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Coughing up blood [ ] Difficulty lying flat [ ] Shortness of breath on exertion [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastrointestinal:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain [ ] Blood in the stool [ ] Change in bowel habits [ ] Nausea or vomiting [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hematology:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy Bruising [ ] Prolonged bleeding [ ] Swollen glands [ ]</td>
<td></td>
</tr>
</tbody>
</table>

**Men Only:**

|  |
|----------------|---|
| Blood in semen [ ] Do you want to discuss a problem with your sexual activity? Yes [ ] No [ ] |

**Women Only:**

|  |
|----------------|---|
| Vaginal bulge [ ] Painful intercourse [ ] Bleeding between periods [ ] Vaginal Discharge/itch [ ] |

<table>
<thead>
<tr>
<th>Skin:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin lesion [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurologic:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty speaking [ ] Dizziness [ ] Memory Loss [ ] Seizures [ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety [ ] Depression [ ]</td>
<td></td>
</tr>
</tbody>
</table>

03-10-2015
Skylands Urology Group, P.A. New Patient Questionnaire

Medications (Doses & Times per day)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Past Medical Problems (Circle all that apply)

- Asthma
- Hypertension
- Diabetes
- High Cholesterol
- Coronary artery disease
- Gout
- Hypothyroidism
- Back pain
- Cancer
- Diverticulitis
- Arthritis
- Gallstones
- Liver Disease

Women Only: GYN History

Date of Last menstrual period: __________  Age/Year of Menopause: __________

Date of Last PAP: __________  Date of Last Mammogram: __________

Do you have a history of STDs? Yes [ ]  No [ ]  If yes, please specify

Choice of Contraception: __________

Sexually Active: Yes [ ]  No [ ]

OB History

Number of Pregnancies: _____  Number of Vaginal Births: _____  Number of C-Sections: _____

Weight of Largest Baby: _____

Forceps: Yes [ ]  No [ ]  Vaccum: Yes [ ]  No [ ]  Episiotomy: Yes [ ]  No [ ]

OTHER Medical Problems

<table>
<thead>
<tr>
<th>Medical Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Allergies (medication and reaction)

1. __________
2. __________
3. __________

Surgeries

1. __________
2. __________
3. __________

4. __________
5. __________
6. __________

Hospitalizations

1. __________
2. __________
3. __________

Family Hx: Has any of your relatives had any of the following? (Please Check)

- Diabetes
- Prostate Cancer
- Kidney stones
- Kidney disease

Marital Status: -Single -Married -Divorced -Widowed

Social Hx: (circle one)

Do you drink alcohol?  -No  -Yes.  If Yes, how often?  daily  weekly  monthly

What kind of work do you do?

03-10-2015

FRONT DESK

NEW PATIENT QUESTIONNAIRE
SKYLANDS UROLOGY GROUP PA
FRANK T. SALVATORE, M.D.
JAMES R. MATTESON, M.D.
DONALD J. MYKULAK, M.D.
MATTHEW S. HALL, M.D.

89 SPARTA AVE.
SUITE 200
SPARTA N.J., 07871
973-726-7220

616 Willow Grove Street
HACKETTSTOWN, NJ 07840
908-813-2622

SPARTA TO HACKETTSTOWN
Take Rt.517 through Andover. You will pass Perona Farms. You will come to a traffic light at Rt.206, follow signs for Rt. 517 south. You will go over Route 80. You will pass Panther Valley and Mattar's restaurant / catering. Look for Bilby Road, this will be on your left hand side. Make a left onto Bilby and follow it to the end. At the stop sign make a right. Skylands Urology is located at 616 Willow Grove Street (left hand side) across the street from the hospital. Park in the front of the building, the office entrance is on the left.

ROCKAWAY RT 80 TO HACKETTSTOWN
Take Rt 80 west to Rt.46 west (exit 26.) Follow Rt. 46 to center of Hackettstown. At traffic light make a right onto Willow Grove Street. (Follow the blue hospital signs.) When you see the hospital on your left, look to your right for a brown building, the number is 616. Park in the front of the building, office entrance is to the left.

MILFORD TO HACKETTSTOWN
Take Rt. 209 south to Rt.206 south. Rt 206 becomes Rt. 206/94. Follow Rt. 206 south (you will travel through Newton, Andover and enter Byram.) Make a right turn onto Waterloo Rd. There is a Shell gas station and a bank on the corner. Waterloo Rd. becomes Willowgrove St. We are on the left hand side across from Hackettstown Regional Medical Center, building number 616 Willow Grove Street. Park in the front, our office is to the left.

HACKETTSTOWN TO SPARTA
Take 517 north past Panther Valley. Contunue on 517 north. At the second stop sign you are at Rt. 206. Make a left onto Rt. 206 and a right back onto 517 north. Continue straight, you will pass Perona Farms. At the traffic light by Pope John High School make a right turn. Go 1.5 miles and we are on the left side #89, The Health and Wellness Center.

VERNON TO SPARTA
From the intersection of Rts. 94 and 23. Take Rt. 94 south to Rt. 15 south. Turn left onto Rt. 15 south. After second set of railroad tracks bear right up the hill (181 south.) Take 181 to the top of the hill. We are on the right hand side just past the Hilltop Country Day School. Turn right into the Health and Wellness Center; Lafayette Road entrance. Park in front of building. Office is at the top of the stairs, Suite 200.

ROCKAWAY TO SPARTA
Take Rt. 80 west to Rt. 15 north. Get off second sparta exit for Rt.517/Franklin. At the light make a left turn. Go straight through two lights. We are after the Shell gas station on the right #89, The Health and Wellness Center.

MILFORD TO SPARTA
Take Rt. 206 south. Stay straight to go onto Rt. 15 south. Turn Right onto 181 south. You will pass a golf course on the right. We will be on the right hand side #89, the Health and Wellness Center.