Las Vegas Urology

ADULT AND PEDIATRIC UROLOGY

DIPLOMATES, AMERICAN BOARD OF UROLOGY

Patient's Name:_______________________________________ Age: __________

Social Security Number: _________________________ Date of Birth: ___________

Home Phone: _________ Work Phone:_______________________ Male/Female

Parent or Legal Guardian (if minor):_______________________________________

Address: __________________ City: _____________ State: _____ Zip: ________

Employer: ______________________ Occupation: ________________________

Address: __________________ City: _____________ State: _____ Zip: ________

*Referred By:____________________

Name of Spouse: _______________________ Date of Birth:__________________

Social Security Number: ____________________________

Employer: ______________________ Occupation: ________________________

Work Phone: _______________________

Nearest Relative Not Residing with You: ____________________________________

Address: __________________ City: _____________ State: _____ Zip: ________

Phone:________________________

Insurance Information

Name of Primary Insurance Carrier:__________________________

Address: _______________________ Phone: ______________________________

ALL identifying numbers on card:____

Secondary Insurance (husband's or wife's): ___________________________________

ALL identifying numbers: ____

THIS FORM MUST BE COMPLETED (and if taken returned within 7 days) IN ORDER FOR US TO BILL YOUR INSURANCE. FAILURE TO DO SO WILL MEAN THAT YOU ARE RESPONSIBLE FOR ALL INSURANCE BILLING!

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to pay directly to the Doctr the amount due on my clain for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

Signed: ___________________________________ Date:____________________

Family History:

Serious Illness/Cause of Death	Mother's Family	Father's Family	Age
Heart disease			
Hypertension			
Stroke			
Cancer			
Diabetes			
Kidney disease			
Prostate disease			
Bladder disease			
Other			

Current Medications: Please list all medications you are currently taking (include all non-prescriptive drugs and birth control pills).

Name of Medication	Amount	Frequency

Medication Allergies: (Please list) ______________________________

____

Urologic History

Are you experiencing…

Any burning with urination? ❒ Yes ❒ No

Any visible blood with urine? ❒ Yes ❒ No

Loss of control of your urine? ❒ Yes ❒ No

Any unusual skin problems or persistent sores? ❒ Yes ❒ No

Any previous infections? ❒ Yes ❒ No

Serious sexual difficulties or change in sexual performance? ❒ Yes No

Any unusual frequency or change in pattern of urination? ❒ Yes ❒ No

Explain: ______________________________

____

____

Average number of times you urinate at night?__________

Generally are you able to completely empty your bladder? ❒ Yes ❒ No

Women:

Date of last menstrual period ____________________

Date of last pap smear ____________________

Age at onset of menstrual period __________

Do you have any unusual problems with your menstrual periods? ❒ Yes ❒ No

# of live births __________ Miscarriages __________

Any Complications: ____________________

Do you examine your breasts each month? ❒ Yes ❒ No

Do you have any unusual vaginal odor, discharge, or itching? ❒ Yes ❒ No

Men:

Do you examine your testicles regularly? ❒ Yes ❒ No

Any previous genital infections? ❒ Yes ❒ No

What is your present Urologic complaint: ______________________________

____

____

____

____

Nurse signature: ____________________ Date: ____________________

Physician signature: ____________________ Time: ____________________

PATIENT HISTORY

Date: ____________________ Referring Dr.: ______________________________

PERSONAL PROFILE:

Name: ____

Address: ______________________________________ Phone: ______________

In case of emergency please notify: ___________________________ Phone: ______________

Date of Birth: ______________________

Age: ________________

Past Medical History:

Yes	No		Yes	No	
❒	❒	Allergies (or unusual reactions to foods or drugs)	❒	❒	Asthma
❒	❒	Bleeding tendency/unusual bruising	❒	❒	Emphysema/bronchitis
❒	❒	Anemia (low, weak blood)	❒	❒	Tuberculosis
❒	❒	Diabetes (sugar)	❒	❒	Pneumonia/pleurisy
❒	❒	Thyroid disease/goiter	❒	❒	Yellow jaundice/hepatitis/liver cirrhosis
❒	❒	Epilepsy (fits, seizures, convulsions)	❒	❒	Gallbladder trouble or gallstones
❒	❒	Arthritis/rheumatism/gout	❒	❒	Stomach trouble/ulcers
❒	❒	Glaucoma	❒	❒	Bowel disorders/colitis
❒	❒	High blood pressure	❒	❒	Blood per rectum
❒	❒	Heart trouble or heart murmur	❒	❒	Cancer/tumors________________
❒	❒	Rheumatic fever	❒	❒	Kidney or bladder trouble, stones
❒	❒	Stroke or paralysis	❒	❒	Venereal disease (syphilis, gonorrhea)
❒	❒	Phlebitis	❒	❒	Nervous/emotional problems

List any other serious illnesses or injuries you have had (give dates): ____________________

____

____

____

Have you ever been admitted to a hospital? ❒ Yes ❒ No If so, please list below starting with most recent:

YEAR	OPERATIONS OR ILLNESS	HOSPITAL NAME AND LOCATION

Do you smoke? ❒ Yes ❒ No How many packs a day? ____________

Do you drink alcohol? ❒ Yes ❒ No Approximate amount per day? ______________

When was your last T.B. (tuberculosis) skin test? ______________ Any reaction, describe: ____________

Did you ever have a blood transfusion? ❒ Yes ❒ No If yes, give date ____________

Have you ever been refused insurance or employment because of your health problems? ❒ Yes ❒ No
Explain: ____

Have you ever been medically disabled? ❒ Yes ❒ No
Explain: ____

Have you ever been regularly exposed to any chemicals, toxins, poisons, fumes, smoke or radioactive materials at home or work? ❒ Yes ❒ No
Explain: ____

Las Vegas Urology

ADULT AND PEDIATRIC UROLOGY

DIPLOMATES, AMERICAN BOARD OF UROLOGY

MEDICAL RECORDS RELEASE

TO:

PATIENT NAME:

SOCIAL SECURITY #:

D.O.B.:

Please release all medical records that you have on file to Dr.__________________________.
Please send the records to address checked below:

☐ **NORTHWEST**
Las Vegas Urology, LLP
2901 North Tenaya Way
Suite 100
Las Vegas, NV 89128
Tel: 702.233.0727
Fax: 702.233.4799

☐ **WEST OFFICE**
Las Vegas Urology, LLP
7200 Cathedral Rock
Suite 180
Las Vegas, NV 89128
Tel: 702.341.9000
Fax: 702.341.5864

If you have any questions, please contact our office at the number listed above.

Patient signature: __________________________________

Date: ____

Witness: ____

Las Vegas Urology

ADULT AND PEDIATRIC UROLOGY

DIPLOMATES, AMERICAN BOARD OF UROLOGY

DEAR PATIENT:

PLEASE PROVIDE THIS OFFICE WITH THE NAME, ADDRESS, ZIP CODE AND PHONE NUMBER OF YOUR REFERRING DOCTOR OR PRIMARY CARE DOCTOR.

THANK YOU,

LAS VEGAS UROLOGY

NAME: ____

ADDRESS: ____

CITY/STATE/ZIP: ____

PHONE NUMBER: ____

Las Vegas Urology

ADULT AND PEDIATRIC UROLOGY

DIPLOMATES, AMERICAN BOARD OF UROLOGY

AUTHORIZATION

FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization authorizes the release of Protected Health Information pursuant to 45 CFR Parts 160 and 164.

1. The undersigned authorizes the above-named providers **Las Vegas Urology**, to release contents of medical records to my insurance company for purposes of billing and collecting as request. The undersigned acknowledges that without this authorization, **Las Vegas Urology**, may be unable to bill and collect from patients insurance company.
2. The information may be disclosed by employees or business associates of **Las Vegas Urology**.
3. The medical record information may also be disclosed to: ________ (insert name of the person or people to which the medical information may also be disclosed).
4. I acknowledge: that I have the right to revoke the authorization at any time, and that I understand that once the information is disclosed, it may no longer be protected by Federal Privacy law.

This authorization will remain in effect until terminated in writing by the undersigned patient.

You may revoke this authorization only in writing sent by certified mail to **Las Vegas Urology**, at the above address. The revocation will be in effective only upon receipt, except (1) to the extent that **Las Vegas Urology**, has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the protected health information to lawfully contest a claim.

Date: ____

Signed by: ____

Print Patient's Name:____

If person signed is other than patient, state authority under which signature is made:

(The patient must be given a copy of the authorization)

Quest Diagnostics Incorporated

PATIENT AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I authorize Quest Diagnostics to use and/or disclose my protected health information (which may pertain to my diagnosis and treatment, laboratory test results, medical history, billing information, ordering and treating physicians, and/or other related information, including but not limited to HIV and drug testing information) as specifically identified below and in the original request attached to this authorization and to the person(s) named in that request. I understand that this authorization will expire when Quest Diagnostics has provided the requested information.

I authorize attorney(s) and their legal staff, as well as the appropriate quest Diagnostics employees, to use and/or disclose my PHI in accordance with this authorization.

This use and/or disclosure of my PHI is at my own request. I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the person or party receiving it; in that case, the information may no longer be protected under federal law.

Notice to the patient:
If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services to you on the receipt of this signed Authorization except if you are participating in a research project;
- You may request a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization;
- We must provide you with a copy of the signed authorization; and
- This authorization only covers PHI that is disclosed by Quest Diagnostics. The information could be re-disclosed by the person(s) who receive it and, in that case, your PHI will not be protected by the HIPAA privacy and security rules.
- You have the right to revoke this Authorization at any time, provided that you do so in writing, except to the extent that we have already relied on this Authorization to use or disclose your information.

PHI Requested:

Date(s) of Service: ______________________________ Test(s) Performed: ________________________________

Patient's Information (#1-3 are *required*):
1. Patient's Name (include all names used during the period of the request)

_____________________ __________ __________________ 2. Date of Birth_________________________
First Name Middle Name Last Name (MM/DD/YYYY)

3. Social Security Number __________________________ OR 3. Ordering Physician's Name (or practice name) ___________________

In addition to the above three items, any ADDITIONAL TWO items must be provided:
4. Gender ☐ Male ☐ Female

5. Patient's Address:
Street____

City_____________________ State _____ ZIP ________

6. Social Security Number (Unless provided above) ___________________

7. Insurance ID# ____

8. QD patient invoice statement number __________________

9. Ordering physician's name (or practice name)______________________

9. Ordering physician's address __________________________

11. Ordering physician's phone number_____________________________

Signature:
I have reviewed and I understand this Authorization.

Name (print) ____

Signed: ____ Date: __________
(Patient)

Or By:____ Date: ___________
(Patient's Representative)

Description of Representative's Authority ____

This authorization will expire when Quest Diagnostics has provided the requested information.

Las Vegas Urology

ADULT AND PEDIATRIC UROLOGY

DIPLOMATES, AMERICAN BOARD OF UROLOGY

Las Vegas Urology, Privacy Practices

I have received a notice of their Privacy Practices

____

Today's date

____

Print your name

____

Sign your name

Las Vegas Urology

ADULT AND PEDIATRIC UROLOGY

DIPLOMATES, AMERICAN BOARD OF UROLOGY

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI may be by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

( ) Home telephone__________________
( ) Ok to leave message with detailed information
( ) Leave message with call-back number only.
( ) Work telephone __________________
( ) Ok to leave message with detailed information
( ) Leave message with call-back number only

( ) Written communication
( ) Ok to mail to my home
( ) Ok to mail to work address
( ) Ok to fax to ____________________
( ) Other ____________________
( ) Provide an envelope ________

______________________________ Patients Signature

______________________________ Date

______________________________ Print Name

______________________________ Birthdate

1. The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

2. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

3. NOTE: Uses and disclosure for TPO (Treatment, Payment, or Operations) may be permitted without prior consent in an emergency.

4. Record of Disclosures of Protected Health Information

Las Vegas Urology

ADULT AND PEDIATRIC UROLOGY

DIPLOMATES, AMERICAN BOARD OF UROLOGY

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.

Section A: Use and Disclosures of Protected Health Information

1. Under applicable law, we are required to protect the privacy of your individual health information (information we refer to in this notice as "Protected Health Information"). We are also required to provide you with this notice regarding our polices and procedures regarding your Protected Health Information, and to abide by the terms of this notice, as it may be updated from time to time.

   We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment and healthcare operations purposes. For the treatment purposes, such use and disclosure will take place in providing, coordination or managing healthcare and its related services by one or more of your providers, such as when your primary car physician consults with a specialist regarding your condition.

   For payment purposes, such use and disclosure will take place to obtain or provide reimbursement for providing healthcare or when your case is reviewed to ensure that appropriate care was rendered.

   For healthcare operations purposes, such use and disclosure will take place in a number of ways, including for quality assessment and improvement, provider review and training, underwriting activities, reviews and compliance activities, planning and development and management and administration. Your information could be used, for example, to assist in the evaluation of the quality of care that you were provided.

   In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

   You may use and disclose year Protected Health Information, without your authorization, as required and permitted under Nevada State law. These laws usually relate to public health and safety.

   Other uses and disclosures will be made only with your written authorization and you may revoke authorization by notifying us as described in section B, as follows.

2. You have the right to request the following with respect to your Protected Health Information: (i) inspection and copying; (ii) amendment or correction; (iii) and accounting of the disclosures of this information by us, and (iv) the right to receive a paper copy of this notice upon request. Such requests must be made in writing by

contacting and coordinating with: Privacy Officer, Las Vegas Urology, 7200 Cathedral Rock Drive, Suite 180, Las Vegas, NV 89128.

In addition, you may request and we must accommodate the request, if reasonable, to receive communications of Protected Health Information by alternative means or at alternative locations. To make this request, please write to: Privacy Officer, Las Vegas Urology, 7200 Cathedral Rock Drive, Suite 180, Las Vegas, NV 89128.

Unless you object, we may disclose to one of your family members, to a relative, to a close personal friend or to any other person identified by you, Protected Health Information that is directly relevant to the person's involvement with your care or payment related to your care. In addition. unless you object, we may use or disclose the Protected Health Information to notify or identify or locate a member of your family, your personal representative, another person responsible for your care or certain disaster relief agencies of your location, general condition or death. Objection to this may be communicated in writing (preferred) or orally to: Privacy Officer, Las Vegas Urology, 7200 Cathedral Rock Drive, Suite 180, Las Vegas, NV 89128.

If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our judgment and experience regarding your best interest in allowing people to pick up medical supplies, x-rays or other similar forms of Protected Health Information.

3. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information we maintain. You have a right to receive any new Notices of Privacy Practices we promulgate. We will post in our waiting room for your review.

Section B: Contacting Us

You may contact us for further information by writing or calling Privacy Officer at our facility: Privacy Officer, Las Vegas Urology, 7200 Cathedral Rock Drive, Suite 180, Las Vegas, NV 89128. Phone: (702) 341-9000.