GREATER LONG BEACH GENITO-URINARY MEDICAL GROUP

JULES M. PERLEY, M.D., F.A.C.S.
STEVEN A. SCHEUER, M.D., F.I.C.S. JONATHAN E. PERLEY, M.D.
3650 SOUTH STREET, SUITE 408
LAKEWOOD, CALIFORNIA 90712-1510
(562) 630-0423

OFFICE USE

ACCT #: ____________

DR #: ____________

INS.: ____________

Date: ____________

PATIENT INFORMATION

LAST NAME: ____________ FIRST NAME: ____________ MI: ____________

ADDRESS: ____________

CITY: ____________ STATE: ____________ ZIP: ____________ ETHNICITY: ____________

HOME PH: ____________ SEX: ☐ MALE ☐ FEMALE AGE: ____________

DATE OF BIRTH: ____________ MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

SOCIAL SEC. #: ____________ DRIVER'S LICENSE #: ____________

PATIENT EMPLOYED BY: ____________ JOB TITLE: ____________

BUSINESS ADDRESS: ____________ WORK PH: ____________

CITY: ____________ STATE: ____________ ZIP: ____________

SPOUSE/PARENT OF MINOR OR RESPONSIBLE PARTY

NAME: ____________ SOC. SEC. #: ____________ DOB: ____________

EMPLOYED BY: ____________ JOB TITLE: ____________

BUSINESS ADDRESS: ____________ WORK PH: ____________

CITY: ____________ STATE: ____________ ZIP: ____________

REFERRED BY: ____________

EMERGENCY CONTACT (not living with patient)

RELATIVE/FRIEND: ____________ HOME PH: ____________

ADDRESS: ____________ WORK PH: ____________

INSURANCE INFORMATION

PRIMARY INSURANCE: ____________

ADDRESS: ____________ CITY: ____________ STATE: ____________ ZIP: ____________

PHONE #: ____________ INS. ID #: ____________ GROUP #: ____________

NAME OF INSURED PARTY: ____________ INSURED'S SS #: ____________ DOB: ____________ F ☐ M ☐

PATIENT'S RELATIONSHIP TO INSURED PARTY: Self Wife Husband Child Dependent Parent Other (Please Circle)

ADDRESS IF DIFFERENT FROM PATIENT: ____________

EMPLOYER INSURANCE PLAN?: YES NO (Please Circle) COVERAGE EFFECTIVE DATE ____________

SECONDARY INSURANCE: ____________

ADDRESS: ____________ CITY: ____________ STATE: ____________ ZIP: ____________

PHONE #: ____________ INS. ID #: ____________ GROUP #: ____________

NAME OF INSURED PARTY: ____________ INSURED'S SS #: ____________ DOB: ____________ F ☐ M ☐

PATIENT'S RELATIONSHIP TO INSURED PARTY: Self Wife Husband Child Dependent Parent Other (Please Circle)

ADDRESS IF DIFFERENT FROM PATIENT: ____________

EMPLOYER INSURANCE PLAN?: YES NO (Please Circle) COVERAGE EFFECTIVE DATE ____________

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION: I HEREBY AUTHORIZE AND REQUEST PAYMENT DIRECTLY TO THE GREATER LONG BEACH GENITO-URINARY MEDICAL GROUP FOR SERVICES RENDERED. I ALSO AUTHORIZE THIS GROUP TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION NEEDED FOR FILING AN INSURANCE CLAIM.

____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

FORM 211381 R/07/02 ITEM 8101 COLWELL SYSTEMS 1.800.637.1140

Patient Name:______________________________ **Date of Birth:**______________

SOCIAL HISTORY:

Occupation____

Did you ever smoke?__________ **How much?**______________ **How long?**______________

Did you ever drink? __________ **How much?**______________ **How long?**______________

Did you ever use illicit drugs? __________ **How much?**______________ **How long?**______________

Has anyone in your family ever had cancer?______________________________

____

____

REVIEW OF SYSTEMS:

Please circle all items that apply:

HEENT:	**sore throat**	**blurry vision**	**headaches**
CARDIOVASCULAR:	**palpitations**	**shortness of breath**	**chest pain**
RESPIRATORY:	**cough**	**wheezing**	**cough up blood**
GASTROINTESTINAL:	**nausea**	**vomiting**	**diarrhea**
GENITO-URINARY:	**bloody urine**	**kidney stones**	
NEUROLOGICAL:	**dizziness**	**numbness**	**tingling**
SKIN:	**rash**	**change in mole**	
CONSTITUTIONAL:	**weight loss**	**poor appetite**	

Office Use Only:

______________________	______________________
Updated/Patient Initials	Updated/Patient Initials
______________________	______________________
Updated/Patient Initials	Updated/Patient Initials
______________________	______________________
Updated//Patient Initials	Updated/Patient Initials
______________________	______________________
Date/Patient Initials	Date/Patient Initials

GREATER LONG BEACH GENITO-URINARY MEDICAL GROUP, INC.

CONFIDENTIAL MEDICAL HISTORY

PATIENT NAME:____ DATE____________

PERSONAL HEALTH RECORD:

PLEASE LIST ANY MEDICAL PROBLEMS:

____

____

____

____

List previous surgeries:

OPERATION:	DATE (YEAR)

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING ON A REGULAR BASIS:

____

____

____

____

List any allergies to foods or medicines:

____

____

For Women: How many pregnancies?____________

How many children?______________

GREATER LONG BEACH GENITO-URINARY MEDICAL GROUP, INC.

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Greater Long Beach Genito-Urinary Medical Group, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by another doctor we may involve in your care.

We may use or disclose your health information for payment of your services; for example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations; for example, different members of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as our software vendor. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send you reminder cards or other information. We may also want to call and remind you about your appointments. If you are not at home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Michelle Bradshaw, at (562) 630-0423.

This notice goes into effect April 14, 2003.

ACKNOWLEDGMENT

I have received a copy of the Greater Long Beach Genito-Urinary Medical Group Notice of Privacy Practices.

Date______________________________

Signed________________________________ Patient Name______________________________

If signing as a parent or guardian, please note the name of the patient:______________________________

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3650 South Street, # 408
Lakewood, CA 90712-1510
(562) 630-0423

13132 Studebaker Rd, #1
Norwalk, CA 90650-2576
FAX: (562) 630.0660

1045 Atlantic Avenue, # 915
Long Beach, CA 90813-3493
(562) 437-3288

FINANCIAL POLICY AND INSURANCE

Thank you for choosing our practice. Our doctors accept most insurances and are affiliated with many health care plans. Both of our doctors are participating physicians in the Medicare and Medi-Cal programs.

Patients who are covered by Medicare are responsible for their yearly deductible and coinsurance when applicable. Remember, however, if you have a secondary and/or supplemental insurance policy, not all plans will pay the Medicare deductible or coinsurance.

Your insurance policy is a contract between you and your insurance company. You are responsible for the unpaid portion of your bill. It is also your responsibility to know your plan's limitations, precertification requirements, deductibles, preferred hospitals and laboratories, etc., in order to avoid any unexpected, unpaid charges. Whenever possible, we will assist you with your insurance questions. As a courtesy to all our patients, we do file all insurance claims, including secondary insurance, at no extra charge to you. We send you a statement only after any and/or all insurances have paid their portion.

If you have an HMO plan, please be aware that you may require authorization to see one of our doctors, even for a follow-up visit. In some cases, appointments will be made only after an authorization from the health plan is received. We ask for your cooperation in helping us work with the HMO plan you have selected.

We do not want finances to stand in the way of good medical care. If you are experiencing financial difficulties, please let the doctor and/or the Billing and Collection Department know. Payment arrangements can be made. For your convenience, we also accept MasterCard, Visa, Discover and American Express cards.

If you have any other questions not answered here, please call our Billing and Collection Department at (562) 630-4372. We will assist you in any way possible.

Again, thank you for choosing us for your medical needs.