Advanced Urology Medical Offices

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WELCOME TO OUR PRACTICE

Thank you for choosing Advanced Urology for your urologic care. Enclosed you will find some information that we request you fill out prior to your appointment. This includes the history sheet of all medical conditions past and present. Please be sure to include all medications and doses that you are taking. If you have any questions, please give our office a call and we will be happy to assist you:

Westchester (310) 670-9119
8540 S. Sepulveda Bl., #911
(on the corner of Manchester)

Downtown Los Angeles (213) 621-2727
420 E. Third Street, #706
(on the corner of San Pedro)

Torrance office (310) 530-5050
3440 W. Lomita Bl., #440
(between Hawthorne & Crenshaw)

When you come in for your appointment, be sure to bring <u>all insurance cards</u> and a <u>picture ID</u>.

You will be asked to fill out a few forms in the office - prior to your appointment. Insurance co-payments will be collected when you arrive. We accept cash and all major credit cards.
.....Be prepared to provide a urine specimen during your appointment.
.....Please arrive 10 minutes prior to your scheduled appointment time.

Your appointment is on _____ at _____
at the _____ location.

<u>Parking:</u> Parking is located in the medical buildings - rates are posted at the entrance. Pharmacies in the building do validate parking with a purchase. Parking is also available on the streets, but please be aware that street signs are enforced.

<u>Disability Claims</u>: There is a charge of $10 for each separate state and private disability form. Please allow four working days for the insurance forms to be completed.

Thank you for your assistance and cooperation. We look forward to seeing you.

dlrt

Welcome To Our Office

NEW PATIENT INFORMATION

DATE _____

PATIENT'S NAME (PLEASE PRINT)	S.S. #	MARITAL STATUS S M W D SEP	SEX M F	BIRTH DATE	AGE	RELIGION (OPTIONAL)
STREET ADDRESS PERMANENT TEMPORARY	CITY AND STATE			ZIP CODE	HOME PHONE #	
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)			HOW LONG EMPLOYED	BUS. PHONE # EXT. #	
EMPLOYER'S STREET ADDRESS	CITY AND STATE				ZIP CODE	
DRUG ALLERGIES, IF ANY						
SPOUSE OR PARENT'S NAME	S.S. #	BIRTH DATE				
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION INDICATED IF STUDENT)			HOW LONG EMPLOYED	BUS. PHONE #	
EMPLOYER'S STREET ADDRESS	CITY AND STATE				ZIP CODE	
*SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED	CITY AND STATE			ZIP CODE	HOME PHONE #	

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE		ZIP CODE	HOME PHONE #
BLUE SHIELD (GIVE NAME OF POLICYHOLDER) ☐	EFFECTIVE DATE	CERTIFICATE #	GROUP #	COVERAGE CODE
OTHER (WRITE IN NAME OF INSURANCE COMPANY) ☐	EFFECTIVE DATE		POLICY #	
OTHER (WRITE IN NAME OF INSURANCE COMPANY) ☐	EFFECTIVE DATE		POLICY #	
MEDICARE # ☐	RAILROAD RETIREMENT # ☐	☐ VISA or ☐ MASTERCARD #	EXP. DATE /	
MEDICAID ☐	EFFECTIVE DATE	PROGRAM # / COUNTY # / CASE #	ACCOUNT #	
INDUSTRIAL ☐	WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO	DATE OF INJURY	INDUSTRIAL CLAIM #	
ACCIDENT ☐	WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO	DATE OF ACCIDENT	NAME OF ATTORNEY	
WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? ☐ YES ☐ NO	IF YES, WHERE WERE X-RAYS TAKEN? (HOSPITAL, ETC.)		DATE X-RAYS TAKEN	
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? INCLUDE NAME OF PHYSICIAN AND FAMILY MEMBER.				
REFERRED BY	STREET ADDRESS, CITY, STATE		ZIP CODE	PHONE #

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder _____ HIC Number _____

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to _____ for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Acknowledgment of Receipt of Privacy Notice - I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures named in the Notice; _____.

Signature _____ Date _____

NEW PATIENT INFORMATION

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

NOTICE OF PRIVACY PRACTICES

Advanced Urology Medical Offices may use and disclose protected health information for treatment, payment and healthcare operations. Examples include, but not limited to, home health agencies and/or referral to other providers for treatment, insurance companies for claims and collection agencies. Healthcare operations include, but not limited to, internal quality control and auditing of records.

Advanced Urology Medical Offices is permitted or required to use or disclose protected health information without the individuals written authorization in certain circumstances. Two examples are for public health requirements or court orders. We may release protected health information about you for workers' compensation or similar programs.

Advanced Urology Medical Offices will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

Advanced Urology Medical Offices may at times contact its patients to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient. We may use protected health information to contact you in regards to clinical research studies in an effort to enhance patient care and conduct clinical trials in our practice. We may disclose protected health information to the related pharmaceutical companies, its monitors and institutional review boards. If you do not want us to contact you for clinical research studies, you must notify our practice in writing.

We may release protected health information about you to those who are involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends the condition that you are in. You will be provided a form to list specific people who we may speak to regarding your medical care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Advanced Urology Medical Offices reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.

Advanced Urology Medical Offices will provide each patient with a copy of any revisions of it's Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.

Anyone may file a complaint to the Practice and to the Dept. of Health and Human Services, Office of Civil Rights if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer: Deanna Williams (310) 670-9119. All complaints will be addressed and the results will be reported to the managing physician.

Effective date: April 14, 2003

Patients have been granted individual rights under the HIPAA Legislation. These include the following:
You have the right to inspect and copy protected health information that may be used to make decisions about your care. This does not include information compiled in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding, or Protected Health Information that is subject to or exempt from the Clinical Laboratories Act of 1988. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer listed above. If you request a copy of the information, we may charge a fee for the costs of copying: including mailing, labor, and other supplies associated with your request.

If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information, your request *must* be made in writing to the Privacy Officer. You *must* provide a reason that supports your request and we may deny your request if it is not in writing or does not include a reason to support the request. We cannot amend information that was not created by us, or is accurate and complete. We may deny your request to inspect and copy in very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our organization will review your request and the denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you that was not made for treatment, payment and health care operations, there are certain exceptions to this right.
To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer listed above. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. This list will be provided for free. The accounting must be provided to you no later than 60 days after the receipt of your request, unless we utilize the 30-day extension period.

You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, research or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer listed above. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. Either you or we may terminate the restriction upon notification of the other.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location like your home or work. To request confidential communications, you must make your request in writing to the Privacy Officer listed above. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You will be asked to sign an acknowledgement of receipt of this Notice of Privacy Practices. You will also be asked to outline or define specific instances or information that you would like kept completely confidential - between you and Advanced Urology Medical Offices. If you have any questions regarding this Notice of Privacy Practices, please do not hesitate to contact our Privacy Officer for more information or clarification.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of Advanced Urology Medical Offices Notice of Privacy Practices.

(X) _____ (X) _____

Signature of patient or personal representative Date

_____

Relationship to patient

If patient refused to sign above, employee must sign & date : _____ _____

P[illegible]IENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE____/____/____ **DATE OF LAST PHYSICAL EXAM**____/____/____

LAST NAME_____ **FIRST NAME**_____ **MIDDLE**_____

Social Security No. _____ **DATE OF BIRTH**____/____/____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

_____

History of Present Illness

Please answer the following questions

Location of the problem

Abdomen Back Leg

Other_____

_____

_____

Front **Back**

On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other_____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other_____

How long does the problem last?

30 minutes 1 hour It is always there

Other_____

Is anything else occurring at the same time?

YES **NO** If yes, please explain.

Nausea Rash Headaches

Other_____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other_____

Does the problem interfere with your normal functions?

YES **NO** If yes, please explain_____

_____

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery **Date**

_____

_____

_____

Do you smoke? **Y** **N**

If yes, how much? _____

Do you drink? **Y** **N**

If yes, how much? _____

Are you on any medications? **Y** **N** **(If yes, list all.)**

_____ _____

_____ _____

Are you on a special diet? **Y** **N** **(If yes, please explain)**

_____

Do you have allergies? **Y** **N** **(If yes, Please explain.)**

_____

_____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5

(OVER)

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**.

Please explain any Yes answers in space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other_____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other_____

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N

Other_____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other_____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other_____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other_____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other_____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other_____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other_____

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N

Other_____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other_____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other_____

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other_____

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other_____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____ Date: ____/____/____