Advanced Urology Medical Center

PATIENT REGISTRATION

(Please Print & Complete in Full)

PATIENT INFORMATION			MEDICAL RECORD #
First Name	Middle Initial	Last Name	
Address		City / State / Zip	
Social Security #	Date of Birth	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Sex: ☐ Male ☐ Female
Home Phone	Ethnicity	Race: ☐ African American ☐ Asian ☐ White ☐ American Indian ☐ Other	Preferred Language
Work Phone	Referring Doctor	Referring Doctor Phone	
Cell Phone	Primary Care Physician (PCP)	PCP Phone	
Email	Pharmacy (Name/Street Address/Phone)		

EMERGENCY CONTACT		
Emergency Contact Name	Relationship	
Home Phone	Work Phone	Cell Phone

RESPONSIBLE PARTY (IF OTHER THAN PATIENT, *example: POA, parent of child*)				
Responsible Party Name			Relationship	
Home Phone	Work Phone		Cell Phone	
Address		City	State	Zip
Date of Birth	Social Security #		Sex: ☐ Male ☐ Female	
If patient is a child, lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other:_____ Name of Person (With Whom Child Lives With): _____				

INSURANCE INFORMATION			
Primary Insurance Name	Policy/ID #	Secondary Insurance Name	Policy/ID#
IPA	Group #	IPA	Group #
Subscriber Name	Subscriber DOB	Subscriber Name	Subscriber DOB

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but not limited to co-pays, deductibles, self pay and all discount plan payments. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all balances that are not covered by my insurance plan. I also authorize Skyline and the insurance company to release any information required to process my claims. If it becomes necessary to collect fees through the services of an attorney or collection agency, I understand this will increase my balance approximately 30%.

PATIENT SIGNATURE: _____ **DATE:** _____

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Patient's Name	Date
Who referred you to this office?	Medical Doctor/PCP
Why are you seeing the physician today?	
When did your problem start?	Pharmacy (Name & Number)

Date of Birth: _____

My Main Problems are:

☐ Enlarged Prostate ☐ Blood in Urine ☐ High PSA ☐ Bladder Infection
☐ Kidney Stones ☐ Prostate Infection ☐ Urinary Incontinence ☐ Bladder Cancer
☐ Prostate Cancer ☐ Erectile Dysfunction ☐ Overactive Bladder ☐ Infertility
☐ Lump in Testicle ☐ Other: _____

Allergies:

☐ None ☐ PCN ☐ Sulfa ☐ Cipro ☐ Iodine/Contrast
☐ Other: _____

Medications (Please list all current medications):

_____

Surgical History: ☐ Appendectomy ☐ Back/Hip/Knee ☐ Cystoscopy ☐ Gallbladder
☐ Heart Bypass ☐ Kidney Stone Surgery ☐ Lithotripsy ☐ Prostate Biopsy ☐ Prostate Seed
☐ Prostate Surgery ☐ Other: _____ ☐ No Changes

Medical History: ☐ Diabetes ☐ Emphysema ☐ Heart Attack ☐ Heart Murmur
☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Parkinson's ☐ Strokes
Cancer: ☐ Prostate ☐ Kidney ☐ Testis ☐ Other: _____ ☐ No Changes

Family History: ☐ Prostate Cancer ☐ Kidney Cancer ☐ Kidney Stones ☐ Heart Disease

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Smoke: ☐ No ☐ Yes Occupation: _____ ☐ Retired

My Symptom(s) are:

General/Constitutional	☐ Fever	☐ Weight Loss	☐ Chills
Eyes	☐ Blurry Vision	☐ Double Vision	☐ Cataracts
Ears, Nose, Mouth, Throat	☐ Hearing Loss	☐ Nasal Stuffiness	☐ Sore Throat
Cardiovascular	☐ Chest Pains	☐ Swollen Ankles	☐ Irregular Heartbeat
Respiratory	☐ Shortness of Breath	☐ Wheezing	☐ Chronic Cough
Gastrointestinal	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels
Genitourinary	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine
Musculoskeletal	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles
Integumentary/Skin	☐ Rash	☐ Persistent Itching	☐ Skin Cancer History
Neurologic	☐ Numbness	☐ Tingling	☐ Dizziness
Hematologic/Lymphatic	☐ Swollen Glands	☐ Abnormal Bleeding	☐ Transfusion History

Urinary Symptom(s) are:

☐ Incomplete Emptying ☐ Frequency ☐ Intermittency ☐ Weak Stream ☐ Straining
☐ Testicle Pain ☐ Pain in Side R / L ☐ Urinating at Night # _____

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Patient's Name	
Date of Birth	
Age	☐ Married ☐ Single ☐ Widowed ☐ Divorced
Occupation (or former occupation)	

Chief Complaint:

What is the main reason for your visit today? (Please describe in detail)_____

_____

_____

History of Present Illness:

Location of problem: Abdomen Back Genitals Other: _____	How long does the problem last? 30 minutes 1 day Always there Other: _____
On a scale of 1-10, with 10 being the most severe, circle the number that best describes your problem 1 2 3 4 5 6 7 8 9 10	Is there anything else occurring at the same time? Yes No If Yes, explain _____ Nausea Rash Headache Other: _____
When did you first notice the problem? 2 days ago 1 week ago 1 month ago Other:_____	Is the problem constant or variable? Dull, then sharp Sharp, then leaves Always there Other: _____
Does anything help or make the problem worse? Yes No Moving around Standing Eating	Does the problem interfere with your normal function? Yes No If yes, explain: _____ _____
Physician use (comments and notes)	

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HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related to health care services.

Uses and Disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

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PF-3000 (b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting your office's Practice Administrator.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Print Patient's Name Patient MRN

_____ _____
Patient or Legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship to Patient

(Notation, if any, by staff)

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

_____ _____
Print Name of person/organization Relationship to Patient

_____ _____
Print Name of person/organization Relationship to Patient

Advanced Urology Medical Center

1211 W. La Palma Ave. Ste. 502
Anaheim, CA 92801
P: 714-776-7090
F: 714-776-5632

NO SHOW POLICY

EFFECTIVE OCTOBER 01, 2012

There will be a $25 charge for No Shows, for a missed appointment, if office is not notified 24 hours in advance of the scheduled appointment.

There will be a $50 charge for a MISSED Procedure (e.g. Cysto, VAS, BX, Urodynamics) if office is not notified 24 hours in advance of the scheduled procedure.

*****ALL PATIENTS WILL BE CONSIDERED A NO SHOW IF THEY MISS AN APPOINTMENT AND DO NOT NOTIFY US 24 HOURS IN ADVANCE OF THE APPOINTMENT**.

Payment of the no show charge must be paid by cash, check or credit card.

I have read and understand the above No Show Policy.

_____ _____

Patient Signature Date

Advanced Urology Medical Center

SIGNATURE FORM

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

Patient Name: _____
MRN#: _____
Date: _____

I understand that I am financially responsible to **Advanced Urology Medical Center** for charges not covered by my insurance carrier. Payment for services is due at time of service unless prior arrangements have been made. I also agree that, should I fail to assume that financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of the doctor's charges. I authorize **Advanced Urology Medical Center** to release to the Social Security Administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original.

_____ _____
Date Signature of Patient or Guardian

EXTENDED PAYMENT REQUEST (One Time Authorization)
(Medicare and Medicaid Patients ONLY)

I request that payment of authorized Medicare benefits or other insurance benefits be made on my behalf to **Advanced Urology Medical Center** for any services furnished me by that provider. This one time signature will be maintained on file as verification for all subsequent services which are provided to you by this provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or other insurance carriers any information needed to determine these benefits or the benefits for related services.

_____ _____
Date Signature of Patient or Guardian

MEDIGAP AUTHORIZATION
(Medicare Patients only)

I request that payment of authorized Medigap benefits be made on my behalf to **Advanced Urology Medical Center** for any services furnished me by that provider. I authorize any holder of medical information about me to.

Release to _____ any information needed to determine these benefits
(Name of Medigap Insurer)
Or the benefits payable for related services.

Medicare Number: _____

Secondary Insurance: _____ Policy: _____

_____ _____
Date Signature of Patient or Guardian