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PATIENT INFORMATION

Patient's Full Name

Date of Birth	Age	Sex
Home Address		Suite/Apt.
City	State	Zip
Home Phone		Cell Phone
Patient's Social Security Number		Marital Status
Parent/Legal Guardian (minors)		

Employer's Name	Work Phone
Employer Address	
City	State
Zip	

Spouse's Name	Date of Birth
Spouse Social Security Number	
Spouse Phone	
Emergency Contact Name	
E. C. Phone	
Emergency Contact Address	
City	State
ZIP-	

****PRIMARY CARE DOCTOR or REFERRING DOCTOR:** _____

INSURANCE INFORMATION (REQUIRED)

Name of Primary Insurance

Insured's Name	Date of Birth	Social Security #
Insurance ID Number		Group Number
Employer Name		Employer Phone

Name of Secondary Insurance

Insured's Name	Date of Birth	Social Security #
Insurance ID Number		Group Number
Employer Name		Employer Phone

**THIS FORM MUST BE COMPLETED 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 Doctor the amount due on my claim for services rendered to my dependent or me. Payment for co-pays and deductibles are required at the time services are rendered. 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 were such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

NO SHOW FEE OF \$25.00 (PATIENT INITIALS) _____
PATIENT SIGNATURE _____

TODAY'S DATE _____

MEDICAL HISTORY

Today's Date

Patient's Full Name

Date of Birth

Age

Check the box next to each condition you have experienced or currently have.

- | | |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Allergies (unusual reactions to foods or drugs) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding tendency / Unusual bruising | <input type="checkbox"/> Emphysema / Bronchitis |
| <input type="checkbox"/> Anemia (low or weak blood) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes (sugar) | <input type="checkbox"/> Pneumonia / Pleurisy |
| <input type="checkbox"/> Thyroid disease / Goiter | <input type="checkbox"/> Yellow Jaundice / Hepatitis / Liver Cirrhosis |
| <input type="checkbox"/> Epilepsy (fits, seizures, convulsions) | <input type="checkbox"/> Gallbladder trouble or Gallstones |
| <input type="checkbox"/> Arthritis / Rheumatism / Gout | <input type="checkbox"/> Stomach Trouble / Ulcers |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Bowel disorders / Colitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blood per rectum |
| <input type="checkbox"/> Heart trouble or heart murmur | <input type="checkbox"/> Cancer / tumors _____ |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Kidney or bladder trouble, stones |
| <input type="checkbox"/> Stroke or Paralysis | <input type="checkbox"/> Venereal disease (syphilis, gonorrhea) |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Nervous / Emotional problems |

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

Have you ever been admitted to a hospital? If so, please list stays below starting with most recent:

DATE OF STAY	OPERATIONS OR ILLNESS	HOSPITAL NAME	LOCATION



Patient Name: _____ DOB: _____

Today's Date: _____

SOCIAL AND FAMILY HISTORY

Do you smoke? ____ How many packs a day? _____ Do you drink alcohol? How much per day? _____

When was your last Tuberculosis (T.B.) Skin test? Any reaction? Describe:

Did you ever have a blood transfusion? If so, when was the transfusion?

Have you ever been refused insurance or employment because of your health problems?

Explain:

Have you ever been medically disabled?

Explain:

Have you been regularly exposed to any chemicals, toxins, fumes, smoke or radioactive materials at home or work?

Explain:

The following questions pertain to your family history, please fill out with if the condition applies to either side.

<i>Serious Illness/Cause of death</i>	<i>Mother's Family</i>	<i>Father's Family</i>	<i>Age it began/ Caused death</i>
<i>Heart Disease</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Hypertension</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Stroke</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Cancer</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Diabetes</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Kidney Disease</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Prostate Disease</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Bladder Disease</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Other _____</i>	<input type="checkbox"/>	<input type="checkbox"/>	

Please list all medications you are currently taking. Include all non-prescription drugs and birth control pills.

<i>Name of medication</i>	<i>Amount</i>	<i>Frequency</i>
<i>List medication allergies:</i>		

UROLOGIC PROFILE

Please check the box next to any symptoms you are currently experiencing.

<input type="checkbox"/> <i>Any burning with urination?</i>	<input type="checkbox"/> <i>Any visible blood with urine?</i>
<input type="checkbox"/> <i>Loss of control with urination?</i>	<input type="checkbox"/> <i>Any unusual skin problems or persistent sores?</i>
<input type="checkbox"/> <i>Any previous infections?</i>	<input type="checkbox"/> <i>Serious sexual difficulties or change in performance?</i>
<input type="checkbox"/> <i>Any change in patter of urination</i>	<input type="checkbox"/> <i>Any change in frequency with urination?</i>
<input type="checkbox"/> <i>Generally, are you able to completely empty your bladder? If not, explain:</i>	
<i>What's the average number of times you urinate at night?</i> _____	
<i>If you have experienced any changes in your pattern or frequency of urination, please explain:</i>	

The following questions are divided into gender specific categories, please answer the ones that apply to you.

WOMEN

<i>Date of last menstrual period?</i> _____	<i>Date of last pap smear?</i> _____
<i>Number of live births</i> _____	<i>Number of Miscarriages, if any</i> _____
<i>Any complications with pregnancy?</i>	
<i>Do you examine your breasts each month?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>Age at onset of menstrual period</i> _____
<i>Do you have any unusual problems with your menstrual periods?</i>	
<i>Do you have any unusual vaginal odor, discharge or itching?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	

MEN

<i>Do you examine your testicles regularly?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>Any previous genital infections?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO

What is your present urologic complaint, main symptoms or the reason for your visit?

NURSE SIGNATURE _____

DATE _____

PHYSICIAN SIGNATURE _____

TIME _____

International Prostate Symptom Score

Patient Name _____ Date of Birth _____ Date _____

Please answer the questions below with a ranking of your symptoms.	Not at all. 0	Less than 1 time in 5. 1	Less than half the time. 2	About half the time. 3	More than half the time. 4	Almost always. 5	Your Score:
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when urinating?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. Nocturia (Night Time) Over the past month, how many times did you usually get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	

Quality of life due to urinary symptoms.	Delighted	Pleased	Mostly Satisfied	Mixed Feelings	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6



PHARMACY INFORMATION

Date: _____

Preferred Pharmacy

Pharmacy Phone Number

Address

I hereby authorize the above pharmacy to transmit information through electronic prescribing. This authorization shall continue and be in full force and in effect until revoked in writing by me.

Patient Name

Date of Birth

SIGNATURE

Date

Patient Signature



Medical Records Release Form

DATE: _____

STAT Request ()

TO: _____

FAX#: _____

Patient Name: _____

Patient Address: _____

DOB: _____

SS#: _____

Please release () All Medical Records () Labs () Radiology Reports () All Doctor Consultation Notes on file to Dr. _____ at the following address:

() 7500 W. Smoke Ranch, #200
Las Vegas, NV 89128
(702) 233-0727
(702) 233-4799 – FAX

() 7200 Cathedral Rock Dr., #180
Las Vegas, NV 89128
(702) 341-9000
(702) 341-5864 – FAX

() 7150 W. Sunset Road, #201A
Las Vegas, NV 89113
(702) 233-0727
(702) 385-4346 - FAX

() 4 Sunset Way, #B-6
Henderson, NV 89014
(702) 454-6226
(702) 454-7290 – FAX

() 1701 N. Green Valley Pkwy, Bldg. #10-C
Henderson, NV 89074
(702) 896-9600
(702) 896-9606 – FAX

() 9053 S. Pecos, #2900A
Henderson, NV 89074
(702) 735-8000
(702) 735-4795 - FAX

() 8915 S. Pecos, #19A
Henderson, NV 89074
(702) 341-9000
(702) 341-5864 - FAX

Patient Signature

Date

Witness Signature

Date

A BRIEF LOOK AT ARBITRATION FOR THE PATIENT

Introduction

Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association, and noted to be a favored method of resolving disputes by the United States Supreme Court.

If you are unfamiliar with arbitration in general, the information included here provides some of the basic principles of arbitration.

What is arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and the doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After a hearing, which is usually less formal than a court proceeding, the arbitrator makes the decision ("award"). Although the procedures are different, generally the same laws and same measure of damages which apply in court proceedings also apply in arbitration.

Does arbitration prevent you from making a claim?

No. By selecting arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does it prevent you from obtaining a financial award?

No, Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim he or she will determine a damage award.

The United States Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

A BRIEF LOOK AT ARBITRATION FOR THE PATIENT, P. 2

May I be represented by an attorney of my choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who is bound by this agreement?

If you chose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by the doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by the doctor. Likewise, the doctor or anyone suing on behalf of a doctor, is bound.

What does arbitration cost?

In general, arbitration is less expensive than court actions. The arbitrator's fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If either party does not like the arbitration result, could there still be a jury trial in court?

Generally, the answer is "No." The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed, and potentially reversed ("Vacated") by a court in limited circumstances.

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator, These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.



PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article I: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article II: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by the Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article III: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. Mail, postage prepaid, to all parties, describing the claim against the physician, the amount of damages sought, and the names and addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206-382.48, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9U.S.C. § 1-4) and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article IV: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or enforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Nevada and Federal law.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE I OF THIS CONTRACT. YOUR SIGNATURE INDICATES THAT OUR OFFICE HAS PROVIDED YOU WITH THE DOCUMENT "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT!"

<i>SIGNATURE</i>	<i>Date</i>
<i>Physician or Duly Authorized Representative</i>	

<i>Date</i>
Physician Name

<i>SIGNATURE</i>	<i>Date</i>
<i>Translator Signature</i>	

<i>SIGNATURE</i>	<i>Date</i>
<i>Print Translator Name</i>	

<i>SIGNATURE</i>	<i>Date</i>
<i>Patient Signature</i>	

<i>PRINT</i>	<i>Date</i>
<i>Print Patient Name</i>	

<i>SIGNATURE</i>	<i>Date</i>
<i>Patient Representative (if applicable)</i>	

<i>PRINT</i>	<i>Date</i>
<i>Name and Relationship to Patient</i>	



PATIENT RECORD OF DISCLOSURES

In general, the HIPPA 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.

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 and adequate record.
3. NOTE: Uses and disclosures for TYP (Treatment, Payment or Operations) may be permitted without prior consent in an emergency.
4. Record of disclosures of Protected Health Information (Attached.)

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

<input type="checkbox"/> Home Phone: _____	<input type="checkbox"/> Work Phone: _____
<input type="checkbox"/> OK to leave message with detailed information	<input type="checkbox"/> OK to mail to my home address
<input type="checkbox"/> Please leave message with call-back number only	<input type="checkbox"/> OK to mail to my work address
<input type="checkbox"/> OK to fax to number: _____	<input type="checkbox"/> Leave message with person: _____

SIGNATURE	Date
Patient Signature	

SIGNATURE
Patient (Guardian)

NAME
Print Patient Name

Date of Birth
Patient (Guardian)



Authorization for the Release of Protected Health Information

This form authorizes the release of Protected Health Information pursuant to 45 CFR Parts 106 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 requested. The undersigned acknowledges that without this authorization, LAS VEGAS UROLOGY may be unable to bill and collect from patient's 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 person or people to whom the medical information may also be disclosed.)
4. I acknowledge: that I have the right to revoke 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 address below. The revocation will be 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 the claim.

SIGNATURE

Date

Signed by:

PRINT

Print Patient Name

AUTHORITY

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

7500 Smoke Ranch Rd., #200
Las Vegas, NV 89128
(702) 233-0727
(702) 233-4799 – FAX

7200 Cathedral Rock Dr., #180
Las Vegas, NV 89128
(702) 341-9000
(702) 341-5864 – FAX

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Las Vegas, NV 89113
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(702) 233-4799 – FAX

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(702) 896-9606 – FAX

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