

# 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 Doctor the amount due on my claim 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: \_\_\_\_\_

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**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:

- |                          |                          |  |                          |                          |   |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| <b>Yes</b>               | <b>No</b>                |  | <b>Yes</b>               | <b>No</b>                |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies (or unusual reactions to foods or drugs) | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding tendency/unusual bruising                 | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema/bronchitis                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia (low, weak blood)                           | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (sugar)                                   | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia/pleurisy                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease/goiter                             | <input type="checkbox"/> | <input type="checkbox"/> | Yellow jaundice/hepatitis/liver cirrhosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy (fits, seizures, convulsions)             | <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder trouble or gallstones         |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis/rheumatism/gout                          | <input type="checkbox"/> | <input type="checkbox"/> | Stomach trouble/ulcers                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma   | <input type="checkbox"/> | <input type="checkbox"/> | Bowel disorders/colitis                   |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                                | <input type="checkbox"/> | <input type="checkbox"/> | Blood per rectum                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble or heart murmur                      | <input type="checkbox"/> | <input type="checkbox"/> | Cancer/tumors _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever                                    | <input type="checkbox"/> | <input type="checkbox"/> | Kidney or bladder trouble, stones         |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke or paralysis                                | <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease (syphilis, gonorrhea)    |
| <input type="checkbox"/> | <input type="checkbox"/> | Phlebitis  | <input type="checkbox"/> | <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?     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: \_\_\_\_\_



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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: \_\_\_\_\_

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## 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.

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**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.

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**PHI Requested:**

Date(s) of Service: \_\_\_\_\_ Test(s) Performed: \_\_\_\_\_

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**Patient's Information (#1-3 are required):**

1. Patient's Name (include all names used during the period of the request)
- \_\_\_\_\_
- First Name                      Middle Name                      Last Name
2. Date of Birth \_\_\_\_\_ (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 \_\_\_\_\_

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**Signature:**

I have reviewed and I understand this Authorization.

Name (print) \_\_\_\_\_

Signed: \_\_\_\_\_  
(Patient)

Date: \_\_\_\_\_

Or By: \_\_\_\_\_  
(Patient's Representative)

Date: \_\_\_\_\_

Description of Representative's Authority \_\_\_\_\_

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

# Las Vegas Urology

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## Las Vegas Urology, Privacy Practices

I have received a notice of their Privacy Practices

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Today's date

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Print your name

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Sign your name

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# Las Vegas Urology

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## 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):

- |  |   |
|--|---|
| <input type="checkbox"/> Home telephone _____                          | <input type="checkbox"/> Written communication      |
| <input type="checkbox"/> Ok to leave message with detailed information | <input type="checkbox"/> Ok to mail to my home      |
| <input type="checkbox"/> Leave message with call-back number only.     | <input type="checkbox"/> Ok to mail to work address |
| <input type="checkbox"/> Work telephone _____                          | <input type="checkbox"/> Ok to fax to _____         |
| <input type="checkbox"/> Ok to leave message with detailed information | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Leave message with call-back number only      | <input type="checkbox"/> 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

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## 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 policies 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 care 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 your 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.