

Date: _____ Dr. Candela _____ Grigoriev _____ Kurtz _____ Sussman _____ Med. Record #: _____
Name/Last: _____ First: _____ Middle Initial: _____
Social Security #: _____ Sex: _____ Date of Birth: _____ Age: _____
Address: _____ Marital Status: _____
City, State, Zip: _____ Telephone #: _____
Referring Physician: _____ Referred by Other: _____

Responsible Party (person responsible for bill)

Insured Name: _____ Telephone #: _____
Relationship to Patient: _____ Social Security #: _____
Address: _____
City, State, Zip: _____

Patient Employer Information

Insured Employer Information

Occupation: _____ Employer: _____
Employer: _____ Address: _____
Address: _____ City, State, Zip: _____
City, State, Zip: _____ Telephone #: _____
Telephone #: _____ Social Security #: _____
Date of Birth: _____

Emergency Contact Information

Name of Contact Not Living With You: _____ Relationship: _____
Address: _____ Telephone #: _____
City, State, Zip: _____

Insurance Information

Primary Insurance: _____ Insureds Name: _____
Social Security #: _____ Date of Birth: _____
ID #: _____ Group #: _____
Additional Insurance: _____ Insureds name: _____
Social Security #: _____ Date of Birth: _____
ID #: _____ Group #: _____

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Desert Urology. We will gladly file your insurance claim, however payment for co-pays and deductibles are required at the time services are rendered. We cannot guarantee payment to Desert Urology. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim you will become responsible for all amounts not covered, payable to Desert Urology. Parents/guardians are responsible for services rendered to a minor.

I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records if necessary.

Signature of Patient or Responsible Party

Date

Fecha: _____ Dr. Candela _____ Grigoriev _____ Kurtz _____ Sussman _____ # de Exp. Med.: _____
Apellido: _____ Nombre: _____ Inicial: _____
de Seguro Social: _____ Sexo: _____ Fecha de nacimiento: _____ Edad: _____
Dirección: _____ Estado Civil: _____
Ciudad, Estado, Z.P.: _____ # de Teléfono: _____
Médico que refiere: _____ Referido por otro: _____

Persona responsable de los gastos

Nombre del asegurado: _____ # de Teléfono: _____
Parentesco con el paciente: _____ # de Seguro Social: _____
Dirección: _____
Ciudad, Estado, Z.P.: _____

Información del trabajo del paciente

Ocupación: _____
Compañía: _____
Dirección: _____
Ciudad, Estado, Z.P.: _____
de Teléfono: _____

Información del trabajo del Asegurado.

Compañía: _____
Dirección: _____
Ciudad, Estado, Z.P.: _____
de Teléfono: _____
de Seguro Social: _____
Fecha de nacimiento: _____

Información en caso de emergencia:

Nombre de una persona que no este viviendo con usted: _____
Parentesco: _____ # de Teléfono: _____
Dirección: _____
Ciudad, Estado, Z.P.: _____

Información de la Aseguración

Aseguración primaria: _____ Nombre del Asegurado: _____
de Seguro Social: _____ Fecha de nacimiento: _____
de Identificación: _____ # Grupo: _____
Aseguración Adicional: _____ Nombre del Asegurado: _____
de Seguro Social: _____ Fecha de nacimiento: _____
de Identificación: _____ # Grupo: _____

La información de arriba está completa y correcta. Yo autorizo a Desert Urology para que pueda dar información necesaria de mi expediente con mi compañía Aseguradora. Desert Urology esta dispuesto a enviar la cuenta a su compañía - Aseguradora por co-pays y deducibles que son requeridos por los servicios medicos prestados; pero nosotros no podemos garantizar que su Compañía Aseguradora nos pague. Nosotros tenemos un compromiso con usted y no con tu Compañía Aseguradora. En su defecto, si su compañía niega un pago usted será responsable por los gastos no cubiertos a favor de Desert Urology. Padres o familiares son responsables pro servicios prestados a un menor.

Yo autorizo que se de mi expediente a mi Médico Familiar y Compañía Aseguradora si es pertinente. Yo autorizo que mi expediente médico sea transmitio por fax si es necesario.

Firma del Paciente o Responsable de Pago.

Fecha



Victor E. Grigoriev, M.D., F.A.C.S. *Diplomate, American Board of Urology*

Steven B. Kurtz, M.D. *Diplomate, American Board of Urology*

Joseph V. Candela, M.D., M.P.H. *Diplomate, American Board of Urology*

Vijay Goli, M.D., F.A.C.S. *Diplomate, American Board of Urology*

O. Alex Lesani, M.D. *Fellowship Trained in Laproscopy & Robotic Surgery*

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Las Vegas Urology originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Las Vegas Urology is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Las Vegas Urology reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

* Our practice may use and disclose your individually identifiable health information (IIHI) for research purposes in limited circumstances. * Accept Decline

I fully understand and accept/decline the terms of this consent.

Patient's Signature

Date

7500 Smoke Ranch, #200, Las Vegas, NV 89128 7150 W. Sunset Rd., #201, Las Vegas, NV 89113
(702) 233-0727 • Fax (702) 233-4799



PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: 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 2: 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 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 3: 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 Physician, the amount of damages sought, and the names, 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 (9 U.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 4: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, 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 1 OF THIS CONTRACT. YOUR SIGNATURE INDICATES THAT OUR OFFICE HAS PROVIDED YOU WITH THE DOCUMENT "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT".

By: _____
Physician or Duly Authorized Representative Signature (Date)

By: _____
Print or Stamp Name of Physician, Medical Group or Association Name

By: _____
Signature of Translator (if applicable) (Date)

Print Name of Translator

By: _____
Patient's Signature (Date)

Print Patients Name

By: _____
Patient's Representative's Signature (if applicable) (Date)

Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records.

NAME: _____ AGE: _____ DATE: _____

WHAT ARE YOUR YOUR MAIN SYMPTOMS? _____

	YES	NO	<u>MEN ONLY</u>	YES	NO
Slow flow or stream	_____	_____	Erectile dysfunction	_____	_____
Incomplete emptying	_____	_____	Partial or total?	_____	_____
Frequent urination	_____	_____	Blood in your semen	_____	_____
Urinating at night	_____	_____	Have you had a vasectomy?	_____	_____
If yes, how many times	_____	_____			
Urinary dribbling	_____	_____	<u>WOMEN ONLY</u>	YES	NO
Blood in your urine	_____	_____	Are you pregnant?	_____	_____
Kidney stones	_____	_____	Last period	_____	_____
Urinary infections	_____	_____	Painful sexual activity	_____	_____
Venereal diseases	_____	_____	Pelvic pain	_____	_____
Incontinence (urine loss)	_____	_____	Endometriosis	_____	_____
Painful or burning urination	_____	_____	Have you had a hysterectomy?	_____	_____

<u>PAST MEDICAL, FAMILY, SOCIAL HX</u> (check and circle which apply)	YOU	FAMILY
Blood pressure, vascular or bypass surgery	_____	_____
Strokes, seizures, head injury, back or spinal injury, Parkinsonism	_____	_____
Heart attacks, heart failure, irregular heart rhythm	_____	_____
Breathing problems (asthma, emphysema, chronic bronchitis)	_____	_____
Stomach disorders (constipation, bloody stool, diverticulitis)	_____	_____
Prosthetic or implant surgery (heart valves, orthopedic, penile)	_____	_____
Diabetes, thyroid or other endocrine conditions	_____	_____
History of tuberculosis or hepatitis	_____	_____
Blood thinners (Coumadin, aspirin, Motrin, Plavix)	_____	_____
History of prostate, bladder, kidney, or _____ cancer	_____	_____
Risk for HIV (homosexual, blood transfusions, hemophilia)	_____	_____
Do you or have you ever smoked? If you quit, when? _____	_____	_____
Alcohol or drug _____ use (social, moderate, heavy)	_____	_____

REVIEW OF SYSTEMS (Circle all those which apply)

- GENERAL SYMPTOMS: Fever/chills; weight loss/gain; other _____
- EYES: Blurred vision; glaucoma; other _____
- NEUROLOGIC: Headache; tremors; dizziness; numbness/tingling; other _____
- ENDOCRINE: Excessive thirst; too hot/cold; tired/sluggish; other _____
- GASTROINTESTINAL: Abdominal pain; indigestion; nausea/vomiting; other _____
- CARDIOVASCULAR: Chest pain; palpitations; swollen or painful legs; other _____
- SKIN: Rash; itching; other _____
- MUSCULOSKELETAL: Arthritis; joint, neck or back pain; other _____
- RESPIRATORY: Frequent cough; coughing blood; shortness of breath; other _____
- HEMATOLOGIC: Anemia; swollen glands; bleed easily; other _____
- PSYCHOLOGIC: Depressed; anxious; other _____

NOMBRE: _____ EDAD: _____ FECHA: _____
 CUALES SON SUS SÍNTOMAS? _____

	SI	NO	<u>SOLO HOMBRES</u>	SI	NO
Orina lento con o dificultad	___	___	Disfusión eréctil?	___	___
Incompleto al orinar	___	___	Parcial o total?	___	___
Orina por la noche	___	___	Sangre en su semen?	___	___
si es sí, cuantas veces	___	___	Ha tenido una vasectomía?	___	___
Goteo urinario	___	___	<u>SOLO MUJERES</u>		
Sangre en su orina	___	___	Esta usted embarazada?	___	___
Piedras en el riñón	___	___	Ultimo periodo	___	___
Infecciones urinarias	___	___	Dolor en su actividad sexual	___	___
Enfermedades venereas	___	___	Dolor pelvico	___	___
Incontinencia (sale la orina)	___	___	Ha tenido una histerectomia?	___	___
Dolor o ardor al orinar	___	___	(quitar la matriz)	___	___

HISTORIA MEDICA, FAMILIAR Y SOCIAL

	TU	FAMILIA
Presión de la sangre, vascular o cirugía coronaria	___	___
Embolia cerebral, ataque, herida en la cabeza, daño columna	___	___
Ataque cardiaco, ritmo irregular del corazón	___	___
Problemas respiratorios (asma, efisema, bronquitis crónica)	___	___
Desorden estomacal (estreñimiento, escremento con sangre, malformación del intestino)	___	___
Cirugía, implante o prótesis (válvula del corazón, ortopédico o del pene)	___	___
Diabetes, tiroides o alguna otra enfermedad endocrina	___	___
Historia de tuberculosis o hepatitis	___	___
Tratamiento para adelgazar la sangre (coumadin, aspirian, motrin)	___	___
Historia de próstata, vejiga, riñón o _____ cancer	___	___
Riesgo por HIV (homosexual, transfusión de sangre, hemofilia)	___	___
Has fumado o fumas? si dejaste de hacerlo, cuando?	___	___
Alochol o droga _____ uso (social, moderado, mucho)	___	___

EXAMEN DE SISTEMAS

Síntomas generales: Fiebre/ escalofrio; Aumento/perdida de peso; otro _____
 Ojos: Vision borrosa, glaucoma, otro: _____
 Neurologico: Dolor de cabeza, temblores; mareo; entumecimiento; otro _____
 Endocrino: Sed excesiva; caliente/frio, cansado/lento _____
 Gastrointestinal: Dolor abdominal; indigestion; nausea/vomito; otro _____
 Cardiovascular: Dolor en el pecho; palpitation; piernas inflamadas, otro _____
 Piel: Sarpullido; picazon; otro _____
 Musculoesqueletico: Artritis; hueso dislocado; cuello o dolor de espalda; otro _____
 Respiratorio: Tos frecuente; sangre al toser; respiracion cortada; otro _____
 Hematologico: Anemia; glandulas inflamadas: facil de sangrar; otro _____
 Psicologico: Deprimido; ansioso; otro _____



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 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.

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.

International Prostate Symptom Score

Patient Name: _____ Date of Birth _____ Date: _____

Please answer the questions below	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always	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 Over the past month, how many times did you most typically 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 about equally satisfied	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

International Prostate Symptom Score

Nombre:

Fecha de nacimiento:

Fecha:

Por favor contestacion los preguntas	No, nunca	menos de 1 vece or mas de 5 veces	menos de la mitad de tiempo	como la mitad de tiempo	Mas de la mitad de tiempo	todo la tiempo	to tante o
1. Incompleto al orinar En el mes pasado, cuantas veccas a teniedo el sensacion que no incompleto al orinar?	0	1	2	3	4	5	
2. Frecuencia En el mes pasado cuantas veces a tener orinar otra vece en dos hors ?	0	1	2	3	4	5	
3. Intermittency En el mes pasado, cuantas veces a sientdo que comienzo orinar ye parar ye comienzo ye parar	0	1	2	3	4	5	
4. Urgente En el mese pasado cuentes veces a sientdo dificultad a postergar to orinar?	0	1	2	3	4	5	
5. Debilidad de chorro? En el mes pasado cuantas veces a teniedo que el chorro de el orin fe debilidad?	0	1	2	3	4	5	
6. Esfuerzo En el mes pasado cuentes veces a teniedo empujon o esfuerzo cuando comienzo de orin?	0	1	2	3	4	5	
7. Nocturia En el mese pasado cuentes veces a teniedo que levantarse por la noche para orinar?	0	1	2	3	4	5	
	Encantado	Contento	Satisfecho	Mas a menos satisfecho	Mas insatisfecho	Descont ento	Malisi mo
Se tenia a vivir con tu sintomas de orinar, como lo sentir?	0	1	2	3	4	5	6