

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: _____

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:

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| Yes | No | | Yes | No | |
| <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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MEDICAL RECORDS RELEASE

TO:

PATIENT NAME:

SOCIAL SECURITY #:

D.O.B.:

Please release all medical records that you have on file to Dr. _____.
Please send the records to address checked below:

NORTHWEST

Las Vegas Urology, LLP
2901 North Tenaya Way
Suite 100

Las Vegas, NV 89128
Tel: 702.233.0727
Fax: 702.233.4799

WEST OFFICE

Las Vegas Urology, LLP
7200 Cathedral Rock
Suite 180

Las Vegas, NV 89128
Tel: 702.341.9000
Fax: 702.341.5864

If you have any questions, please contact our office at the number listed above.

Patient signature: _____

Date: _____

Witness: _____

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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)

Las Vegas Urology

ADULT AND PEDIATRIC UROLOGY

DIPLOMATES, AMERICAN BOARD OF UROLOGY

Las Vegas Urology, Privacy Practices

I have received a notice of their Privacy Practices

Today's date

Print your name

Sign your name

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

Las Vegas Urology

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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.