COMPREHENSIVE UROLOGY

Today's Date: _____

PATIENT INFORMATION

☐Mr. ☐Mrs. ☐Miss. ☐Ms.

Patient's Last Name:	First Name:	Middle Name:
Is this your legal name? ☐Yes ☐No	If not, what is your legal/former name? ☐Yes ☐No	Sex: ☐M ☐F
Date of birth:	Age:	SSN:

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Race:		Ethnicity:
☐ American Indian/Alaska Native	☐ Other Pacific Islander	☐ Hispanic/Latino
☐ Asian	☐ White	☐ Non-Hispanic /Latino
☐ Black/African American	☐ Refuse to Report	☐ Other: _____
☐ Native Hawaiian		
Preferred Language:		

ADDRESSES HOME & WORK

Home Address:	City:	State	Zip code:
Home/Cell Phone Number:	**Email:**		
Employer Address:	City:	State:	Zip code:
Occupation/Position:	Employer/Business Phone Number:		

HOW DID YOU HEAR ABOUT OUR CLINIC?

☐ Family/Friend	☐ Hospital	☐ Online
☐ Insurance Plan	☐ Close to home/work	☐ Other

Where you referred to us by your doctor? ☐ YES ☐No

If yes, please write your doctor's name _____ and their phone number _____

Primary Physician's Name:

Phone Number:

INSURANCE INFORMATION

Define Coverage Type:

☐ Self-Pay (no insurance) ☐ Insurance ☐ Other Insured (spouse) ☐ Workers Comp

Insurance carrier:	ID:
Secondary Insurance carrier (if applicable):	ID:
Other Person Responsible for my bill:	
Name:	Relationship to patient:
Date of Birth:	Contact Phone Number:

IF A MINOR ONLY:

Fathers Name:	Mothers Name:

IN CASE OF EMERGENCY

Name of local friend or relative (not living with you):	Relationship to patient:	Phone Number:

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MEDICAL INFORMATION RELEASE FORM

This form is to allow Comprehensive Urology Medical Group, its physicians, and its staff to release the stated medical information to designated family and/or friends.

I, _____ hereby authorize Comprehensive Urology Group to provide information about my medical information to family or friends that I name in this document. Comprehensive Urology may release information relating to the items checked below.

Please list the persons allowed to receive information and your relationship.

1. _____
2. _____
3. _____
4. _____
5. _____

Information to be released:

☐ Appointment information
☐ Lab results
☐ General health inquiry
☐ Surgery pre-op and post-op instructions
☐ Request copies of medical records
☐ Other _____

By checking the item(s) above, I acknowledge that I have authorized Comprehensive Urology Medical Group to release such information. I have read and reviewed the foregoing release and understand its contents.

I acknowledged that Comprehensive Urology Medical Group is hereby released from any all claims, demands, or liabilities arising out of or in any way related to the disclosure of the information above.
I also have the right to change or revoke this request at any time.

_____
Print Patient's Name

_____ _____
Patient's Signature Date

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AUTHORIZATION TO PAY MEDICAL & SURGICAL BENEFITS
DIRECTLY TO ATTENDING PHYSICIAN

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Comprehensive Medical Group (providers of service, including but not limited to; Drs. Dino Deconcini, Kia Michel, Alex Nourian, Jeannie Su, and/or Comprehensive Urology Medical Group) all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and laboratory in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and lab's expenses.

This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and full understand this agreement.

_____
Print Patient's Name

_____ _____
Patient's Signature Date

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PATIENT CREDIT CARD ON FILE AGREEMENT

We have implemented a new billing policy which improves efficiency and minimizes the number of statements that are generated to you monthly. This policy enables you to retain your credit card information securely on file on an encrypted web-site. In providing us with your credit card information, you are giving Comprehensive Urology Medical Group permission to automatically charge your credit card on file for your co-pay [or any other patient(s) you have listed on this form] at time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays*:* Co-pays are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, we will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize Comprehensive Urology Medical Group, to charge co-pays and outstanding balances on my account to the following credit card:

☐ *VISA*
☐ *MASTERCARD*
☐ *AMERICAN EXPRESS*
☐ *DISCOVER*

Credit Card Holder's Name: _____

Last 4 digits of Credit Card: _____ *Expiration Date:* (MM/YYYY): ___/_____ *CVC:* _____

If you wish to leave this credit card on file for other patient(s), please print name(s) below:

Patient Full Name: _____

Patient Full Name: _____

Patient Signature: _____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices.

Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice.

I, _____, have received a copy of this office's *Notice of Privacy Practices*.

_____
Print Patient's Name

_____
Patient's Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please specify) _____

COMPREHENSIVE UROLOGY

NOTICE OF PRIVACY PRACTICES
COMPREHENSIVE UROLOGY MEDICAL GROUP
Effective January 1, 2005

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. Our practice uses health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our practice.

HOW OUR PRACTICE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

For Treatment. Our practice may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as physicians, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and not how you respond to these actions.

For Payment. Our practice may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. Our practice may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to member of the medical staff, risk or quality improvement personnel, and others in order to:

- evaluate the performance of our staff;
- assess the quality of care and outcomes in your case and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide

Appointments. Our practice may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required by Law. Our practice may use and disclose information about as required by law. For example, our practice may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be used to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donations. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

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Research. Our practice may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and Safety. Your health information may be disclosed to avert a serious threat to health or safety of you or any other person pursuant to applicable law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Worker's Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation.

Other Uses. Other uses and disclosures will be made only with your written authorization, and you may revoke the authorization except to the extent of our practice has taken action in reliance on such.

YOUR HEALTH INFORMATION RIGHTS

You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 C.F.R. 164.522; however, our practice is not required to agree to a requested restriction;
- obtain a paper copy of the notice of information practices upon request;
- inspect and obtain a copy of your health record as provided for in 45 C.F.R.164.524;
- request that your health record be amended as provided in 45 C.F.R. 164.526;
- request communications of your health information by alternative means or at alternative locations; and
- receive an accounting of disclosures made of your health information as provided by 45 C.F.R. 164.528.

COMPLAINTS

You may complain to our Privacy Officer and/or to the Department of Health and Human Services if you believe your privacy right have been violated. You will not be retaliated against for filing a complaint.

OBLIGATIONS OF OUR PRACTICE

Our practice is required by law to:

- maintain the privacy of protected health information;
- provide you with this notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this notice;
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed; and
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.
- notify you if a breach in the security of your Protected Health Information (PHI) occurs

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Our practice reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by in-office handouts or via our website.

CONTACT INFORMATION

If you have any questions of complaints, please contact:
Privacy Officer: Lina Barricello

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Name: _____ **Date:** _____

DOB: _____

Welcome to our office or welcome back. We want to provide you with the best possible care, so please take a few moments to complete the following pages. Thank you.

What is the main urologic issue you would like to discuss?

_____

_____

_____

Do you have any other urologic issues you would like addressed?

_____

_____

_____

_____

Please list any medical conditions you have (high blood pressure, diabetes, etc.:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any prior surgeries or procedures:	**Date of surgery/procedure:**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Please list any current medications/herbal supplement:	**Dose:**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

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Name: _____ **DOB:** _____

Please list any medications you are allergic to: **Reaction:**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Please list any serious illness in your family:

Relative: _____ Illness: _____
Relative: _____ Illness: _____
Relative: _____ Illness: _____

FEMALE PATIENTS ONLY:

Ashkenazi Jewish Ancestry? Yes ☐ No ☐
Have you or any one in your family been diagnosed with ovarian cancer? Yes ☐ No ☐
Have you or any one in your family been diagnosed with pancreatic cancer? Yes ☐ No ☐
Have you or any one in your family been diagnosed with breast cancer <50 years old? Yes ☐ No ☐
Have you or any one in your family been diagnosed with any other type of cancer(s)? If yes, please indicate what type: _____ Yes ☐ No ☐

Number of pregnancies: ____ Number of deliveries: _____
Vaginal or C-section: _____ Birth weights: _____
Age of menopause: _____ Hormone replacement: _____

****

Please indicate your current marital status:
Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐

On average, how many alcoholic beverages do you have in a week? _____
Did you ever smoke on a regular basis? Yes ☐ No ☐
If yes, how many packs a day? For how many years?
Are you still smoking? Yes ☐ / No ☐ If no, when did you quit? _____
Have you had a colonoscopy in the last 5 years? Yes ☐ / No ☐
Do you have an Advanced Care Plan in place? Yes ☐ / No ☐ /No ☐ (my cultural and/or spiritual beliefs preclude me from having a discussion regarding advance care planning)
If yes… ☐ Living Will ☐ Do Not Resuscitate ☐ Power of Attorney

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Name: _____ **DOB:** _____

REVIEW OF SYSTEMS

Do you or have you recently had any problems related to the following?
If your answer is Yes, please explain in the space provided.

	YES	NO
Constitutional		
Fever	☐	☐
Chills	☐	☐
Weight Loss	☐	☐
Other		
Eyes		
Blurred vision	☐	☐
Glaucoma	☐	☐
Other		
Ears/Nose/Throat		
Difficulty hearing	☐	☐
Sinus problems	☐	☐
Difficulty swallowing	☐	☐
Other		
Respiratory		
Shortness of breath	☐	☐
Chronic cough	☐	☐
Other		
Cardiovascular		
Chest pain	☐	☐
Heart attack	☐	☐
High blood pressure	☐	☐
Other		
Genitourinary		
Frequent urination	☐	☐
Wake to urinate	☐	☐
# of times		
Slow stream	☐	☐
Push to urinate	☐	☐
Retaining urine	☐	☐
Painful urination	☐	☐
Urinary tract infection	☐	☐
Incontinence	☐	☐
# of pads per day		
Sexual activity	☐	☐
Low libido	☐	☐
Difficulty reaching orgasm	☐	☐
Pain with intercourse	☐	☐
Vaginal dryness	☐	☐
Other		

	YES	NO
Gastrointestinal		
Abdominal pain	☐	☐
Nausea/vomiting	☐	☐
Constipation/diarrhea	☐	☐
Other		
Musculoskeletal/Neck		
Back pain	☐	☐
Leg pain	☐	☐
Muscle pain	☐	☐
Other		
Neurological		
Migraines	☐	☐
Dizzy spells (Lightheadedness)	☐	☐
Numbness/tingling	☐	☐
Other		
Integumentary		
Skin rash	☐	☐
Skin lesion(s)	☐	☐
Breast (lumps, etc.)	☐	☐
Other		
Allergic/Immunologic		
Hay fever	☐	☐
Environmental allergies	☐	☐
Food allergies	☐	☐
Other		
Hematologic/Lymphatic		
Blood clotting disorder	☐	☐
Anemia	☐	☐
Swollen glands	☐	☐
Other		
Endocrine		
Excessive thirst	☐	☐
Too hot/cold	☐	☐
Tired/sluggish	☐	☐
Other		
Psychological		
Depression	☐	☐
Anxiety	☐	☐
Other		

_____ _____

Physician Signature Date