



TRI VALLEY UROLOGY MEDICAL GROUP

PATIENT REGISTRATION

Date: _____ Social Security #: _____

Patient's Last Name: _____ First Name: _____ M.I.: _____

Mailing Address: _____ City: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____

Telephone #: _____ Cell Phone #: _____

Referring Physician: _____

Guarantor/Subscriber: _____

Work #: _____ Occupation: _____

Marital Status: _____ Spouse's Name: _____

Spouse's Date of Birth: _____ Age: _____ S.S. #: _____

Primary Insurance: _____

I.D. #: _____ Group #: _____

Nearest Relative Not Living With You: _____

Telephone #: _____

Reason for Seeing Doctor:

Signature of Patient/Guarantor: _____



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Today's Date: _____ Name: _____

Reason for this visit:

On a scale of 1-10, how severe is the problem: 1 2 3 4 5 6 7 8 9 10

Approximately when did you first notice the problem? _____

How long does the problem last? _____

Is the problem constant or variable? _____

Does the problem interfere with your normal function? YES NO

Does anything help the problem?

Does anything make the problem worse?

CURRENT URINARY SYMPTOMS:

Hesitancy starting urinary stream	YES	NO
Decreased force of stream	YES	NO
Interrupted stream	YES	NO
Dribbling after urination	YES	NO
Blood in urine	YES	NO
Urgency to urinate	YES	NO
Burning sensation with urination	YES	NO
Increased frequency of urination (_____/day)	YES	NO
Getting up at night to urinate (_____/times)	YES	NO
Erectile Dysfunction (ED) (for men)	YES	NO



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URINARY INCONTINENCE SYMPTOMS: (loss of urine)

With coughing, laughing, sneezing	YES	NO
With activity or exercise	YES	NO
With standing	YES	NO
While sleeping	YES	NO
With an urgency or warning prior	YES	NO
All the time	YES	NO
Protective pads worn (____pads/day)	YES	NO

CURRENT MEDICAL PROBLEM: (eg. Diabetes, heart disease, kidney disease, cancer, arthritis, etc.)

CURRENT MEDICATIONS: (name and dosage)

PAST SURGICAL HISTORY: (what type and approximately when)

OTHER PRIOR HOSPITALIZATIONS: (when and why)

ALLERGIES: YES NO (If yes, please list allergies and type of reactions)



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FINANCIAL POLICY FOR PATIENT CARE SERVICES

To help us provide the most efficient and reasonable health care services, it is necessary for us to have a Financial Policy stating our requirements for payment of services provided to our patients. Patients are responsible for the payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have accurate and complete insurance information. The balance due is still your responsibility if we have not received payment from the insurance company within 30 days. If we receive duplicate payment from the insurance company, we will then prepare a refund for any overpayment and send it to you

If you have insurance and we file with your carrier, we ask that you pay ahead of time on the balance which is your responsibility according to your plan, i.e., any deductible, copay, coinsurance amounts. For Medicare patients, we will wait until we have received payment and then bill the patient for any remaining balance due. Since we are not a party to the agreement between you and your insurance company, we ask that you assist us in contacting them in the event that services are not paid within 30 days.

For Worker's Compensation claims, it is our policy to bill your employer or the Worker's Compensation carrier for services rendered. If you are covered we will accept the payment made by Worker's Compensation as payment in full. If Worker's Compensation denies payment or goes into litigation, the entire balance will become your responsibility and will be due within 10 days from the date of denial. It is your responsibility to contact us with the name and address of your employer or insurance company at the time of appointment is made and provide the office with a copy of your Notice of Compensation Payable Letter from Worker's Compensation.

If you do not have insurance and are not covered by either Medicare or Medicaid, you will be considered a "SELF PAY" patient. Payment is due in full at the time of service. This assists us in cutting down on billing and operating expenses.

Patient "No Show" and cancellations are a tremendous loss for a practice. Please help our office reduce those losses by canceling within 24 hours if you cannot keep your appointment. Failure to give notice 24 hours prior to your appointment will result in a \$25 fee to be paid by patient.

We ask that you read this policy and aid us in keeping our costs down by ensuring that we are able to be reimbursed for our services on a timely basis. We welcome the opportunity to discuss any aspects of our financial policy.

To help in this policy we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company and to keep all changes up to date.
2. Make payment at the time of service for the entire balance if you are a "SELF PAY" patient, or the amount of any deductible, copays that may be due.
3. Discuss your account balance only with the check-out or our business staff. Please do not discuss the financial aspects of your care with the physician(s). It is important for them to be allowed to practice medicine and provide patient care. Please work with the rest of the office staff on any account questions or problems you may have. If they cannot help you or answer your questions to your satisfaction, then please, do not hesitate to contact the office manager.

Patient Signature

Date

Staff Signature



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- * Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- * Obtain payment from third-party payers.
- * Conduct normal health care operations such as quality assessment and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date:	Initial:	Reason:
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TRI VALLEY UROLOGY MEDICAL GROUP

COMMUNICATION CONSENT AGREEMENT

I UNDERSTAND THAT UNDER FEDERAL LAW (HIPAA), THIS MEDICAL OFFICE MAY **NOT** RELEASE ANY MEDICAL INFORMATION TO ANY INDIVIDUAL, WITHOUT MY EXPRESS WRITTEN PERMISSION. LAW ENFORCEMENT AND COURT ORDER ARE TWO EXCEPTIONS TO THIS REQUIREMENT. I, THEREFORE, **GIVE** PERMISSION TO THIS OFFICE TO RELEASE MEDICAL INFORMATION ON MY BEHALF, TO THE FOLLOWING PERSON(S):

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____ AGE: _____ BIRTH DATE: _____

DRIVERS LICENSE #: _____ S.S #: _____

OTHER FORMS OF IDENTIFICATION: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____ AGE: _____ BIRTH DATE: _____

DRIVERS LICENSE #: _____ S.S #: _____

OTHER FORMS OF IDENTIFICATION: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____ AGE: _____ BIRTH DATE: _____

DRIVERS LICENSE #: _____ S.S #: _____

OTHER FORMS OF IDENTIFICATION: _____

PATIENT SIGNATURE: _____ DATE: _____