Some Important Reminders:

1. Please have all your insurance cards and forms of ID (State issued or military ID) for your appointment. **(We will not see you if you do not have your insurance cards or form of ID.)** As a reminder, we are not preferred providers for the following insurances:

AETNA PPO
ONE HEALTH PPO
ASSURANT PPO

We will continue to see patients who have the aforementioned insurances. We will be happy to bill you insurance, but you will have a higher deductible and/or out-of-pocket expense. It is possible that you may not have non- participating benefits at all. If you have any questions about your coverage and/or benefits, please call your insurance and inquire about non- participating coverage.

2. Please complete all paperwork. **(If your paperwork is not completed, it could delay your appointment.)**

3. If you had any recent radiology tests or blood work please inform the front office. If you have had any radiology tests please bring your films with you to your visit.

PATIENT REGISTRATION FORM

PATIENT'S ACCOUNT #	GUARANTOR	CHART NUMBER	CATEGORY
NAME (LAST, FIRST INIT.)	HOME PHONE NO.	DOB	DL#
ADDRESS	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO.	SEX (M/F)	MARITAL STATUS	
OCCUPATION	EMPLOYER	NATURE Of BUSINESS	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER PHONE NO.	REFERRAL	IN CASE Of EMERGENCY CONTACT PERSON AND PHONE NO.	

INSURANCE INFO.

PLEASE PROVIDE COPY OF INSURANCE CARD

INSURANCE NAME & ADDRESS			
SUBSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO
ANNUAL DEDUCTIBLE	DEDUCTIBLE MET / CO-PAYMENT	% OF COVERAGE	PAY PLAN
CLAIM NUMBER	INSURED'S NAME	INSURED'S DATE Of BIRTH	
INSURED'S SEX (M/fl	INSURED'S PHONE NO.	INSURED'S SOCIAL SECURITY NO.	
INSURED'S ADDRESS	CITY	STATE	ZIP CilOE
INSURED'S EMPLOYER		EMPLOYER'S PHONE NO.	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

INSURANCE INFO.

PLEASE PROVIDE COPY Of INSURANCE CARD

INSURANCE NAME & ADDRESS			
SUBSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO
ANNUAL DEDUCTIBLE	DEDUCTIBLE MET / CO-PAYMENT	% OF COVERAGE	PAY PLAN
CLAIM NUMBER	INSURED'S NAME	INSURED'S DATE Of BIRTH	
INSURED'S SEX (M/F)	INSURED'S PHONE NO.	INSURED'S SOCIAL SECURITY NO.	
INSURED'S ADDRESS	CITY	STATE	ZIP CODE
INSURED'S EMPLOYER		EMPLOYER'S PHONE NO.	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

I authorize payment of medical benefits be made directly to the physician provider for services rendered.

DATE SIGNED (Insured or Authorized)

I authorize any insurance company, organization, employer, hospital. physician, or pharmacist to release any information to this claim and the expenses reported.

DATE SIGNED (Insured or Authorized)

I understand that I am responsible for all fees at time of service regardless of insurance coverage including any legal costs incurred in the collection of this account if delinquent.

Date Signed (Insured or Authorized)

Urological Medical Group of North Orange County
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.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.

- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer: Rondi Kaspari-Muller

Phone number: 714-870-5970

Fax number: 714-870-4792

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on 01/01/2015.

Urological Medical Group of North Orange County
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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

- < Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- < Obtain payment from third-party payers
- < Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. 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 to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices Acknowledgment but was unable to do so as documented below:

Date:	Initials:	Reason:

HIPAA Authorization / Release of Medical Information Form

Patient Name:_____ Date of Birth:_____

BY SIGNING BELOW, I AUTHORIZE *Urological Medical Group of North Orange County* TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

Relationship: Name of Designated Person(s):

Spouse: YES NO _____

Children: YES NO _____

Caregivers: YES NO _____

Parents: YES NO _____

Persons listed above may also have permission to pick up prescriptions, x-rays, etc. and I understand that *Urological Medical Group of North Orange County* will ask for identification of the person picking up medical information.

Urological Medical Group of North Orange County may leave a detailed message, such as appointment reminders and test results on my voicemail:

Home: YES NO Phone #_____

Cell: YES NO Phone #_____

Work: YES NO Phone #_____

I understand that I have the right to revoke this authorization in writing at any time by giving written notice to the practice's Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the Personal Health Information (PHI) or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the physician from a third party.

This authorization shall be in force and effect until superseded by a later-dated authorization or written revocation submitted to the practice's Privacy Officer.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

(Copy Available Upon Request)

Patient Name:_____ Date:_____

DOB:_____ Primary Care Physician:_____ Referred By:_____

Pharmacy Name (Street / City):_____

Reason for seeing doctor: _____

Height: _____ **Weight:** _____ **Blood Pressure** _____/_____

Medication Allergies: _____

List of Current Medications: (continue on back if more space is needed)

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

5._____ 6._____ 7._____ 8._____

Surgical History / Date

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Colonoscopy (date) _____ Pneumonia Vaccination (date) _____

Medical History:

Diabetes Emphysema Heart Disease Heart Arrhythmia Hepatitis Parkinson's Disease Stroke/TIA

High Blood Pressure Elevated Cholesterol MS Other: _____

Family History: (circle all that apply and family member it applies to.)

Kidney Stones Kidney Cancer Heart Disease Prostate Cancer Other: _____

Social History: (circle all that apply)

Marital Status: Single Married Divorced Widowed Separated

Smokeless Tobacco YES _____ NO _____

Smoke: 1. YES packs/day _____ #of years_____ 2. NEVER 3. QUIT when? _____ packs/day_____

Caffeinated Drinks (coffee, soda, etc.): 1. YES drinks/day_____ 2. NO

Alcohol: 1. YES drinks/week_____ 2. NEVER 3. QUIT when? _____

Recreational Drugs: YES _____ NO _____ List type: _____

Blood Transfusion History: YES NO

Ethnicity / Race: White Hispanic Black Asian Native American Other: _____

Preferred Language: English ____ Spanish ____ Chinese _____ German _____ Italian _____ Other _____

My Current Symptoms Include: (circle all that apply)

Constitutional:	Fevers	Chills	Weight Loss
Eyes:	Glaucoma	Blurred Vision	Double Vision
Ear/Nose/Mouth/Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat
Cardiovascular:	Chest Pain	Swollen Ankles	Irregular Heartbeat
Respiratory:	Shortness of Breath	Wheezing	Cough
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Change in bowel habits
Genitourinary:	Incontinence	Painful Urination	Blood in Urine
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles
Skin:	Rash	Itching	Skin Cancer
Neurological:	Numbness	Tingling	Dizziness
Heme/Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusion History

Signature: _____ Date: _____ Initial: _____ Date: _____

Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____