Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

PACIFIC UROLOGY

100 N. WIGET LANE, SUITE 290, WALNUT CREEK, CA 94598 - (925) 937-7740, FAX (925) 933-9868
2222 EAST STREET, SUITE 250, CONCORD, CA 94520 - (925) 609-7220, FAX (925) 689-3298
5201 NORRIS CANYON RD, SUITE 140, SAN RAMON, CA 94583 - (925) 830-1140, FAX (925) 275-0454

PATIENT INFORMATION

Please Print Clearly & Fill Out Completely

Last Name	First Name	Middle Initial
Date of Birth	Age	Social Security Number
Address		
City	State / Zip	Email
Home Phone ( ) -	Cell Phone ( ) -	Work Phone ( ) -

PHYSICIAN INFORMATION

Physician Who Referred You To Our Office	Diagnosis or Reason for Referral
Primary Care Physician	Physician You Are Seeing At Our Office

PRIMARY INSURANCE COVERAGE

Insurance Company Name	Insurance Care is in the Name of? ❑ Self ❑ Spouse ❑ Other _____

Complete the following information for the person whose name appears on the Insurance Card:

Name	Date of Birth	Social Security Number
Group #	Plan Name	
Policy ID #	Medical Group Name	Co-Pay $

Does your insurance require a referral to see a Specialist? ❑ NO ❑ YES (If YES, please give referral slip to Receptionist)

SECONDARY INSURANCE COVERAGE

Insurance Company Name	Insurance Care is in the name of? ❑ Self ❑ Spouse ❑ Other _____

Complete the following information for the person whose name appears on the insurance card:

Name	Date of Birth	Social Security Number
Group #	Plan Name	
Policy ID #	Medical Group Name	Co-Pay $

Does your insurance require a referral to see a Specialist? ❑ NO ❑ YES (If YES, please give referral slip to Receptionist)

EMERGENCY CONTACT

Name	Relationship	Phone

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize my physician and Pacific Urology (PU) to submit insurance claims on my behalf. I authorize my insurance company or its carriers to disclose any information requested by my physicians regarding claims for medical services they provide me. I authorize John Muir Medical Center, San Ramon Valley Medical Center or any other hospital where I may be a patient to release information requested by PU. I authorize PU to release information to physicians referred by PU. I authorize payments of assigned medical benefits to be paid directly to my physician and PU. I am responsible for deductibles, coinsurance, and non-covered items. I agree to pay any co-payments required by my insurance plan at the time of service. I understand that Pacific Urology does not bill tertiary insurances, other than Medicare or MediCal.

***** SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

PATIENT DEMOGRAPHICS

RACE / ETHNICITY

- ❑ Decline to Answer
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian / Pacific Islander
- ❑ White / Caucasian

GENDER / STATUS

GENDER: ❑ Male ❑ Female

MARITAL STATUS:

- ❑ Decline to Answer ❑ Single
- ❑ Divorced ❑ Married
- ❑ Domestic Partner ❑ Widow
- ❑ Other

PREFERRED LANGUAGE

- ❑ Decline to Answer ❑ Vietnamese
- ❑ English ❑ Chinese
- ❑ Spanish ❑ Russian
- ❑ French ❑ Tagalog
- ❑ Punjabi ❑ Italian
- ❑ Hindi ❑ Other
- ❑ Sign Language - Deaf

CONTACT PREFERENCE

Check <u>One</u>:
❑ HOME ❑ CELL ❑ WORK ❑ MAIL

OCCUPATION

Current or Previous:

PRACTICE SELECTION

What factors helped you choose our practice for your medical care? *(Check all that apply)*

- ❑ Referred by Physician
- ❑ Hospitalist Referral
- ❑ Convenient Location
- ❑ Comprehensive Services
- ❑ Reputation of Practice
- ❑ Reputation of Physicians
- ❑ Family/Friend Recommended
- ❑ Website
- ❑ Internet Search
- ❑ News Story
- ❑ Articles in Papers
- ❑ Newspaper Ad
- ❑ Community Event
- ❑ Social Media
- ❑ Speaker Program
- ❑ Other

May we keep you informed of PU news & events via confidential Email? ❑ Yes ❑ No Email:

PATIENT INFORMATION AUTHORIZATION – HIPAA PRIVACY

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). Completion of this form tells us your preferences with regard to telephone messages and whom you give authorization for our office to speak with on your behalf. Further authorization may be needed under more specific circumstances.

CONTACT PREFERENCE *(Check <u>ONE</u>):* ❑ HOME ❑ CELL ❑ WORK ❑ MAIL

Below…Please check <u>ALL</u> that apply:

HOME PHONE	**CELL PHONE**	**WORK PHONE**	**MAIL / EMAIL / FAX**
❑ OK to leave detailed message*****	❑ OK to leave detailed message*****	❑ OK to leave detailed message*****	Billing Statements & Correspondence will be mailed to your Home unless you provide alternate address:
❑ Leave message with call-back number only	❑ Leave message with call-back number only	❑ Leave message with call-back number only	❑ OK to contact you via Email **EMAIL:**
HOME # ( ) -	**CELL #** ( ) -	**WORK #** ( ) -	**HOME FAX #** ( ) - **WORK FAX #** ( ) -

***** *Either with any individual, other than yourself, whom answers the phone or on an answering machine.*

OTHER AUTHORIZED INDIVIDUALS

Other individuals I authorize to take messages or receive my Protected Health Information are:

NAME *(List <u>all</u> that apply)*	**RELATIONSHIP TO YOU**	**CONTACT INFO**
	Spouse / Significant Other	Phone: ( ) -
		Phone: ( ) -
		Phone: ( ) -
		Phone: ( ) -

I request the following <u>restrictions</u> to the use or disclosure of my health information:

My signature below authorizes Pacific Urology (PU) to use my Protected Health Information per my instructions above and acknowledges that I have received PU's Notice of Privacy Practices & I consent to the use and disclosure of my health information for treatment, payment or healthcare operations.

***** SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient
PU Witness Name / Signature	Date

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

FINANCIAL POLICIES

CO-PAYMENT, DEDUCTIBLE & CO-INSURANCE COLLECTION POLICY

We are required by law, and your health plan, to collect co-payments at the time of service. Co-payments are required each time you are seen by the physician or nurse practitioner. This co-payment is for the limited office visit charge that covers the medical management that the physician provides in overseeing your treatment. **This policy is established by your health plan** and is explained in your benefits handbook and is usually printed on your insurance card.

It is our policy to collect coinsurance and deductibles at the time of service. Prior to any scheduled hospital procedure, any coinsurance and deductible will be collected at the time of the pre-operative visit. If you have any questions or concerns about your insurance coverage, please call your insurance carrier directly.

It is the patient or guardian's responsibility to determine if the doctor you are seeing is a contracted provider with your insurance. If required insurance cards, co-pays and/or authorizations are not provided at the time of your service, your appointment may be rescheduled.

INSURANCE REIMBURSEMENT & BILLING POLICIES

BILLING STATEMENT: We are happy to bill your insurance as a courtesy to you. Each month you will receive a statement from us describing your current balance and any charges incurred during the statement month. You can submit this bill yourself, along with the appropriate forms, to your insurance carrier. Or, as many of our patients prefer, we will bill your primary and secondary insurance carrier for you. Pacific Urology does not bill tertiary insurance coverage other than Medicare or MediCal. For us to do so, you must sign the "*Release of Information & Assignment of Benefits*" statement on the first page of this packet. We will bill your insurance a maximum of three (3) times, then the responsibility for handling issues with insurance reimbursement rests with you. You are ultimately responsible for payment of your bill.

When you receive our monthly statement, payment is expected within thirty (30) days. Payments are considered delinquent after sixty (60) days. If Pacific Urology or its physicians are not contracted with your insurance carrier, you are considered a "self-pay" patient and payment is due in full at the time of service.

ATTORNEY FEES AND COLLECTION COSTS: If any legal action is necessary to enforce or interpret the terms of these billing policies, the prevailing party shall be entitled to reasonable attorneys' fees, costs and necessary disbursements in addition to any other relief to which that party may be entitled. You agree by your signature below to pay all collection costs, including attorneys' fees on all delinquent payments.

SUSPENSION OF CARE (EXCEPT EMERGENCY CARE): If no payment is received after ninety (90) days, we may be forced to suspend all but emergency care until a payment is received. Please discuss all billing issues directly with our billing department.

ADMINISTRATIVE FEES

Due to the high volume of requests we receive, we charge administrative fees for copying of all or part of a medical record, completion of disability forms, printouts of your billing statements, and other such administrative requests. The current fee schedule (which is subject to change) is:

Printing of Medical Records Fee:	$ 25.00 (extensive records will be charged at a higher rate)
Established Patient No-Show:	$ 25.00
New Patient No-Show:	$ 50.00
Reschedule of Surgery:	$100.00
Disability Forms:	$ 25.00
Pre-Authorization of Medications:	$ 25.00
Returned Check Charge:	$ 25.00

My signature below indicates that I have read, understood and agreed to the Financial Policies of Pacific Urology

Signature: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

A copy of this page will be provided to you at your request. *Revised: 07/15/2013*

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

PRE-VASECTOMY QUESTIONNAIRE:

How old are you? _____

How old is your wife? _____

How many children do you have? _____ **Are they healthy?** _____

How long have you been married? _____

How tall are you? _____ **How much do you weigh?** _____

BRIEF MEDICAL HISTORY			
	YES	**NO**	**Comment**
Do you have any allergies?	☐	☐	
Do you take any medications:	☐	☐	
a) Medication:	☐	☐	What? Dosage?
b) Medication:	☐	☐	What? Dosage?
c) Medication:	☐	☐	What? Dosage?
d) Medication:	☐	☐	What? Dosage?
Do you have any medical problems?	☐	☐	
(Please elaborate):			
Have you ever had surgery?	☐	☐	
(Please elaborate):			
Have you ever had a urologic problem?	☐	☐	
Have you ever had a urinary tract infection?	☐	☐	
Have you had an infection of the prostate, epididymis or testicle?	☐	☐	
Do you have a problem with bleeding?	☐	☐	
Do you take aspirin, Motrin, Ibuprofen, Advil or similar medications?	☐	☐	

Any comments or things you think we should know? _____

_____

_____

PREFERRED OUTSIDE PHARMACY
Name & Address (Location) of Preferred <u>OUTSIDE</u> Pharmacy: Is this is a MAIL ORDER PHARMACY? ☐ Yes ☐ No Please list a local pharmacy for urgent prescriptions if primary is a mail order. Name & Address of LOCAL pharmacy:

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First *Middle Initial* *Last*

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PRE-VASECTOMY INSTRUCTIONS:

1. No aspirin or aspirin-like products like Ibuprofen, Motrin, Advil, etc. for a week before the vasectomy. These medications have anti-platelet effects and make bleeding more likely after the vasectomy.

2. Please shave the entire scrotum from the base of the penis to the bottom of the scrotum the night before or morning of the vasectomy. It is usually more comfortable to shave it wet with shaving cream rather than dry.

3. If you can, take a warm shower before coming in for your vasectomy. It relaxes the scrotum and makes the vas easier to identify.

4. You may want to stock up on ice packs or bags of frozen peas or frozen corn. Your Urologist will tell you how long you need to ice your scrotum.

5. Wear tight briefs or an athletic supporter for 48 hours after the vasectomy.

6. If you are taking Valium, please take 60 minutes before the procedure. Please make sure someone is able to drive you to and from the appointment.