LAS VEGAS UROLOGY

Doctor You Are Scheduled With Today: _____

Patient Demographics

Social Security#: _____

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

E-Mail Address: _____

Employer: _____

Employer Address: _____

_____

Home Tel: _____

Work Tel: _____

Cell #: _____

Sex: (Female) or (Male)

Date of Birth: _____

Marital Status: _____

Emergency Contact/Name and Tel#

_____

Race: Please choose one:
Asian
Native Hawaiian
Other Pacific Islander
Black/African American
American Indian/Alaska Native
White
More than 1 Race
Unreported/Refused to Report

Ethnicity: Please choose one:
Hispanic/Latino Not Hispanic/Latino
Unreported/Refused to Report

Preferred Language: _____

Spouse Name: _____

Date of Birth: _____ **Phone #:** _____

Spouse Employer: _____

Spouse SS # _____

Physician Information

Referring Doctor: _____

Primary Care Doctor: _____

Other Physicians:

Insurance Information

Name of Insurance: _____ Subscriber Name: _____

Relationship to subscriber: _____ Subscriber Date of Birth: _____

Policy Number: _____ Group Number: _____

Secondary Insurance

Name of Insurance: _____ Subscriber Name: _____

Relationship to subscriber: _____ Subscriber Date of Birth: _____

Policy Number: _____ Group Number: _____

This form must be completed 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 my insurance company to pay directly to the doctor the amount due on my claim for services rendered to my dependent or me. Payment for co-pays and deductibles are required at the time services are rendered. 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 were such that it is not covered by the policy, I will be responsible to the doctor for payment of the entire bill.

Patient Signature: _____ **Date:** _____

LAS VEGAS UROLOGY

Name: _____

Pharmacy: _____ DOB: _____

Pharmacy Tel #: _____ Date: _____

ALLERGIES: Please list all medication allergies - If None, check here: _____

_____

_____

Please list all medications you currently take, including dosage and frequency:
If none, check here: _____

_____

_____

_____

SURGICAL HISTORY: Please list all surgeries, including dates:
If none, check here: _____

_____

_____

_____

MEDICAL HISTORY: Check all conditions for which apply:

_____Diabetes mellitis

_____Hypertension

_____Emphysema/COPD

_____Asthma

_____Glaucoma

_____Thyroid disease

_____Heart troubles

_____Ulcer disease

_____Diverticulosis

_____Colitis

_____Stroke

_____Liver disease/cirrhosis/hepatitis

_____Anemia/bleeding disorders

_____Gout

_____Cancer; please list site of origin _____

_____Other

FAMILY HISTORY: Please list medical conditions present in your family.

Mother:	Father:	Siblings:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY: Check all that apply:

Marital status: ____Married ____Single ___Divorced ___ Widowed ___Separated
Smoking: ____Current Smoker ____Former Smoker ____Never Smoked ____Unknown
Alcohol: _____Never _____Quit _____Yes _____Drinks per day
Caffeinated drinks: _____per day
Blood transfusion: _____ Yes _____ No
Language spoken: _____
Race: _____
Ethnic origin: _____

REASON FOR VISIT: Please write the reason you are seeing the Urologist, and your current symptoms:

_____

_____

_____

UROLOGY HISTORY: Check all that apply:

_____Burning with urination
_____Incontinence
_____Chronic urinary tract infections
_____Elevated PSA
_____Awakening at night to urinate
_____History of urologic cancer:
_____History of kidney stones
_____Other: _____

_____Blood in urine
_____Change in urinary frequency
_____Problems with erections
If yes, please list date:_____
If yes, how many times: _____
If yes, list site: _____

If you have had any diagnostic tests related to this visit, please list facility and test:

_____

_____

Height: _____ Weight: _____

REVIEW OF SYSTEMS: Check all that apply

_____Recent weight loss	_____Night Sweats	_____Chills
_____New onset seizures	_____Headache	_____Change in sensation
_____Blurred vision	_____Double vision	_____Change in acuity
_____Excessive thirst	_____Fatigue	_____Hot flashes
_____Blood in stools	_____Black stools	_____New onset diarrhea
_____New onset chest pain	_____Palpitations	_____Shortness of breath while lying flat
_____New onset swelling	_____Cyanosis	_____Leg discomfort
_____New onset of rash	_____Itching	_____Jaundice
_____New onset joint pain	_____Swelling	_____Decreased range of motion
_____New onset cough	_____Coughing of blood	_____Shortness of breath
_____New onset paleness	_____Weakness	_____Easy bruising
_____New onset depression	_____Anxiety	_____Suicidal ideation

_____

Signature Date

LAS VEGAS UROLOGY

International Prostate Symptom Score

Patient Name _____ **Date of Birth** _____ **Date** _____

Please answer the questions below with a ranking of your symptoms.	Not at all. 0	Less than 1 time in 5. 1	Less than half the time. 2	About half the time. 3	More than half the time. 4	Almost always. 5	Your Score:
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when urinating?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. Nocturia (Night Time) Over the past month, how many times did you usually get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	

Quality of life due to urinary symptoms. If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	Delighted 0	Pleased 1	Mostly Satisfied 2	Mixed Feelings 3	Mostly Dissatisfied 4	Unhappy 5	Terrible 6

LAS VEGAS UROLOGY

PHARMACY INFORMATION

Date: _____

Preferred Pharmacy

Pharmacy Phone Number

Address

I hereby authorize the above pharmacy to transmit information through electronic prescribing. This authorization shall continue and be in full force and in effect until revoked in writing by me.

Patient Name

Date of Birth

SiGNATURE *Date*

Patient Signature

MEDICAL RECORDS RELEASE FORM

DATE: _____ **STAT REQUEST ( )**

TO: _____

FAX#: _____

Patient Name: _____

Patient Address: _____

DOB: _____ SSN: _____

Please release: ( ) ALL Medical Records ( ) Labs ( ) Radiology Reports

( ) All Doctor Consultation Notes

( ) 7500 Smoke Ranch Rd., #200
Las Vegas, NV 89128
(702) 233-0727
(702) 233-4799 – FAX

( ) 7200 Cathedral Rock Dr., #180
Las Vegas, NV 89128
(702) 341-9000
(702) 341-5864 – FAX

( ) 7150 W. Sunset Rd., #201A
Las Vegas, NV 89113
(702) 233-0727
(702) 233-4799 – FAX

( ) 4 Sunset Way, #B-6
Henderson, NV 89014
(702) 454-6226
(702) 454-7290 – FAX

( ) 1701 N. Green Valley Pkwy, #10-C
Henderson, NV 89074
(702) 896-9600
(702) 896-9606 – FAX

( ) 9053 S. Pecos Rd., #2900A
Henderson, NV 89074
(702) 735-8000
(702) 735-4795 – FAX

( ) 8915 S. Pecos, #19A
Henderson, NV 89074
(702) 341-9000
(702) 341-5864 – FAX

( ) 5320 S. Rainbow Blvd., #272
Las Vegas, NV 89118
(702) 948-1199
(702) 948-1198

_____ Date:
Patient Signature

_____ Date
Witness Signature

LAS VEGAS UROLOGY

A BRIEF LOOK AT ARBITRATION FOR THE PATIENT

Introduction

Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association, and noted to be a favored method of resolving disputes by the United States Supreme Court.

If you are unfamiliar with arbitration in general, the information included here provides some of the basic principles of arbitration.

What is arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and the doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After a hearing, which is usually less formal than a court proceeding, the arbitrator makes the decision ("award"). Although the procedures are different, generally the same laws and same measure of damages which apply in court proceedings also apply in arbitration.

Does arbitration prevent you from making a claim?

No. By selecting arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does it prevent you from obtaining a financial award?

No, Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim he or she will determine a damage award.

The United States Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

LAS VEGAS UROLOGY

A BRIEF LOOK AT ARBITRATION FOR THE PATIENT, P. 2

May I be represented by an attorney of my choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who is bound by this agreement?

If you chose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by the doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by the doctor. likewise, the doctor or anyone suing on behalf of a doctor, is bound.

What does arbitration cost?

In general, arbitration is less expensive than court actions. The arbitrator's fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If either party does not like the arbitration result, could there still be a jury trial in court?

Generally, the answer is "No." The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed, and potentially reversed ("Vacated") by a court in limited circumstances.

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators). who then select a third. neutral arbitrator, These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of tria! and the publicity that may accompany judicial proceedings.

Our goal, of course. is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

LAS VEGAS UROLOGY

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article I: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article II: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by the Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article III: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. Mail, postage prepaid, to all parties, describing the claim against the physician, the amount of damages sought, and the names and addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be goverened pursuant to Nevada Revised Statues (NRS) 38.206-382.48, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9U.S.C. § § 1-4) and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article IV: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or enforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Nevada and Federal law.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE I OF THIS CONTRACT. YOUR SIGNATURE INDICATES THAT OUR OFFICE HAS PROVIDED YOU WITH THE DOCUMENT "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT."

SIGNATURE	*Date*	*SIGNATURE*	*Date*
Physican or Duly Authorized Representative		*Patient Signature*	
	Date	*PRINT*	*Date*
Physician Name		*Print Patient Name*	
SIGNATURE	*Date*	*SIGNATURE*	*Date*
Translator Signature		*Patient Representative (if applicable)*	
SIGNATURE	*Date*	*PRINT*	*Date*
Print Translator Name		*Name and Relationship to Patient*	

A signed copy of this document is to be given to the patient. The original is to be filed in Patient's medical records.

LAS VEGAS UROLOGY

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA 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.

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 and adequate record.
3. NOTE: Uses and disclosures for TYP (Treatment, Payment or Operations) may be permitted without prior consent in an emergency.
4. Record of disclosures of Protected Health Information (Attached.)

I wish to be contacted in the following manner (check all that apply)

☐ ***Home Phone:_____***	☐ ***Work Phone:_____***
☐ ***OK to leave message with detailed information***	☐ ***OK to mail to my home address***
☐ ***Please leave message with call-back number only***	☐ ***OK to mail to my work address***
☐ ***OK to fax to number:_____***	☐ ***Leave message with person:_____***

SIGNATURE	*Date*
Patient Signature	

SIGNATURE
Patient (Guardian)

NAME
Print Patient Name

Date of Birth
Patient (Guardian)

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
LAS VEGAS UROLOGY

This form authorizes the release of Protected Health Information pursuant to 45 CFR Parts 106 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 requested. The undersigned acknowledges that without this authorization, LAS VEGAS UROLOGY may be unable to bill and collect from patient's 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 person or people to whom the medical information may also be disclosed.)
4. I acknowledge that I have the right to revoke authorization at any time, and 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 address below. The revocation will be 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 the claim.

_____ Date:
Patient Signature

Patient Name: DOB:

_____
Authority: If person signed is other than patient, state authority under which signature is made.

7500 Smoke Ranch Rd., #200
Las Vegas, NV 89128
(702) 233-0727
(702) 233-4799 – FAX

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