Urological Surgeons of Northern California, Inc.

PATIENT NAME: _____ DATE: _____
FIRST M.I. LAST

DATE OF BIRTH: _____ AGE: _____ ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ N/A - CHILD

STREET ADDRESS: _____ HOME PHONE: (_____) _____

CITY: _____STATE: _____ ZIP: _____ CELL PHONE: (_____) _____

PATIENT'S SOC. SECURITY #: _____ BUS. PHONE: (_____) _____

EMPLOYED BY: _____ OCCUPATION: _____

PREFERRED METHOD OF CONTACT: ☐ EMAIL ☐ PHONE: HOME / WORK / CELL

RACE: ☐ CAUCASIAN ☐ ASIAN ☐ AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

☐ HISPANIC ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ OTHER_____

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NON-HISPANIC OR LATINO

PREFERRED LANGUAGE: _____ EMAIL ADDRESS: _____

FAMILY PHYSICIAN: _____ PH: (_____) _____

REFERRED BY: _____ PH: (_____) _____

EMERGENCY CONTACT: _____ _____ (_____) _____
NAME RELATIONSHIP PHONE NO.

NAME OF INSURED: _____ INSURED'S DATE OF BIRTH: _____

INSURED EMPLOYED BY: _____ RELATIONSHIP TO PATIENT: _____

PHARMACY NAME: _____ PHARMACY LOCATION: _____

INS CARRIER-PRIMARY: _____ POLICY # _____ GROUP # _____

INS CARRIER-SECONDARY_____ POLICY #_____ GROUP #_____

WE BILL ALL INSURANCES IF PROVIDED WITH PROPER INFORMATION. PLEASE PRESENT ALL INSURANCE CARDS TO US.

MANAGED CARE PATIENTS: IT IS YOUR RESPONSIBILITY TO KEEP THIS OFFICE INFORMED REGARDING REFERRALS, AUTHORIZATIONS, AND ANY SPECIAL X-RAY OR LAB REQUIREMENTS.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

I authorize the release of any medical or other information necessary to process this claim or for preauthorization requirements. I authorize payment of medical benefits to my physician for services rendered. I have read the Notice of Privacy Practices for Urological Surgeons of Northern California.

Signed: _____ Date: _____

EL CAMINO UROLOGY MEDICAL GROUP

2490 Hospital Drive, Ste 210, Mountain View, CA 94040 Health History

Circle Y or N to all illnesses/conditions that apply to you now or in the past				
Illness	**Currently**		**Previously**	**Explain or describe**
Cancer(type_____)	**Y N**		**Y N**	
Diabetes	**Y N**		**Y N**	
Heart Disease	**Y N**		**Y N**	
Hepatitis	**Y N**		**Y N**	
High Blood Pressure	**Y N**		**Y N**	
High Cholesterol	**Y N**		**Y N**	
Kidney Disease/Stones	**Y N**		**Y N**	
Thyroid Disease	**Y N**		**Y N**	
Vascular Disease/Blood clots	**Y N**		**Y N**	
Other medical illnesses:				

What is your height:_____ and approximate weight:_____

Do you take antibiotics before going to the dentist? Yes / No. If Yes, why_____

SURGICAL HISTORY		
Operation	**Month/Year**	**Where was the surgery done**

FAMILY HISTORY		
Has anyone in your family had problems with:		**If Yes, parent, sibling, grandparent, or other**
Infertility	**Y N**	
Heart Disease	**Y N**	
Kidney Stones	**Y N**	
Prostate Cancer	**Y N**	
Urologic/gynecologic cancers	**Y N**	

SOCIAL HISTORY

Do you smoke? Yes/ No ; Packs/day_____; Years smoked _____; Quit in _____

Do you drink? Yes/ No. If yes, Number of drinks per day_____per week_____

Do you exercise regularly? Yes or No. If yes, type & frequency of activity_____

Occupation_____

Patient Name : _____

Today's Date: _____ MD Initials_____Date_____

EL CAMINO UROLOGY MEDICAL GROUP

2490 Hospital Drive, Ste 210, Mountain View, CA 94040 Health History

Please list your current medications below			
Medications & Dosage	**Frequency**	**Medications & Dosage**	**Frequency**

Allergies to any medications: YES / NO

Name & Reaction_____

Have you ever had an allergic reaction to iodine/ shellfish / Imaging contrast? YES/ NO

If yes describe your reaction_____

Are you allergic to LATEX? YES / NO (If yes, describe your reaction) _____

Have you been diagnosed in the last week with an Infectious Cough / Shingles / Chicken Pox / Meningitis / TB : YES / NO (We are not providers for this and are trying to protect our patients and staff.)

Do you now or have you had problems related to the following systems? Circle Y or N

General Health			
Fever	**Y / N**	Chills	**Y / N**
Eyes			
Blindness	**Y / N**	Eye Pain	**Y / N**
Ear/Nose/Throat/Mouth			
Frequent Nosebleeds	**Y / N**	Deafness	**Y / N**
Cardiovascular			
Palpitations	**Y / N**	Chest Pain	**Y / N**
Respiratory			
Shortness of Breath	**Y / N**	Frequent Cough	**Y / N**
Gastrointestinal			
Nausea/Vomiting	**Y / N**	Constipation	**Y / N**
Genitourinary			
Blood in Urine	**Y / N**	Painful Urination	**Y / N**
Integumentary			
Rashes	**Y / N**	Itching	**Y / N**
Neurologic			
Numbness	**Y / N**	Tingling	**Y / N**
Musculoskeletal			
Back Pain	**Y / N**	Neck Pain	**Y / N**
Hematologic/Lymphatic			
Blood clotting problem	**Y / N**	Swollen glands	**Y / N**

Patient Name : _____

Today's Date: _____ MD Initials_____Date_____

EL CAMINO UROLOGY MEDICAL GROUP INC.
A Division of USNC

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: _____
Name

_____
Address

_____ _____ _____
City State Zip Code

Phone:_____ Fax: _____

The medical information/records will be used for the following purpose: _____

_____

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse_____(initial)
Tests for Antibodies to HIV_____(initial)
Psychiatric/Mental Health _____(initial)
HIV Diagnosis/Treatment _____(initial)

DURATION

This authorization shall be effective immediately and remain in effect until_____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

There will be a $35.00 fee if additional copies are requested.__(initial)

_____ _____

Signature of patient *or legal/personal representative* Relationship *if other than patient*

_____ _____

Patient's Name (PRINT) Date

_____

Date of Birth

There will be a $35.00 fee if additional copies are requested. _____ (initial)

EL CAMINO UROLOGY MEDICAL GROUP, INC.
A Division of USNC

Larry H. Kretchmar, M.D., F.A.C.S.
Sari R. Levine, M.D., F.A.C.S.
Frank C. Lai, M.D. F.A.C.S.
Edward Karpman, M.D., F.A.C.S.
Wesley G. Kong, M.D., F.A.C.S.

2490 Hospital Dr., Ste. 210
Mountain View, CA 94040
Tel: 650-962-4662
Fax: 650-962-4652

Authorization for Disclosure or Release of Health Information

As required by the Health information Portability and Accountability Act of 1996 (HIPAA) and California law, our office may not use or disclose your personal health information except as provided in our Notice of Privacy Practice without your authorization. Your completion of this form means you are giving permission for release described below. Please review and complete this form carefully. It may be invalid if not completed.

I hereby authorize this medical practice to use or disclose health information concerning

_____
(Patient name)

Person(s) authorized to receive my medical information:

1. __**X**__ my insurance company
2. __**X**__ primary care physician and other treating physicians
3. _____ spouse
4. _____ parent(s)
5. _____ family members, please indicated names _____
6. _____ others, please indicate _____

_____

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

This AUTHORIZATION is effective now and will remain in effect until further notice.

I understand that I have a right to receive a copy of this authorization.

Signed: _____ Date: _____

Print Name: _____

Signature of Personal Representative (if applicable) _____

EL CAMINO UROLOGY MEDICAL GROUP
2490 Hospital Drive, Suite 210, Mountain View, CA 94040
Phone: (650) 962-4662 Fax: (650) 962-4652

Over the past month, typically how often have you experienced:	Not at all	Less than 1 time in 5.	Less than half of the time.	About half of the time.	More than half of the time.	Almost Always.
INCOMPLETE EMPTYING A sensation of not emptying your bladder completely after you finished urinating.	0	1	2	3	4	5
FREQUENCY Urinating again less than 2 hours after you finished urinating.	0	1	2	3	4	5
INTERMITTENCY Stopping and starting again several times when you urinate.	0	1	2	3	4	5
URGE TO URINATE Finding it difficult to postpone urination.	0	1	2	3	4	5
WEAK STREAM Minimal urinary stream.	0	1	2	3	4	5
STRAINING Needing to push or strain to begin urination.	0	1	2	3	4	5
URINATING AT NIGHT Number of times you typically 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

How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
	0	1	2	3	4	5	6

Gynecologic / Obstetric History

Menstrual History:

Age at First Menses _____
Currently menstruating? YES or NO
If YES, are periods regular? YES or NO
Spacing of periods: _____ Duration of Bleeding: _____
If NO, when did periods stop? _____
Menopause or Hysterectomy?
Date of last PAP smear: _____ Any abnormal PAP smears? YES or NO
If YES, specify: _____

Obstetric History:

Total pregnancies: _____ Vaginal deliveries: _____ C-sections: _____ Abortions: _____ Miscarriage: _____
Complicated deliveries? YES or NO
If YES, specify: _____

What is your main concern that you would like the doctor to address?

Patient Name: _____

Today's Date: _____ **MD Initials:** _____ **Date:** _____

Urological Surgeons of Northern California, Inc.

Shahram Shawn Gholami, MD
David H. C. King, MD
Frank C. Lai, MD
Mark W. Noller, MD
Patrick E. Wherry, MD

Lawrence Y. Hwong, MD
Wesley Kong, MD
Sari R. Levine, MD
David M. Nudell, MD

James Hwong, MD
J. Kersten Kraft, MD
Han P. Lo, MD
Robert P. Panvini, MD

Edward Karpman, MD,
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Mountain View, CA 94040
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ELECTRONIC PAYMENTS AND CONVENIENT PAYMENTS

Urological Surgeons of Northern California, Inc. goal is to provide you with the best, most current medical care available in a positive and supportive environment. Today insurance plans are becoming more complicated in how they determine what the medical practice can collect and what the patient actually owes. Insurance plans now have numerous different co-payments and deductibles that are often confusing to their clients and can even elude the smartest medical practice office manager. What a patient actually owes once insurance pays its portion is a function of the individual's co-payment, deductible, maximum out-of-pocket expenses and where the patient falls within this continuum.

In an effort to streamline this system and make it more cost effective for everybody we are asking every patient to provide us with a credit card, HSA debit card, or a voided check at the time of service. Nothing will be charged to your credit card or checking account until the Explanation of Benefits (EOB) returns from your insurance company and we can enter the contractual write-offs and amount paid by your insurance company into our system. The only amount charged to your credit card or checking account will be the PATIENT RESPONSIBILITY portion as defined on your insurance company's EOB (similar to an invoice). You will receive a statement via mail for any pending balances once insurance has paid. Ten days following the statement an E-MAIL notification with the amount to be charged to your credit card or deducted from your checking account will be sent. You will have 3 days to respond if you need to set up a payment plan, or change your form of payment. This will significantly reduce the costs of repeat statements and collection attempts. As a small business operating on fixed insurance reimbursements with rising costs and expenses, we must do everything possible to reduce the length of time that we extend credit to our patients. Thank you for your cooperation and understanding.

AUTHORIZATION TO CHARGE MY CREDIT CARD, HSA DEBIT CARD, OR CHECKING ACCOUNT FOR THE "PATIENT RESPONSIBILITY" PORTION OF MY INSURANCE PAYMENT

I authorize Urological Surgeons of Northern California, Inc. and Convenient Payments. to charge my credit card, HSA debit card, or my checking account with the balance due (patient responsibility) portion of my insurance explanation of benefits (EOB). I understand that I can dispute the charge at any time with my credit card company or Convenient Payments; however the actual amount of the charge can only be disputed with my insurance company. If I feel the "patient responsibility" portion of the explanation of benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company. Any change in the EOB by the insurance company will be reflected as a credit or additional charge on my credit card, HSA debit card, or directly in my checking account.

PATIENT NAME: _____ SIGNATURE: _____

DATE: _____ DATE OF BIRTH: _____

E-MAIL ADDRESS: _____

Card Holders
Name_____

Credit Card/Checking Account #: _____ Expiration Date: _____

_____□ Visa □ MC

EL CAMINO UROLOGY MEDICAL GROUP
2490 Hospital Drive, Ste 210, Mountain View, CA 94040

Review of Systems

Have you had problems related to the following systems **SINCE YOUR LAST VISIT**? Circle Y or N

General Health			
Fever	**Y / N**	Chills	**Y / N**
Eyes			
Blindness	**Y / N**	Eye pain	**Y / N**
Ear/Nose/Throat/Mouth			
Frequent nosebleeds	**Y / N**	Deafness	**Y / N**
Cardiovascular			
Palpitations	**Y / N**	Chest Pain	**Y / N**
Respiratory			
Shortness of breath	**Y / N**	Frequent cough	**Y / N**
Integumentary			
Rashes	**Y / N**	Itching	**Y / N**
Gastrointestinal			
Nausea/Vomiting	**Y / N**	Constipation	**Y / N**
Genitourinary			
Blood in Urine	**Y / N**	Painful Urination	**Y / N**
Neurologic			
Numbness	**Y / N**	Tingling	**Y / N**
Musculoskeletal			
Back Pain	**Y / N**	Neck Pain	**Y / N**
Hematologic/Lymphatic			
Blood clotting problem	**Y / N**	Swollen glands	**Y / N**

SINCE YOUR LAST VISIT

Any new Allergies	
Any Surgeries	

Since your last visit any change in : Smoking: YES / NO Alcohol: YES / NO
Since your last visit any change in your Family Medical History: YES / NO
Have you been diagnosed in the last week for an Infectious Cough / Shingles / Chicken Pox / TB / Meningitis : YES / NO (We are not providers for this and are trying to protect our patients and staff.)

Patient Name:_____ MD Initials_____ Date_____

Today's Date:_____ Rev 08/2014

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Patrick E. Wherry, MD

Financial Policy

Welcome to our office. Thank you for choosing us for your care. The following is a statement of our Financial Policy which must be read and signed prior to any treatment. We hope this helps to answer any questions you may have regarding our billing policies.

Insurance:
Our office contracts with most insurance companies. Your Insurance Company provides you with proof of insurance that must be presented prior to all services. We bill all primary insurance plans for our patients. *Payment for co-payments, deductibles, and payment for any non-covered service is required at the time of your visit. Services not considered reasonable or medically necessary by your insurance will be patient responsibility.* If you have no insurance, your account will be treated as a cash account and we will collect payment in full at the time of service. For your convenience we accept check, cash, Visa, and MasterCard.

Your individual insurance plan is an agreement between you and your insurance company. It is necessary for you to know the specific details of your plan. If your plan requires a referral for specialty services, it is especially important to notify us if there are restrictions on referrals to outside facilities for services. It is your responsibility to arrange for all appropriate referrals and authorizations required for insurance payment. You will be liable for all charges billed for outside providers if they are not contracted with your plan and you have not received the proper pre-authorization. It is your responsibility to know if your referral has expired and to obtain a new referral if needed.

Patient Information:
You will be asked to fill out a patient information form at your initial visit and each year thereafter. In order to keep our file up to date, please inform us of any changes to your information such as a new insurance coverage, address, telephone number, medical history, or medications.

Missed Appointments:
Please cancel your appointment at least 24 hours in advance. If you fail to cancel before this time, you may be charged a missed appointment fee of $50 for office visits, and $150 for procedures. Please help us to serve you better by keeping your scheduled appointments.

Returned Checks:
A fee of $25 will be charged for a returned Check

After Hours Services:
All non-emergency services rendered after regular business hours are subject to an additional fee. Our regular business hours are Monday through Friday, 9:00 AM – 5:00 PM excluding holidays.

Your signature below indicates that you have read, understood, and agreed to this Financial Policy.

Signature:_____Date:_____

Please Print Patient Name: _____