LAS VEGAS UROLOGY

Physician you are scheduled with today: _____

Patient Demographics

Name: SS Number: Address: City:
State: Zip Code: Home Ph: Cell: Work:
Sex: (Male) or (Female)
Date of Birth: E-mail Address:
Employer: Employer Address:

Please choose one:
Race: Asian Native Hawaiian Other Pacific Islander Black/African American
American Indian/ Alaska Native White More than one race Unreported/Refused to Report
Ethnicity: Hispanic/Latino Not Hispanic Latino Unreported/Refused to Report
Preferred Language:

Marital Status: Spouse's Name: Spouse's DOB: Spouse's Employer:
Spouse's SS#:

Emergency Contact Name and Phone:

Physician Information

Referring Doctor: Primary Care Doctor: Other Treating Physicans:

Insurance Information

Primary Insurance:	**Secondary Insurance:**
Name of Insurance:_____	Name of Insurance:_____
Policy Num:_____	Policy Num:_____
Group Num:_____	Group Num:_____
Subscriber Name:_____	Subscriber Name:_____
Subscriber's Date of Birth: _____	Subscriber's Date of Birth: _____
Relationship to Subscriber:_____	Relationship to Subscriber:_____

Acknowledgment of Financial Policies

Please initial each line:

_____ Office appointments cancelled with less than 24 hours' notice are subject to a $25 cancellation fee, and procedure cancellations without 5 business days' notice are subject to a $50 cancellation fee. Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Fees may be waived by management approval only.

_____ As a courtesy, Las Vegas Urology verifies benefits with your insurance company. A quote of benefits is not a guarantee of coverage or payment. Payment for services is due at the time of service unless other financial arrangements are made in advance. You are responsible for all charges incurred. We highly recommend you contact your insurance carrier and verify your plan benefits.

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 herby 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 copays 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:_____ Today's Date:_____

LAS VEGAS UROLOGY

Patient Name: Date of Birth:

Today's Date:

Medical Information Profile

Height:_____Weight:_____

Allergies:_____

_____

If none, please check here:_____

Medications:

Please list all medications you currently take-

Medication name	Dosage	Frequency

If you are not currently on any medications, please check here:_____

Surgical History:

Please list all surgeries including dates-

_____

_____

_____

If none, please check here: _____

Medical History:

Check all conditions for which you are under the care of a physician-

	Anemia/Bleeding Disorder		Diverticulosis		Hypertension
	Asthma		Emphysema/COPD		Liver (disease/cirrhosis/hepatitis)
	Atrial fibrillation		Gallbladder Disease		Stroke
	Colitis		Glaucoma		Thyroid Disease
	Congestive heart failure		Gout		Ulcer Disease
	Diabetes Mellitus		Heart troubles		Cancer; please specify site of origin:_____

LAS VEGAS UROLOGY

Patient Name: Date of Birth:

Today's Date:

Urology History:

Check all that apply-

	Burning with Urination		Blood in Urine
	Incontinence		Change in Urinary Frequency
	Chronic Urinary Tract Infections		Problems with Erections
	Elevated PSA If yes, please list date:_____		Awakening at night to urinate
	History of urologic cancer If yes, list site:_____		History of Kidney Stones
	Other: Please Specify:_____		

Family History:

Please list medical conditions present in your family-

Mother	Father	Siblings

Social History:

Check all that apply-

Marital Status: _____Married _____Single _____Divorced

Smoking Status: _____Never _____Quit _____Yes _____Packs per day

Alcohol: _____Never _____Quit _____Yes _____Drinks per day

Caffeinated drinks: _____Per day

Blood Transfusion: _____Yes _____No

Review of System:

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 up blood		Shortness of breath
	New onset paleness		Weakness		Easy bruising
	New onset depression		Anxiety		Suicidal ideation

Reason for Visit:

Please indicate the reason you are seeing the urologist and your current symptoms:

_____

_____

_____

LAS VEGAS UROLOGY

Patient Name: Date of Birth:

Today's Date:

Diagnostic Tests Related to this visit:

Please indicate if you have had any diagnostic tests (i.e. labs, imaging, etc.) related to this visit. Please list the facility and tests below:

_____

_____

International Voiding Symptom Score:

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
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
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
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
Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Straining Over the past month, how often have you had to push to strain to begin urination?	0	1	2	3	4	5
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

Pharmacy Information:

Preferred Pharmacy Name: _____Phone Number:_____

Pharmacy Address (or major cross streets): _____

I hereby authorize electronic prescribing. This authorization shall continue and be in full force until revoked in writing by me.

Patient Name: Date of Birth:

Today's Date:

Patient Signature: _____Today's Date:_____

LAS VEGAS UROLOGY

MEDICAL RECORDS RELEASE FORM

Date: _____ **STAT REQUEST ( )**

To: _____

Fax#: _____

Patient Name: _____ DOB: _____

Patient Address: _____

SSN: _____

Please release:

( ) ALL Medical Records **( ) Labs** **( ) Radiology Reports** **( ) All Doctor Consultation Notes**

To:

Please select the Las Vegas Urology location you are being seen at:

	Smoke Ranch 7500 Smoke Ranch Rd Ste 200 Las Vegas, NV 89128 Phone (702) 233-0727 Fax (702) 233-4799		**Vijay Goli, MD** 7150 W. Sunset Rd. Suite 202B Las Vegas, NV 89113 Phone (702) 909-7000 Fax (702)776-6788
	Sunset 7150 W. Sunset Rd. Suite 201A Las Vegas, NV 89113 Phone (702) 385-4342		**Red Rock** 3150 N Tenaya Way Ste 480 Las Vegas, NV 89128 Phone (702) 577-0024 Fax (702) 608-4737
	Henderson 2310 Corporate Circle Ste 200 Henderson, NV 89074 Phone (702) 735-8000 Fax (702) 735-4795		**William Steinkohl, MD** 1701 N. Green Valley Pkwy Building/Suite 10C Henderson, NV 89074 Phone (702) 896-9600 Fax (702) 896-9606

Patient Signature: _____ **Today's Date:** _____

LAS VEGAS UROLOGY

Patient Record of Disclosures and Authorization for the Release of Protected Health Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health informant (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 an adequate record.
3. Uses and disclosures for TYP (Treatment, Payment or Operations) may be permitted without prior consent in an emergency.

This form authorizes the release of Protected health Information pursuant to 45 CFR Parts 106 and 164.

1. The undersigned authorizes the providers of 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. 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.

_____ _____

Patient's Name Date of Birth

_____ _____

Signature Today's Date

_____ _____

Guardian's Signature if applicable Today's Date

LAS VEGAS UROLOGY

Opioid (Narcotic) Consent Form and Management Agreement

This consent and agreement for treatment between the undersigned patient and prescribers at Las Vegas Urology, is to establish clear conditions and consent for the prescription and of use of pain controlling opioid medications or other controlled substances prescribed by the healthcare provider for the patient.

These medications are being prescribed only for treating pain. Along with medications, other medical care may be prescribed to improve the ability to do daily activities. This may include exercise, use of non-opioid analgesics (i.e. acetaminophen, ibuprofen, etc.), physical therapy, psychological evaluation/counseling, weight management, classes on managing pain, or other beneficial therapies for treatment.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Physician/Physician Assistant for the patient. Failure to comply with the conditions in this agreement may result in the medication being discontinued and possible terminating of the prescriber/patient relationship.

I understand that a reduction in the intensity of my pain AND improvement in my daily life functions are the goals of this program. Should it become evident that these goals are not being met with the use of pain medications, I understand the medications may be weaned and or discontinued.

1. I must comply with the following guidelines:
    a. I will take the prescribed medication at the dose and frequency prescribed.
    b. EARLY refills may not be given.
    c. I will not attempt to get pain medication from any other healthcare provider.
    d. I will obtain all medications from one pharmacy.
    e. I will consent to random drug screening at the provider's request. Unexpected results may result in changing or discontinuing my medications.
    f. I agree to bring my pain medication into the office to be counted if requested.
    g. I will not share, trade or sell my medication for money, goods, or services. I understand that these are prosecutable offenses and may be reported to the authorities.
    h. If my medications are lost or stolen a re-evaluation of my competence to continue these medications may be performed.
    i. I am required to keep my physician up to date on all medications that I am taking.
    j. I have been advised on the proper use, storage, and disposal of the narcotic medication.

2. I understand refills of my prescriptions should be addressed in person at scheduled office visits. I will not stop by the office without an appointment and I understand I will not be seen, and refills will not be addressed without an appointment. Refills may not be made nights, weekends, or holidays.

3. I understand that the long-term effects of opioid therapy have yet to scientifically be determined and treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of opioids and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.
    a. In women of child-bearing age, I understand that opiate medications can have multiple short and long-term effects on a fetus including, but not limited to, neonatal withdrawal syndrome and various birth defects.
    b. I understand that all medications have potential side effects. For narcotic pain medications, these include but are not limited to: addiction, physical dependence, chemical dependence, constipation which may be severe enough to require medical treatment, difficult with urination, drowsiness, cognitive.
    c. impairment, nausea, itching, depressed respiretion, reduced sexual function and adverse effects or injury to the organs, as well as OVERDOSE and DEATH. A distinct clinical syndrome, “hyperalgesia syndrome”, has been described in the literature and can result in increased pain from continual and escalated doses of opioid medication.

4. I understand that opioid antagonists (antidotes) are available at pharmacies in Nevada without a prescription. These include medications such as naloxone (Narcan®) nasal spray.

I have read the above and have had all my questions answered. I know that pain can be managed with many types of treatments. I understand that I am receiving this drug for short term pain relief and consent to receive the drug and understand the possible risk of tolerance and/or dependency with the prolonged use of this drug. I consent to the treatment and agree to use the medication as prescribed by my physician.

_____ _____

Patient Signature Date

_____ _____

Print Patient Name Date of Birth

_____

Witness (receipt of copy of agreement)

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.

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 trial 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.

Please let the front desk staff know if you would like a copy of this document.

_____ _____

Patient's Name Today's Date

_____

Signature