

WELCOME

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____

_____ Name of Insurance Company(ies)

and assign directly to Dr. _____

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____

_____ Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

 Signature of Beneficiary, Guardian or Personal Representative

 Please print name of Beneficiary, Guardian or Personal Representative

 Date Relationship to Beneficiary

3 PHONE NUMBERS

Home (____) _____ Cell (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____

Work Phone (____) _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
DECEASED	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

Diabetes Cancer Bleeding tendency Kidney disease Tuberculosis

Heart disease Stroke High blood pressure Nervous illness Allergy Other _____

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HEALTH HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Numbness
- Sweats

MUSCLE/JOINT/BONE

- Pain, weakness, numbness in:
- Arms Hips
 - Back Legs
 - Feet Neck
 - Hands Shoulders

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest pain
- High/Low blood pressure
- Irregular/Rapid heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache/Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes/Halos

SKIN

- Bruise easily
- Hives
- Itching/Rash
- Change in moles
- Scars
- Sore that won't heal

MEN only

- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other _____

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- | | |
|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol |

- | | |
|---|---|
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |

Describe serious illnesses or operations _____

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MEDICATIONS/ALLERGIES

List medications you are currently taking _____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

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HEALTH HABITS

Check (✓) which you use and how much:

- Caffeine _____
- Street Drugs _____
- Tobacco _____
- Other _____

Check (✓) if your work exposes you to:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other _____

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SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date



**SOUTHERN CALIFORNIA
CENTER FOR ADVANCED
UROLOGY**

FEMALE GENITO-URINARY SYMPTOM QUESTIONNAIRE
(CONFIDENTIAL)

Vaginal and Labial Symptoms

- | | |
|---|---|
| <input type="checkbox"/> I have had difficult births | <input type="checkbox"/> My vagina feels too loose |
| <input type="checkbox"/> My labia are larger than what I want | <input type="checkbox"/> I have decreased sensations |
| <input type="checkbox"/> I do not like the way my labia look | <input type="checkbox"/> I feel pelvic heaviness |
| <input type="checkbox"/> My labia rub, tug, and pull on my clothing | <input type="checkbox"/> I rely on my appearance at work |
| <input type="checkbox"/> I am unable to wear the type of clothing I want | <input type="checkbox"/> Sex is uncomfortable and unpleasant at times |
| <input type="checkbox"/> I have had unflattering comments about my genital region | |

How often do you urinate: during the **day**? _____Times
during the **night**? _____Times

Do you leak urine (incontinence)? Yes No
Duration of incontinence? _____ Months _____ Years
Is it caused by **coughing, laughing, sneezing, running, sports**, etc.? Yes No
Is the amount of urine you usually pass : Large Average Small
Do you have difficulty starting your urinary flow? Yes No
Do you strain to void your urine? Yes No
Do you feel that you empty your bladder completely? Yes No
Do you notice dribbling of urine after voiding? Yes No
Do you have to assume abnormal positions to urinate? Yes No
Do you need to wear protective 'pads' for this type of incontinence? Yes No

Are you bothered by a **strong sense of urgency** to void? Yes No
Can you overcome the sensation of urgency to void? Yes No
Do you sometimes not make it to the bathroom in time (urgency?) Yes No
What activities seem to cause you to lose control of your urine?
- sight, sound or feel of running water Yes No
- standing up after being seated or lying down Yes No
- "key in the door" when you return home Yes No
Do you lose your urine during intercourse? Yes No
if yes - with deep penetration Yes No
- with orgasm? Yes No
Do you lose urine without any warning (without activity or urgency) Yes No

When urinating, can you usually stop your stream? Yes No

Do you ever wet the bed while asleep? Yes No

Would you describe the amount of urine that you leak as being
(you may answer more than one)

- frequent small volumes..... Yes No
- unconscious/continuous loss (always damp or wet) Yes No
- infrequent but single large volumes of loss Yes No

Is your urine flow: (circle one) Strong Weak Dribbling Intermittent

How many pads do you usually use per day for protection? (circle) 1, 2, 3, 4, 5, 6, 7, 8, more.

Has urine leakage limited your ability to: not at all | min | mild | mod | greatly

- do household chores (cooking, house-cleaning, laundry)? 0 1 2 3 4
- recreation such as walking, swimming, or other exercise? 0 1 2 3 4
- participate in activities (church, movies, concerts)? 0 1 2 3 4
- travel more than 30 minutes from home? 0 1 2 3 4
- participate in social activities outside your home? 0 1 2 3 4
- participate in, enjoy, or feel comfortable with sexual activity? 0 1 2 3 4

Do you have reduced self-esteem, depression, frustration, nervousness? Yes No

Do you have frequent urinary infections? Yes No

How often have these occurred in recent years? 1, 2, 3, 4 or more per year. (circle choice)

Do you ever see blood in your urine? Yes No

Do you have pain during urination? Yes No

Do you have pain in the lower abdomen? Yes No

Is the pain related to:

- your bladder being full? Yes No
- your menstrual cycle? Yes No
- intercourse? Yes No
- bowel movements? Yes No



**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, SCCAU may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to SCCAU's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. SCCAU reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to SCCAU'S Privacy Officer at 23101 Sherman Place Suite #304 West Hills, CA 91307. With my consent, SCCAU may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, SCCAU may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. With my consent, SCCAU may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that SCCAU restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to SCCAU's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, SCCAU may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name Date

Print Name of Patient or Legal Guardian



FINANCIAL POLICY

We recognize the need for a definitive understanding between you the patient and your doctor regarding financial arrangements for your medical care.

We will bill your insurance as a courtesy to you but you are ultimately responsible for all services that we provide. We are contracted with numerous plans but it is your responsibility to contact your insurance carrier if you would like to be sure the treating physician is in your network of covered physicians.

We ask that every patient supply us with current insurance information and copies of any insurance identification cards. If your health insurance is through any of the companies with which we currently hold contracts, we will verify your benefits and collect only the portion of the bill obligated to you.

Your insurance plan may require that you pay a certain annual deductible and a co-payment at the time of service. We will verify your health benefits before you are seen by the doctor and request payment based upon the information provided to us by your insurance carrier. All co-payments and deductibles not yet satisfied are due at the time of service.

****Note:** We are not Medi-cal providers. If you have straight Medi-cal as your 2nd insurance, you will be responsible for 20% (this is the balance after Medicare pays). Any tests/procedures done at the time of your appointment, will result in a bill for 20%. You can be made aware of this amount at your appointment, but only at your request.

If you need to cancel your appointment we require notification of cancellation at least 24 hours in advance of the appointment. There is a fee for missed appointments, or cancelled appointments without 24 hours notice (3 business days for Hospital/Surgery Center procedures). The fees are as follows:

Office visits	\$50.00
Office procedures	\$100.00
In/out patient Surgery	\$500.00 ** 3 Business days notice required

I have read and understand the above policy.

Patients Signature

Date

(Version 2.0.6T):

MUTUAL AGREEMENT

Dr. Michael H. Safir and Center For Advanced Urology agree to provide treatment to: _____ [insert Patient's name]. The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are almost always forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Even after recent Congressional attempts to tighten this restriction, however, there are still loopholes that some medical practices can use to profit from marketing activities. For example, there are exceptions for drugs currently prescribed to the patient and for recommending items or services covered by the patient's health plan. More importantly, there is no prohibition against a physician putting his patient on the spot and asking for permission to allow third parties access to information to market to patients, which could authorize essentially unlimited unwanted marketing information. Even to the extent still allowed, Physician agrees not allow others access to use Patient's medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's permission for a third party to market directly to Patient.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Importantly, Physician agrees to abide by a Code of Internet Ethics. What that means: Physician agrees to enforce no rights enabled by the assignment if Patient's commentary conforms to typical Internet Rating Sites' Terms of Use (such as Google Maps -see http://www.google.com/help/terms_maps_earth.html). Such terms include, as examples, no obscenity, no personal attacks, and the like. To be clear, constructive commentary, even if negative, helps us build a better practice. The Code of Internet Ethics encourages posting of all constructive commentary, good, neutral, and even, negative.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS ___DAY OF _____, 201___. _____(PATIENT)

Dr. Michael H. Safir and Center For Advanced Urology

AGREEMENT AS TO RESOLUTION OF CONCERNS

“I”, “Patient/Guardian” shall be understood to mean _____. (*Insert name of patient or guardian*)

“Physician” shall be understood to mean Michael H. Safir, MD and Center For Advanced Urology.

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties (“ABMS”) board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and / or code of conduct defined for expert witnesses by the American Board of Urology.

In further consideration for this, Physician agrees to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician’s reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Michael H. Safir, MD

Physician

Patient/Guardian Signature

Effective from Date of Treatment

Date of Signature