

Canyon State Urology

Patient History Form - Male

Name: _____ Date of Birth: _____ Date: _____

Primary Care Physician: _____ Height _____ Weight _____

Past Medical History – Please check any of the following you have been diagnosed with in the past.

<input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Autoimmune Disorder <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Blood Transfusions <input type="checkbox"/> Brain Tumor <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> _____ <input type="checkbox"/> C O P D <input type="checkbox"/> C V A /Stroke/TIA	<input type="checkbox"/> Cerebrovascular Disease <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> D V T/Pulmonary Embolism <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes- Gestational <input type="checkbox"/> Diabetes-Type 1 <input type="checkbox"/> Diabetes-Type 2 <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Other _____	<input type="checkbox"/> G E R D <input type="checkbox"/> G I Bleed <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Hyperlipidema <input type="checkbox"/> Hypertension <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stone <input type="checkbox"/> Liver Disease <input type="checkbox"/> M I/Heart Attack <input type="checkbox"/> Neurologic Disorder <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> P U D (Ulcers) <input type="checkbox"/> PVD (Vascular Disease) <input type="checkbox"/> Renal Failure – Acute <input type="checkbox"/> Renal Failure – Chronic <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> STD <input type="checkbox"/> Stones (kidney, ureter, bladder) <input type="checkbox"/> Thyroid Disorder <input type="checkbox"/> Tuberculosis <input type="checkbox"/> U T I – Recurrent <input type="checkbox"/> Uterine Anomaly <input type="checkbox"/> Valvular Heart Disease <input type="checkbox"/> Valley Fever <input type="checkbox"/> Varicose Veins/Phlebitis
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Past Surgical History – Please check any of the following you have had in the past.

<input type="checkbox"/> Artificial Sphincter <input type="checkbox"/> Circumcision <input type="checkbox"/> ESWL <input type="checkbox"/> Male Sling <input type="checkbox"/> Nephrectomy: <input type="checkbox"/> Penile Prosthesis <input type="checkbox"/> Prostate - Brachytherapy <input type="checkbox"/> Prostate - Laser <input type="checkbox"/> Prostate - Microwave <input type="checkbox"/> Prostate - TUNA <input type="checkbox"/> Prostate - XRT <input type="checkbox"/> Radical Prostatectomy <input type="checkbox"/> Removal Testicle <input type="checkbox"/> Remove Both Testicles <input type="checkbox"/> TURP (Transurethral Prostatectomy) <input type="checkbox"/> UPJ Repair <input type="checkbox"/> Ureteral Stent	<input type="checkbox"/> Ureteroscopy <input type="checkbox"/> Vasectomy <input type="checkbox"/> Abd Surg - _____ <input type="checkbox"/> Appendectomy <input type="checkbox"/> Gallbladder <input type="checkbox"/> Colon Resection <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Dialysis Catheter <input type="checkbox"/> Hernia – Inguinal R L <input type="checkbox"/> Hernia – Abdominal <input type="checkbox"/> Other _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Aorto-Fem Bypass - Left <input type="checkbox"/> Aorto-Fem Bypass - Right <input type="checkbox"/> Angioplasty <input type="checkbox"/> Aortic Valve Replacement <input type="checkbox"/> AV Fistula Creation <input type="checkbox"/> AV Graft <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> CABG <input type="checkbox"/> Carotid Endarterectomy <input type="checkbox"/> Lung Removal <input type="checkbox"/> Mitral Valve Replace <input type="checkbox"/> Pacemaker <input type="checkbox"/> Vascular Bypass (Femoral) <input type="checkbox"/> Do you have any medical condition that requires anti-biotics prior to surgery? <div style="text-align: center;">Yes No</div>	<input type="checkbox"/> Amputation <input type="checkbox"/> Back Surgery <input type="checkbox"/> Breast Surgery <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Cataract Extraction <input type="checkbox"/> Craniotomy <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hip Replacement <input type="checkbox"/> Interventional pain procedure <input type="checkbox"/> Knee Arthroscopy <input type="checkbox"/> Knee Replacement <input type="checkbox"/> Kyphoplasty <input type="checkbox"/> Parathyroidectomy
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Family History – Please check any that apply

<input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Anesthetic Complication <input type="checkbox"/> Anxiety <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Clots <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Cervical Cancer <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Other Diseases

Social History

<p>Tobacco: Do you currently smoke? Yes No</p> <p>If Yes, How much? _____</p> <p>If you quit, how long did you smoke? _____</p> <p>When did you quit? _____</p> <p>Alcohol: Do you drink alcohol? Yes No</p> <p>If yes, how much? _____</p> <p>Marital Status: Married / Single / Divorced</p> <p>Children: Y or N If yes, how many? _____</p> <p>Occupation: _____</p>

Canyon State Urology

Patient History Form – Page 2

Name: _____ Date: _____

Review of Systems

Please check any that Apply

General

- Chills
- Fatigue/Weakness
- Fever
- Loss of appetite
- Weight loss

Urologic Male

- Blood in urine
- Burning with urination
- Decreased libido
- Dribbling
- Erectile Dysfunction
- Incontinence
- Nighttime urination
- Incomplete emptying
- Urinary frequency
- Urinary hesitancy
- Urinary tract infections
- Urinary urgency

Cardiac

- Chest pains
- Fainting
- Palpitations
- Swelling of feet, ankles or Hands

Pulmonary

- Shortness of breath
- Sleep Apnea

Gastrointestinal

- Abdominal pain
- Change in bowel habits
- Constipation
- Diarrhea
- Indigestion/heartburn
- Nausea
- Vomiting

Neurologic

- Difficulty walking
- Dizziness/lightheadedness
- Headaches
- Muscle weakness
- Numbness/tingling
- Tremors

Endocrine

- Cold intolerance
- Excessive thirst
- Excessive urination
- Heat intolerance

Musculoskeletal

- Back pain
- Joint pain
- Joint swelling
- Muscle cramps
- Muscle weakness

Derm

- Dryness
- Genital sores
- Itching
- Rash

Psychological

- Anxiety
- Depression
- Memory loss
- Prior treatment for Psychiatric disorder

Hematologic

- Abnormal bruising
- Abnormal clotting
- Anemia

Eyes

- Blurring
- Double vision
- Irritation

ENT

- Decreased hearing
- Nasal congestion
- Nosebleeds
- Ringing of ears

Other

- _____
- _____
- _____

Medications – List ALL medications you take on a regular or occasional basis

Allergies (List medical allergies)

Pharmacy (please list your pharmacy name, address, phone # and fax # if available (this will allow us to automatically fax your prescriptions to your pharmacy)).

I have read this document thoroughly and have answered the questions to the best of my ability.

Signature

Canyon State Urology, P.C.
Patient Registration Form

Patient Information

Last Name: _____ Gender: F / M Marital Status: _____ Age: _____
First Name: _____ Middle Initial: _____ D.O.B.: ____/____/____
Home Address: _____ E-mail: _____
City/State/Zip: _____ Home Phone: _____
Employer: _____ Social Sec #: _____
Employer Address: _____
City/State/Zip: _____ Work Phone: _____
Primary MD: _____ CSU MD: Tay Nelson Stewart Han
Referring MD: _____ (Circle one)

Responsible Party

Last Name: _____ Relationship to patient: _____
First Name: _____ Middle Initial: _____ D.O.B.: ____/____/____
Home Address: _____ E-mail: _____
City/State/Zip: _____ Home Phone: _____
Employer: _____ Social Sec #: _____
Employer Address: _____
City/State/Zip: _____ Work Phone: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Ins: _____ Insured ID#: _____
Address: _____ Group#: _____
City/State/Zip: _____ Phone: _____
Policy Owner: _____ Policy Owner SSN: _____
Patient relationship to policy owner: _____ Policy Owner DOB: _____
Secondary Ins: _____ Insured ID#: _____
Address: _____ Group#: _____
City/State/Zip: _____ Phone: _____
Policy Owner: _____ Policy Owner SSN: _____
Patient relationship to policy owner: _____ Policy Owner DOB: _____

Authorization to release information

I hereby authorize the release of any information required in the course of my assessment or treatment. I hereby authorize payment of medical benefits directly to Canyon State Urology, P.C.. I understand that I am financially responsible for charges that are not covered by this authorization. I understand that payment is due at the time of services unless previous arrangements have been made and that I will be provided with an insurance form to file for reimbursement. Further, I understand that I am responsible for all charges incurred in the collection of this account and will pay all fees involved should this account be placed with a collection service.

Signature: _____ Date: _____



ARIZONA UROLOGY SPECIALISTS, PLLC

Experienced care one patient at a time

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Canyon State Urology, PC a division of Arizona Urology Specialists, PLLC ("CSU"/"AUS") as your healthcare provider. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for full payment for his/her treatment and care.
Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your claim. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients are responsible for contacting their insurance carrier for explanation of any service not covered. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
Patients may incur, and are responsible for the payment of additional charges at the discretion of AUS. These charges may include but are not limited to (subject to change at any time):
Charge for returned checks. \$25.00
Charge for missed appointments without 24 hours advance notice \$25.00
Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions. \$80.00
Charge for copying and distribution of patient medical records. \$.20/per copy
Charge for forms completion, including but not limited to disability and FMLA forms. \$25.00
Charges for providing non-English speaking interpreters. Price varies depending on language
Any costs associated with collection of patient balances, including 3rd party collection agency fees.

Patient Authorizations

- By my signature below, I hereby authorize AUS and the physicians, staff, labs and hospitals associated with AUS to release ALL medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
By my signature below, I hereby authorize assignment of financial benefits directly to AUS and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
By my signature below, I understand the physicians that treat me may have a financial interest in the facility they refer me to including, but not limited to, surgery centers, lithotripsy centers, labs, oncology treatment centers and medical related entities.
By my signature below, I authorize AUS personnel to communicate by phone, mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Printed Name of Patient

Printed Name of Guardian (if applicable)

Signature of Patient or Guardian

Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Signature of Patient or Guardian

Date

Canyon State Urology, PC

Authorization to use or disclose my health information (revised 083107)

Patient Last Name, First Name

Date of Birth

Previous Name / Maiden Name

Patient Signature

**Guardian / Parent Signature if patient
is 17 years of age or younger**

Date

By signing this form, you authorize Canyon State Urology and its staff to release medical information to the following persons and / or answering devices.

Please check and complete the following:

Yes

No

____ Name _____ Phone # _____

____ Name _____ Phone # _____

____ Answering Machine at home Phone # _____

____ Answering Machine at work Phone # _____

____ Mobile # _____

____ Fax # _____

____ Pharmacy # _____

Acknowledgment of receipt of privacy notice (original to be maintained in patient's medical records)

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Patient or legally authorized individual signature

Please print your name if you have signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc)

Date

Canyon State Urology, P.C.

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office is required by a federal regulation, known as the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice.

This office is permitted by federal privacy laws to make uses and disclosures of your health information for the purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Your Health Information Rights

The health and billing records we maintain are the physical property of Canyon State Urology. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office—we are not required to grant the request but we will comply with any request granted;
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information (“Notice”) by making a request at our office;
- Request that you be allowed to inspect and copy your medical and billing record—you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support it, to our office using the form we provide to you upon request (We are not required to make such amendments);
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include uses and disclosures of information for treatment, payment, or health care operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; or to family members or friends or uses relevant to that person’s involvement in your care or in payment for such care; or uses or disclosures to notify family or others responsible for your care of your location, condition, or your death; we may charge a cost-based fee for more than one accounting in a 12-month period.
- Request that confidential communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our office administrator, in person or in writing, during normal business hours. Our Privacy Officer will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the acknowledgement authorizing use and disclosure of your protected health information of treatment, payment, and health care operations purposes.

Our Responsibilities

This office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling or requesting a copy of our “Notice” or by visiting our office and picking up a copy.

To Request Information or File a complaint

If you have questions, would like additional information, want to report a problem regarding the handling of your information, or if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact our office administrator. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment for the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses We Can Make Without Your Written Authorization

Notification of Family/Friends

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family/Friends

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Disaster Relief

We may use and disclose your health information to assist in disaster relief efforts.

Employers

We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute an authorization for the release of that information to your employer.

Deceased Persons

We may disclose your health information to funeral directors, medical examiners, or coroners consistent with applicable law to allow them to carry out their duties. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Organ Procurement Organizations

Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Appointment Reminders, Marketing and Treatment Alternatives

We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not disclose your health information without your written authorization.

Food and Drug Administration (FDA)

We may disclose to the FDA your health information relating to adverse events with respect to food, supplements, products, and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

If you are seeking compensation through Workers' Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers' Compensation.

Public Health

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse, Neglect & Domestic Violence

We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.

Sign in Sheet

We may use and disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime on our premises; to report crime in emergencies; and other appropriate situations permitted by law.

Health Oversight

We may disclose your health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as direct by a proper court order or in response to a subpoena, with your authorization, discovery request or other lawful process if certain specific requirements are met.

Serious Threat

To avert a serious threat to health or safety, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

We may disclose your health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses

Other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously in this Notice.

Website

If we maintain a website that provides information about our office, this Notice will be on the website.

Research

We may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information

Funding

We may contact you as part of a fund raising effort. If you do not want to receive these materials, please notify our Privacy Officer.

Original Effective Date: April 14, 2003

Effective Date of Last Revision (if any): _____