# ORANGE COUNTY UROLOGY ASSOCIATES, INC.

A Medical Group

Don T. Bui, M.D. • Fuad Elkhoury, M.D. • Tammy S. Ho, M.D. • Moses Kim, M.D., Ph.D. • James P. Meaglia, M.D. • Leah Y. Nakamura, M.D. • Josh M. Randall, M.D. • Poone Shoureshi, MD • Karan J. Singh, M.D. • Aaron Spitz, M.D. • Daniel Su, M.D.• Neyssan Tebyani, M.D.

Patient Name: _____ Birth Date: _____
Last First MI

Sex: *(circle one)* M F Social Security #_____ Drivers License#_____

Address_____ City_____ State_____ Zip_____

Home # _____Cell # _____ Work # _____

**E-mail Address** _____

***Preferred means of communication (circle one) Cell Phone Home Phone Email USPS Mail Any None***

Primary Physician_____ | Employer _____

Referring Physician_____ | Occupation _____

Marital Status ***(Circle one)*** **S M D W** | Pharmacy Name_____

Spouse's Name_____ | Phone # _____

Spouse Phone#_____ | Pharmacy *(Street, City)* _____

Emergency Contact **(*other than spouse*)** _____

Relationship to you_____ Phone # _____

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**Race** ***(circle one)*** • African-American/Black • Asian • Asian/Pacific Islander • Chinese • Korean • Native Hawaiian • Native American/Alaskan Native • Vietnamese • White • Other_____ • Decline to State

**Ethnicity** ***(circle one)*** • Hispanic/Latino • Non-Hispanic/Non-Latino

**Language Choice** ***(circle one)*** • English • Spanish • Chinese • Tagalog • Vietnamese • Korean • Farsi Other_____

## RESPONSIBLE PARTY –If other than self or you are a minor.

Name: _____ Relationship:_____

Address_____ City_____ State_____ Zip_____

Home #_____ Work #_____ S.S. #_____

## MEDICAL INSURANCE (please present insurance cards for us to photocopy)

Primary Insurance Company: _____ Subscriber's Name_____

Subscriber's Relationship to Patient _____

Insured's ID#_____ Group #_____ Medicare #_____

Secondary Insurance Company: _____ Subscriber's Name_____

Subscriber's Relationship to Patient_____

Insured's ID#_____ Group #_____ Medicare #_____

PLEASE BE ADVISED THAT YOU WILL RECEIVE SEPARATE BILLS FOR ANY LAB TESTS, X-RAYS, ETC. THAT MAY BE ORDERED FOR YOU, AS THEY ARE DONE BY AN OUTSIDE SOURCE.

### Assignment of Benefit-Financial Agreement

Assignment and Release. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I hereby assign my benefits to be paid directly to my physician and any assisting physicians. I understand a monthly service fee will be charged on all balance 61 days and older. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I authorize this provider to release any information required to process this claim to my insurance company.

Date:_____ Your Signature X_____

***THANK YOU FOR YOUR CAREFUL COMPLETION OF THIS IMPORTANT FORM*** Revised 8/22/14

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## PF-2000 Acknowledgement of Receipt of Notice of Patient Privacy

Orange County Urology Associates, Inc. reserves the right to modify the privacy practices outlined in the notice.

*I have received a copy of the Notice of Privacy Practice of Orange County Urology Associates, Inc.*

_____ _____

*Signature of Patient* *Name of Patient* ***(Please Print)***

_____ _____

*Date* *Patient Date of Birth*

**Preferred/Secure Phone Options:** ☐ **Yes** ☐ **No**

If yes, Please provide a phone number in which we may leave a message on your voicemail with your personal health information. ❒Home ❒Cell ❒Work

Phone#:_____

**Authorized Email Address:** To facilitate communication between OCUA and our patients, I give permission to use my email address in a secure online environment. The email communication will be through secure, encrypted messaging. I understand the email address I provide will be used primarily for accessing my patient portal on the OCUA website at www.orangecountyurology.com. It will also be used to contact me for future appointment reminders. Unless I inform OCUA that my email address has changed, OCUA has permission to use the email address below. OCUA will not share this address with any other entity.

Email Address: (Please print clearly) _____

**Expanded Medical Release Option:** **Please note: This is Valid for 1 Year**

Please list any person(s) you would like to authorize to have access to your billing, appointments or health information.
*** Such as a Spouse, Parents, Family Members, and/or Friends*.

*** With the exclusion of information that is protected under State or Federal law*

**Name** **Relationship**

_____ _____

_____ _____

**Signature of Patient/Representative** **Relationship of Patient Representative**

*** Please note that State Federal law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor*

# *Orange County Urology Associates, Inc.*
# *Financial Policy*

Welcome to Orange County Urology Associates, Inc. Your initial visit can range from $200 to $500. Here are some guidelines to help you get your insurance information ready for your visit:

**MEDICARE**

- Do you have a supplemental plan?
  - YES – We will bill both insurances on your behalf. You will be billed for any balance owed by you after the insurances have paid their amounts.
  - NO –
    i. Have you met your deductible? If not; (2014: $147 Part B)
    ii. You will be required to pay your co-insurance percentage and any portion of the deductible that has not been met at check in.

**PPO PLAN**

- You will be expected to pay your share of cost at check in.
  - This will include any office services including drugs

- Are we contracted with your insurance company?
  - YES – You will be required to pay your co-payment and/or deductible at check in.
  - NO – You will be required to pay in full at check in.

- Do you have a SECONDARY INSURANCE?
  - YES – You will be required to pay your co-payment and co-insurance amounts at check in. We will bill your secondary insurance; if we receive payment we will reimburse you any excess amounts.

- You may receive charges from an outside laboratory. These charges were incurred because the tests were necessary to diagnose and/or treat your condition.

- We will bill your insurance(s) as a courtesy. Payments received in excess of your account balance will be refunded to you.

**HMO, EPO, POS OR MANAGED CARE PLANS**

- Has your primary care physician AUTHORIZED your visit?
  - Visits with prior approval. If your plan requires a co-payment, you will be required to pay at check in.
  - Visits without prior approval. You will be required to pay in full at check in.

**You will be required to PAY IN FULL at check in if;**

- You are **OUT OF NETWORK**
- You have **NO INSURANCE**
- We are **NOT CONTRACTED WITH YOUR INSURANCE**

***We recommend that you verify your benefits with your insurance plan prior to your visit.***

**IF YOU FAIL TO PROVIDE COMPLETE, UP-TO-DATE, ACCURATE INSURANCE INFORMATION**

- You will be considered a **CASH** patient and will be **required to pay in full** at check in.
- OCUA will not be responsible for billing insurance for this date of service retroactively

Effective May 1, 2009 the Federal Trade Commission (FTC) has implemented a new regulation known as the Red Flag Rule requiring physicians to develop and implement identity theft detection and prevention programs. **TO PROTECT YOU AGAINST IDENTITY THEFT** we are required to ask for a photo ID, and a second type of identification.

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**I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY FOR ORANGE COUNTY UROLOGY ASSOCIATES, INC.**

| _____ | _____ | _____ |
|---|---|---|
| Print Name | Signature | Date |

**Point of Service Option**

We understand you have the ability to use a Point of Service (**POS**) or HMO option. Orange County Urology Associates, Inc. holds contracts with several HMO groups. If we hold a contract it is best for you to take advantage of your HMO option, this will decrease your out of pocket expense.

If you choose to use your POS option Orange County Urology Associates, Inc. will collect your entire out of pocket expenses.

Please be aware if you choose the POS option your plan may not allow you to switch over to the HMO option for your future care.

| | |
|---|---|
| _____ | _____ |
| Print Name | Sign Name |
| _____ | _____ |
| OCUA Signature | Date |

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# Vasectomy Questionnaire

**Patient Name:** _____ Age: _____ **Date:** _____/_____/_____
**Occupation:** _____
**Referred by:** _____

**Marital History:**

1. Wife's Name: _____ Age: _____
2. How long have you been married? _____
3. How many children by this marriage? _____
4. Children by previous marriage? _____ ☐ None

**Urologic History:**

1. Have you had any injury to the genitals? ☐ Yes ☐ No
2. Have you had groin or testicular surgery? ☐ Yes ☐ No
3. Have you had a urinary or genital infection? ☐ Yes ☐ No
4. Do you have difficulty with urination? ☐ Yes ☐ No
5. Do you have a history of urethral stricture? ☐ Yes ☐ No
6. Have you had prostatitis or prostate disease? ☐ Yes ☐ No
7. Have you had kidney stones? ☐ Yes ☐ No
8. Do you have problems obtaining erections? ☐ Yes ☐ No

**General Medical History:**

1. Any serious medical conditions under treatment? ☐ Yes ☐ No
   If yes please list:_____
2. Any previous surgery? ☐ Yes ☐ No
   If yes please list:_____
3. Do you take any prescribed medications? ☐ Yes ☐ No
   If yes please list:_____
   _____
4. Do you have any known bleeding disorder? ☐ Yes ☐ No
5. Are you **allergic** to any medications? ☐ Yes ☐ No
   If yes please list:_____
   _____
6. Have you ever had any reaction to novocaine, anesthesia or local anesthesia? ☐ Yes ☐ No
7. Do you have sleep apnea? ☐ Yes ☐ No

**Additional questions**

1. Has either spouse been treated by a psychiatrist for mental health problems or disorders? ☐ Yes ☐ No
2. Are there any serious marital problems? ☐ Yes ☐ No
3. Do you have any questions about the vasectomy procedure or about the information you have been given to read? ☐ Yes ☐ No
4. Is there any religious issue or conflict for you to resolve before proceeding with a vasectomy? ☐ Yes ☐ No
5. Do you have any fear vasectomy will diminish your manhood or affect future sexual enjoyment? ☐ Yes ☐ No
6. **Do you wish to be permanently sterile?** ☐ Yes ☐ No