

ORANGE COUNTY UROLOGY ASSOCIATES, INC.

A Medical Group

Don T. Bui, 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: _____

Sex: (circle one) M F Social Security # _____ Drivers License# _____
Last First MI

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 # _____

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*

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____

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*