

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: _____
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 _____

Referring Physician _____

Other Physician(s) involved in your care _____

Employer _____

Occupation _____

Pharmacy Name _____

Phone # _____

Pharmacy (Street, City) _____

Marital Status (Circle one) S M D W

Spouse's Name _____

Spouse Phone# _____

Emergency Contact (other than spouse) _____ Relation 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

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#: _____

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*

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Signature of Patient/Representative

Relationship of Patient Representative

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Orange County Urology Associates – New Patient Information Form (Male)

Name: _____ Today's Date: _____

Age _____ Date of Birth: _____ Who referred you? _____

Office Use Only	
Date	ROS by

Present Illness

In your own words, what medical problem or concern brings you to our office today?

For how long? _____ Degree of Severity 0 1 2 3 4 5 6 7 8 9 10

Current Urinary Symptoms

- | | |
|---|---|
| <input type="checkbox"/> Incontinence (Involuntary Loss of Urine) | <input type="checkbox"/> Frequency of urination |
| <input type="checkbox"/> with urgency | • Number of voids during the day? _____ |
| <input type="checkbox"/> with cough or sneeze | • Number of voids during the night? _____ |
| <input type="checkbox"/> Number of pads used per day? _____ | <input type="checkbox"/> Urgency |
| <input type="checkbox"/> Blood in urine | • Number of voids during the day? _____ |
| <input type="checkbox"/> Pain in testicles | • Number of voids during the night? _____ |
| <input type="checkbox"/> Flank Pain | <input type="checkbox"/> Burning/ Painful urination |
| <input type="checkbox"/> Fevers/Chills | <input type="checkbox"/> Urethral discharge |

Prior Urological History

- | | |
|--|--|
| <input type="checkbox"/> Previous prostate surgery: _____ | <input type="checkbox"/> Urethral Stricture |
| <input type="checkbox"/> Medication to urinate better | <input type="checkbox"/> Kidney infections/pyelonephritis |
| <i>name of drug:</i> _____ | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Elevated PSA | <input type="checkbox"/> Family history of kidney stones: <i>Whom?</i> _____ |
| <input type="checkbox"/> Prostate Inflammation/Prostatitis | <input type="checkbox"/> Hydrocele |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Other urinary tract disorder: _____ |
| <input type="checkbox"/> Family history of prostate cancer | <input type="checkbox"/> Sexual Dysfunction (impotence or ED) |
| <i>Whom?</i> _____ | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Premature Ejaculation |
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Previous Sexually Transmitted Disease's |

Please answer the following questions:	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
1. How often do you urinate again less than 2 hours after a prior urination?	0	1	2	3	4	5	F Freq
2. How often do you find it difficult to postpone urination?	0	1	2	3	4	5	U Urge
3. How often do you have a weak urination stream?	0	1	2	3	4	5	↓ Stream
4. How often do you push or strain to begin urination?	0	1	2	3	4	5	S Strain
5. How often do you find that you stop and start again when you urinate?	0	1	2	3	4	5	I Interm
6. How often do you have a sensation of not emptying your bladder after urination?	0	1	2	3	4	5	PVR
7. How many times do you typically get up to urinate when you go to bed at night?	None	1 time	2 times	3 times	4 times	5 or more	N Next

TOTAL SCORE _____/35

Quality of Life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed, equally satisfied and dissatisfied	Mostly Dissatisfied	Unhappy	Terrible
8. How would you feel about spending the rest of your life with your urinary condition just the way it is now?	0	1	2	3	4	5	6

Current Medications: Please list the medication you are currently taking and the dosage if you know it. Exclude vitamins or other supplements but include over the counter medications you take regularly.

Name of Medication	Dose	Times per Day	Name of Medication	Dose	Times per Day

Allergies **NO KNOWN DRUG ALLERGIES**

List medications to which you are allergic.

Please describe the reaction.

Drug Name: _____

Allergic Reaction: _____

Drug Name: _____

Allergic Reaction: _____

Are you allergic to latex? Yes No

Have you had an allergic reaction to IVP dye, iodine, or x-ray contrast? Yes No

Do you require antibiotics to see your dentist? Yes No

Do you have **sleep apnea**? Yes No

Review of Past Medical History Please check previous health problems in the past or active problems at this time.

All conditions should be marked with Yes or No.

<p>Yes No <u>Eyes</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Retinal detachment</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>	<p>Yes No <u>Neurological/Orthopedic</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Carpal tunnel</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Fracture</p> <p>List bones: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic migraine/ headache</p> <p><input type="checkbox"/> <input type="checkbox"/> Spinal disc disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Parkinson's disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>	<p>Yes No <u>Cardiovascular</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Congestive heart failure</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Elevated Cholesterol</p> <p><input type="checkbox"/> <input type="checkbox"/> Rhythm disturbances, irregular heartbeat. List what kind _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Hypertension, high blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Aneurysm</p> <p><input type="checkbox"/> <input type="checkbox"/> Aortic valve problem</p> <p><input type="checkbox"/> <input type="checkbox"/> Mitral valve problem</p> <p><input type="checkbox"/> <input type="checkbox"/> Peripheral vascular problem</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>
<p>Yes No <u>Ears, Nose, Throat</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Allergic rhinitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck mass</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinusitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>	<p>Yes No <u>Liver</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p>	<p>Yes No <u>Psychiatric</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Bipolar Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>
<p>Yes No <u>Pulmonary</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic obstructive lung</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema from smoking</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> <input type="checkbox"/> Pulmonary Edema</p> <p><input type="checkbox"/> <input type="checkbox"/> Pulmonary Embolism</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleep Apnea</p>	<p>Yes No <u>Gastrointestinal</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Polyps</p> <p><input type="checkbox"/> <input type="checkbox"/> Crohn's disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Small bowel obstruction</p> <p><input type="checkbox"/> <input type="checkbox"/> Diverticulitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Peptic Ulcer</p> <p><input type="checkbox"/> <input type="checkbox"/> Gallstone</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemorrhoids</p>	<p>Yes No <u>Skin</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Skin cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>
<p>Yes No <u>Blood disorders</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Clotting problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Leukemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Lymphoma</p>	<p><u>Cancers</u></p> <p>List any cancers you have had:</p> <p>_____</p> <p>_____</p>	

Surgical History. Review this list of surgical procedures. Mark those you have had and write your age or the approximate year of the surgery.

Head and Neck

- | | | | |
|--------------------------|--------------------------|-------|----------------------------|
| Yes | No | Year | |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Cataracts and Lens Implant |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Nasal Septum |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Laser eye surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Thyroidectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Tonsils and Adenoids |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: _____ |

Cardiovascular/Thoracic

- | | | | |
|--------------------------|--------------------------|-------|-------------------------------|
| Yes | No | Year | |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Abdominal Aneurysm surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Angioplasty |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Bypass surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Heart valve replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Cardiac stent |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Carotid artery |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Defibrillator implant |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Lung resection |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Peripheral vascular procedure |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Vein stripping |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: _____ |

General/Gastrointestinal

- | | | | |
|--------------------------|--------------------------|-------|-------------------------------|
| Yes | No | Year | |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Appendectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Bowel Resection Small |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Breast biopsy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Breast removal- mastectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Gallbladder removed (Open) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Gallbladder removed (Lap) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Colon Resection |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Gastrectomy (stomach removal) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Hemorrhoid procedure |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Hernia repair – umbilical |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: _____ |

Orthopedic/Neurosurgical

- | | | | |
|--------------------------|--------------------------|-------|------------------------------|
| Yes | No | Year | |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Arthroscopy - knee |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Arthroscopy - shoulder |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Carpal tunnel repair |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Craniotomy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Fracture – surgical repair |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Fracture – closed treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Laminectomy (spine) cervical |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Laminectomy (spine) lumbar |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Total hip replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Total knee replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: _____ |

Plastic/Reconstructive

- | | | | |
|--------------------------|--------------------------|-------|--------------------------|
| Yes | No | Year | |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Cosmetic |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Hand procedure or repair |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Rhinoplasty |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Skin tag or lesion |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: _____ |

Urologic

- | | | | |
|--------------------------|--------------------------|-------|-----------------------------------|
| Yes | No | Year | |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Bladder tumor-transurethral |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Urethral injections |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Kidney stone – removal with scope |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Urethral injections |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Kidney stone – lithotripsy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Kidney stone – open |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: _____ |

Family History

Deceased relation	Age at death	Cause of death	Living relation	Age	Illness

Social History

Occupation? _____ If retired, former occupation? _____

Marital status (optional) Married Widowed Divorced Single

Number of children? _____ Ages? _____

Smoking Classification

- Never smoked
- Current smoker
- Ex-smoker

How many years? _____ Packs/day _____
How many years? _____ Packs/day _____
What year did you quit? _____

Alcohol Classification

- Never drank
- Quit
- Current Drinker

Year you quit _____
Amount you drink Beer _____ ounces or 6 packs/week
 Wine _____ ounces or liters/week
 Liquor _____ ounces week

Social Drug Use

- Never used
- Past or current usage: *describe* _____

Current Review of Systems: Please check any *active* problems at this time.

Constitutional

- Yes No Fever
- Yes No Chills
- Yes No Fatigue
- Yes No Weight loss
- Yes No Loss of appetite

HEENT

- Eyes**
- Yes No Poor vision
 - Yes No Blurry vision
 - Yes No Double vision

- Ears**
- Yes No Hearing loss
 - Yes No Ringing in ears

- Nose**
- Yes No Nose bleeds
 - Yes No Nasal obstruction

- Throat, Mouth**
- Yes No Sore throat
 - Yes No Dentures

- Other: _____
- Cardiovascular**
- Yes No Chest pain/angina
 - Yes No Palpitations
 - Yes No Swelling of feet/ankles
 - Yes No Shortness of breath/activity
 - Yes No Trouble sleeping w/1 pillow

Other: _____

Respiratory

- Yes No Cough
- Yes No Shortness of breath
- Yes No Wheezing

Other: _____

Gastrointestinal

- Yes No Jaundice
- Yes No Abdominal pain
- Yes No Diarrhea
- Yes No Nausea/Vomiting
- Yes No Bloody or black stools
- Yes No Constipation
- Yes No Pancreatitis
- Yes No Peptic ulcers

Other: _____

Musculoskeletal

- Yes No Backache
- Yes No Joint pain
- Yes No Muscle aches

Other: _____

Neurological

- Yes No Tremors
- Yes No Numbness
- Yes No Dizziness
- Yes No Headaches
- Yes No Fainting

Psychiatric

- Yes No Nervousness
- Yes No Hallucinations
- Yes No Anxiety
- Yes No Depression

Endocrine

- Yes No Hot flashes
- Yes No Excessive thirst/sweating
- Yes No Hot or cold intolerance

Other: _____

Skin

- Yes No Sores
- Yes No Rash
- Yes No Itching

Other: _____

Hematologic/Lymphatic

- Yes No Easy bruising/bleeding
- Yes No Swollen lymph nodes/glands

Other: _____

Allergic/Immunologic

- Yes No Rash
- Yes No Hives

Other: _____

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of a very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with you doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for each question.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?

Very low 1	Low 2	Moderate 3	High 4	Very High 5
---------------	----------	---------------	-----------	----------------

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

No sexual activity 0	Almost Never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
-------------------------	----------------------------	---	--------------------------------------	--	------------------------------

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Did not attempt sexual activity 0	Almost Never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
--------------------------------------	----------------------------	---	--------------------------------------	--	------------------------------

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Did not attempt sexual activity 0	Extremely Difficult 1	Very Difficult 2	Difficult 3	Slightly Difficult 4	Not Difficult 5
--------------------------------------	--------------------------	---------------------	----------------	-------------------------	--------------------

5. When you attempted sexual intercourse, how often was it satisfactory for you?

Did not attempt sexual activity 0	Almost Never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
--------------------------------------	----------------------------	---	--------------------------------------	--	------------------------------

Score: _____

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.

**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



UROLOGY ASSOCIATES, INC.
A Medical Group

25200 La Paz Road, Suite 200
Laguna Hills, CA. 92653
ph (949) 855-1101 fax 855-8710

You have been referred to the Male Infertility Centre at Orange County Urology Associates. We provide highly specialized care for men with infertility.

As a part of our efforts to provide the best care possible for couples with infertility, we are trying to understand more about the causes of infertility, so that we can better treat couples with infertility. We are involved with a research study with 30 other centers in North America to gather more information about couples with infertility. This information will be used to understand more about the causes and treatments of infertility.

If you agree to participate in this important study on infertility, simply fill in the attached sheet with information on your personal history and previous treatments, and hand the completed sheet to our staff with your other paperwork. The information you enter will remain confidential at all times. Your information will be kept without any personal identifiers so it will not be possible to withdraw your information from the study once it is submitted. If you decide to not participate in this study, your care at our center will not be affected.

ARC Fertility History Form

ARC Centre:

Centre Record Number:

Zip Code / Postal Code:

Height: ft Inches

Weight: lbs

Race:

- American Indian or Alaska Native Native Hawaiian or Other Pacific Islander
 Asian White
 Black or African American Other Race

Ethnic background:

- Hispanic or Latino
 Not Hispanic or Latino

Your birth year:

Partner birth year:

No Partner

Fertility History

Who referred you to this Male Infertility Clinic? Self referred Gynecologist/reproductive endocrinologist/woman's fertility specialist
 Primary care physician/family doctor Other (please specify)

Pregnancy with current partner: Yes No Yes No If Yes, children's ages:

With your current partner:
 How long have you had unprotected sex not resulting in pregnancy? Years / Months On average, how often do you have vaginal sex each week? / week

Pregnancy with previous partner: Yes No Yes No If Yes, children's ages:

Have you had a vasectomy? Yes No If yes, in what year?

Previous Infertility Testing & Treatment

Has your wife/partner had a fertility evaluation? Yes No Does she have a fertility problem? Yes Unknown No

Have you had sperm testing (Semen Analysis)? Yes No Was the test abnormal? Yes Unknown No

Have you had a fertility investigation by a male fertility specialist? Yes No

IUI (artificial insemination)/Sperm Wash Yes No

IVF (in vitro fertilization)/ICSI intracytoplasmic sperm injection) Yes No

Lifestyle

Current tobacco use.... Yes No If yes: <1 1 2 >2 pack(s) per day How many years?

Alcohol..... Yes No If yes: <1 1 2 3 ≥4 drink(s) per day

Marijuana.....Used in last six months? Yes No If yes: Daily Few times/week Weekly Monthly or less

Cocaine.....Used in last six months? Yes No

Other drugs...Used in last six months? Yes No Type _____

Are you presently taking or have you taken within the last 6 months

Finasteride (propecia) or dutasteride?..... Yes No

Testosterone or anabolic steroids?..... Yes No

Was the testosterone prescribed by a doctor? Yes No If yes, what type of doctor? Family Dr Urologist Endocrinologist other doctor

Why are you using testosterone? Athletics Low energy Increase strength Low testosterone Treat infertility Other (please specify): _____ Low sex drive Unknown

For clinic use only

Fertility Diagnosis (check all that apply)
 NOA OA Oligospermia Asthenospermia Oligoasthenospermia Low ejaculate volume Anejaculation Varicocele

Orange County Urology Associates, Inc. Media Consent Form

Orange County Urology Associates is committed to educating the public and other healthcare providers about medical treatments and innovations. One of the most effective ways to share health and medical news is through personalized patient stories. Thank you for agreeing to participate in these educational efforts. This form ensures that you understand how your information will be used and that you agree to its release.

The information includes:

Patient testimonials (text, audio, video)

I understand that any written testimonial, photograph, movie, video or audiotape taken will become and remain the sole property of Orange County Urology Associates. I agree that the interview, negatives, prints, videotapes, audiotapes or computer graphics may be used for any purpose, including brochures, magazines, email campaigns, Web sites (including Twitter, Facebook and YouTube), individual OCUA physician Web sites, billboards, advertisements, exhibits, audiovisual or multimedia presentations, kiosk imaging, news stories and broadcasts (including their websites), and any other news, public service, promotional or advertisement reason.

I understand that news media organizations are not covered by federal privacy regulations and, once released, may become available for use by the media at any time in the future.

Patient Name	Signature	Phone	Date
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Spouse Name	Signature	Phone	Date
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Street Address

City	State	Postal/ZIP Code
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Patient Email	Spouse Email
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Parent/Guardian Name (Minors Only) (Please Print)	Signature	Date
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Practice Administrator, Orange County Urology Associates, Inc. (Please Print)	Signature	Date
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Please mail your signed copy to: Orange County Urology Associates, Attn: Christie Leach, 25200 La Paz Road, Laguna Hills, CA 92653. We will then send you a duplicate of the signed final copy. Thank you again for your participation in these patient education activities.

This authorization will not expire.

Rev. 12/12/13 OCUA