Chart Number

Thomas X. Minor, M.D. / Nadeem Rahman, M.D. / Zhoobin Bateni, M.D. / Anas Hamdi, M.D. / Timothy Juwono, M.D.

782 Medical Center Dr E. Ste 311
Clovis, CA 93611
Ph: (559)-472-4600 Fax: (559)-472-4601

Patient Information

Last Name	First Name	Middle Name	
Street Address	City	State	Zip Code
Home Telephone Number / Cell phone Number	Work Telephone		Patient's Age
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow	Social Security Number		Date of Birth / /
Occupation	Employer		
Emergency Contact Name	Relationship to Emergency Contact	Emergency Contact Telephone	
Email Address	Patient's Pharmacy		

Insurance / Insured Information

Name of Insured / Responsible Party/Guarantor	Telephone Number	Work Phone / Cell Phone	
Street Address	City & State	Zip Code	
Marital Status of Insured ☐ Single ☐ Married ☐ Divorced ☐ Widow	Social Security Number	Sex M F / Age	Date of Birth / /
Patient's Relationship to the Insured ☐ Insured ☐ Spouse ☐ Child ☐ Other	Occupation		
Employer	Employer's Address		

Name of Insurance	ID Number	Group Number	Plan Number

Referring Physician	Primary Care Physician
Name:	Name:
Address:	Address:
Phone Number:	Phone Number:

Assignment of Benefits - I hereby assign all medical and surgical benefits to which I am entitled, including government programs, private insurance, major medical benefits and any other health plan, to California Urology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature of Patient	Date

INSURANCE

California Urology is contracted with most insurance plans. Our staff will make a good faith attempt to determine benefit levels and estimate any charges you may incur. However it is ultimately your responsibility to understand your level of coverage from your insurance company. It is your responsibility to supply us with appropriate billing information, which includes current insurance identification as well as the billing address and anything else required by your insurance carrier for payment of claims. It is your responsibility to be sure that your referral and authorization arrive prior to your visit. If you consent to receive medical services that are considered a "non-covered benefit", you will be held financially responsible for these charges.

PAYMENT

Unless prior arrangements are made all copayments, deductibles and share of costs are due at the time of service. For your convenience our office accepts cash, checks, Visa and MasterCard.

RETURNED CHECKS

If your check is returned for non sufficient funds, you could be liable for three (3) times the amount of the check or $100.00 whichever is greater, plus the face value of the check and any court costs. Our normal charges for a returned check are the check amount plus $25.00 to cover the bank return fees and administrative processing. Depending on the circumstance you may be required to pay cash for all future services if you have returned checks.

FORMS

We will gladly complete your disability forms, however please allow 72 hours for completion. A fee of $ 25.00 will be collected prior to completion for each form.

AFTER HOURS CARE

If you have a medical emergency, please call 911. If you have a non-emergent question or need, you may call our office and the phone service will contact the physician on call.

CANCELLATIONS

We realize that unforeseen circumstances might make it impossible for you to keep your appointment. If this should occur, we ask that you kindly call our office 24 hours prior to your appointment and reschedule for a more convenient time.

MISSED APPOINTMENTS

If you fail to show up for a scheduled appointment you will be charged $25.00.

I understand the above

Patient Name: _____ Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES
CONSENT FORM

By my signature below, I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for California Urology, Inc.

_____
Name of Patient or Personal Representative

_____
Signature of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

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Financial Liability

Patient Name: _____

ACCT # _____

DOB: _____

INSURANCE / BENEFITS / CONSENT

I hereby give consent to release or obtain information to/from physicians and other medical personnel, as may be required in the rendering of treatment. I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action, I shall be responsible for any legal fees incurred. This authorization expires one (1) year from the date of signature.

California Urology makes a good faith attempt to determine benefit levels & estimate any charges you may incur. It is ultimately your responsibility to understand your level of coverage from your insurance company and whatever financial responsibility you will ultimately have. It is your responsibility to supply us with appropriate billing information. This includes current insurance identification as well as the billing address and anything else required by your insurance carrier for payment of claims. It is your responsibility to be sure that your referral and authorization arrive prior to your visit. If you consent to receive medical services that are considered a "non-covered benefit" by your insurance, you will be held financially responsible for these charges.

Patient Signature: _____

Parent or guardian (if patient is under 18 years old) _____

For office use only, collected by: _____

Note: California Urology is a part of Community Foundation Medical Group (CFMG). All billing statements regarding charges incurred by any services provided by our physicians will come from and be processed by CFMG.

782 Medical Center Dr. East, Ste. 311, Clovis, CA 93611
Phone # (559)-472-4600 Fax # (559)-472-4601

CALIFORNIA UROLOGY

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

DATE: _____

PATIENT NAME: _____ **DOB:** _____

This letter will serve as written permission for any member of California Urology to speak to the below parties in relation to my healthcare. This authorization will include matters that pertain to appointment scheduling, appointment rescheduling, appointment confirmations, and surgery scheduling, and obtaining results of tests performed by my physician within California Urology. This authorization will remain in effect from the date signed until I give a written retraction notice.

I give permission to speak to the following individuals on my behalf related to my care.

Printed Name & Relation: _____ Phone Number: _____

Printed Name & Relation: _____ Phone Number: _____

Printed Name & Relation: _____ Phone Number: _____

Printed Name & Relation: _____ Phone Number: _____

Patient Signature: _____ Date: _____

Office Staff Witness: _____ Date: _____

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Patient History Form

NAME: _____

DATE: _____

CHIEF COMPLAINT: In your own words, why are you seeing the doctor today?

_____

_____

How long has this problem been present? Have recent tests been performed for this problem?

_____

What facility were these tests performed at? _____

PAST MEDICAL AND SOCIAL HISTORY:

Do you currently smoke? _____Yes _____No How many packs? _____ How many years? _____

Have you ever smoked? _____Yes _____No How many packs? _____ How many years? _____

Have you ever quit smoking? _____Yes _____No For how long? _____

Marital Status: _____Single _____Married _____Widowed _____Divorced

Children? _____Yes _____No How many? _____

Do you drink alcohol? _____Never _____Rarely _____ Moderately _____Heavily

Occupation? _____

ALLERGIES TO MEDICATIONS AND REACTIONS:

_____

_____

_____

CURRENT PRESCRIPTIONS MEDICINES YOU TAKE ON A REGULAR BASIS:

_____ _____

_____ _____

_____ _____

LIST AND DATE ANY PREVIOUS SURGERIES YOU HAVE HAD:

_____

_____

_____

DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE?

_____ Diabetes _____ Bladder Cancer _____ Tuberculosis

_____ High Blood Pressure _____ Prostate Cancer _____ Heart Disease

_____ Kidney Stones_____ Colon/Rectal Cancer _____ Other: _____

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CHECKLIST: Review of Systems

Checklist:

General-
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

Skin-
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair and nail changes

Head-
- ☐ Headache
- ☐ Head injury

Ears-
- ☐ Decreased hearing
- ☐ Ringing in ears (tinnitus)
- ☐ Earache
- ☐ Drainage

Eyes-
- ☐ Vision
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Last eye exam

Nose-
- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus pain

Throat-
- ☐ Teeth
- ☐ Gums
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores
- ☐ Last dental exam

Neck-
- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Breasts-
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breast-feeding

Respiratory-
- ☐ Cough (dry or wet, productive)
- ☐ Sputum (color and amount)
- ☐ Coughing up blood (hemoptysis)
- ☐ Shortness of breath (dyspnea)
- ☐ Wheezing
- ☐ Painful breathing

Cardiovascular-

- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of breath with activity (dyspnea)
- ☐ Difficulty breathing lying down (orthopnea)
- ☐ Swelling (edema)
- ☐ Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)

Gastrointestinal-

- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin (jaundice)

Urinary-

- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine (hematuria)
- ☐ Incontinence
- ☐ Change in urinary strength

Genital-

Male-

- ☐ Pain with sex
- ☐ Hernia
- ☐ Penile discharge
- ☐ Sores
- ☐ Masses or pain
- ☐ Erectile dysfunction
- ☐ STD's

Female-

- ☐ Pain with sex
- ☐ Vaginal dryness
- ☐ Hot flashes
- ☐ Vaginal discharge
- ☐ Itching or rash
- ☐ STD's

Vascular-

- ☐ Calf pain with walking (Claudication)
- ☐ Leg cramping

Musculoskeletal-

- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Neurologic-

- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

Hematologic-

- ☐ Ease of bruising
- ☐ Ease of bleeding

Endocrine-

- ☐ Head or cold intolerance
- ☐ Sweating
- ☐ Frequent urination (polyuria)
- ☐ Thirst (polydypsia)
- ☐ Change in appetite (polyphagia)

Psychiatric-

- ☐ Nervousness
- ☐ Depression
- ☐ Memory loss
- ☐ Stress

Signature:_____ Date:_____

CALIFORNIA UROLOGY

A Member of Community Foundation Medical Group
A Part of Sutter Health Family of Care

NOTICE OF PRIVACY PRACTICES

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 Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or other health care operations and for other purposes that are permitted or required by law. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be effective for all protected health information that we maintain. Upon your request we will provide you with a copy of our revised notice by calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

I. Permitted Uses and Disclosures of Protected Health Information

- Treatment: Your physician will use or disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g. a specialist or a laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

- Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include activities that your health plan may undertake before it approves or pays for health care services that we recommend for you. These activities include: determining eligibility, reviewing services for medical necessity, and utilization review activities.

- Health Care Operations: We may use or disclose your protected health information to support the business activities of our office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the front desk where you will be asked to sign your name and indicate your physician, we may call you by name in the waiting room when your physician is ready to see you, or we may use your information as necessary, to contact you to remind you of an appointment.

- Central California Health Information Exchange. We participate in the Central California Health Information Exchange (the "Exchange"), which is an electronic health record that is shared with other health care providers who participate in the Exchange and, in other certain limited circumstances, with other health care providers who are not Exchange participants, such as a specialist to whom you have been referred. Your electronic health record may also be available electronically for health care providers to access when it is determined that you require emergent care.

II. Uses and Disclosures Based on Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization unless otherwise permitted or required by law as described below. You may revoke an authorization, at any time, in writing, except to the extent we have relied on the use or disclosure of protected health information indicated in the authorization.

III. Permitted Uses and Disclosures Without Your Authorization or Opportunity to Object

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your protected health information for public health activities and purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs and medical devices.

Communicable Diseases: We may disclose protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Healthy Oversight: We may be required to disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil right laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to a subpoena or administrative tribunal (to the extent such disclosure is expressly authorized).

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. For example, to provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened somewhere else.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes or to determine the cause of death; to a funeral director, as authorized by law, to aid in burial; or to organizations that handle organ and tissue donations.

Research: We may disclose your protected 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.

Criminal Activity: We may use or disclose your protected health information to prevent a serious threat to health or safety.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Business Associates: We may disclose your protected health information to third party "business associates" who perform health care operations for us and who agree to keep your health information private.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

IV. Patient Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to request access or a copy of your protected health information. You may request access and/or a copy of your medical information maintained in our records, including medical and billing records. Your request must be in writing. Following is our fee schedule for copying medical records:

Patient Request: $25.00 per copy of record

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We do not have to agree to the request, however if we do, we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. You may request a restriction by completing a "Restriction Request Form" available at the front desk. You will receive a response in writing within seven (7) days of receiving your request.
Your physician may deny the restriction request if he/she believes it is in your best interest to permit the use and disclosure of your protected health information.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office manager.

You have the right to request an amendment to your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us from which we may prepare a rebuttal. We will provide you with a copy of any such rebuttal. Please fill out an "Amendment Request Form" available at the front desk if you would like to request that an amendment be made to your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations or pursuant to a valid authorization as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

V. Complaints

If you believe we have not properly protected your privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights, you may contact our Corporate Privacy Officer, Juan Carlo Muro at (559) 228-5479 or by e-mail at JCMuro@santehealth.net. You may also send a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights as follows:

U.S. Department of Health and Human Services
Office for Civil Rights
Attn: Regional Manager
50 United Nations Plaza, Room 322
San Francisco, CA 94102
1-415-437-8310

California Urology Inc. will ensure that you will not be penalized nor will the care you receive at our facilities be impacted if you file a complaint.

This notice was published and becomes effective on April 1, 2019.