NORTHWEST UROLOGY ASSOCIATES

A DIVISION OF ACHO

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

PATIENTS NAME: LAST FIRST M

ADDRESS: (LOCAL)

CITY STATE ZIPCODE+4

PHONE: ( ) CELL PHONE: ( )

ADDRESS: (OUT OF AREA)

CITY STATE ZIPCODE

PHONE: ( ) MARITAL STATUS: M S W D

DATE OF BIRTH: PREFERRED LANGUAGE:

SEX: M F RACE: ETHNICITY:

SPOUSE: DATE OF BIRTH:

FAMILY DOCTOR (LOCAL) PHONE: ( )

(OUT OF AREA) PHONE: ( )

LOCAL PHARMACY: PHONE: ( )

ADDRESS:

EMERGENCY CONTACT: NAME:

PHONE: ( ) RELATIONSHIP:

EMPLOYER INFORMATION NAME:

ADDRESS: PHONE: ( )

CITY STATE ZIPCODE

RESPONSIBLE PARTY IF NOT PATIENT:

NAME: PHONE: ( )

ADDRESS:

CITY STATE ZIPCODE

RELATIONSHIP TO PATIENT:

MEDICAL POWER OF ATTORNEY: Y N LIVING WILL: Y N

NORTHWEST UROLOGY ASSOCIATES
A DIVISION OF ACHO
BIREN G. PATEL, MD S. JAYACHANDRAN, MD
IAN L GOLDMAN, MD SHELDON D ROBERTS, MD
GANESH SIVARAJAN, MD

TELEPHONE
(623) 546-1400

FAX
(623) 546-0745

DEAR PATIENT: THERE ARE TIMES WHEN WE RECEIVE CALLS FROM FAMILY MEMBERS, PERSONAL REPRESENTATIVES OR FRIENDS AND THEY WISH TO DISCUSS PERSONAL, MEDICAL OR FINANCIAL INFORMATION ABOUT YOU. BECAUSE YOUR PRIVACY AND THE PROTECTION OF YOUR PRIVACY IS SO IMPORTANT TO US, WE MUST HAVE YOUR PERMISSION BEFORE WE CAN DISCUSS ANYTHING ABOUT YOU WITH ANY OTHER PERSON. IF YOU WISH TO GIVE PERMISSION FOR US TO TALK WITH OR GIVE OUT INFORMATION TO ANYONE OTHER THAN YOUR SELF, PLEASE FILL OUT THE FOLLOWING AUTHORIZATION.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, GIVE THE DOCTORS OF VALLEY UROLOGIC ASSOCIATES, THEIR OFFICE STAFF AND BILLING AND INSURANCE STAFF, HELEN-ANN SIROIS AND PRS. INC. PERMISSION TO DISCUSS WITH AND RELEASE INFORMATION ABOUT MY PERSONAL, MEDICAL AND FINANCIAL INFORMATION TO:

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

I UNDERSTAND THAT THE DOCTORS OF VALLEY UROLOGIC ASSOCIATES AND THEIR OFFICE AND BILLING STAFF WILL NOT DISCUSS ANYTHING ABOUT ME WITH ANYONE OTHER THAN MYSELF OR THE PERSON(S) I HAVE WRITTEN IN ABOVE. I UNDERSTAND THAT I MAY CHANGE MY MIND ABOUT THIS PERMISSION, IN WRITING, AT ANYTIME. I ALSO UNDERSTAND THAT IF I DO CHANGE MY MIND, THE DOCTORS OF VALLEY UROLOGIC ASSOCIATES AND THEIR ABOVE MENTIONED STAFF WILL NOT BE HELD RESPONSIBLE FOR ANY INFORMATION THAT IS IN THE PROCESS OF BEING RELEASED OR ALREADY HAS BEEN RELEASED.

_____ _____ _____
SIGNATURE DATE DATE OF BIRTH

IF SIGNED BY OTHER THAN THE PATIENT, DESCRIBE AUTHORITY TO ACT FOR THIS INDIVIDUAL

_____ _____
WITNESS DATE

THIS AUTHORIZATION EXPIRES ONE YEAR FROM DATE SIGNED

PLEASE FILL OUT OTHER SIDE OF THIS FORM

INSURANCE / PAYMENT INFORMATION

HOW DO YOU INTEND TO PAY? ( ) CASH ( ) CHECK ( ) INSURANCE ( ) MEDICARE

PRIMARY INSURANCE:

Primary Insurance Co Name | Insured's Name | Insured's SSN

Primary Insurance Co Address | City | State | Zip

Member I.D. # / Policy # | Group #

SECONDARY INSURANCE:

Insurance Co Name | Insured's Name | Insured's SSN

Insurance Co Address | City | State | Zip

Member I.D. # / Policy # | Group #

AUTHORIZATION

I request that all surgical or medical benefits, if any, otherwise payable to me for services rendered, be paid to the provider of service. I understand that I remain financially responsible for all charges whether or not paid by insurance. I authorize the provider of service to release all information necessary to secure the payments of benefits. I also consent to the examination and/or treatment of myself and all minor children listed above by physicians, physicians assistants, and other medical personnel.

DATE | SIGNATURE

If other than patient, state relationship.

THIS AUTHORIZATION EXPIRES ONE YEAR FROM DATE SIGNED.

NORTHWEST UROLOGY ASSOCIATES/A DIVISION OF ACHO
PATIENT HISTORY FORM

LAST NAME _____ FIRST NAME _____ DOB _____ DATE _____

PATIENT ID# _____

Review of Systems

Do you now or have you had any problems related to the following systems?

Circle Yes or No

Constitutional Symptoms		**(Comments)**
Weight Change	Y N	
Chills	Y N	
Sleep Disorder	Y N	
Other		

Eyes		**(Comments)**
Double Vision	Y N	
Glaucoma	Y N	
Cataracts	Y N	
Other		

Ear/Nose/Throat/Mouth		**(Comments)**
Hearing Changes	Y N	
Sore Throat	Y N	
Sinus Problems	Y N	
Other		

Cardiovascular		**(Comments)**
Chest Pain	Y N	
Irregular Heartbeat	Y N	
Swelling Ankles	Y N	
Other		

Psychologic		**(Comments)**
Are you generally happy?	Y N	
Do you feel depressed?	Y N	
Do you feel anxious?	Y N	
Do you feel safe at home?	Y N	

Endocrine		**(Comments)**
Excessive Thirst	Y N	
Too Hot/Too Cold	Y N	
Tired/Sluggish	Y N	
Other		

Hematologic/Lymphatic		**(Comments)**
Swollen Glands	Y N	
Blood Clotting Problems	Y N	
Bruising	Y N	
Other		

Allergic/Immunologic		**(Comments)**
Hay Fever	Y N	
Drug Allergies	Y N	
Other	Y N	

Genitourinary		**(Comments)**
Change in Stream	Y N	
Nocturia (getting up at night)	Y N	
Urinary Frequency	Y N	
Other		

Musculoskeletal		**(Comments)**
Bone Pain	Y N	
Muscle Pain	Y N	
Joint Pain	Y N	
Other		

Integumentary (Skin)		**(Comments)**
Rash	Y N	
Lumps or Bumps	Y N	
Moles, Skin Tags	Y N	
Other		

Neurological		**(Comments)**
Tremors	Y N	
Dizzy Spells	Y N	
Numbness/Tingling	Y N	
Other		

Respiratory		**(Comments)**
Wheezing	Y N	
Frequent Cough	Y N	
Shortness of Breath	Y N	
Other		

Gastrointestinal		**(Comments)**
Abdominal Pain	Y N	
Nausea/Vomiting	Y N	
Indigestion/Heartburn	Y N	
Other		

Sexual History		**(Comments)**
Change in sex drive?	Y N	
Sexual Performance Satisfactory?	Y N	
Other (Sexual Trauma)	Y N	

Last Eye & Dental Exam	**(Comments)**
Date -Last Eye Exam _____	
Date - Last Dental Exam _____	

LAST NAME _____ FIRST NAME _____ DOB _____ DATE _____

Medical History

Medical ☐*None (High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.)*

Pregnancy History

		Year	Sex	Complications

Last Pap: **Last Mammogram:** **LMP:** **Prostate Screening**

Surgical ☐*None (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)*

Allergies to medications ☐*None (If Yes, please explain type of reaction, i.e., hives, wheezing, upset stomach, swelling, etc)*

Current prescription medicines ☐*None*

Name of drug	mg dose	#tablets	#times per day

Current prescription medicines

Name of drug	mg dose	#tablets	#times per day

OTC medicines *(Aspirin, Tylenol, Ibuprofen, Aleve, Vitamins and Herbals)*

Family History

Father: Living – Age:_____ Deceased, Age at Death _____ (Cause) _____
Mother: Living – Age:_____ Deceased, Age at Death _____ (Cause) _____
Siblings: Number Living _____ Number Deceased _____ (Cause)_____

List other illnesses in your family (Example – Diabetes, Heart Disease, Colon Cancer, Breast Cancer, Prostate Cancer,etc.)

Family Member	Illness	Family Member	Illness	Family Member	Illness

Social History

Smoke? Yes No If yes, how much? _____# of packs/day _____# of years? When did you stop smoking _____
Alcohol: Yes No If yes, how much? _____
Have you ever use recreational drugs? (i.e. marijuana, cocaine) If yes, what/when _____
Exercise regularly? Yes No If yes, what and how frequently _____
Routinely wear seatbelts? Yes No Routinely wear a helmet? Yes No

International Prostate Symptom Score (I-PSS)

Patient's Name _____ Date of Birth _____ Date Completed _____

	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. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
	None	1 time	2 times	3 times	4 times	5 times or more	
7. Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	

Total I-PSS Score _____

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Adapted with permission from Chatelain C et al, eds.

The International Prostate Symptom Score (1-PSS) is based on the answers to 7 questions concerning urinary symptoms. Each question allows the patient to choose 1 of 6 answers indicating increasing severity of the particular symptom. The answers are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptomatic to symptomatic).

The International Scientific Committee notes that physicians who counsel men with lower urinary tract symptoms (LUTS) use these measures not only during the initial interview but also during and after treatment in order to monitor treatment response.

The International Scientific Committee, under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), has agreed to use the symptom index for BPH, which has been developed by the American Urological Association (AUA) Measurement Committee, as the symptoms assessment tool for patients.

NORTHWEST UROLOGY ASSOCIATES
A DIVISION OF ARIZONA CENTER FOR CANCER CARE

Biren G. Patel, MD
S. Jayachandran, MD
Ganesh Sivarajan, MD
Sheldon Roberts, MD

Acknowledgment of Receipt of Privacy Notice and Patient Rights & Responsibilities

Original to be maintained in the patient's medical record

I acknowledge that I have received a copy of the office's notice of privacy practices and patient rights and responsibilities.

Patient/Legal Representative

Signature:_____ Date:_____

CONSENT TO TREATMENT: I understand that my physicians, physician assistants, and/ or nurse practitioners will direct my healthcare. I consent to receive all medical and surgical treatment as ordered by the responsible physicians, including all physician services. I understand that I may be asked to give consent to additional specific procedures or tests during my treatment. I agree that this consent to treatment will be valid until I am discharged from this outpatient service.

ACKNOWLEDGEMENTS: I certify that I have read all forms in this packet and received a copy for my reference. I certify that I am the patient or a duly authorized representative of the patient, that my questions have been answered, and that I understand and agree to the terms of this document.

Patient/Legal Representative

Signature:_____ Date:_____

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 to 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 Organization

- Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in procurement, banking, or transplantation or organs for the purpose ot 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 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 heath or legal Authorities.

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 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 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 directed 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 disclose your health information consistent with applicable to prevent or lessen a serious, imminent threat to the heath 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.

.0Example of use of your health information for health care operations:

- We obtain services from our insurers or other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical transcription, medical review, legal services, and insurance. We will share health information about you with our insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office. 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 record and billing record- you may exercise this right by delivering the request in writing to our offices 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 records 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 b 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 then 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.

NORTHWEST UROLOGY ASSOCIATES

A DIVISION OF ACHO

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

This office is required by a federal regulation, known as the HIPPA 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.

The office is permitted by federal privacy laws to make uses and disclosures of your health information for 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 of treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- A nurse or medical assistant obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he will need to consult with another specialist in the area. He will share the information with such a specialist and obtain his/her input,

Examples of use of your health information for payment purposes:

- We submit request for payment to your health insurance company. The health insurance company (or other business associates helping us obtain payment) requests health information from us regarding medical care given. We will provide information to them about you and the care given, which may include copies or excerpts of your medical record which are necessary for payment of your account. For example, a bill sent to your health insurance company may include information that identifies your diagnosis, and the procedures and supplies used.

Patient Rights and Responsibilities

You have the right to:

- Be treated with dignity, respect, and consideration.
- Not be discriminated against base on race, age, gender, national origin, religion, sexual orientation, disability, marital status or diagnosis.
- To receive privacy in treatment and care for personal needs.
- To receive treatment that supports and respects your individuality, choices, strengths and abilities.
- Not be subjected to misappropriation of personal and private property by your provider or its staff.
- To review upon written request, your medical record.
- Safe care and not be subjected to neglect, exploitation, coercion, manipulation, abuse (physical, sexual, emotional) or sexual assault.
- Know the identity of those professionals that are treating you.
- Participate or have your representative participate in the development of, or decisions concerning, treatment
- Have access to an interpreter, free of charge.
- To receive a referral to another provider if our clinic cannot provide services needed.
- Refuse treatment to the extent permitted by law including research or experimental treatment.
- Receive explanation prior to any transfer of care.
- Have assistance from a family member, representative or other individual in understanding, protecting, or exercising your rights.
- File a complaint with a manager, the Department of Health Services, or your provider without retaliation.
- Understand why someone is involved or observing care.
- Not be restrained or secluded.
- Receive, on request, information about schedule of rates, charges, explanation of bill, regardless of source of payment.
- Have an advanced directive concerning treatment.
- Except in an emergency, informs patient of alternative to a proposed psychotropic medication or surgical procedures along with any associated risks and possible complications of the proposed treatment.

You have the responsibility to:

- Provide accurate & complete information concerning present complaints, past Medical history, and other matters relating to his/her health.
- Make it known whether you clearly comprehend the course of treatment and what is expected of him/her.
- Follow the treatment plan established by his/her physician, including the instructions of nurses and other health care professionals, as they carry out the physician's orders.
- Keep appointments; notify Northwest Urology Associates or physician when unable to do so.
- Accept responsibility of your actions should you refuse treatment or not follow physician's orders.
- Assure that financial obligations of your care are fulfilled as promptly as possible.
- Follow Northwest Urology Associates policies and procedures.
- Be considerate of the rights and property of other patients and facility personnel.
- Notify the Northwest Urology Associates staff of request for interpreter services.

If you have any comments or concerns regarding services provided by Northwest Urology Associates, please contact our Practice Administrator at (623)546-1400 or write to us at, 14155 N. 83rd Avenue, Suite 127, Peoria AZ 85381.