Valley Urologic Associates

State of the Art with Compassion and Sensitivity

Patient Portal

Connecting You Electronically

Once you register, you will have electronic access to our practice **anytime** and be able to:

- Access your electronic medical records
- Exchange secure messages with your healthcare provider/staff
- Request and manage your office appointments
- Request medication renewals
- Billing/insurance questions

We are excited about our patient portal and hope you will register and start taking advantage of these great features!

Email: _____

Check your email for portal registration!

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Request for Confidential Communication:

Patient Name: _____ DOB: ____/____/_____

I give my permission to Valley Urologic Associates to leave a *detailed* voice message in the event that communication needs to take place with me.

☐ Yes ☐ No

If Yes, Please give the phone number that the detailed voice message can be left.

Phone Number: _____

Preferred Method of Reminders:

☐ Text Message Mobile Phone: _____
☐ Email (for secured portal) Email Address:_____
☐ Voice Message (if different) Phone: _____

The following have permission to receive medical information:

Name: _____

Relation: _____ Phone: _____

Name: _____

Relation: _____ Phone: _____

_____ _____
Patient or Legally Authorized Individual Signature Date

Valley Urologic Associates

NEW PATIENT HISTORY AND PHYSICAL ADULT

Date: _____
Name: _____
Date of Birth: _____
Age: _____
Primary care Doctor: _____

Past Medical and Surgical History (Please fill out completely)

Do you have any drug **allergies**: ☐ No known Drug Allergies

☐ Penicillin ☐Sulfa ☐Tetracycline ☐Cipro/Levaquin ☐Erythromycin ☐IV Iodine ☐ Macrobid ☐ Gentamycin

Other Allergies: _____

Do you have any **medical problems** in the past or currently taking medications for: ☐ None

☐ Diabetes	☐ High Blood Pressure	☐ Coronary Heart Disease	☐ Atrial Fibrillation	☐Asthma
☐ COPD	☐ Kidney Stones	☐ Hypothyroidism	☐ High cholesterol	☐ Stroke
☐ Gastric Reflux	☐ Gout	☐ Arthritis	☐ Morbid Obesity	☐ Seizures
☐ Seasonal Allergies	☐ Depression	☐ Cancer (Type _____)	☐ Renal Insufficiency	☐ PACEMAKER

PLEASE LIST ANY OTHER MEDICAL PROBLEMS (NOT LISTED ABOVE) THAT YOU HAVE BEEN TREATED IN THE PAST:

Please list all your past **surgeries** : ☐ None

☐ Appendectomy	☐ Tonsillectomy	☐ Hysterectomy (uterus)	☐ Cholecystectomy (gall bladder)
☐ Back Surgery	☐ Colonoscopy	☐ Hernia Location _____	☐ Hip Replacement
☐ Knee R L	☐ Shoulder R L	☐ Coronary Stents	☐ Coronary Bypass Graft ___ vessels
☐ C- Section	☐ Tubal Ligation	☐ Gastric Bypass	☐ Peripheral Vascular Bypass

PLEASE LIST ANY OTHER SURGICAL PROCEDURES (NOT LISTED ABOVE) THAT YOU HAVE BEEN TREATED IN THE PAST:

Please list all of your **medications/Supplements**: (include name, dosage, and how many times a day): ☐ None

Preferred Local Pharmacy

Name: _____ Phone:_____Fax:_____
Address_____City/State/Zip:_____

Mail Order Pharmacy

Name: _____ Phone:_____Fax:_____
Address_____City/State/Zip:_____

NEW PATIENT HISTORY AND PHYSICAL FORM

Please detail your **social** history:

Do you currently smoke: ☐ Yes ☐ No How many packs a day? _____ For how many years _____

Have you quit: ☐ Yes ☐ No What year _____ How many years did you smoke _____

Do you drink alcohol ☐ Yes ☐ No How many drinks per week _____

Do you use any illicit drugs (please list) : _____

Please detail your **family** history: (any disease that your parents, grandparents, or siblings have had)

Prostate cancer ☐ Kidney Cancer ☐ Bladder Cancer ☐ Kidney Stones ☐

PLEASE LIST ANY OTHER FAMILY PROBLEMS (NOT LISTED ABOVE):

Are you ☐ Married ☐ Single ☐ Divorced ☐ Widowed

How many pregnancies (if applicable): _____ How many children do you have: _____

What is your occupation: _____

Review of systems (please check any ***new*** symptoms that you have recently had)

Genitourinary □Urinary frequency □Urinary urgency □Blood in the urine □Flank pain □Sense of not empyting bladder □Burning/ painful urination □Incontinence of urine **Constitutional** □Fever □Chills □Headaches **Integumetary** □Skin rash □Boils □Persistent itch **Gastrointestinal** □Hepatitis □Ulcer/reflux □Constipation	**Musculoskeletal** □Back pain/surgery □Muscle disorder □Joint disorder **Sight/Sound** □Blurred vision □Glaucoma □Loss of hearing/ringing **Pulmonary** □Wheezing □Frequent Cough □Shortness of breath **Endocrine** □Diabetes □Thyroid disease □Parathyroid disease **Ear/Nose/Throat** □Ear infection □Sore Throat □Difficulty Swallowing	**Circulatory** □Chest pain □High blood pressure □Varicose vein **Neurological** □Dizziness □Migraine □Multiple Sclerosis **Hematologic/Lymphatic** □Lymph node swelling □Bleeding disorder □Immune disorder (HIV)

What is your Height _____ What is your Weight: _____

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AUA Symptom Score Questionnaire

The American Urological Association (AUA) has created this symptom index to give you and your physician an understanding of the severity of your enlarged prostate symptoms.

Circle a score for each question that best describes your urinary symptoms.

Question	None	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your score
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	
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	
Intermittency: Over the past month, how often have you found that you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency: Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
Weak-stream: Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining: Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
Nocturia: Over the past month, how many times did you typically get up at night to urinate?	0	1	2	3	4	5	

Symptom Score

(Add up the points for all questions to determine the severity of your symptoms)

Total score

If you scored 8 points or higher, you should consult your physician.

Symptom Score (Severity) — 0 to 7 (Mild), 8 to 19 (Moderate), 20 to 35 (Severe)

Valley Urologic Associates
Financial and No Show Policy

Thank you for choosing Valley Urologic Associates as your healthcare provider. On your initial visit, the doctor's **consultation fee ranges from $172.00 to $425.00**. This fee does not include any laboratory, procedure, medication, and medical supply or x-ray fees. At the initial visit, the patient is responsible for co-payment/coinsurance amount plus any deductible. If our office cannot verify insurance benefits, payment in full is due when you check in for your appointment.

If your insurance carrier sends payment directly to you, payment in full is due at each visit. Should an overpayment occur on the deductible or percentage amounts charged, a refund will be given.

If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, MasterCard, Cash or Check.

Delinquent accounts will be subject to the following action. Accounts past due 90 days or more will be subject to collections. All fees, including, but not limited to collection fees, attorney fees, and court fees incurred shall become your responsibility, in addition to the balance due to this office.

We require that an adult (parent or legal guardian) accompany a minor patient unless prior written authorization is given to this office. The adult accompanying the minor patient is required to pay in accordance with our policies. We do not accept third party assignments nor do we recognize or enforce the terms of divorce decrees.

There is a $35 service fee on all returned checks. NSF checks must be redeemed with certified funds-cashier's check, money order, certified check or cash.

<u>Cancellations of Appointments/No Show</u>
If you find it necessary to cancel your appointment, we ask that you give us reasonable notice so that we may let another patient have your appointment time. **Cancellations/No Shows of in-office procedures (vasectomy, cystoscopy, biopsy, urodynamics, flowrate) are charged $150 unless you provide us with a 48hr notice. No Shows for routine appointments will be charged a $50 fee.** After three No Show occurrences, the practice may elect to terminate our relationship with you. In addition, your consent to proceed with surgery requires a substantial amount of time and effort on the part of our staff and our participating hospitals. **If you need to cancel for non-medical reasons, we request a one week notice to allow us to accommodate other patients. Otherwise, you will be charged a $150 fee.**

I have read and understand the Financial Policy and agree to abide by the terms of the policy.

Signed: _____ Date: _____

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Acknowledgment of Receipt of Privacy Notice

Original to be maintained in Patient's permanent medical record.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____ _____

Patient or Legally authorized individuals signature *Date*

_____ _____

Printed Name *Relationship (Self, Parent, Legal Guardian,Personal Representative, Etc.)*

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

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Notice of Privacy Practices
September 18, 2015

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Valley Urologic Associates. If you have questions and would like additional information, you may contact us at 13555 W. McDowell Rd., Suite 304, Goodyear, AZ 85395.

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
-To receive a referral to another provider if our clinic cannot provide services needed
-Refuse or withdraw 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.
-Consent to photographs before one is taken, except for photos taken for identification / administrative purposes
-Have an advanced directive concerning treatment.
-Except in an emergency, provide you with 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 Arizona Center for Cancer Care 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 AZCCC policies and procedures.
-Be considerate of the rights and property of other patients and facility personnel.
-Notify the AZCCC staff of request for interpreter services.

If you have any comments or concerns regarding services provided by Arizona Center for Cancer Care, please contact our Site Administrator at (623) 935-5522 or write to us at, 14155 N. 83rd Avenue, Suite 127, Peoria AZ 85381. If you are still not satisfied or have further concerns, you may file a complaint with the AZ Department of Health.