

Peninsula Urology Center, Inc.

Adult and Pediatric Urology * Male Infertility * Impotence

Dear _____:

Welcome to Peninsula Urology Center. We are pleased that you have chosen us to provide you with your medical services.

Please request your primary care or referring physician to fax to our office any pertinent medical information prior to your appointment.

Enclosed are the new patient registration forms and information. Please complete and bring with you to your appointment:

- Patient information sheet;
- Health history form;
- Consent / authorization form
- Financial policy
- **If you are unable to bring the completed forms with you, please plan on arriving 30 minutes early to finish the forms prior to your appointment time.**

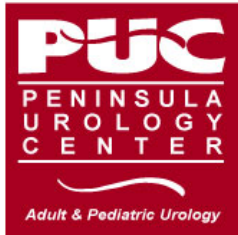
Upon arrival for your appointment, we ask that you check-in with our receptionist. In addition to the completed forms you will be giving her, she will ask for:

- A copy of your insurance card(s);
- Photo Identification – (Due to new HIPAA/Identity Theft rules if the address is incorrect on your ID we will need a copy of a utility bill showing proof of your correct address)
- “Referral” or “authorization” form from your health plan (if required)
- Co-payments your health plan requires.

It is our desire to make your visit a pleasant one. If you have any questions, please ask – we want to be of assistance and look forward to meeting you.

Your appointment is scheduled at Peninsula Urology Center on _____ at _____ am / pm; in the following office location:

3351 El Camino Real
Ste. 101
Atherton, CA 94027
Ph:(650) 306-1016 – Fax: (650) 369-3627



Chris B. Threatt, M.D.
Dieter Bruno, M.D., F.A.C.S.
Diplomate, American Board of Urology

3351 El Camino Real, Suite 101
Atherton, California 94027

Phone: (650) 306-1016
Fax: (650) 369-3627
Web Site: puc@pucenter.com

DIRECTIONS TO THE ATHERTON OFFICE 3351 EL CAMINO REAL, SUITE 101

HEADING SOUTHBOUND ON 101

TAKE THE WOODSIDE ROAD EXIT WESTBOUND.
CONTINUE ON WOODSIDE ROAD UNTIL YOU SEE SOUTH EL CAMINO REAL (IT WILL BE A RIGHT TURN).
TAKE SOUTH EL CAMINO REAL PAST 4 STOP LIGHTS – STAY IN LEFT LANE.
AFTER THE FOURTH STOP LIGHT, MAKE THE FIRST LEFT TURN WHICH WILL BE LOYOLA AVENUE.
WE ARE ON THE CORNER OF LOYOLA AND EL CAMINO REAL.
YOU CAN PARK ON THE STREET OR IN THE PARKING LOT BEHIND THE BUILDING.

HEADING NORTHBOUND 101

TAKE THE MARSH ROAD EXIT WESTBOUND.
CONTINUE ON MARSH ROAD UNTIL IT DEAD ENDS AT MIDDLEFIELD.
TURN RIGHT ON MIDDLEFIELD.
MAKE THE FIRST LEFT THAT YOU CAN WHICH WILL BE FAIR OAKS.
CONTINUE ON FAIR OAKS UNTIL YOU COME TO THE STOP LIGHT WHICH WILL BE EL CAMINO REAL.
TURN RIGHT ON EL CAMINO REAL.
WE ARE LOCATED APPROXIMATELY 1 MILE DOWN ON THE RIGHT HAND SIDE ON THE CORNER OF LOYOLA AND EL CAMINO REAL.
YOU CAN PARK ON THE STREET OR IN THE PARKING LOT BEHIND THE BUILDING.

FROM 280 IN EITHER DIRECTION

TAKE THE WOODSIDE ROAD EXIT EASTBOUND
CONTINUE ON WOODSIDE ROAD UNTIL YOU SEE SOUTH EL CAMINO REAL (IT WILL BE A RIGHT TURN)
TAKE SOUTH EL CAMINO REAL PAST 4 STOP LIGHTS – STAY IN LEFT LANE.
AFTER THE FOURTH STOP LIGHT, MAKE THE FIRST LEFT TURN WHICH WILL BE LOYOLA AVENUE.
WE ARE ON THE CORNER OF LOYOLA AND EL CAMINO REAL.

Peninsula Urology Center, Inc.

FINANCIAL POLICY

CASH PATIENTS

- Full payment at time of service
- We accept CASH, CHECK, and VISA, MASTERCARD, and AMERICAN EXPRESS.

HMO / PPO HEALTH PLANS

- "REFERRALS" from your primary care physician and CO-PAYMENTS and / or your percentage are due at the time of your visit or service.

PRIVATE INSURANCE CARRIERS

- When we are provided with insurance information, we will submit the visit to your insurance company for you.
- On subsequent visits, we will bill your insurance carrier; although we expect any deductibles and co-payment percentages at the time of your visit. **If your co-payment is not made at the time of your visit a \$5 processing fee will be added to your statement.** If your insurance has not paid the full balance within 45 days, then you are responsible and we expect payment from you within 15 days upon the receipt of our statement.

Insurance coverage is a contract between you and your insurance company. We are not a party to this contract in most cases. Your insurance claim is filed as a courtesy to our patients. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, etc., other than to supply factual information as necessary. **You are ultimately responsible for all charges regardless of any existing medical coverage.**

MEDICARE, MEDI-CAL, WORKERS COMPENSATION

- If you are covered by Medicare, Medi-Cal, Workers Compensation or any other government-sponsored program, we require that you have proof of such coverage for billing purposes.

Should your account become past due after insurance payments, you will be responsible for any finance charge or collection charges for this account.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

CANCELLED APPOINTMENTS

- **A \$50.00 charge will be assessed for appointments not canceled with 24 hours prior notice. A \$75.00 charge will be assessed for all procedures not canceled with 24 hours prior notice.**

Responsible Party Signature

Dated

**CHRIS THREATT, M.D.
DIETER BRUNO, M.D., F.A.C.S.
PATIENT RECORD OF DISCLOSURES**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I have received the Peninsula Urology Center, Inc. Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any further Notice of Privacy Practices if amended.

I wish to be contacted in the following manner (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail to my work/office address
<input type="checkbox"/> O.K. to fax to this number _____ |
| <input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Family members authorized to receive medical information _____

_____ |

Print Patient Name

Patient's Birthdate

Patient Signature or authorized representative/ relationship (if applicable)

Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

1. Check this box if the disclosure is authorized
2. Type key: T- Treatment Records, P-Payment Information, O-Healthcare Operations
3. Enter how information was released: F-Fax, Ph-Phone, E-email, M-Mail, O-Other

Today's Date: _____

MALE PATIENT HISTORY FORM

PATIENT'S NAME: _____ DATE OF BIRTH: _____ AGE: _____

PRIMARY CARE PHYSICIAN (FAMILY DOCTOR) _____

CHIEF COMPLAINT: (What is the main reason for your visit to the urologist today? How long have you been having this problem?) _____

HISTORY OF PRESENT ILLNESS

Circle your score for each below

1-7	Mild
8-19	Moderate
20-35	Severe

Total IPSS Score

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

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 two hours after you finished urinating?.....0.....1.....2.....3.....4.....5

HESITANCY

- 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

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

None 1 time 2 times 3 times 4 times 5 times

NOCTURIA

- Over the last month, how many times did you most typically get up to urinate from the time you went to bed until the time you get up?.....0.....1.....2.....3.....4.....5

BOTHERSOME SCORE

Mostly Delighted Mostly Pleased 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

Do you have or have you recently had any of the following listed below? Please circle your response.

- Blood in your urine?▶ YES NO Fertility problems?▶ YES NO
- Burning or pain when you urinate?▶ YES NO Undescended testicles?▶ YES NO
- Discharge from penis?▶ YES NO Have you ever had kidney xrays?▶ YES NO
- Kidney or bladder stones?.....YES NO
- Bladder or kidney infections?.....YES NO
- Bedwetting or daytime wetting of clothes?.....YES NO
- History of a sexually transmitted disease (herpes, gonorrhea, Chlamydia, etc.)?.....YES NO
- Pain with sexual intercourse?.....YES NO
- Swollen or painful testicles?.....YES NO
- Skin problems in the genital or groin area?.....YES NO

Chris Threatt, M.D.

Dieter Bruno, M.D., F.A.C.S.

Today's Date: _____

PATIENT'S NAME: _____ Date of Birth: _____

PAST MEDICAL AND SURGICAL HISTORY

Serious Medical Illnesses (Check all that apply and provide details below that you feel are important for us to know)

- Heart attack? Kidney failure? Diabetes? → If yes, do you use insulin? _____
- Heart failure? Chronic lung disease? Cancer? → If yes, what type? _____
- Heart valve problem? Angina? Asthma? Peptic ulcers?
- High cholesterol? Joint replacement? Bleeding disorder? Thyroid problems?
- High blood pressure? Neurological/Psychiatric problems? Other? _____

Details _____

PREVIOUS SURGERIES (PLEASE LIST)

Year	Type	Year	Type

MEDICATIONS (Please write full dosages)

Please list all prescriptions and over-the-counter medications, including vitamins and herbs that you are taking.

.....

.....

.....

Do you use any nitroglycerin medications (medicine for chest pain?) Yes No

ALLERGIES TO MEDICATIONS

NKDA (No known drug allergies)

..... Have you had a reaction to iodine x-ray dye? Yes No

..... If yes, what type of reaction? _____

SOCIAL HISTORY

Married Single Widowed Separated Divorced

Occupation: _____ How many children do you have? _____

Tobacco: Packs per week _____ Quit _____ Quit When? _____ Never _____

Alcohol: Beer _____ /wk Liquor _____ /wk Wine _____ /wk None _____

Caffeine: Coffee/day _____ Tea/day _____ Chocolate – Yes / No Soft Drinks w/ caffeine/day _____

FAMILY HISTORY (Write "F" for father, "M" for mother, "S" for sibling)

- Prostate cancer Heart disease
- Kidney cancer Lung disease
- Bladder cancer High blood pressure
- Kidney failure Neurological problems
- Kidney stones
- Other illnesses? _____

Physician use only

Chris Threatt, M.D.

Dieter Bruno, M.D., F.A.C.S.

Today's Date: _____

PATIENT'S NAME: _____ Date of Birth: _____

REVIEW OF SYSTEMS

Do you currently have any problems related to the areas outlines below? Please circle all that apply.

• **GENERAL**

Weight loss Loss of appetite Night sweats Fatigue Nausea Fever Chills

___ *Negative Review*

• **HEAD/EYES/EARS/NOSE/THROAT**

Headaches/Migraines Hearing problems Ringing in ears Nasal congestion Eye pain

Dental problems Dry mouth Difficulty swallowing Vision problems Sore throat

___ *Negative Review*

• **RESPIRATORY**

Cough Phlegm Bloody Phlegm Shortness of breath

___ *Negative Review*

• **CARDIOVASCULAR**

Chest pain Irregular heart beat Leg cramps Easy breathing

___ *Negative Review*

• **GASTROINTESTINAL**

Pain with swallowing Stomach pain Vomiting Bloody stools Black stools Constipation

Diarrhea

___ *Negative Review*

• **NEUROLOGICAL**

Numbness Tremor Developmental problems Balance problems Poor memory

___ *Negative Review*

• **MUSCULOSKELETAL**

Weakness Difficulty walking Bone or joint pain Loss of muscle mass

___ *Negative Review*

• **ENDOCRINE**

Excessive thirst Temperature intolerance Poor growth

___ *Negative Review*

• **SKIN**

Change in skin or nail texture Itchy skin Hives Dry skin Hair loss

___ *Negative Review*

• **LYMPHATIC**

Inguinal node tenderness

___ *Negative Review*

Leave for doctor:

• **CONSTITUTIONAL:** BP _____ T _____ P _____ HT _____ WT _____

Reviewed by: _____ Date: _____

