

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:

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- 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.**

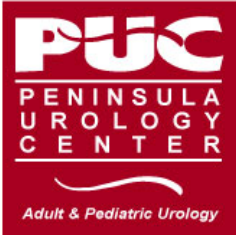
Upon arrival for your appointment, we ask that you check-in with our receptionist. In addition to the completed forms you will be giving her, she will need:

- 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
- To take your picture for our electronic medical records

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:

□ 2900 Whipple Ave.
Ste. 132
Redwood City, CA 94062
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
2900 Whipple Ave, Suite 132
Redwood City, California 94062
Phone: (650) 306-1016
Fax: (650) 369-3627
Web Site: puc@pucenter.com

DIRECTIONS TO THE REDWOOD CITY OFFICE 2900 WHIPPLE AVE, SUITE 132

HEADING SOUTHBOUND ON 101

TAKE THE WHIPPLE AVE EXIT TURN RIGHT ON TO WHIPPLE AT THE STOP LIGHT.
CONTINUE ON WHIPPLE AVE PAST 4 STOP LIGHTS AND CONTINUE PAST SEQUOIA HOSPITAL.
AFTER THE HOSPITAL EMERGENCY ROOM ENTRANCE YOU WILL TURN RIGHT AT THE NEXT
DRIVEWAY. CONTINUE ALL THE WAY TO THE BUILDING AT THE TOP OF THE HILL WHICH IS 2900
WHIPPLE AVE. WE ARE LOCATED ON THE FIRST FLOOR.

HEADING NORTHBOUND 101

TAKE THE WHIPPLE AVE EXIT TURN LEFT ONTO WHIPPLE AT THE STOP LIGHT.
CONTINUE ON WHIPPLE AVE PAST 5 STOP LIGHTS AND CONTINUE PAST SEQUOIA HOSPITAL.
AFTER THE HOSPITAL EMERGENCY ROOM ENTRANCE YOU WILL TURN RIGHT AT THE NEXT
DRIVEWAY. CONTINUE ALL THE WAY TO THE BUILDING AT THE TOP OF THE HILL WHICH IS 2900
WHIPPLE. WE ARE LOCATED ON THE FIRST FLOOR.

FROM 280 IN EITHER DIRECTION

TAKE THE EDGEWOOD RD EXIT EASTBOUND.
CONTINUE ON EDGEWOOD UNTIL THE LIGHT AT ALAMEDA TURN RIGHT ONTO ALAMEDA. MAKE
ANOTHER RIGHT AT THE NEXT LIGHT WHICH IS WHIPPLE AVE.
CONTINUE PAST SEQUOIA HOSPITAL. MAKE A RIGHT TURN ON THE ROAD JUST PAST THE
EMERGENCY ROOM ENTRANCE. CONTINUE ALL THE WAY TO THE BUILDING AT THE TOP OF THE
HILL WHICH IS 2900 WHIPPLE. WE ARE LOCATED ON THE FIRST FLOOR.

PENINSULA UROLOGY CENTER, INC.
Chris B. Threatt, M.D. – Dieter Bruno, M.D., F.A.C.S.
Please PRINT and complete ALL sections below

Acct # _____

REGISTRATION FORM

PATIENT'S PERSONAL INFORMATION

Name: _____ Date of Birth: _____
Last Name First Name Initial
Address: _____
Street City State Zip Code
Home Phone: _____ Social Security# _____ - _____ - _____ Sex: M F Marital Status: S M W D
Ethnicity: _____ Race: _____ Preferred Language: _____
Work Phone: _____ Cell Phone: _____ E-Mail: _____

If Under 18, Parent's Name or Responsible Party)

Guarantor's Name _____ Social Security #: _____ - _____ - _____
Address: _____
Street City State Zip Code
Home Phone: _____ Cell Phone: _____

PRIMARY INSURANCE INFORMATION

Please provide copy of insurance card

Insurance Name: _____ Insurance Address: _____
Subscriber ID# _____ Group # _____ Effective Date: _____
Subscriber Name: _____ Subscriber's Date of Birth: _____
Social Security# _____ - _____ - _____ Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Name: _____ Insurance Address: _____
Subscriber ID# _____ Group # _____ Effective Date: _____
Subscriber Name: _____ Subscriber's Date of Birth: _____
Social Security# _____ - _____ - _____ Relationship to Patient: _____

PATIENT'S REFERRAL INFORMATION

Primary Care Physician: _____ Referred by: _____
Address: _____ City: _____ State: _____ Zip: _____

Person to Contact In An Emergency: _____ Relationship: _____
Day Phone: _____ Cell/Evening Phone: _____

Preferred Pharmacy: _____ (location) _____

Do you give us consent to download your medication history? YES / NO

I acknowledge the above information is correct.

Patient Signature (Or Parent, if Minor): _____ Date: _____

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 or 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 APPONTMENTS

- **This office requires a 24-hour notice if you are unable to keep your scheduled appointment. For office visit cancellations of less than 24-hours you will be charged \$50.00 and for office procedure cancellations of less than 48-hours you will be charged \$75.00.** _____ Intials

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

_____ |

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, if completed properly, will constitute an adequate record.

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

- **AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES**
I hereby authorize Peninsula Urology Center, Inc. to release any information in the course of my examination and/or treatment to my insurance company(s) for the purpose of billing. I also authorize the release of information to my employer if my examination and/or treatment are work related.
- **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**
I hereby authorize the medical and/or surgical benefit payments to be made directly to Peninsula Urology Center, Inc. It is understood that benefits are not to exceed the reasonable and customary charge of these services and any monies received from the insurance company over and above indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges not covered by this authorization.
- **INFORMED CONSENT FOR OFFICE PROCEDURES**
I hereby authorize the staff and physicians of Peninsula Urology Center, Inc. to perform those diagnostic and/or therapeutic office procedures deemed necessary to evaluate and/or treat my current medical illness(es). I make this authorization with the knowledge that the above names company will verbally describe the nature of said procedures in lay terminology, including possible complications, alternatives, and side effects and obtain verbal consent prior to procedures. I retain the right to verbally refuse any procedure, either diagnostic or therapeutic, after being informed of its nature, complications, and side effects.
- **PATIENT ACKNOWLEDGMENT OF PHYSICIAN DISCLOSURE OF OWNERSHIP % INTEREST**
This is to advise you that the doctors have ownership interest in certain diagnostic equipment and diagnostic treatment centers to which you may be referred. This is to further advise you that you may choose any facility available for the purpose of obtaining the particular procedure or test being performed and to let the physician know if you wish to choose a certain facility or center other than the one which you have been referred. The facilities or centers whereby the physicians have ownership interest may include; but are not limited to:

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS.

Print Patient Name

Patient's Birthdate

Patient Signature or authorized representative/ relationship (if applicable)

Date

CHILD'S HISTORY FORM

CHILD'S NAME: _____ DOB: _____ AGE: _____

CHILD'S REGULAR DOCTOR: _____

CHIEF COMPLAINT

What is the main reason for your visit to the urologist today?

How long has this been a problem?

HISTORY OF PRESENT ILLNESS

Does your child have or has he/she recently had any of the following listed below? Please circle your response.

- Blood in urine..... YES NO
- Weak, dribbling stream or trouble starting a stream (poor force)..... YES NO
- Urinating more frequently than usual? If yes, how often?..... YES NO
- Awakening frequently at night to urinate? If yes, how often?..... YES NO
- Wetting the bed at night?..... YES NO
- Daytime wetting of clothes?..... YES NO
- Burning or pain with urination?..... YES NO
- Back pains?..... YES NO
- Abdominal pains?..... YES NO
- Leakage of urine when coughing, straining, sneezing, or exercising?..... YES NO
- Leakage of urine if he/she doesn't get to the bathroom immediately?..... YES NO
- Urinary tract infections?..... YES NO
- Skin problems in the genital or groin area?..... YES NO
- Ever had kidney x-rays (IVP or ultrasound) performed?..... YES NO

Physician Use Only

PATIENT'S NAME: _____ Date of Birth: _____

PAST MEDICAL AND SURGICAL HISTORY

- Serious Medical Illnesses (Check all that apply)

- Heart Problems Kidney disease Diabetes
- Lung (breathing) problems Arthritis Frequent infections
- Cancer Bleeding Problems Neurological and Developmental problems

- Is your child presently under the care of a doctor for any chronic medical or surgical problem? Yes No
 - If yes, please briefly explain _____
- What was your child's birth weight? _____
- To date, has your child attained **age-appropriate** developmental milestones such as crawling, walking, talking, feeding and dressing self? Yes No
- Is your child in school or daycare? Yes No
- How many siblings does your child have? _____
- Is your child exposed to cigarette smoke? Yes No

MEDICATIONS

Please list all prescription and over-the-counter medications, including vitamins and herbs which your child is taking?

ALLERGIES TO MEDICATION NKDA(No Known Drug Allergies) **Allergy to Latex?** Yes No

_____ Has your child had a reaction to iodine x-ray dye? Yes No

_____ If yes, what type of reaction? _____

_____ Is your child allergic to shellfish? Yes No

FAMILY HISTORY (Check all that apply)

- Heart disease Diabetes
- Lung disease Arthritis
- High blood pressure Cancer
- Strokes Tuberculosis
- Kidney disease or stones Neurological problems

Physician Use Only

Reviewed by: _____ Date: _____

PATIENT'S NAME: _____ Date of Birth: _____

REVIEW OF SYSTEMS

Do you currently have any problems related to the areas outlined 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 bruising High/Low Blood Pressure

____ *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*

Physician Use Only

The Patient is currently undergoing evaluation and/or treatment for the items circled above by the following physician:

Reviewed by: _____ Date: _____