

Welcome to Our Practice!

We are extremely happy that you have chosen our group to care for your Urological needs. We will strive to make your interactions with Urology Specialists of Nevada both pleasant and productive. Attached are our office forms that we would like for you to complete. This will help ensure that your visit and interactions with our office are smooth and efficient. Please bring this completed package back to us on your appointment day; which has been scheduled for:

Day	Date	At	Time	AM
				PM

WITH:

- Robert B. McBeath, M.D., F.A.C.S.*
- Mark E. Leo, M.D, F.A.C.S.*
- Helen T. Housley, M.D., F.A.C.S.*
- Jason N. Zommick, M.D., F.A.C.S.*
- Michael P. Finkelstein, M.D.*
- Mulugeta D. Kassahun, M.D., F.A.C.S.*
- Matthew R. Eskridge, M.D.*
- Avi C. Weiss, M.D.*
- Christopher C. Minott, M.D.*

LOCATION:

- | | | |
|--|---|---|
| <input type="checkbox"/> West Las Vegas Office
5701 West Charleston Blvd. #201
Las Vegas, NV 89146 | <input type="checkbox"/> Green Valley Office
56 North Pecos Road #B
Henderson, NV 89074 | <input type="checkbox"/> Northwest Office
3150 N. Teneya Way #165
Las Vegas, NV 89128 |
|--|---|---|

To make your visit to our office a little smoother, we have enclosed patient forms to be filled out as well as some useful information. Please do not mail these forms back to us, rather, bring the **completed forms** with you on your initial visit. Additionally, we ask that you bring picture I.D. (preferably driver's license or Nevada ID) and your insurance card. Any applicable co-payments, co-insurances and/or unmet deductibles will also be collected at the time of your visit. We accept cash, checks, Visa, and Master Card. We do not accept postdated checks nor will we hold checks.

IMPORTANT: PLEASE HAVE ALL FORMS FILLED OUT PRIOR TO COMING TO THE OFFICE FOR YOUR APPOINTMENT.

PLEASE BRING ALL FILMS WITH YOU TO YOUR APPOINTMENT

Again, welcome to our practice. We look forward to providing you with your urologic health care needs. If you have any questions you may contact us directly at: **(702) 877-0814**

Sincerely,
 Urology Specialists of Nevada Physicians and Staff.

Enclosures: Patient Registration Form, Urologic History Form, Voiding Symptom Score Sheet, Office Information Sheet, Authorization of Use and Disclosure of Protected Health Information, Consent to Use and Disclosure of Protected Health Information.

Adult & Pediatric Urology

The physicians and staff at Urology Specialists of Nevada feel that we can better serve your health care needs if you are familiar with the following policies and procedures of the group:

Office Hours: Our office is open Monday through Friday from 8:00 am to 5:00 p.m. The physicians are available on an emergency basis at any time.

Office Location: For your convenience we have three office locations. The office in West Las Vegas is located in the Red Rock Medical Center Building at 5701 West Charleston, Suites 201 and Suite 205, Las Vegas, NV 89146. The building is located in the block between Decatur and Jones at the Westwind Road intersection. The office in Green Valley is located at 56 North Pecos Road, Suite B, Henderson, NV 89074. The building is located on Pecos in the block between Wigwam and Pebble (off of I-215) in the Pecos Commons Business Park. The office in Summerlin is located in the Nevada Cancer Institute at 1 Breakthrough Way, Las Vegas, NV 89113. We are in the main building of the NCVI campus, which is set on I-215 between Town Center Blvd and Hualapai Way.

Appointments: Appointments may be made by calling (702) 877-0814 during our office hours. Appointments may be requested with the physician of your choice. Every effort will be made to provide the earliest possible attention for the convenience of the patient. Due to the unscheduled nature of emergencies imposed upon the physicians, occasional delays do occur. We hope that you will understand that these delays are unavoidable.

BROKEN APPOINTMENT POLICY

NEW PATIENT: \$100.00 ESTABLISHED PATIENT: \$30.00

THESE FEES WILL BE CHARGED FOR BROKEN APPOINTMENTS UNLESS 48 BUSINESS HOURS NOTICE IS GIVEN.

Emergencies: Call our main number at (702) 877-0814. A physician is available on call 24 hours a day, 7 days a week to meet emergency needs.

New Patient Registration: All forms are required for patient registration for your initial appointment with our office. **PLEASE HAVE ALL FORMS FILLED OUT PRIOR TO COMING TO THE OFFICE FOR YOUR APPOINTMENT.** New patients making their first visit to our practice are requested to arrive 15 minutes before their scheduled appointment for the purpose of registration. Please be sure to bring information pertaining to your visit with our office (i.e.: lab results, x-ray films, etc.) as well as your picture ID and insurance cards.

Referrals: Many patients are sent to us by referral of their family physician for specialty care. If you were referred to our office, please make this fact known so that we may share our findings with your personal physician.

Hospitalization: If you require hospitalization, our office will make arrangements for your admission. Any business matters regarding the payment of the hospital account are customarily discussed with the Hospital Admitting Office at the time of the admission. Our office and the hospitals are separate business organizations, and bills for each will be submitted separately. Our office bill will include medical care administered by our physicians during your hospital stay.

Insurance Claims: If you have insurance that will pay for services rendered by our physicians, it is our policy to submit a medical claim for you. Therefore, it is imperative that you provide our billing department with accurate information in regard to your insurance coverage and notify us of any changes as they occur. It must be understood, however, that financial responsibility for the account rests with the patient.

Payment for Services: Patients are requested to pay their portion of the charges (co-pay/deductibles/coinsurance) at the time the service is rendered. For your convenience, USON accepts cash, personal checks, Visa and MasterCard. We do not accept postdated checks.

Inquiries: If you have questions regarding your account or the filing of your insurance, call our billing office at (702) 877-0814 opt. 5. We will be happy to assist you.

Prescription Refills: Please have your pharmacy fax a request to (702) 877-0351. Please allow 48 business hours to complete these requests.

Medical Records: Requests for medical records or disability forms could take up to one week.

NEW PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

Last Name	First Name	M.I.
Address	Apt #	City/State/Zip
Home Phone	Work Phone	Ext./Dept.
Date Of Birth	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Language	Race	Ethnicity
Social Security #	Email Address:	Hispanic or Not Hispanic
Employer		
Employer Address		

SPOUSE INFORMATION

Name	Date of Birth	SSN
Employer		Work Phone
Employer Address		

Who is your Primary Care Doctor?	
Who referred you to our office?	
Referring Dr. Address:	Phone #
Preferred Pharmacy	
Pharmacy Address	

Person to contact in case of emergency (not living with you)	Phone #	
Responsible Party Last Name	First Name	Relation
Address/City/State/Zip		
Telephone	Resp. Party SSN:	

INSURANCE INFORMATION

(Please provide copies of your cards and/or insurance forms)

1	First Insurance Name	
	Policy Holder Last Name	First Name
	Certificate/ID #	Group Name/No.
	Is this insurance from an employer group? Y/N	If yes, Employer
2	Second Insurance Name	
	Policy Holder Last Name	First Name
	Certificate/ID #	Group Name/No.
	Is this insurance from an employer group? Y/N	If yes, Employer

ASSIGNMENT OF INSURANCE BENEFITS

SIGNATURE	I hereby authorize the attending physician to furnish my insurance carrier with all information which said insurance carrier may request concerning my illness or injury. I additionally assign to the attending physician all payments to which I am entitled for medical and/or surgical expenses relative to the services reported. This authorization is in effect until rescinded by me in writing. A photocopy of this authorization is as valid as the original.
	SIGNATURE (Patient or Parent/Legal Guardian if Patient is a Minor)
	DATE

PATIENT AUTHORIZATION AND AGREEMENT FORM

Patient: _____ SSN: _____

DISCLOSURE: Urology Specialists of Nevada is a for-profit professional corporation solely owned and providing medical services to the community.

I hereby authorize Urology Specialists of Nevada to furnish my insurance carrier with all information which said insurance carrier may request concerning my illness or injury and/or illness or injury of my dependent listed above.

I hereby assign to Urology Specialists of Nevada all payment to which I am entitled for medical and/or surgical expenses relative to the services reported, and I understand that I am financially responsible for charges not covered by my insurance company at the time of service.

I understand that Urology Specialists of Nevada bill the insurance as a courtesy to me. I agree to provide accurate and complete information in a timely manner.

I agree to respond to any additional information that the insurance company may request in a timely manner. And, I understand that if the payment of the claim is delayed more than 90 days from the date of service due to my lack of cooperation with the insurance company, the physician(s) reserve the right to collect the balance in full from me immediately.

I understand that all co-payments, co-insurances, deductibles and charges for items not covered by my insurance are payable at the time service is rendered. USON accepts cash, personal checks, Visa and MasterCard only.

I understand that certain lab tests will be sent to an outside laboratory that is not affiliated with this practice and I will be billed by the laboratory for those charges.

I understand that there is an additional charge of \$25.00 for any check that is returned by my bank for any reason. Unpaid returned checks will be sent to the District Attorney's office.

I understand that balances not paid within 90 days from the date of service will be referred to an outside collection agency, and I will be responsible for attorney's fees, collection expenses and interest. I also understand that this account will be listed with local and national credit bureaus.

BROKEN APPOINTMENT POLICY

NEW PATIENT \$100.00 ESTABLISHED PATIENT \$30.00

THESE FEES WILL BE CHARGED FOR BROKEN APPOINTMENTS UNLESS 48 HOURS NOTICE IS GIVEN.

A photocopy of this authorization is as valid as the original.

SIGNATURE _____

DATE _____

Name: _____

USON PATIENT HISTORY FORM – PAST MEDICAL HISTORY

Name: _____ Birth Date: _____ Primary Doctor: _____

Age: _____ Pharmacy Name/Location: _____ Today's Date: _____

Medical problems (past & present) & date (approx.) when first occurred:

Condition:	Date:	Condition:	Date:
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Surgical procedures (include minor surgeries) & date (approx.):

Condition:	Date:	Condition:	Date:
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Current medications, dose, date started (approx.): {Please attach separate sheet if more than 8}

Medication and Dose:	Instructions:	Medication and Dose:	Instructions:
<i>Example: Zocor – 20mg</i>	<i>One per day</i>		
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Allergies to medications, food or substance and if severe, moderate or mild reaction:

Allergy:	Reaction Type:	Allergy:	Reaction Type:
<i>Example: Penicillin</i>	<i>Rash, Shortness of Breath</i>		
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

OB History (if Female) # of Pregnancies # of Live Births # of C-Sections

Current marital status (circle one)? Single Married Divorced Widowed

If married, number of years? _____ Number of children? _____

Second marriage? _____ Number of years? _____ Number of children? _____

USON PATIENT HISTORY FORM – SOCIAL AND FAMILY HISTORY

Highest level of education completed? (circle one)

Junior high school High school Trade school College 2-yr degree
 College 4-yr degree Master's degree PhD Professional MD/DDS/JD

Travelled outside of the country recently? YES NO If yes, where/when? _____

Physical Activity

Describe your current physical activity level: None to very little Moderate Very Active
 Type of activity: Walking Jogging Running Other: _____ Frequency: _____

Occupation _____ Retired? YES NO Yr Retired _____

Tobacco Use Current Smoker? YES If yes, how many packs/ day? _____ NO

Have you ever smoked? YES NO If yes, age when quit _____ Age when began _____

Caffeine Use Type: SODA COFFEE TEA Approx. # of cups per day? _____

Alcohol Use Do you drink alcohol? YES NO If yes, type: BEER WINE OTHER

If yes, estimated intake in ounces (*example: 1 beer = 1oz, 1 glass wine = 1 oz, 1 shot vodka = 1 oz*)

Frequency: DAILY _____ WEEKLY _____ MONTHLY _____ YEARLY _____

IV or Recreational Drug Use NONE List your drug(s) of choice: _____

Last Used: CURRENTLY W/IN 12 MONTHS W/IN 1-5YRS MORE THAN 5YRS

Family History: *What is the age and state of health of your blood relatives? If deceased, what was their age at the time of death and any other major medical conditions?*

Father: LIVING DECEASED Age: _____ Medical Conditions: _____ Cause of Death: _____

Mother: LIVING DECEASED Age: _____ Medical Conditions: _____ Cause of Death: _____

Brothers: LIVING DECEASED Age: _____ Medical Conditions: _____ Cause of Death: _____

 LIVING DECEASED Age: _____ Medical Conditions: _____ Cause of Death: _____

Sisters: LIVING DECEASED Age: _____ Medical Conditions: _____ Cause of Death: _____

 LIVING DECEASED Age: _____ Medical Conditions: _____ Cause of Death: _____

Mother's Mother: LIVING DECEASED Age: _____ Medical Conditions: _____ Cause of Death: _____

Mother's Father: LIVING DECEASED Age: _____ Medical Conditions: _____ Cause of Death: _____

Father's Mother: LIVING DECEASED Age: _____ Medical Conditions: _____ Cause of Death: _____

Father's Father: LIVING DECEASED Age: _____ Medical Conditions: _____ Cause of Death: _____

Family history of (circle all that apply): Cancer/Type: _____ Diabetes Heart Disease High Blood Pressure

Liver Disease Stroke Prostate Problems Depression Kidney Stones Other: _____

USON PATIENT HISTORY FORM – REVIEW OF SYSTEMS

If you have had any of these problems, please circle YES.

CONSTITUTIONAL/GENERAL

FEVER YES
 WEIGHT LOSS YES
 LOSS OF ENERGY YES
 DIFFICULTY SLEEPING YES

HEAD AND NECK

BLURRED/DOUBLE VISION YES
 TEMPORARY BLINDNESS YES
 DIFFICULTY SWALLOWING YES
 DIFFICULTY SMELLING YES
 SORES IN MOUTH OR THROAT YES
 LUMPS IN NECK YES
 EAR INFECTIONS YES

CARDIOVASCULAR

SHORT OF BREATH ON EXERTION YES
 IRREGULAR HEART BEAT YES
 CHEST PAIN YES
 LEG PAIN WITH EXERTION YES
 HEART ATTACK YES
 STROKE YES
 AWAKING AT NIGHT SHORT OF BREATH YES
 SWELLING IN ANKLES YES

RESPIRATORY

CHRONIC COUGH YES
 COUGHING UP BLOOD YES
 SHORTNESS OF BREATH AT REST YES
 WHEEZING YES
 HISTORY OF PNEUMONIA OR BRONCHITIS YES

GASTROINTESTINAL

FOOD INTOLERANCE YES
 INDIGESTION/HEARTBURN YES
 VOMITING BLOOD YES
 JAUNDICE (YELLOW SKIN/EYES) YES
 CHRONIC DIARRHEA YES
 CHRONIC CONSTIPATION YES
 BLOOD IN STOOLS YES
 BLACK OR TARRY STOOLS YES
 STOMACH OR INTESTINAL ULCERS YES
 HISTORY OF H. PYLORI INFECTION YES

HEMATOLOGIC

EASY BRUISING YES
 BLEEDING TENDENCY YES
 ANEMIA YES
 ON BLOOD THINNERS YES
 SEASONAL ALLERGIES YES

MUSCULOSKELETAL

PAIN IN JOINTS OR BACK YES
 SWELLING/EFFUSION IN JOINTS YES
 STEROID SHOTS IN JOINTS/BACK YES

GENITOURINARY**

BLOOD IN URINE YES
 KIDNEY OR BLADDER STONES YES
 KIDNEY / BLADDER INFECTIONS YES
 GONORRHEA, SYPHILIS/CHLAMYDIA YES
 LOSS OF BOWEL OR BLADDER CONTROL YES
 PAIN OR BURNING W/URINATION YES
 LEAK URINE WHEN COUGH/SNEEZE YES
 PROBLEMS W/FERTILITY YES
 WEAK URINARY STREAM YES
 INCOMPLETE BLADDER EMPTYING YES
 INTERMITTENT STREAM YES
 STRAINING TO URINATE YES
 URINARY URGENCY YES
 HAVING TO URINATE AT NIGHT YES

IF MALE:

PROSTATE INFECTION YES
 PENILE/URETHRAL DISCHARGE YES
 TESTIS OR SCROTAL INFECTION YES
 SWELLING IN SCROTUM YES
 PROBLEM W/ERECTIONS YES
 BLOOD IN EJACULATE (SEMEN) YES

IF FEMALE:

ABNORMAL PAP SMEAR YES
 PAIN W/INTERCOURSE YES
 FREQUENT VAGINAL INFECTIONS YES
 VAGINAL DRYNESS YES
 HOT FLASHES YES
 HISTORY OF PID OR TUBAL INFECTION YES

SKIN/BREAST

LUMPS IN BREAST YES
 NIPPLE DISCHARGE YES
 PAIN IN BREAST YES

NEURO

WEAKNESS IN EXTREMITIES YES
 NUMBNESS IN EXTREMITIES YES
 PAIN SHOOTING DOWN EXTREMITIES YES
 SEIZURES YES
 VERTIGO (DIZZINESS) YES
 CHRONIC DEPRESSION YES
 UNCONTROLLED ANXIETY/PANIC ATTACKS YES

ENDOCRINE

TEMPERATURE INTOLERANCE YES
 EXCESSIVE THIRST YES
 THYROID PROBLEMS YES
 STEROID THERAPY YES

USON NEW PATIENT HISTORY FORM – VOIDING SYSTEM SCORE

Patient Name: _____

Date Completed: _____

VOIDING SYMPTOM 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	Your Score
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 two 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 urinating?	0	1	2	3	4	5	
		None	1 time	2 times	3 times	4 times	5+ times	
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	
(Please add your above scores)								
Total I-PSS Score:								
		Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
Quality of Life due to Urinary Symptoms								
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

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS OR SELECTED PERSONAL CAREGIVERS

INFORMATION to Be Used or Disclosed

The information covered by this authorization includes:

All medical records and billing information and Protected Health Information

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Urology Specialists of Nevada

Persons to Whom Information May be Disclosed

Information described above may be disclosed to:

Authorization to disclose Protected Health Information to selected family members:

1.	_____	_____	_____
	Name	Date	Initials
2.	_____	_____	_____
	Name	Date	Initials
3.	_____	_____	_____
	Name	Date	Initials
4.	_____	_____	_____
	Name	Date	Initials
5.	_____	_____	_____
	Name	Date	Initials
6.	_____	_____	_____
	Name	Date	Initials

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Urology Specialists of Nevada. You should contact the Privacy Official to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of Patient (Print or Type)

Signature of Patient Date

Signature of Patient Representative Relationship of Patient Representative to Patient