COAST UROLOGICAL MEDICAL GROUP, INC.

PLEASE PRINT AND COMPLETE ALL SECTIONS

PATIENT'S PERSONAL INFORMATION: MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

HOME ADDRESS: _____ CITY: _____ ZIP CODE: _____

PRIMARY PHONE # ( )_____ SECONDARY PHONE # ( )_____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____ SEX: MALE _____ FEMALE_____

EMAIL: _____

EMPLOYER: _____ OCCUPATION:_____

SPOUSE'S NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # _____

IF PATIENT IS A MINOR OR STUDENT:

MOTHER'S NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # _____

[ ] CHECK IF HOME ADDRESS IS SAME AS PATIENT / IF NOT: _____

EMPLOYER: _____ OCCUPATION: _____ CELL PHONE # ( ) _____

FATHER'S NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # _____

[ ] CHECK IF HOME ADDRESS IS SAME AS PATIENT / IF NOT: _____

EMPLOYER: _____ OCCUPATION: _____ CELL PHONE # ( ) _____

PATIENT'S INSURANCE INFORMATION: SPECIALIST CO-PAY: _____ VAS CO-PAY: _____

PRIMARY INSURANCE: _____ INSURANCE ID # _____ GROUP # _____

***PRIMARY POLICY HOLDER:** _____ ***DATE OF BIRTH:** _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER _____ CELL PHONE # ( ) _____

SECONDARY INSURANCE: _____ INSURANCE ID # _____ GROUP # _____

SECONDARY POLICY HOLDER: _____ ***DATE OF BIRTH:** _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER _____ CELL PHONE # ( ) _____

ADDITIONAL INFORMATION:

REFERRING PHYSICIAN: _____ PHONE # ( ) _____

PRIMARY CARE PHYSICIAN: _____ PHONE # ( ) _____

ALTERNATE CONTACT: _____ RELATIONSHIP: _____
(Outside of Home)

ADDRESS: _____ PHONE # ( ) _____

PREFERRED PHARMACY: _____ PHONE # ( ) _____

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT:

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Coast Urological Medical Group, Inc., and any assisting physicians, for services rendered. I understand that I am responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits; and agree that a photocopy of this agreement shall be as valid as the original. No guarantees have been made to me regarding the outcome of care.

Date: _____ Signature: _____

Information provided above is still current as of the following date:

Date: _____ Signature: _____

Information provided above is still current as of the following date:

Date: _____ Signature: _____

COAST UROLOGICAL
MEDICAL GROUP

Michael Norris, M.D. Stephen A. Hightower, M.D.

Diplomates, American Board of Urology

Marc A. abboud, M.D.

Date: _____

PATIENT HISTORY

WELCOME TO OUR PRACTICE. TO PROVIDE YOU WITH THE BEST CARE POSSIBLE, PLEASE PROVIDE THE FOLLOWING INFORMATION WHICH WILL BE CONFIDENTIAL AND RELEASE ONLY WITH YOUR WRITTEN PERMISSION.

PLEASE PRINT:

Last Name: _____ First Name: _____ Middle Initial: _____

Chief Complaint: _____ Age: _____

Brief History of Problem: _____

_____

_____

LIST THE OPERATIONS YOU HAVE HAD: _____

_____

_____

PAST MEDICAL HISTORY (PLEASE CHECK YES OR NO):

	Yes	No		Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Hypertension	☐	☐	Mumps	☐	☐	Tuberculosis	☐	☐
Stroke	☐	☐	Gynecologic Problems	☐	☐	Liver Disease	☐	☐	Blood in Urine	☐	☐
Ulcers	☐	☐	Lung Problems	☐	☐	Pneumonia	☐	☐	Blood Clots	☐	☐
Anemia	☐	☐	Kidney Stones	☐	☐	Asthma	☐	☐	Cancer	☐	☐
Heart Disease	☐	☐	Bleeding Disorders	☐	☐	High Blood Pressure	☐	☐			
Bladder/Kidney Infection	☐	☐									

Have you ever had a serious accident? No _____ Yes _____, Please describe:

_____

_____

Have you ever had a blood transfusion? No _____ Yes _____ If "Yes", what year? _____

(CONTINUED ON SECOND PAGE)

REVIEW OF SYMPTOMS: (CHECK ALL THOSE THAT ARE APPLICABLE)

GENERAL: Fever _____ Chills _____ Weight Loss _____ Weakness _____

SKIN: Rash _____ Itching _____

HEMATOPOIETIC: Bruising _____ Bleeding _____ Anemia _____

HEENT: Vision Change _____ Double Vision _____ Glaucoma _____ Vertigo _____ Hearing Problems _____

RESPIRATORY: Cough _____ Coughing Blood _____ Shortness of Breath _____ Infections _____

CARDIOVASCULAR: Chest Pain _____ Murmurs _____ Pain in Legs with Walking _____ Swelling in the Legs _____

G.I.: Constipation _____ Diarrhea _____ Bleeding _____ Hemorrhoids _____ Indigestion _____ Hepatitis _____

MUSCULOSKELETAL: Joint Pain _____ Weakness _____ Back Pain _____ Cramps _____

NEUROLOGIC: Headache _____ Dizziness _____ Seizures _____ Blackouts _____ Depression _____

Alcohol (aver./day) _____

Caffeine (aver./day) _____ Number of Children _____

Tobacco (aver./day) _____ Recreational Drugs _____

Educational Level _____

FAMILY HISTORY:

Member	Living	Dead	Illness/Cause of Death or State of Health	Any Cancer of Prostate, Diabetes, or Kidney Stones?
Father				
Mother				
Brother				
Brother				
Sister				
Sister				

Is there anything else regarding your health that you would like the Doctor to know?

_____

_____

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PATIENT NAME: _____ DATE OF BIRTH: _____

KNOWN MEDICAL ALLERGIES INCLUDING REACTION:

MEDICATIONS I TAKE (Prescription, non-prescription, vitamins, herbals)

CHANGE	DATE	SIGNATURE
YES NO		
YES NO		
YES NO		
YES NO		
YES NO		
YES NO		

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ELIGIBILITY & BENEFITS WAIVER

I, _____, herby certify that I am eligible for _____ insurance effective _____.

I have chosen Dr. _____as my urologist. I understand that if I am found to be ineligible, or if the services rendered are found to be non-covered benefits under my plan, I am responsible for all costs incurred in the delivery of my medical services and will pay these charges within thirty (30) days of billing.

_____ _____
PATIENT SIGNATURE (Parent or Guardian) DATE

_____ _____
WITNESS SIGNATURE DATE

3771 Katella Avenue, Suite 210 • Los Alamitos, CA 90720 • (562) 430-0581 • Fax (562) 598-2110
• www.coasturologygroup.com •

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Patient Responsibility Agreement

Patient Name: _____ DOB: _____

Insurance Company: _____ Subscriber ID: _____

Patient/Guardian Signature: _____ Date: _____

BILLING STATEMENT

As a courtesy to our patients, we will bill your insurance company for services rendered. Contracts with insurance companies vary greatly and often times providers are considered out of network for many insurance plans. If we are NOT a network provider for your insurance plan, you will be responsible for the balance of the contracted rate remaining after payment is made by your insurance company. We will apply the appropriate payments and adjustments to your account before the remaining balance is billed to you. **Deductibles, co-payments and any denied charges are always the responsibility of the patient.** For additional information regarding your deductible or co-payment responsibility, you can contact your insurance carrier directly.

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FINANCIAL POLICY OF PRACTICE

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of your service.

Co-payments are accepted in the form of cash or check only. For your convenience, we accept all major credit cards when making a payment towards a previous balance, co-insurance or deductible.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required co-payment, co-insurance and/or deductible at the time of service. The co-payment will be collected when you arrive for your appointment. **In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement. A late fee of $25 will be assessed if payment is not received within 14 days of the statement due date. Any balance which remains unpaid after 30 days may be referred to a collections agency.

We will also bill your health plan for all services we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, we ask that you call us as early as possible if you know you will need to reschedule your appointment. Failure to do so may result in a fee for the missed appointment.

DELINQUENT ACCOUNTS

Any account balance unpaid beyond 90 days is considered past due. Once an account becomes delinquent, the account may be charged an additional 25% of the past due principle account balance. If the account continues to remain delinquent, it will be subject to outside collection agency action.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.
I also understand and agree that such terms may be amended from time-to-time by the practice.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR	TODAY'S DATE
X	
PRINT NAME OF THE PATIENT	
X	

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FINANCIAL FEES OF PRACTICE

TO OUR PATIENTS

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an element of your care and treatment.

We understand that appointments may need to be rescheduled, but a courtesy call **24 hours in advance** will allow us to accommodate another patient in that clinic time slot.

A courtesy of **72 hours in advance** applies for procedures performed both in our office and at the hospital. Much preparation and effort goes into scheduling urologic procedures affecting our physicians, the hospital, your internist and the various ancillary services.

As such, the following fees have been instituted. These fees are not billable to your insurance and payment will be required prior to the next scheduled visit. If you have any questions, we are happy to discuss them with you.

THE FOLLOWING FEES WILL BE CHARGED:

Missed Appointments $ 40.00

Missed Procedure $ 150.00

Missed Surgery $ 250.00

Copying Medical Records $ 30.00 (minimum charge)

Dictated Physician Letter $ 50.00

Forms-EDD, FMLA, DMV, Jury Duty $ 25.00

Prior Authorization for Prescriptions $ 25.00

Short Notice Cancellations $ 25.00
(Less than 24 hours' notice)

Short Notice Procedure Cancellation $ 100.00
(Less than 72 hours' notice)

Short Notice Surgery Cancellations $ 150.00
(Less than 72 hours' notice)

Mailing of Prescriptions $ 10.00 Handling Charge
(No charge for office pick up)

Non-Sufficient Funds Check $ 10.00

Billing Records $ 15.00

I understand that all fees listed above are NOT covered by insurance and must be paid in full prior to any new or rescheduled appointment, procedure or surgery.

I have read and understand the financial fees of the practice and I agree to be bound by its terms.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR	TODAY'S DATE
x	
PRINT NAME OF THE PATIENT	
x	

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