# 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 # ______

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**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 # ( ) ______

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**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 # ( ) ______

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**ADDITIONAL INFORMATION:**

REFERRING PHYSICIAN: ______ PHONE # ( ) ______

PRIMARY CARE PHYSICIAN: ______ PHONE # ( ) ______

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

ADDRESS: ______ PHONE # ( ) ______

PREFERRED PHARMACY: ______ PHONE # ( ) ______

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**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

William T. Naftel, M.D. Michael Norris, M.D. Stephen A. Hightower, M.D.

*Diplomates, American Board of Urology*

Edward J. Park, D.O.

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) ____________________

Tobacco (aver./day) ____________________

Educational Level ____________________

Number of Children ____________________

Recreational Drugs ____________________

**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

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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.

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

• www.coasturologygroup.com •

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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

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

Missed Procedure $ 150.00

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

Missed Surgery $ 250.00

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

Copying Medical Records $ 30.00 (minimum charge)

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

Dictated Physician Letter $ 50.00

Non-Sufficient Funds Check $ 10.00

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

Billing Records $ 15.00

Prior Authorization for Prescriptions $ 25.00

**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<br>x | TODAY'S DATE |
|---|---|
| PRINT NAME OF THE PATIENT<br>x | |