

ORINDA UROLOGY, INC.
Peter A. Schneider, M.D.

PATIENT REGISTRATION FORM

Name: _____ Date: ___/___/___
Address: _____ City: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Employer: _____ Occupation: _____
Date of Birth: _____/_____/____ Age Today _____
Primary Care Physician _____ Who referred you to us? _____

RESPONSIBLE PARTY (if other than above)

Name: _____ Date of Birth ___/___/___
Address: _____ City: _____ Zip: _____
Telephone: _____ Employer: _____

INSURANCE INFORMATION

Primary: _____	Supplemental: _____
Address: _____ _____	Address: _____ _____
ID# : _____	ID# : _____
Group# : _____	Group# : _____
Policy Holder: Self / Spouse / Parent / Other	Policy Holder: Self / Spouse / Parent / Other

EMERGENCY INFORMATION

Emergency Contact: _____ Relationship: _____
Telephone: _____

YOUR PREFERRED PHARMACY

Pharmacy Name: _____ Telephone # _____
Address: _____ City: _____ Zip: _____

(continued)

ORINDA UROLOGY, INC.
Peter A. Schneider, M.D.

(Registration continued)

Patient name: _____ Date of Birth: _____

BILLING POLICY

We will bill your insurance company for you. Your signatures at (A) and (B) below give us permission to do so. We submit the bills to the insurance companies immediately. It often takes several months before we are paid. All fees we are paid are SET BY YOUR insurance company. We accept their rates in full.

When the insurance company pays us they will reduce that amount by any deductible and/or co-payments they say you owe and instruct us to bill you directly for that deductible or co-payment amount. Therefore, we will not know for several months (or longer) whether or not to send you a bill. It can be very frustrating for patients to receive a bill from us as much as 6-12 months after a service. Please understand it is out of our control and not our choice.

AUTHORIZATION FOR RELEASE

A.) I hereby authorize the release of any and all information, acquired in the course of my examination, to my insurance company as they may require.

SIGNATURE: **X** _____ DATE _____

FINANCIAL AGREEMENT

B.) I hereby authorize the payment of medical benefits directly to Orinda Urology, Inc., for services rendered when applicable.

SIGNATURE: **X** _____ DATE _____

NOTICE OF PRIVACY PRACTICES

Notice to Patients:

We are required to provide you with a copy of our Notice of Privacy Practices (attached). Patient privacy and confidentiality are of paramount importance to us. We do not share or release any patient information except with your co-treating doctor(s) or with your insurance company (as above) if they require.

I acknowledge that I have been offered a copy of this office's Notice of Privacy Practices.

SIGNATURE: **X** _____ DATE _____

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices

ORINDA UROLOGY, INC.
Peter A. Schneider, M.D.

PATIENT COPY

NOTICE OF PRIVACY PRACTICES

Orinda Urology, Inc.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other Health Care Professionals who provide treatment and/or services to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your Health Information to seek payment for services we provide you. This disclosure involves our business office staff and may include Insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of emergency involving care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing some to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.

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Marketing Health-Related Services: We will not use your health information for such purposes.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this notice. Once approved, an appointment can be made to review your records. Copies, of your chart if requested will be \$50.00, unless you file is excessively large then the fee will increase and be determined at the time of request. This does include postage. Please contact the Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: Your have the right to receive a list of non routine disclosure we have made for your health care information. (When we make routine disclosures of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures information for reasons other than treatment, payment or healthcare operations.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTION AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Resources.

HOW TO CONTACT US:

PRACTICE NAME: ORINDA UROLOGY, INC.

ADDRESS: 25 ORINDA WAY

SUITE#100

ORINDA, CA 94563

PRIVACY OFFICER: Peter A. Schneider, MD

TELEPHONE: 925-253-1650

FAX: 925-253-1705

PATIENT HISTORY

Page 1
ORINDA UROLOGY, INC.
Peter A. Schneider, MD

NAME (Last, First) _____ D.O.B. _____

DATE _____ REFERRING PHYSICIAN _____ AGE _____

Chief Complaint:

What is the main reason for your visit today?

Three horizontal lines for writing the chief complaint.

History of Present Illness Please answer the following questions:

Location of the problem?

Abdomen Back Pelvis

Other _____

How long does the problem last?

minutes hours always there

Other: _____

On a scale of 0-10, with 10 being the most severe circle the number that best describes the problem?

0 1 2 3 4 5 6 7 8 9 10

Is anything else occurring at the same time? Yes No

When did you first notice the problem?

__ days ago __ weeks ago __ months ago

__ years ago

Frequency of the problem?

constant variable

Other : _____

Does anything make the problem worse?

Yes No

Does the problem interfere with your normal functions?

[] Yes No

Physician use only : (Comment/Notes)

Past Medical History

List all personal medical conditions and surgery.

Medical problems and surgery: Date

Four horizontal lines for listing medical problems and surgery.

none []

Family History

List all serious illnesses in your immediate family (Example: diabetes, prostate cancer, breast cancer, heart disease)

Family medical problems:

Four horizontal lines for listing family medical problems.

none []

Patient History (continued)

Patient Name: _____ d.o.b. _____ Date _____

Are you on any medications? Yes No (If yes, please list all)

Do you have any **allergies** to medication or iodine or shellfish? Yes No (If yes, please explain) _____

Do you smoke cigarettes? Yes No

Do you drink alcohol? Yes No Occasional

Occupation: _____

Urologic History: please check if "yes" or check "none"

- | | | |
|---|---|--|
| <input type="checkbox"/> Urinary infection | <input type="checkbox"/> Urinate too often | <input type="checkbox"/> Urinary tract surgery |
| <input type="checkbox"/> Blood in the urine | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Slow urination | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Kidney disease |
| | | <input type="checkbox"/> none |

Review of Systems

Do you now have any of the following problems?

	YES	NO		YES	NO		YES	NO
General			Gastrointestinal			Respiratory		
fever	<input type="checkbox"/>	<input type="checkbox"/>	nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>
weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular			Hematologic		
Eyes			chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>	Blood clotting		
glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	problems?	<input type="checkbox"/>	<input type="checkbox"/>
Neurological			heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Do you take		
stroke	<input type="checkbox"/>	<input type="checkbox"/>	Dermatologic			coumadin?	<input type="checkbox"/>	<input type="checkbox"/>
lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	skin rash	<input type="checkbox"/>	<input type="checkbox"/>	Do you take		
Endocrine			Musculoskeletal			daily aspirin?	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>			

Physican use only: (Comments/Notes)