

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.

Providers:

- Robert B. McBeath, 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.*
- Avi C. Weiss, M.D.*
- David V. Ludlow, M.D.*
- Sarah Ryan, M.D.*
- Craig Hunter, D.O.*
- Ranjit Jain M.D.*
- Jeffrey Wilson, M.D.*
- Scott Slavis, M.D.*

LOCATION:

Central Las Vegas Office
2010 Wellness Way, Suite 200
Las Vegas, NV 89106

Green Valley Office
58 North Pecos Road
Henderson, NV 89074

Northwest Office
3150 N. Tenaya Way #165
Las Vegas, NV 89128

Southwest Campus
6190 S. Fort Apache, Suite 200
Las Vegas, NV 89148

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 a 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, American Express, Discover and Master Card. We do not accept postdated checks nor will we hold checks. Again, welcome to our practice. We look forward to providing you with your urology 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 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 four office locations. The office in Central Las Vegas is located at 2010 Wellness Way, Suite 200 Las Vegas, NV 89106. The Goldring Medical Plaza building is located in the block between S. Tonopah Drive and Wellness Way, with the closest major intersection being S. Rancho Drive and W. Charleston Blvd. The office in Green Valley is located at 58 North Pecos Road, 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 Northwest Campus is located at 3150 N. Tenaya Way Suite 165, Las Vegas, NV 89128, in the Mountain View Medical Office Building. The southwest campus is located at 6190 S. Fort Apache, Suite 200 Las Vegas, NV 89148.

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 PROCEDURE APPOINTMENT: \$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, USONV accepts cash, personal checks, Visa, MasterCard, American Express, and Discover Card. 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 option 7. 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		Work Phone		Ext./Dept.	
Date Of Birth		Sex	Male Female	Marital Status	
Primary Language		Race		Ethnicity	Hispanic or Not Hispanic
Social Security #		Email Address:			
Employer					
Employer Address					
Person to contact in case of emergency (not living with you)		Phone #			

SPOUSE INFORMATION

Name		Date of Birth		SSN	
Employer				Work Phone	
Employer					

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

Responsible Party Last Name		First		Relationship	
Address/City/State/Zip					
Telephone		Resp. Party			

INSURANCE INFORMATION

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

1	First Insurance Name				
	Policy Holder Last		First Name		Relationship
	Certificate/ID #		Group Name/No.		Date of Birth
	Is this insurance from an employer group?		If yes, Employer		
2	Second Insurance				
	Policy Holder Last		First Name		Relationship
	Certificate/ID #		Group Name/No.		Date of Birth
	Is this insurance from an employer		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 Name: _____ 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 will bill the insurance company 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. USONV accepts cash, personal checks, Visa, MasterCard, American Express and Discover 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.

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

SIGNATURE _____ DATE _____

USONV PATIENT HISTORY FORM – PAST MEDICAL HISTORY

Name: _____ Birth Date: _____ Primary Doctor: _____

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

Did you ever have a Pneumonia Vaccination? Yes No Estimated Date _____

Did you have a Flu Shot in the last 12 months? Yes No Estimated Date _____

Did you ever have a Colonoscopy Yes No Estimated Date _____

Did you ever have a Mammography? Yes No Estimated Date _____

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

<u>Condition:</u>	<u>Date:</u>	<u>Condition:</u>	<u>Date:</u>
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

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

<u>Condition:</u>	<u>Condition:</u>
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

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

<u>Medication and Dose:</u>	<u>Instructions:</u>	<u>Medication and Dose</u>	<u>Instructions:</u>
<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 reactions:

<u>Allergy:</u>	<u>Reaction Type:</u>	<u>Allergy:</u>	<u>Reaction Type:</u>
<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? _____

USONV 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: _____ **Year Retired:** _____

Tobacco Use: Current Smoker? YES NO Former Smoker YES NO

Age when began: _____ Age when quit : _____ How many packs per day : _____

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 number of drinks (circle one): 1-2 DRINKS 3-4 DRINKS 5-6 DRINKS 7-8 DRINKS 9+ DRINKS

Frequency (circle one): RARELY OCCASIONALLY 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: _____

Patient Name: _____ DOB: _____

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 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:

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

SKIN/BREAST

LUMPS IN BREASTS 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
 STERIOD THERAPY YES

USONV NEW PATIENT HISTORY FORM – VOIDING SYMPTOM SCORE

Patient Name: _____ DOB: _____

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 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

Patient Name: _____ DOB: _____

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information (PHI)

Your protected health information will be used by Urology Specialists of Nevada or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

This acknowledges your receipt and reading of USONV'S Notice of Privacy Practices. You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You should review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

USONV may or may not agree to restrict the use or disclosure of your protected health information.

If USONV agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

USONV reserves the right to modify the privacy practices outlined in this notice.

Signature

I have reviewed this consent form and give my permission to USONV to use and disclose my health information in accordance with it.

Name of Patient (Print or Type)

Signature of Patient Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

Patient Name: _____ DOB: _____

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

To be present while I am receiving services from Urology Specialists of Nevada, and to hear/participate in discussions of my medical conditions, treatments, and billing information either in person or by phone. I understand that the named individual(s) listed may also view my medical information displayed on a computer monitor by Urology Specialists of Nevada clinical staff.

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

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) DOB

Signature of Patient Date

Signature of Patient Representative Relationship of Patient Representative to Patient

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities. We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 702-877-0814.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 702-877-0814.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：702-877-0814