Urology Specialists
OF NEVADA
Part of OptumCare®

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 (USONV) both pleasant and productive.

Providers:

- ☐ Robert B. McBeath, MD, FACS
- ☐ Jason N. Zommick, MD, FACS
- ☐ Michael P. Finkelstein, MD
- ☐ Mulugeta D. Kassahun, MD, FACS
- ☐ David V. Ludlow, MD
- ☐ Sarah Ryan, MD
- ☐ Craig Hunter, DO
- ☐ Ranjit Jain, MD
- ☐ Jeffrey Wilson, MD
- ☐ Scott Slavis, MD
- ☐ Jason Orien, MD

Locations:

Central Office
2010 Wellness Way, Ste. 200
Las Vegas, NV 89106

Green Valley Office
58 North Pecos Road
Henderson, NV 89074

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

Northwest Office
3150 N. Tenaya Way, Ste. 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 a picture ID (preferably driver's license or Nevada ID) and your insurance card. Any applicable copayments, coinsurances and/or unmet deductibles will also be collected at the time of your visit. We accept cash, checks, Visa, American Express, Discover Card and Mastercard. 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.

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 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 (copay/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.

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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 (M/F)**		**Marital status**	
Primary language		**Race**		**Ethnicity**	
Social security #		**Email address**			
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**		**Relationship**	
Address/City/State/Zip					
Telephone		**Resp. party SSN:**			

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Insurance information

(Please provide copies of your cards and/or insurance forms)					
1	**First insurance name**				
	Policy holder last name		**First name**		
	Certificate/ID #		**Relationship**		
	Group name/No.		**Date of birth**		
	Is this insurance from an employer group? Y/N		**If yes, employer**		
2	**Second insurance name**				
	Policy holder last name		**First name**		
	Certificate/ID #		**Relationship**		
	Group name/No.		**Date of birth**		
	Is this insurance from an employer group? Y/N		**If yes, employer**		

Assignment of insurance benefits

	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 name: _____ DOB: _____

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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 copayments, coinsurances, 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 Card 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 procedure appointments $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: _____

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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: _____

Medication 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			5		
2			6		
3			7		
4			8		

OB history (if Female)

# of pregnancies _____ **# of live births** _____ **# C- sections** _____

USONV patient history form – past medical history *(continued)*

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

Allergies to medications, food or substance and if <u>severe</u>, <u>moderate</u> or <u>mild</u> reactions:

	Allergy	Reaction type		Allergy	Reaction type
	Example: ***penicillin***	***Rash, shortness of breath***			
1			6		
2			7		
3			8		

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USONV patient history form – social and family history

Highest level of education completed? (select 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 _____

USONV patient history form – social and family history *(continued)*

Alcohol use

Do you drink alcohol? ☐ Yes ☐ No If yes, type: ☐Beer ☐Wine Other _____

If yes, estimated number of drinks (select one):

☐ 1–2 drinks ☐ 3–4 drinks ☐ 5–6 drinks ☐ 7–8 drinks ☐ 9+ drinks

Frequency (select one):

☐ Rarely ☐ Occasionally ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

IV or recreational drug use

☐ None Drug(s): _____

Last used: ☐ Currently ☐ W/in 12 months ☐ W/in 1–5 years ☐ More than 5 years

Current marital status (select one)? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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

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

Patient name: _____ DOB: _____

USONV patient history form – social and family history *(continued)*

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 (select 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		**Genitourinary****	
Fever	Yes	Blood in urine	Yes
Weight loss	Yes	Kidney or bladder stones	Yes
Loss of energy	Yes	Kidney/bladder infections	Yes
Difficulty sleeping	Yes	Gonorrhea/syphilis/chlamydia	Yes
Head and neck		Loss of bowel or bladder control	Yes
Blurred/double vision	Yes	Pain or burning	Yes
Temporary blindness	Yes	Leak urine when cough/sneeze	Yes
Difficulty swallowing	Yes	Problems w/ fertility	Yes
Difficulty smelling	Yes	Weak urinary stream	Yes
Sores in mouth or throat	Yes	Incomplete bladder emptying	Yes
Lumps in neck	Yes	Intermittent stream	Yes
Ear infections	Yes	Straining to urinate	Yes
Cardiovascular		Urinary urgency	Yes
Short of breath on exertion	Yes	Having to urinate at night	Yes
Irregular heart beat	Yes	**If male:**	
Chest pain	Yes	Prostate infection	Yes
Leg pain with exertion	Yes	Penile/urethral discharge	Yes
Heart attack	Yes	Testis or scrotal infection	Yes
Stroke	Yes	Swelling in scrotum	Yes
Awaking at night short of breath	Yes	Problem w/ erections	Yes
Swelling in ankles	Yes	Blood in ejaculate (semen)	Yes
Respiratory		**If female:**	
Chronic cough	Yes	Vaginal dryness	Yes
Coughing up blood	Yes	Pain w/ intercourse	Yes
Shortness of breath at rest	Yes	Frequent vaginal infections	Yes
Wheezing	Yes	Hot flashes	Yes
History of pneumonia or bronchitis	Yes	History of PID or tubal infection	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	
Ear 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

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
Steroid therapy	Yes

Patient name: _____ DOB: _____

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USONV new patient history form – voiding symptom 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 x	2x	3 x	4x	5+x	

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:**	

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
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: _____

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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: _____

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Authorization of use and disclosure of protected health information to family members of 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
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

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