Urology Care Center
Cu N. Phan, MD
400 Newport Center Drive #409
Newport Beach, CA 92660
Phone: (949) 718-4315
Fax: (949) 718-4316

NOTICE OF FINANCIAL RESPONSIBILITY TO OUR PATIENTS

FOR CASH PATIENTS AND INSURANCE HOLDERS

At Urology Care Center, we strive to provide you with excellent medical care. We also keep your convenience in mind by billing your medical insurance for you. However, you are financially responsible for you action including co-payment, deductible and any services not covered by your medical insurance. Our office will mail you a statement, and any fees are due in 30 days. If somehow your payment is not received in 30 days, we will re-bill you with a second statement. For cash patients, your payment is due at the time of your visit.

Cancellation Policy

We want our patients to have the best experience and be able to get an appointment in a timely manner. We also want to make sure that you get the proper care you need. Due to this we have a **cancellation policy**. There is a 50-dollar fee for “no-show” “no call” patients and cancellations within 24 hours without a valid excuse. This is not billable to your insurance.

Co-payments are due at the time of visit.
There is a 50 fee for no-shows or cancellations within 24 hours.

If you have any questions regarding this notice of your financial responsibility, please contact the Urology Care Center- Cu N. Phan, MD.

Name of Patient:____

Patient Signature: ____

Today’s Date: ________________________________

Notice of Privacy Practice

To our patients: This notice describes how health information about you (as a patient of this practice) may be used disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPPA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information:

Use and disclosure of your health information in certain special circumstances

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceeding in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the information that may be used to make decisions about you, including patient medical and billing records, but not including psychotherapy notes. You must submit your request in writing to Urology Care Center, Cu N. Phan, MD.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Urology Care Center, Cu N. Phan, MD. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact our front desk.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Urology Care Center, Cu N. Phan, MD. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this Notice or our health information privacy policies, please contact Urology Care Center, Cu N. Phan, MD.

I hereby acknowledge that I have been presented with a copy of Urology Care Center's Notice of Privacy Practices.

Signature ______________________________ Today's Date__________________________

Name of Patient __________________________

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Authorization for Release of Medical Records

To Dr./Practice Name: ____

Address: ____

City, State, Zip: ____

Phone: ______________________ Fax: __________________________

Please leave blank, for office use only

I hereby authorize and request the following medical records be release to Dr. Cu N. Phan

☐All urologic records	☐ CT/MRI scans	☐ Nuclear scans
☐X-rays	☐ Ultrasounds	☐ Biopsy results
☐ER records	☐ Pathology results	☐ Other:________________

Please sign here

Patient Name:_____________________________ Date of Birth:___________________

*Signature:_________________________________ Date:__________________________

Print Your Name (if different from patient's): __________________________

Relationship:__________________________

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Patient Information and Demographics

<u>If you are in a wheelchair, please note our patient rooms can only accommodate wheelchairs up to 27.5" in width and we apologize that we are unable to accommodate gurneys**</u>**

Name (Last, First):_______________________________________ Soc #:_______________________

Date of Birth: ______________________________

▪Provide your email below to become web-enabled via our patient portal. This will give you online access to medical records (e.g. labs, notes, etc.)
▪It is important to provide your email so that we may contact you in the event you cannot be reached by phone

Sex: Male ___ Female ____ Other_____

Email:____

Address:____

City: _____________________________ State: _________ Zip Code: _________________________

Home phone: _____________________________ Cell phone: ________________________________

Marital Status: Single _______Married______ Domestic Partner_____ Divorced_____ Widow______

Optional: Race: _________________ Ethnicity: _________________ Language: _________________

Insurance Information

<u>Please bring your driver's license and insurance cards on the day of your appointment</u>

Primary Insurance: ___________________________ Secondary: _______________________________

Responsible Party (Policy Holder): __________________________Relationship: __________________

If different from patient:

Policy Holder Address: ___________________________________ Phone: ______________________

▪ May we leave messages such as lab results, reminder calls (eclinical messenger) or other medication information on an answering machine? Yes _____ No_____ Prefer: Home_____ Cell______

▪ Please list 3 names with whom we can leave messages with if you are not available

1. Name: ________________________________ Phone: ________________________________
2. Name: ________________________________ Phone: ________________________________
3. Name: ________________________________ Phone: ________________________________

Pharmacy Information

Pharmacy Name: ______________________________ Phone: ________________________________

City:

Emergency Contact

In case of emergency, notify:

Name : __________________________ Phone: ______________________Relationship: ____________

Date of Visit: ______________

Patient Name:_______________

Patient DOB:_________________
Gender: M/F

UROLOGY QUESTIONNAIRE

Once you complete the form, please email it to staff@cuphanmd.com, fax to (949) 718-4316, or mail to us

Referring doctor: ______________________________ Primary care doctor: ___________________________

Other physicians that you have seen:

Cardiologist: _______________________________ Gastroenterologist: ___________________________

Pulmonologist: _________________________________ Other: ____

Have you ever seen Dr. Cu Phan before? _______ Yes _______ No If yes, where?___________________

Chief Complaints/Reason for Visit: ____

____.

Duration of the problem: ______ days, ______ months, ______ years

Severity of the problem: ______ mild, ______ moderate, ______ severe

Previous treatment for this problem: ______ Yes ______ No

Have you ever seen other doctors (urologists) for this problem(s)? ______ Yes ______ No

Who: ___________________________________ When: ____________________________________

Medication List, Dosage, and Time (Including over the counter Rx aspirin, motrin, etc.) or we can make a copy of your medication list:

____mg_____________________x/day
____mg_____________________x/day
____mg_____________________x/day
____mg_____________________x/day
____mg_____________________x/day
____mg_____________________x/day
____mg_____________________x/day
____mg_____________________x/day
____mg_____________________x/day
____mg_____________________x/day
____mg_____________________x/day
____mg_____________________x/day
____mg_____________________x/day

Past Medical History:

Kidney Stones: _______ Yes _______ No
High Blood Pressure: _______ Yes _______ No
Lung Disease: _______ Yes _______ No
Cancer: _______ Yes _______ No
Other: ___________________________

Heart Disease: _______ Yes _______ No
Undescended Testis: _______ Yes _______ No
Diabetes: _______ Yes _______ No
Seizure: _______ Yes _______ No

Allergies/Intolerances: _______ Yes _______ No Which: ____________________________________
Seafood/Iodine: _______ Yes _______ No

Date of Visit: ______________ Patient Name:________________

Surgical History:

Kidney stone surgery: ____ Yes ____ No Year: _________
Prostate surgery: ____ Yes ____ No Year: _________
Hysterectomy: ____ Yes ____ No Year: _________
Bladder Lift: ____ Yes ____ No Year: _________
Heart By-Pass: ____ Yes ____ No Year: _________
Hernia surgery: ____ Yes ____ No Year: _________
Appendix surgery: ____ Yes ____ No Year: _________
Other: ______________________________ Year:________

Family History:

Prostate Cancer: ____ Yes ____ No
Kidney Stones/Cyst: ____ Yes ____ No
Other: ____

Social History:

Cigarette Smoking: ____ Yes ____ No
Amount per day: _____________ Years Since Quit Smoking:_________
Alcohol: ____ Yes ____ No
Drinks per day: ____________
Recreational Substances: ____ Yes ____ No
Occupation: _________________________
(Or occupation prior to retirement)

Review Of Systems (ROS):

Painful Urination: ____ Yes ____ No
Frequent Urination: ____ Yes ____ No
Urgent Urination: ____ Yes ____ No
Slow Urine Stream: ___ Yes ____ No
Night Time Urination: ___Yes ____ No If yes, how many times per night? _________
Blood in Urine: ____ Yes ____ No
Leakage of Urine: ____ Yes ____ No If yes, number of pads per day: _________
With coughing: ________ With laughing: _______
Fever: ____ Yes ____ No
Flank/Back Pain: ____ Yes ____ No
Weight Loss: ____Yes ____ No
Severe Headache: ____ Yes ____ No
Change in Vision: ____ Yes ____ No
Sexual Problem: ____ Yes ____ No If yes, duration: ________ months, ____________ years
Desire: ____Strong _____Poor
Chest pain: ____ Yes ____ No
Shortness of Breath: ____ Yes ____ No
Nausea/Vomiting: ____ Yes ____ No
Diarrhea: ____ Yes ____ No
Constipation: ____ Yes ____ No
Numbness/Weakness:___ Yes ____ No
Bleeding Problem: ____ Yes ____ No
Fainting Problem: ____ Yes ____ No