REDDING UROLOGIC ASSOCIATES
A Medical Corporation

Dear Patient:

Welcome to REDDING UROLOGIC ASSOCIATES. You have been referred by your physician to our Urologic specialists. We will strive to deal with your problem in an efficient and comprehensive manner.

In order to schedule your appointment as quickly as possible, the following is mandatory:

- Complete the enclosed Patient Information and History forms in their entirety and return them to the office. Please DO NOT EMAIL the forms. You may mail them, fax them, or bring them to the office.
- Once we receive this completed packet back, we will call to schedule your appointment.
- Bring **all** of your medication bottles including vitamins and herbs to your office visit.
- Keep this letter for your reference and directions to our office.

If you have any questions, please do not hesitate to call our office staff.

The length of your appointment will vary depending on the nature of your problem. We will try our best to honor your appointment time as closely as possible. Please understand that the nature of our practice is such that there will be occasional surgical emergencies and unforeseen delays which may contribute to longer waiting periods. If you are unable to keep your appointment, or wish to reschedule, please notify us as soon as possible so we may accommodate your needs.

Sincerely,

REDDING UROLOGIC ASSOCIATES

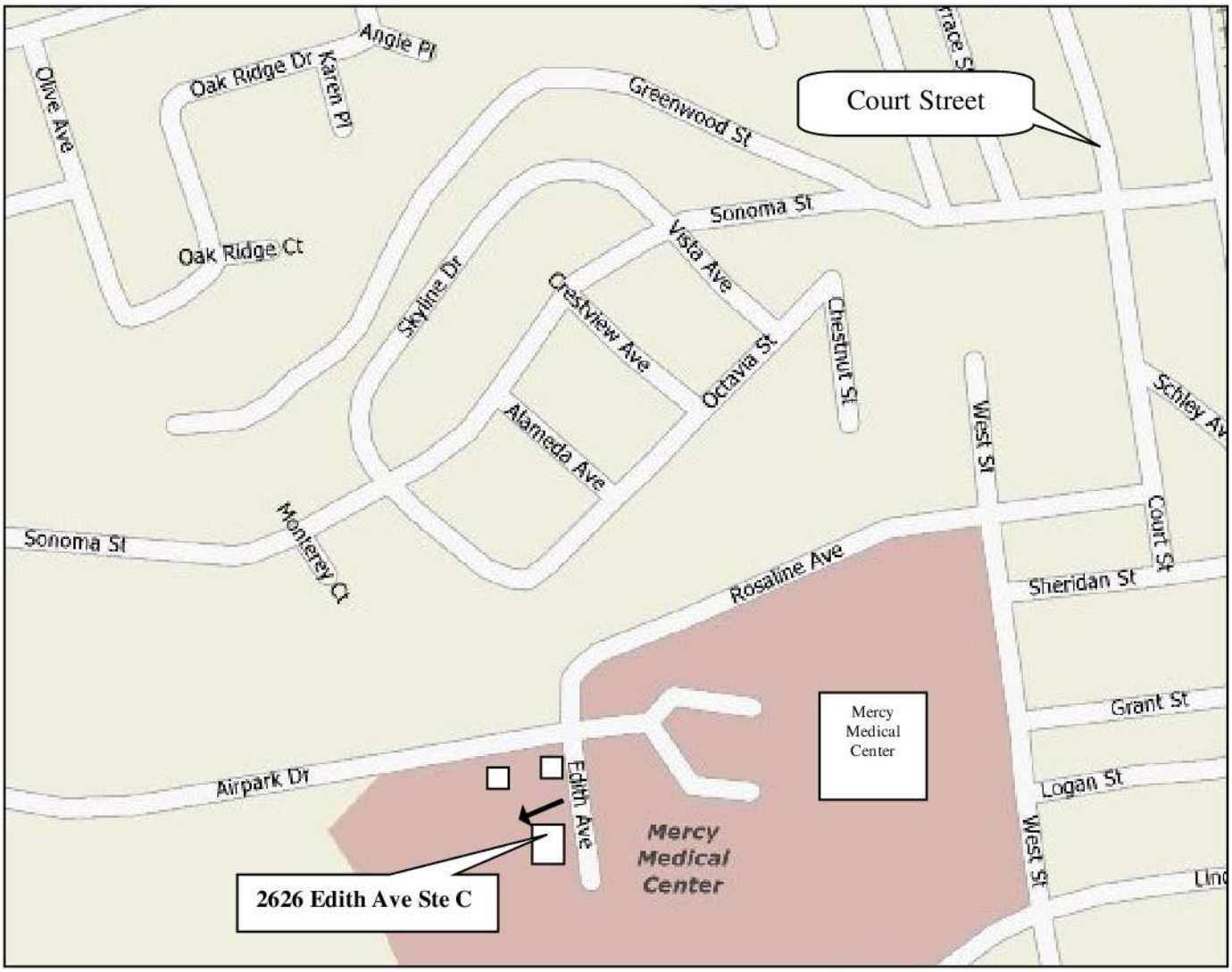
Patrick Fowler, M.D. ● Victoriano Romero, M.D.
Tiffany Perkins, M.D. ● Christopher Stockdale, M.D.
530.241.3316 ● 800.400.3316 ● 530.241.6319 fax
2626 Edith Ave Ste C ● Redding, CA 96001
www.rua.com

Directions to Redding Urologic Associates

From Interstate 5: Take exit number 678 for Highway 44 West. This will take you into downtown Redding, and you will be on Shasta St. Stay in the middle lane and follow for approx 5 stop lights. Turn LEFT on Court St. Drive south on Court St. until the street splits like a Y. Stay to the RIGHT, and follow the blue "H" hospital sign. Turn RIGHT on Rosaline Ave. At the top of the hill you will come to a four way stop go straight, *the street changes from Rosaline to Edith Ave*. Take the first RIGHT into Clairmont Doctors Park. We are the first building on the left.

From 299W: Turn RIGHT on Buenaventura Blvd. (by Sunset Marketplace.) Turn LEFT on Placer St. Turn RIGHT on Airpark Dr. When you reach the stop signs, turn RIGHT on Edith Ave. Take the first RIGHT into Clairmont Doctors Park. We are the first building on the left.

From 299E: Take Interstate 5 south. Follow above directions from Interstate 5.



WELCOME TO THE OFFICE OF
REDDING UROLOGIC ASSOCIATES

Patient's legal name: _____ **Birthdate:** _____

Mailing address: _____ **City:** _____ **State:** ____ **Zip:** _____

Phone 1: _____ ☐Mobile ☐Home ☐Work ☐Other: _____

Phone 2: _____ ☐Mobile ☐Home ☐Work ☐Other: _____

Phone 3: _____ **Consent to text:** ☐Yes ☐No

Email: _____ **Portal Access:** ☐ Yes ☐ No

Patient's marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Birth Sex: ☐ Male ☐ Female **Patient's social security number:** _____

Language: _____

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian ☐ White ☐ Declined ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Responsible party name: _____ ☐ **Self**

Relationship to patient: _____

Address: _____ **City, State, Zip:** _____

Home phone: _____ **Cell phone:** _____

Birthdate: _____ **Social security number:** _____

Marital status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other: _____ **Sex:** ☐ Male ☐ Female

Spouse's name: _____ **(or 2nd Parent)**

Cell phone: _____ **Other phone:** _____

Primary insurance name: _____

Name of Subscriber: _____ **Subscriber Employer:** _____

Member ID: _____

Secondary insurance name: _____

Name of Subscriber: _____ **Subscriber Employer:** _____

Member ID: _____

Name of nearest friend/relative not residing w/ you: _____ **Phone:** _____

Relationship to you: _____

Family physician name: _____ **Phone:** _____

Whom may we thank for referring you: _____ **Phone:** _____

Continued on Back

FINANCIAL POLICY

Redding Urologic Associates thanks you for the trust you have placed in us by selecting our practice for your urologic needs. We are acutely aware of the escalating costs of health care and insurance and strive to maintain fees, which are reasonable and customary for our area. We believe that communication is critical to our relationship and have established the following financial policies for the practice. Of course, we welcome any questions or comments you may have. Our staff stands ready and willing to make your visit with us as smooth as possible.

Thank you for taking the time to read and understand our policies.

1. **Medicare Patients**-We are Medicare providers **ONLY**. All **co-pays** and **deductibles** are due at the time of service, **unless** it is a known benefit of the supplemental/secondary plan. We do not contract with any Medicare HMO plans.

2. **Private Pay**- Patients will be required to pay a **$100 minimum deposit** for service at the time of check in.

3. **Anthem/Blue Cross**- All co-pays and deductibles are due at the time of service. However, we are **NOT** contracted with any HMO plan, Medi-Cal/Anthem or Medi-Cal/California Health and Wellness.

4. **Private Insurance**- Please contact your insurance PRIOR to your appointment to confirm your Out of Network benefits and coverage. All balances must be cleared within 90 days from the date of service. There is a copayment of 40% of our fee for office visits and 50% for any procedures performed, not including deductible. (Excluding elective procedures)

    - **We bill all private insurance as a courtesy. Payment is expected at the time services are rendered.**

5. **Blue Shield**, **United Healthcare, and Aetna** – We are contracted providers. All co-pays and deductibles are due at the time of service.

6. Should your insurance company require a REFERRAL/AUTHORIZATION prior to receiving medical services and the patient has NOT obtained this, you **WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.**

7. We will assess a billing fee of $ 10.00 per visit for all balances due but not paid at the time of service.

8. A 24-hour notice of cancellation for your appointment is required. A missed appointment fee of $35.00 will be charged for each visit scheduled, but not attended, due to the patient not calling to cancel prior. Two business days' notice of cancellation or rescheduling is required for surgical procedures or a fee of $100 will be charged.

9. Our Billing Manager must approve any other financial arrangements, **in advance**.

10. As a courtesy to our patients, we accept Discover, MasterCard, Visa and Care Credit at no charge.

This will acknowledge that I have read and fully understand the financial policies discussed above and further agree to be responsible for payment of all medical services rendered on my behalf or of those for whom I am financially responsible. I authorize this office to release to the named insurance company any information necessary to expedite insurance payment.

_____ _____

Patient/Guardian Signature Date

***A $25.00 charge will be added for all returned checks.**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used:

- **For Treatment:** We are permitted to use your health information or disclose it to others outside Redding Urologic Associates in order to provide, plan and direct proper medical care for you.
- **For Payment:** We are permitted to disclose health information about your treatment and services in order to submit bills for the care and services you receive, and collect payment from you, your insurance company or a third party payer.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

I understand your **Notice to Privacy Practices** containing a more complete description of the uses and disclosures of my health information are available to me. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time to obtain a current copy of the **Notice of Privacy Practices**.

♦♦♦ **I Do / Do not (Please circle one)** authorize Redding Urologic Associates to release any information to my spouse, family members, or caregivers.

Patient name: _____

Signature (of Patient or Legal Guardian): _____

Relationship to Patient: _____

Date: _____

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Date: _____

Name: _____ Date of Birth: _____

Referring Doctor: _____ Family Physician: _____

Have you ever seen a **heart doctor/cardiologist**? _____

List who and when last seen: _____

Other Treating Physicians: _____

Reason for your urology visit: _____

How long have you had this problem/pain? _____

What improves/worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous, or does it come and go? _____

What is the nature of the pain? (Sharp, dull, etc) _____

Have you tried any medicine/treatment or seen a doctor for this problem before this visit? _____

_____

Pharmacy

	Name	Location
1.		
2.		
3.		

Allergies

Please list *ALL types* (drug, seasonal, pets, animals, environment and foods) and *your reaction to each*.

☐ No Known Drug Allergies

Name of Medication	Reaction

Current Medications

Please list ALL medications you are currently taking. Include any over-the counter drugs, vitamins or herbal medications.

Complete Drug Name	Strength	Directions (ex. 1 a day)	List condition medication taken for

Surgical History

Date	Surgery (Type of Surgery)

Colonoscopy: Have you had a colonoscopy? ☐ Yes ☐ No Date of colonoscopy_____

Pneumonia Shot: Have you had a pneumonia shot? ☐ Yes ☐ No Date of shot_____

Past Medical History

Please mark with an "x" if you have had any of the following diseases or conditions

CARDIOVASCULAR
- ☐ Aortic aneurysm
- ☐ Arrhythmia
- ☐ Atrial fibrillation
- ☐ Congestive heart failure
- ☐ Deep Vein Thrombosis
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hypertension
- ☐ Mitral insufficiency
- ☐ Mitral stenosis
- ☐ Mitral valve prolapse
- ☐ Rheumatic fever
- ☐ Stroke

ENDOCRINE /METABOLIC
- ☐ Diabetes Mellitus
  - ☐ Type 1
  - ☐ Type 2
  - ☐ Peripheral Neuropathy
- ☐ Gout

GENERAL
- ☐ Hepatitis
  - ☐ A
  - ☐ C
- ☐ Bleeding Disorder

GI
- ☐ Other _____

GUI
- ☐ Bladder infection
- ☐ Chronic Kidney Disease
  - ☐ I
  - ☐ II
  - ☐ III
  - ☐ IV
  - ☐ V
  - ☐ End Stage
- ☐ Kidney Cancer
- ☐ Prostate Infection
- ☐ Other _____

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Herniated disc

NEUROLOGICAL /PSYCHOLOGICAL
- ☐ Alzheimer's disease
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease

RESPIRATORY
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep apnea
- ☐ Tuberculosis

OTHER: _____
_____

Family History

Please indicate which family member has had any of the following

☐ Bladder cancer _____ ☐ Kidney stones _____ ☐ Other _____
☐ Kidney cancer _____ ☐ Prostate cancer _____ _____

Social History

Smokeless Tobacco: ☐ Yes ☐ No

Tobacco: ☐ **Current Every Day Smoker*** ☐ **Current Some day Smoker*** ☐ **Former Smoker*** ☐ Never Smoked
***Current Smoker:** Approximate year you started smoking _____. You smoke _____ packs per day
***Former Smoker:** How long did you smoke before you quit? _____ years. When did you quit? ____(Approx. Year)

You smoked _____of packs per day.

Caffeinated Drinks (How many in a day): ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Alcohol: ☐ Yes ☐ Not Anymore ☐ Never Drank

Recreational drugs: ☐ No **If Yes:** ☐ Amphetamine ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other:_____

Blood Transfusions: ☐ Yes ☐ No

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Common Law Spouse

Dependents Please indicate # of each:

____Sons ____Daughters ____Stepchildren ____Adopted ____Foster

Review of Genitourinary Systems

Please mark with an "x" if currently have the following symptoms

☐ Back/Flank pain
☐ Bedwetting
☐ Blood in urine
☐ Burning on urination
☐ Erection/Ejaculation problems
☐ Kidney failure
☐ Kidney stones
☐ Prostate infection
☐ Testes/Scrotal swelling
☐ Urinary incontinence
☐ Urinary tract infection
☐ Urinary retention
☐ Other _____
_____

Review of Systems

Please mark with an "x" if currently have the following symptoms or conditions

Constitutional
☐ Chills
☐ Fever
☐ Fatigue
☐ Weight loss
☐ Other _____

Eyes
☐ Blindness
☐ Other _____

Neurological
☐ Lightheaded
☐ Other _____

Endocrine
☐ Diabetes
☐ Thyroid disease
☐ Other _____

Gastrointestinal
☐ Abdominal pain
☐ Constipation
☐ Diarrhea
☐ Nausea/vomiting
☐ Other _____

Cardiovascular
☐ Chest pain/angina
☐ Heart murmur
☐ High blood pressure
☐ Irregular heartbeat
☐ Other _____

Skin
☐ Rash
☐ Other _____

Musculoskeletal
☐ Back Pains
☐ Other _____

Respiratory
☐ Asthma
☐ Shortness of breath
☐ Sleep Apnea
☐ Other _____

Hematologic/Lymphatic
☐ Swollen glands
☐ Bleeding problems
☐ Blood clotting problem
☐ Hepatitis
☐ HIV (AIDS)
☐ Other _____

Men

Circle the number that best applies to you for each question

	NOT AT ALL	LESS THAN 1 TIME IN 5	LESS THAN 1/2 THE TIME	ABOUT 1/2 THE TIME	MORE THAN 1/2 THE TIME	ALMOST ALWAYS
1. INCOMPLETE EMPTYING: Over the last month or so, 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: During the last month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. INTERMITTENCY: During the last month or so, how often have you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. URGENCY: During the last month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. WEAK STREAM: During the last month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING: During the last month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	NONE	1 TIME	2 TIMES	3 TIMES	4 TIMES	5 OR MORE TIMES
7. NOCTURIA: During the last month, how many times did you most typically 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

Add the score for each number above and write the total in the space to the right.

SYMPTOM SCORE = 1-7 Mild 8-19 Moderate 20-35 Severe **TOTAL** _____

	DELIGHTED	PLEASED	MOSTLY SATISFIED	MIXED	MOSTLY DISSATISFIED	UNHAPPY	TERRIBLE
QUALITY OF LIFE: How would you feel if you had to live with your urinary condition the way it is now, no better and no worse, for the rest of your life?	0	1	2	3	4	5	6

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