Las Vegas Pediatric Urology

Adult **Patient Demographics**

Doctor You Are Scheduled With Today:
Andrew Hwang, MD

Social Security#: ____________________

Name: ____________________

Address: ____________________

City:__________ **State:** ______ **Zip Code**:__________

E-Mail Address: ____________________

Employer:____________________

Employer Address:____________________

____

Home Tel: ____________________

Work Tel: ____________________

Cell #: ____________________

Sex: (Female) or (Male)

Date of Birth: ____________________

Marital Status: ____________________

Emergency Contact/Name and Tel#

____

Race: Please choose one:
Asian
Native Hawaiian
Other Pacific Islander
Black/African American
American Indian/Alaska Native
White
More than 1 Race
Unreported/Refused to Report

Ethnicity: Please choose one:
Hispanic/Latino Not Hispanic/Latino
Unreported/Refused to Report

Preferred Language: ____________________

Spouse Name: ____________________

Date of Birth:__________ **Phone #:**__________

Spouse Employer:____________________

Spouse SS # ____________________

Physician Information

Referring Doctor:____________________

Primary Care Doctor: ____________________

Other Physicians:

Insurance Information

Name of Insurance:__________ Subscriber Name: __________

Relationship to subscriber: __________Subscriber Date of Birth: __________

Policy Number: __________Group Number: __________

Secondary Insurance

Name of Insurance:__________ Subscriber Name: __________

Relationship to subscriber: __________Subscriber Date of Birth: __________

Policy Number: __________Group Number: __________

This form must be completed in order for us to bill your insurance. Failure to do so will mean that you are responsible for all insurance billing.

Assignment of insurance benefits: I hereby authorize my insurance company to pay directly to the doctor the amount due on my claim for services rendered to my dependent or me. Payment for co-pays and deductibles are required at the time services are rendered. I further agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for payment of the difference; and if the nature of the disability were such that it is not covered by the policy, I will be responsible to the doctor for payment of the entire bill.

Patient Signature:____________________ **Date:** __________

Las Vegas Pediatric Urology

Adult Patient Information Sheet

REASON FOR VISIT: ____

UROLOGIC CONDITIONS:

[ ] Kidney stones
[ ] Frequent Urination
[ ] Slow urine stream
[ ] Urinary tract infection
[ ] Blood in urine
[ ] Difficulty with erection
[ ] Scrotal swelling
[ ] Incontinence
[ ] Abnormal PSA

ALLERGIES to Medications: None ____________________ ____________________

Medication and reaction   Medication and reaction

CURRENT MEDICATIONS: None ____________________ ____________________

____________________ ____________________ ____________________ ____________________

PHARMACY Name: ______________________ Phone: ______________________

Street address: ______________________ City: ______________________

MEDICAL HISTORY: Check all conditions for which apply:

___Diabetes mellitus
___Hypertension
___Emphysema/COPD
___Asthma
___Heart troubles
___Thyroid disease
___Ulcer disease
___Gout
___Stroke
___Diverticulosis
___Colitis
___Glaucoma
___Liver disease/cirrhosis/hepatitis
___Cancer. Site of origin: ____________________
___Anemia/bleeding disorders
Other: ______________________________

PRIOR SURGERIES: None

______________________________ ______________________________

______________________________ ______________________________

FAMILY HISTORY: Please list medical conditions present in your family.

Mother	Father	Siblings
____________________	____________________	____________________
____________________	____________________	____________________

SOCIAL HISTORY: Check all that apply:

Marital status: ____Married ____Single ___Divorced ___ Widowed ___Separated

Smoking: ____Never Smoked ____Former Smoker ____Current Smoker, ____ packs per day

Alcohol: ____Never ______Quit ______Yes, ______drinks per day

Caffeinated drinks: ______per day

Blood transfusion in the past: ______ Yes ______ No

Recreational drug use: ___Never ___Former user ____Current user, drug of choice________

REVIEW OF SYSTEMS: If you have any of the symptoms below, please circle the condition

GENERAL	HEAD & NECK	CARDIOVASCULAR
Fever Night sweats Unexpected weight loss Difficulty sleeping Loss of Energy	Blurry or double vision Temporary blindness Ringing in ears Ear infections Difficulty smelling Nose bleeds easily Difficulty swallowing Sore throat Lump in neck	Short of breath on exertion Chest pain Irregular heartbeat Leg pain with exertion Swelling in ankles Wake up at night short of breath
RESPIRATORY	**GASTROINTESTINAL**	**HEMATOLOGIC**
Chronic cough Cough up blood Shortness of breath at rest Wheezing History of pneumonia or bronchitis	Indigestion or heartburn Stomach ulcers Vomiting blood Blood in stool Tarry stool Chronic diarrhea / colitis Jaundice Chronic constipation	Easy bruising or bleeding tendencies Anemia Poor immune system On blood thinners
MUSCULOSKELETAL	**SKIN & BREAST**	**ENDOCRINE**
Pain or swelling in joints Pain in the spine	Lumps or pain in breast Nipple discharge Abnormal breast engorgement	Temperature intolerance Thyroid problems Excessive thirst Steroid use
GYNECOLOGIC	**NEUROLOGIC/PSYCHIATRIC**	**GENITOURINARY**
Abnormal PAP smear Pain with intercourse Vaginal dryness Frequent vaginal infections Hot flashes Prior PID or tubal infections	Weakness in extremities Numbness or tingling in extremities Pain shooting down extremities Seizures Dizziness Vertigo (room spinning around you) Chronic depression Anxiety disorder	Blood in urine Kidney or bladder stones Kidney or bladder infections Loss of bladder or bowel control Pain or burning with urination Leak urine with cough, sneeze, or laugh Leak urine with urge

LAS VEGAS UROLOGY

Las Vegas Pediatric Urology

International Voiding Symptom Score

Patient Name ______________________ **Date of Birth** __________ **Date** __________

Please answer the questions below with a ranking of your symptoms.	Not at all. 0	Less than 1 time in 5. 1	Less than half the time. 2	About half the time. 3	More than half the time. 4	Almost always. 5	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 urinating?	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 urination?	0	1	2	3	4	5	
7. Nocturia (Night Time) Over the past month, how many times did you usually 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	

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?	Delighted	Pleased	Mostly Satisfied	Mixed Feelings	Mostly Dissatisfied	Unhappy	Terrible
	0	1	2	3	4	5	6

Last Updated 10/05/11

MEDICAL RECORDS RELEASE FORM

DATE: ________________________________ **STAT REQUEST ( )**

Patient Name: ____

Patient Address: ____

DOB: ________________________________ SSN: ___________________________________

Please release all pertinent medical records, imaging studies, and laboratory test results to:

Las Vegas Pediatric Urology
653 N. Town Center Dr., Suite 407
Las Vegas, NV 89144
Tel: 702-728-5686 Fax: 702-628-9030

____ _________________________
Signature of Patient or Authorized Patient Representative Date

____
Relationship to Patient
(Mother, Father, Legal Guardian, Foster parent, court-appointed case worker, etc.)

LAS VEGAS PEDIATRIC UROLOGY
AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This form authorizes the release of Protected Health Information pursuant to 45 CFR Parts 106 and 164.

The undersigned authorizes the above-named providers, LAS VEGAS PEDIATRIC UROLOGY, to release contents of medical records to my insurance company for purposes of billing and collecting as requested. The undersigned acknowledges that without this authorization, LAS VEGAS PEDIATRIC UROLOGY may be unable to bill and collect from patient's insurance company.

The information may be disclosed by employees or business associates of LAS VEGAS PEDIATRIC UROLOGY for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

I acknowledge that I have the right to revoke authorization at any time and that it must be requested in writing, and I understand that any use or disclosure that has already occurred prior to the date on which revocation of consent is received will not be affected and may no longer be protected by Federal Privacy Law.

This authorization will remain in effect until terminated in writing by the undersigned patient or legal patient representative.

Notice of Privacy Practices
This acknowledges your receipt and reading of Las Vegas Pediatric Urology Notice of Privacy Practices. You should review the document carefully to learn how your protected health information may be used or disclosed. You should review the notice prior to signing this consent.

_______________________________________ _______________________________________
Patient Signature Date Patient Name DOB

____
Authority: If person signed is other than patient, state authority / relationship to patient

TREATMENT AUTHORIZATION

The persons listed below, in addition to the parents and legal guardians, are authorized to bring

(child's name) _________________________ to the OFFICE of Las Vegas Pediatric Urology for treatment or consultation.

Please note that a parent or an authorized legal guardian (e.g. court-appointed case worker) must be present to sign hospital or anesthesia consents for SURGERY at the hospital.

_______________________________________ _______________________________________
Name Relationship to patient

_______________________________________ _______________________________________
Name Relationship to patient

_______________________________________ _______________________________________
Name Relationship to patient

_______________________________________ _______________________________________
Name Relationship to patient

Las Vegas Pediatric Urology

A BRIEF LOOK AT ARBITRATION FOR THE PATIENT

Introduction

Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association, and noted to be a favored method of resolving disputes by the United States Supreme Court.

If you are unfamiliar with arbitration in general, the information included here provides some of the basic principles of arbitration.

What Is Arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and your doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After a hearing, which is usually less formal than a court proceeding, the arbitrator makes the decision ("award"). Although the procedures are different, generally the same laws and same measure of damages which apply in court proceedings also apply in arbitration.

Does Arbitration Prevent You From Making A Claim?

No. By selecting arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does It Prevent You From Obtaining A Financial Award?

No. Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim, he or she will determine a damage award.

The United States Supreme Court has, in fact previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

May I Be Represented By An Attorney Of My Choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who Is Bound By This Agreement?

If you choose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by the doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by the doctor. Likewise, the doctor or anyone suing on behalf of a doctor is bound.

What Does Arbitration Cost?

In general, arbitration is less expensive than court actions. The arbitrator's fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If Either Party Does Not Like The Arbitration Result, Could There Still Be A Jury Trial In Court?

Generally, the answer is "No". The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed, and potentially reversed ("vacated") by a court in limited circumstances.

A Message To Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between healthcare providers and their patients have long been recognized and approved by the courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators) who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article I: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article II: All Claims Must Be Arbitrated: It is the intention of the two parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by the Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article III: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by US Mail, postage prepaid, to all parties, describing the claim against the physician, the amount of damages sought, and the names and addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206-382.48, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9USC 1-4) and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article IV: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or enforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Nevada and Federal law.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE I OF THIS CONTRACT. YOUR SIGNATURE INDICATES THAT OUR OFFICE HAS PROVIDED YOU WITH THE DOCUMENT "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT".

Andrew Hwang 01/01/2015
Physician Signature Date

Andrew H. Hwang, M.D.
Physician Name

Patient Signature Date

Print Patient Name

Patient Representative Signature Date

Print Name of Patient Representative and Relationship to Patient

Translator Signature Date

Print Translator Name

Las Vegas Pediatric Urology
Patient Authorization and Agreement to Office Policies and Fees

DISCLOSURE: Las Vegas Pediatric Urology is a solely-owned for-profit professional Limit Liability Company that provides medical services to the community.

I hereby authorize Las Vegas Pediatric Urology to furnish my insurance carrier(s) with all information upon their request concerning my illness or injury and/or illness or injury of my dependent listed above. I agree to respond to any additional information that the insurance company may request in a timely manner.

I hereby assign to Las Vegas Pediatric Urology all payments to which I am entitled from my insurance carrier(s) for medical and/or surgical expenses related to the services reported. I understand that I am financially responsible for charges not covered by my insurance company at the time of service.

I understand that Las Vegas Pediatric Urology bills the insurance as a courtesy to me. I agree to provide accurate and complete information in a timely manner. If my failure to do so results in payment of the claim being delayed more than 90 days from the date of service, the physician reserves the right to collect the balance in full from me immediately. If I am unable to pay or cannot be contacted, the bills may be sent to a collection agency. In such a scenario, 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.

I understand that all co-payments, co-insurances, deductibles and charges for items and services not covered by my insurance are payable at the time service is rendered. I will be billed a service charge of $10 if it is paid later. LVPU accepts cash, personal checks, Visa, MasterCard, American Express, and Discover only. I agree to pay a $25 penalty charge for each dishonored check. Unpaid returned checks will be sent to the District Attorney's office.

I understand that I will be charged a fee of $35 for all FMLA, Disability, Jury Duty and other extended forms filled out by Dr. Hwang. School or work excuses and permission notes for office visits and operations are free of charge.

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 separately by the laboratory for those charges.

Unkept Appointment Penalty
I understand that surgery scheduling requires extensive coordination amongst the surgeon(s), the anesthesiologist, the hospital, and if needed, third party equipment companies. Failure to appear at the designated time and date for surgery results in lost time and resources for all providers, and deprives other patients the opportunity to have their surgery done more timely.

I understand that failure to cancel or reschedule a **surgery** appointment at least 24 hours prior will result in a $100 fee billed to me that is not covered by my insurance. It may also result in my dismissal from the practice.

I understand that if I will be charged $25 for broken **office** appointment unless 24 hour notice is given.

Medical Records
All requests for the release of records must be submitted to our office in writing either via fax or U.S. mail. Please allow 48-72 hours for all requests for medical records to be processed. Please note that records released to attorneys, insurance companies, or any party other than another doctor's office may be subject to a fee of $0.60 per page to be remitted upon receipt of medical records. Mailing postage and handling are charged extra.

I may request FREE online access to my personal health records through the electronic health record system (Practie Fusion / Patient Fusion) by providing my email address.

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

__________________________ Signature

____________________ Date

__________________________ Print Name

____________________ Social Security Number