MALE PATIENTS

PATIENT INFORMATION
Please complete ALL Areas

Date:_____ MRN:_____ SSN:_____

Last Name:_____First Name:_____ MI____

DOB:_____ Age:_____ Gender: M F Race:_____

Ethnicity_____ Marital Status_____Preferred Language_____

Address:_____City_____ State____

Zip Code:_____

Home Phone:_____ Cell Phone_____

Work Phone:_____ email:_____

Employer:_____ Occupation:_____

Address:_____ City:_____State___

Zip Code:_____

Primary Doctor:_____ Phone:_____

Referred By:_____

If Minor, name of responsible party:

Name:_____Relationship_____ Phone:_____

In Case of an Emergency, contact:

Name:_____Relationship:_____Phone:_____

Insurance Coverage:_____ Guarantor_____

Medicare #_____ Medical #_____

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Phone:_____

Date **Signature**

Golden Gate Urology – Intake form Male **Date:** _____

First Name: _____ **Middle:** _____ **Last:** _____

Reason for Consultation: ( ) Blood in the Urine ( ) Circumcision ( ) Infertility ( ) Enlarged Prostate

( ) Impotence ( ) Kidney/Ureter Stones ( ) Prostate CA ( ) Prostate Infection ( ) Testis Mass ( ) Testis Pain

( ) Urinary Incontinence ( ) Vasectomy ( ) Kidney Tumor ( ) Bladder Cancer ( ) Frequency Urgency

( ) Elevated PSA ( ) Other _____

Review of Systems Check only The ones you now have or have had recently.

General	Skin	Head	Eyes	Ears	Endocrine
( ) Fever ( ) None	( ) Skin Rashes ( ) Itching ( ) Skin Sores ( ) None	( ) Headaches ( ) None	( ) Glaucoma ( ) None	( ) Hard of hearing ( ) None	( ) weight loss ( ) low blood sugar ( ) high blood sugar ( ) None
Neck	**Lungs**	**Heart**	**Blood**	**Neurological**	**Psychiatric**
( ) Neck Masses ( ) None	( ) Persistent Cough ( ) Coughed Blood ( ) shortness of breath ( ) wheezing ( ) None	( ) Murmur ( ) Swollen Ankles/Feet ( ) chest pains ( ) varicose veins ( ) blood clots ( ) Irregular heart beat ( ) high blood pressure ( ) None	( ) Anemia ( ) Prolonged Bleeding ( ) None	( ) Seizures ( ) Dizziness/Loss of Balance ( ) Hand Trembling ( ) Tingling Burning Numbness ( ) None	( ) Depression ( ) Insomnia ( ) Anxiety/Stress ( )Alcohol Abuse ( ) None
Musculoskeletal	**Gastrointestinal**	**Gastrointestinal Continue :**	**Genitourinary**		
( ) Neck Pain ( ) Joint Pain ( ) Back Pain ( ) None	( ) Abdominal Pain ( ) Nausea ( ) Vomiting ( ) Heartburn ( ) Indigestion ( ) Diarrhea ( ) Constipation	( ) Hernias ( ) Black Tarry Stools ( ) Rectal Bleeding ( ) Hemorrhoids ( ) None	( ) Urinary Frequency ( ) Genital Sores ( ) Urinary Urgency ( ) Testicular Pain ( ) Urinary Incontinence ( ) Impotence ( ) Urinary Straining ( ) Urinary Dribbling ( ) Flank Pain R____ L _____ ( ) Urination at Night____ ( ) Kidney/Urinary Stones ( ) Urination slow to Start ( ) Urinary Burning/Pain ( ) Premature Ejaculation ( ) Bed Wetting ( ) History of Vasectomy ( ) Bloody urine ( ) Reproductive Problems ( ) Slow Stream ( ) Low Sexual Desire ( ) Urethral Discharge ( ) Abnormal Ejaculation ( ) None		

Vital Signs:

Temp _____ **Height** _____ **Weight** _____ **DOB** _____

BP _____ **Pulse** _____ **MA Initials**_____

Medications – List all medications you are currently taking. Include All medications even the Over the counter ones.

Drug Name (Generic Brand)	Dosage	Frequency

Surgery – List all Surgery/Hospitalizations and approximate date (examples tonsils, hernia, stroke pneumonia)

Surgery	Date
Hospitalizations	**Date**

Family of Prostate Cancer, kidney stones, kidney Cancer, bladder cancer – please circle

Allergies and Habits – List all known Allergies and reactions if known

Drug, Environmental or Food Allergy	Reaction

Tobacco	Never	Packs per day	Quit	Quit when?
Alcohol	Beer /week	Liquor /week	Wine /week	None
Caffeine	Coffee /day	Tea /day	Chocolate yes/no	Soft drinks /day

Patient Financial Policies

We would like to provide you with the best service possible for your urologic care. In order to avoid any confusion or misunderstanding, we would like to clarify our financial policies.

Your Insurance – Please submit your current insurance information during your visit with us and we will bill your insurance company for all services that we provide which are covered under your insurance policy. Services not covered must be paid at the time of your visit.

- We will make our best effort at estimating your share of the office visit or procedure. However, until your insurance company has processed our claim, we will not know exactly how much you will have to pay. You may choose to contact your insurance company to inquire about the estimated cost. We do request payment of the estimated amount at the time of your visit and any overpayments will be promptly refunded upon receipt of a finalized, processed claim from your insurance company. Any balance due will be billed to you and payable within 30 days.
- It is your responsibility to verify with your insurance company if we are a participating provider for your particular insurance plan. You are financially responsible for all services rendered regardless of the decision involving reimbursement by your insurance company. Since our providers are providing urologic care directly to you and not your insurance company, you are ultimately financially responsible for all fees incurred.
- Copayments and unmet deductible amounts must be paid prior to your visit with our provider and there can be a $10.00 billing fee charged when these amounts are not paid prior to your visit with our provider.

Medicare Patients – Medicare pays 80% of the allowable charges after your annual deductible is met. If you do not have a secondary insurance, you are responsible for the remaining 20% and any unmet deductible amount.

Self Pay Patients (No Insurance) – We request payment at the time of service.

Form Completion Fees – There may be instances where the paperwork you wish us to complete is more extensive than usual. In those cases, we will let you know in advance if additional charges are due. Payment is due with your request and we anticipate 5-7 business days to prepare your requested forms

Medication prior authorization $20
Insurance appeal for non-coverage of medication $50
Each miscellaneous form $20 - $40
Employer/State disability $20

Medical Records – There will be a $20 fee (additional copying charges may be assessed depending on the number of pages requested) for the preparation and release of medical records. Please allow 5 – 7 business days for the preparation of your medical records

Cancellation Policy – We require advanced notice for any cancellation or rescheduling

Office Visit – 24 hours advanced notice $50 (if not cancelled or rescheduled in time)
Office Procedures – 24 hours advanced notice $100 (if not cancelled or rescheduled in time)
Surgery (Hospital or Surgery Center) – 5 business days $200 (if not cancelled or rescheduled in time)

(Your insurance company will NOT pay for these cancellation charges and therefore will be solely your responsibility for payment)

Collection Policy – All payments are due within 30 days of billing. Thereafter, monthly finance charges of 1% (12% per annum) may be accessed ($5.00 minimum) along with a $10 re-billing fee for each statement generated because of non-payment. If your account is 60 days past due, immediate payment in full is advised to avoid collection proceedings. In the event of default, any and all collection fees will be your responsibility for payment. If you need to discuss alternative payment arrangements, please call our office and arrange to speak with our Practice Manager.

Disclosures – Please notify us of any changes to your address, phone number (cell phone number needed) and email address so we may send electronic reminders of your upcoming appointments. I authorize payment of medical benefits to Golden Gate urology, Inc. for all covered services performed and I authorize any requested release of information to your insurance company in order to process our billing for payment.

Accepted Forms of Payment – All Major credit cards will be accepted including cash and personal checks. A $40 fee will be charged for all returned checks

Your signature below will acknowledge your understanding and agreement to these terms

Patient Name: Date:

_____ _____

Signature: _____

Discrimination is Against the Law
Golden Gate Urology, Inc.

Robert Hoang, M.D., Chief Compliance Official
Phone: 415/202-0260 Email: compliance@goldengateurology.com

Revised Date: September 1, 2019
Effective Date: August 15, 2017

Golden Gate Urology, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GGU does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Golden Gate Urology, Inc. will:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as: (a) Qualified sign language interpreters; (b) Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as: (a) Qualified interpreters; (b) Information written in other languages

If you need these services, please call our office and ask to speak with our Office Manager. If you believe that GGU has failed to provide these services or discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Robert Hoang MD 139 Townsend Street, Suite 100 San Francisco, CA 94107 415/202-0260 Email: compliance@goldengateurology.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Robert Hoang, M.D. is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

GOLDEN GATE UROLOGY, INC.

Acknowledgement of Receipt of Notice

Golden Gate Urology, Inc.

Robert Hoang, M.D., Chief Compliance Official
Phone: 415-543-2830 Email: compliance@goldengateurology.com

I hereby acknowledge that I received a copy of Golden Gate Urology, Inc.'s (GGU) Notice of Privacy Practices and Discrimination Statement.

❑ Yes ❑ No

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:_____.

Signed:_____ Date:_____

Print Name:_____ Telephone:_____

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

- ❑ Signed form received by:_____
- ❑ Acknowledgment refused

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

GOLDEN GATE UROLOGY, INC.

NOTICE OF PRIVACY PRACTICES

Golden Gate Urology, Inc.
Robert Hoang, M.D., Chief Compliance Official
Phone: 415-543-2830 Email: compliance@goldengateurology.com

Revised Date: September 1, 2019
Effective Date: August 15, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Official listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal

law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. **Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. **Sign-in Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. **Notification and Communication with Family.** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. **Required by Law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

8. **Public Health.** We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

9. **Health Oversight Activities.** We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

10. **Judicial and Administrative Proceedings.** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

11. **Law Enforcement.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

12. **Coroners.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

13. **Organ or Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

14. **Public Safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. **Specialized Government Functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

16. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

17. **Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

18. **Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing

because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. **Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. **Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. **Right to Notice of Privacy Practices.** You have a right to a notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Official listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. Our website will also have the most current notice.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Official listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX Office of Civil Rights U.S. Department of Health & Human Services
90 7th Street, Suite 4-100 San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD) (415) 437-8329 (fax)

You may also file a complaint on the OCR website at: https://www.hhs.gov/hipaa/filing-a-complaint/index.html. You will not be penalized in any way for filing a complaint.