GOLDEN GATE UROLOGY, INC.

Rodman S. Rogers, M.D.
Yevgeniy Veltman, MD
Stacey Pickering, MSN, ANP-C

2186 Geary Blvd., Suite 214 San Francisco, CA 94115
Phone: (415) 922-3255 Fax: (415) 992-2527

Patient Demographic Form

Today's Date: _____

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

Date of Birth: _____ **Gender**: _____ **Social Security #**: _____

Race: Asian American Indian Black or African American Declined Unknown White Pacific Islander

Marital Status: Single Married Divorced Widowed

Ethnicity: Declined Hispanic or Latino Non-Hispanic or Latino

Address: _____ **Apartment/Room #**: _____
(No PO Box Address)

City: _____ **State**: _____ **Zip Code**: _____

Home Phone: _____ **Cell Phone**: _____ **E-Mail**: _____

Highest Level of Education: Grade School High School College Graduate/Professional Degree

Name of Spouse: _____ **Phone**: _____

Emergency Contact: _____ **Phone**:_____ **Relationship**:_____

Current Employment: Full Time Part Time Retired Student Unemployed Disabled

Name of Employer: _____ **Phone**: _____

Address: _____ **City**: _____ **State**: _____ **Zip Code**: _____

Occupation: _____ **Primary Language**: _____

Primary Care Physician: _____ **Phone**: _____

Address: _____

INSURANCE INFORMATION

I authorize payment of medical benefits be made directly to the physician provider for services rendered. I also authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information necessary to process this request.

Signature: _____ Date: _____

DEDUCTIBLES AND COPAYMENTS ARE DUE AT TIME OF SERVICE

PLEASE BRING YOUR INSURANCE CARD

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Initial Visit

To help our doctor to understand your full medical condition, please complete the information below:

Today's Date: _____

Your Name: _____ **Date of Birth**: _____

Your Primary Care Physician's Name: _____

Your Current Medication(s):

Name of Medication: Dosage: how often you take the medication(s):

_____

_____

_____

Any Allergies to medication(s)? _____

Surgical Procedures in the past, and date:

_____

Medical and psychiatric conditions diagnosed (for example high blood pressure, diabetes, heart disease, stroke, lung disease, thyroid problem, cancer) _____

Have you ever had a kidney stone, urinary infection or seen blood in urine?_____

Tobacco use/exposure? Yes No if yes, amount and duration: _____

What is your current level of alcohol intake (number of drink/week) _____

Please check below if you have experienced any of the following recently:

Yes	No		Yes	No	
___	___	Unexpected weigh loss	___	___	Unexplained skin changes
___	___	Fever or chills	___	___	Chest Pain
___	___	Tremors or dizzy spells	___	___	Back or neck pain
___	___	Overly tired/sluggish	___	___	Frequent cough/wheezing
___	___	Lymph node enlargement	___	___	Shortness of breath
___	___	Abdominal pain, nausea/vomiting	___	___	Excessive thirst
___	___	Painful or frequent urination	___	___	Severe depression
___	___	Blood in the urine	___	___	Muscular weakness
___	___	Visual changes	___	___	Seizure/stroke
___	___	Infections/Allergies	___	___	Ear/nose/throat problems

Other problems not mentioned above: _____

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Cancellation and Missed Appointment

Dear Patient:

We try earnestly to offer friendly and timely service that accommodates your needs. Our goal is always to offer the earliest and most convenient appointment for you to achieve this goal; we need to live with some rules. Many of you wait anxiously for your turn and we want to make that wait as short as possible. Please understand this policy benefits everyone. Help us be available for you.

OFFICE APPPOINTMENTS

No fee will be assessed when an appointment is cancelled or re-scheduled 72 hours or more in advance.

When an appointment is "missed" (no show) without any notification or when an appointment is cancelled with less than 72 hours notification, the following fees will apply

- $100 will be assessed for a Vasectomy unless there is a valid medical reason.
- $50 will be assessed for a Cystoscopy or any other procedure scheduled in the office, unless there is a valid medical reason.
- $25.00 for a missed and/or cancelled appointment (no show) or less than 72 hours notification, unless there is a valid medical reason.

HOSPITAL OR OUTPATIENT SURGERIES

No fee will be assessed for surgeries cancelled or re-scheduled more than 7 days in advance.

When a surgery is rescheduled or cancelled within 7 days, a $100 fee will be assessed.

GENERAL CONSIDERATION

If an appointment is rescheduled with less than 48 hours' notice or missed more than 3 times in a period of 6 months, the office will offer the contact information of other practitioners that might better suit your schedule.

I HAVE READ AND UNDERTAND THESE POLICIES AS WRITTEN ABOVE

Print Name: _____

Signature: _____ Date: _____

Appendix A
Notice of Privacy Practices
For: Golden Gate Urology Inc.

Practice Administrator

Effective Date: 03/07/2011

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 and to provide individuals with notice of our legal duties and privacy practices with respect to 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 Officer listed above.

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. 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 which 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.

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 before it will pay us. 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 to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-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 efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

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 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.

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 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. We reserve the right to accept or reject your 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 e-mail 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 and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal 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. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

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 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or 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. You have 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 Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend 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.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer 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:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Golden Gate Urology Inc.

Practice Administrator

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

ٱ 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 relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

Notice of Privacy Practices Acknowledgments Tracking Information

Name of Patient: _____

Address: _____

_____

For Office Use Only:

Date received:	Processed by:
Practice Follow-up: ❑ Yes ❑ No	Date of Practice Follow-up:

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____