Erik Pasin, M.D.

UROLOGY

ADULT AND PEDIATRIC UROLOGY

Date: _____

## FEMALE PATIENT INFORMATION

Name: _____
Last First M.I.

Address: _____
Street City State Zip

Phone #: ( ) _____ Cell #: ( ) _____ E-mail: _____

Ethnicity: _____ Race: _____ Date of Birth: _____ Sex: _____

Social Security #: _____ Driver's License: _____

Occupation: _____ Employer: _____

Address: _____ Work Phone: ( ) _____

## NAME OF HUSBAND OR WIFE (IF SINGLE NEAREST RELATIVE):

Name: _____ Phone #: ( ) _____

Address: _____

## PERSON RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED:

Name: _____ Phone #: ( ) _____

Referred by: _____ Family or Primary Care Dr.: _____

Pharmacy Name: _____ Phone #: ( ) _____

## INSURANCE INFORMATION

Insurance Company: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber I.D.: _____

Subscriber Employer: _____

Group #: _____

**PLEASE SIGN AND RETURN TO RECEPTIONIST**

I hereby give consent for medical information to be sent to my Referring and/or Primary Care Physician. I also request that payment of authorized insurance benefits be made on my behalf to Erik Pasin, M.D. for any service furnished me by Dr. Pasin, I authorize any holder of medical information about me to release such information necessary to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I understand that if I am found to be ineligible for insurance coverage, I am responsible for all costs incurred in the delivery of medical services to me and will pay these charges within 30 days of billing. Co-payments will be collected at the time of service. I further agree in the event of non-payment to bear the cost of collection and/or court fees. I will be responsible to pay $25.00 for any missed appointment.

Signature: _____ Date: _____

**There will be a $25.00 fee on each returned check.**

POS Recorder # 1822437

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# FEMALE NEW PATIENT FORM

| Patient's Name | Date |
|---|---|
| Who referred you to this office? | Medical Doctor/PCP |
| Why are you seeing the physician today? | |
| When did your problem start? | Pharmacy (Name & Number) |

**MRN:** _____

**My Main Problems are:**
☐ Blood in urine ☐ Bladder Cancer ☐ Bladder Infection ☐ Bladder Pain
☐ Kidney Stones ☐ Interstitial Cystitis ☐ Leak Urine ☐ Overactive Bladder
☐ Dropped Bladder ☐ Other: _____

**Allergies:**
☐ None ☐ PCN ☐ Sulfa ☐ Cipro ☐ Iodine/Contrast
☐ Other: _____

**Medications:** ☐ None ☐ Aspirin ☐ Lortab ☐ Percocet ☐ Plavix ☐ Nitroglycerin
☐ Detrol ☐ Detrol LA ☐ Vesicare ☐ Allopurinol ☐ Coumadin
☐ Antibiotic: _____ ☐ Other: _____

**Surgical History:** ☐ Appendectomy ☐ Back/Hip/Knee ☐ Bladder Tack ☐ C-Section #_____
☐ Cystoscopy ☐ Gallbladder ☐ Heart Bypass ☐ Hysterectomy ☐ Kidney Stone Surgery
☐ Lithotripsy ☐ Sling (TVT) ☐ Vaginal Deliveries #_____ ☐ Other: _____
☐ **No Changes**

**Medical History:** ☐ Diabetes ☐ Emphysema ☐ Heart Attack ☐ Heart Murmur
☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Last Period: _____ ☐ Menopause
☐ Parkinson's ☐ Pregnant ☐ Strokes ☐ Cancer: _____
☐ Other: _____ ☐ **No Change**

**Family History:** ☐ Kidney Cancer ☐ Kidney Stones ☐ Heart Disease

**Social History:**
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Smoke: ☐ No ☐ Yes **Occupation:** _____ ☐ Retired

**My Symptom(s) are:**

| | | | |
|---|---|---|---|
| General/Constitutional | ☐ Fever | ☐ Weight Loss | ☐ Chills |
| Eyes | ☐ Blurry Vision | ☐ Double Vision | ☐ Cataracts |
| Ears, Nose, Mouth, Throat | ☐ Hearing Loss | ☐ Nasal Stuffiness | ☐ Sore Throat |
| Cardiovascular | ☐ Chest Pains | ☐ Swollen Ankles | ☐ Irregular Heartbeat |
| Respiratory | ☐ Shortness of Breath | ☐ Wheezing | ☐ Chronic Cough |
| Gastrointestinal | ☐ Abdominal Pain | ☐ Nausea/Vomiting | ☐ Change in Bowels |
| Genitourinary | ☐ Incontinence | ☐ Painful Urination | ☐ Blood in Urine |
| Musculoskeletal | ☐ Chronic Back Pain | ☐ Chronic Neck Pain | ☐ Sore Muscles |
| Integumentary/Skin | ☐ Rash | ☐ Persistent Itching | ☐ Skin Cancer History |
| Neurologic | ☐ Numbness | ☐ Tingling | ☐ Dizziness |
| Hematologic/Lymphatic | ☐ Swollen Glands | ☐ Abnormal Bleeding | ☐ Transfusion History |

**Urinary Symptom(s) are:**
☐ Frequency ☐ Urgency ☐ Leakage ☐ Straining ☐ Abdominal Pain
☐ Bladder Pain ☐ Pain in Side R / L ☐ Not Emptying Bladder ☐ Urinating at Night #_____

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| Patient's Name | |
|---|---|
| Date | |
| Age | ☐ Married ☐ Single ☐ Widowed ☐ Divorced |
| Occupation (or former occupation) | |

MRN: _____

**Chief Complaint:**

What is the main reason for your visit today? (Please describe in detail)

_____

_____

_____

**History of Present Illness:**

| | |
|---|---|
| Location of problem:<br>Abdomen Back Genitals<br>Other:_____ | How long does the problem last?<br>30 minutes 1 day Always there<br>Other:_____ |
| On a scale of 1-10, with 10 being the most severe, circle the number that best describes your problem.<br>1 2 3 4 5 6 7 8 9 10 | Is there anything else occurring at the same time?<br>Yes No If Yes, explain_____<br>Nausea Rash Headache<br>Other:_____ |
| When did you first notice the problem?<br>2 days ago 1 week ago 1 month ago<br>Other:_____<br>_____ | Is the problem constant or variable?<br>Dull, then sharp Sharp, then leaves<br>Always there<br>Other:_____ |
| Does anything help or make the problem worse?<br>Yes No<br>Moving around Standing Eating | Does the problem interfere with your normal function?<br>Yes No<br>If yes, explain:_____<br>_____ |
| Physician use (comments and notes) | |

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# RECORDS RELEASE FORM

REQUEST MEDICAL RECORDS FROM: _____

ADDRESS: _____

I hereby authorize and request the release of copies of the following information:

Complete Medical Records X-Rays Lab Reports Other _____

PLEASE SEND RECORDS INCLUDING CURRENT AND PREVIOUS MEDICAL RECORDS FROM OTHER PRACTICES AND PRACTITIONERS, HOSPITALS, AND/OR CLINIC WHICH ARE A PART OF MY MEDICAL RECORDS.

TO: _____

ADDRESS: _____

This information has been released to you specifically with the consent of the patient or his/her authorized representative. It is strictly confidential and no further release or use of the information is authorized without the consent of the patient or authorized representative. I hereby release the facility from any liability, which may arise as a result of the use of the information contained in the records released.

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

Signature: _____ Date: _____

Single Disclosure continuing disclosure for 90 days Expiration Date: _____

I hereby release the facility from any liability, which may arise as a result of the use of the information contained in the records released.

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## HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related to health care services.

1. Uses and Disclosure of Protected Health information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as - needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings, Law Enforcement: Coroners, Funeral Directors, and Organ donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and disclosures: Under the Law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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## Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You may have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

## Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Names:

_____ Signature: _____ Date: _____

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____ acknowledge that I have received a copy of
(Name of Patient)

Erik Pasin, M.D.'s Notice of Privacy Practices. This notice describes how Erik Pasin, M.D. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

I give permission for Erik Pasin, M.D. to share medical information regarding me and my care with: (spouse, caregiver, family member).

_____
Name & phone number

_____ _____
Signature of Patient or Authorized Representative Date

_____
Relationship to Patient

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