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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.		



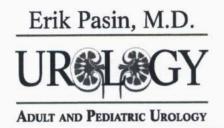
Erik Pasin, M.D	. MA	LE NEW PATIENT I	FORM
	Patient's Name	1	Date
UK然L悉G	Who referred you to this	office?	Medical Doctor/PCP
Adult and Pediatric Urolo	Why are you seeing the p	hysician today?	
	When did your problem s	start?	Pharmacy (Name & Number)
MRN:			
My Main Problems are:			
☐ Enlarged Prostate	☐ Blood in Urine	☐ High PSA	☐ Bladder Infection
☐ Kidney Stones	□ Prostate Infection	☐ Urinary Incontinence	☐ Bladder Cancer
☐ Prostate Cancer	☐ Erectile Dysfunction	Overactive Bladder	☐ Infertility
Lump in Testicle	Other:		
Allergies:			
□ None □ PCN	☐ Sulfa	☐ Cipro	☐ Iodine/Contrast
Other:			
Medications:	□ Aspirin □ Lortab	□ Percocet □ P	
☐ Detrol ☐ Antibiotic:	☐ Detrol LA ☐ Vesicare	Allopurinol C Other:	
		k/Hip/Knee	
	dney Stone Surgery	otripsy Prostate No Chai	
Medical History:	☐ Diabetes ☐ Emphysema	☐ Heart Attack	☐ Heart Murmu
	☐ Hernia ☐ Hypertension		☐ Strokes
	☐ Kidney ☐ Testis	Other:	
Family History:	ostate Cancer	Cancer	nes
Social History:			
Marital Status: Single	☐ Married ☐ Divor	ced Widowed	
Smoke:	☐ Yes Occupat	10 (F)	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 Histor
☐ Neurologic ☐ Numbness		☐ Tingling	☐ Dizziness
☐ Hematologic/Lymphatic ☐ Swollen Glands		☐ Abnormal Bleeding	☐ Transfusion History
Union and Computer (-)			
Urinary Symptom(s) are: ☐ Incomplete Emptying ☐ 1	Frequency	ency	Straining
가 (mail) 이 사람이 있는 이 사람들이 속하는 것이 없는 것이 하는 것이 모든 것이 됐다.	Pain in Side R / L Urinating	12 12 15 17 17 17 17 17 17 17	

Erik Pasin, M.D.	Patient's Name	
UR L&GY	Date	
ADULT AND PEDIATRIC UROLOGY	Age	☐ Married

Erik Pasin, M.D.	Patient's Name	
UR&L&GY	Date	
Adult and Pediatric Urology	Age	☐ Married ☐ Single ☐ Widowed ☐ Divorced
MRN:	Occupation (or former occupation	on)
Chief Complaint: What is the main reason for you	r visit today? (Ple	ease describe in detail)
YY' (P A TIII A		
History of Present Illness:		

History of Present Illness:

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



RECORDS RELEASE FORM

REQUEST MEDICAL RECORDS FROM:	
ADDRESS:	
I hereby authorize and request the release of copies of the foll	owing information:
Complete Medical Records X-Rays Lab Rep	ports Other
PLEASE SEND RECORDS INCLUDING CURRENT AND FROM OTHER PRACTICES AND PRACTITIONERS, HOS A PART OF MY MEDICAL RECORDS.	
TO:	
ADDRESS:	
This information has been released to you specifically with the authorized representative. It is strictly confidential and no fur authorized without the consent of the patient or authorized refrom any liability, which may arise as a result of the use of the released.	ther release or use of the information is presentative. I hereby release the facility
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 aris	se as a result of the use of the information

contained in the records released.

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.

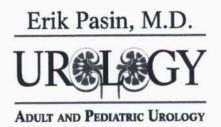
<u>Payment:</u> Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital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



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

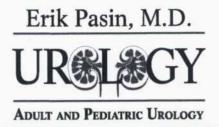
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

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:



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,		acknowledge that I have received a copy of
	(Name of Patient)	
disclose my p		the describes how Erik Pasin, M.D., may use and ons on the use and disclosure of my healthcare in health information.
	sion for Erik Pasin, M.D., to share medical i giver, family member).	nformation regarding me and my care with:
	Name & phone number	
Signatur	e of Patient or Authorized Representative	Date
	Relationship to Patient	