PACIFIC COAST
UROLOGY
Medical Center

Welcome to *Pacific Coast Urology Medical Center.* We are so pleased that you have chosen us for your urology care and look forward to meeting you when you come in for your first appointment.

To get acquainted with you, and to understand your healthcare needs, there are several forms enclosed with this letter. Please fill them out completely and bring them with you at the time of your first visit. Please bring all insurance information with you, too, including your insurance cards, information about co-pays and deductibles, etc. We promise to keep paperwork to a minimum, but these forms help us learn about your medical history and allow us to process bills efficiently for you.

We accept many insurance plans. Most of these are of the fee-for-service type, including PPOs and Medicare. We may also offer limited participation in some managed care plans. We offer courtesy billing of your insurance company without charge. *Pacific Coast Urology Medical Center's* payment policy is to wait up to 1 month for payments to be made by your insurance plan. If no payment is received by that time, you are responsible for the full amount. All co-payments and deductibles must be paid at the time a service is provided to you.

Your first appointment is scheduled for: _____at _____ in our office located at:

_ 3801 Katella Ave., Suite 110, **LOS ALAMITOS**, CA 90720

(For maps and/or directions to each location, please go to our website, www.pacificcoasturology.com). Click on the CONTACT US tab and select the location required to find a map and create directions to our offices.)

We ask that you arrive 30 minutes early for your first appointment to process your paperwork and let us get acquainted. ***If you are unable to keep this appointment, please provide us with at least 48 hours notice so we can offer the time to other patients who may be waiting. Please also be sure to confirm your appointment when we call you. Appointments that are not confirmed within the requested time will be cancelled.*** If you are not sure how to get to our office please call us for directions.

You can be assured that we will make every effort to ensure that your care and treatment will meet the high standards we have set for ourselves. We always strive to merit your continued confidence in *Pacific Coast Urology Medical Center*

Once again, welcome to *Pacific Coast Urology Medical Center.* We look forward to a long and rewarding relationship with you!

Sincerely,

Robert G. Pugach, M.D.
& the Staff of *Pacific Coast Urology Medical Center*

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PATIENT REGISTRATION FORM

Your Name _____ Birth Date _____ Age _____ Sex _____ Marital Status _____

How Would You Like Us To Address You? (First Name, Mr., Mrs., Dr. etc.) _____ Driver's License # _____

Address (including **Street, City, State & Zip Code**) _____ Home Telephone Number _____

Your Social Security Number _____ **Your Email Address** _____ Cell Phone Number _____

Your Occupation (former if retired) _____ Your Employer _____ Work Telephone Number _____

PLEASE SELECT ONE OPTION...
I prefer to have my appointments confirmed by: HOME # ___, CELL # (phone call) ___, CELL # (text msg) ___

Your Ethnicity _____ Your Race _____ Your Preferred Language _____

Person To Contact In Emergency _____ Relationship _____ Phone Number (other than your #) _____

Who Referred You To *Pacific Coast Urology*? _____ Who Is Your Primary Doctor? _____ Where Is His/Her Office? _____

_____/_____/_____/_____
Please List Any Allergies You Have

_____/_____/_____/_____

_____/_____/_____/_____
Please List All Prescription Medications That You Take

_____/_____/_____/_____
Please List All Over The Counter (Non-Prescription) Medications That You Take

Do You Use Tobacco Products? ____ YES ____ NO ____ QUIT _____ years ago

Do You Use Alcohol? ____ YES (Amount = ____ Occasional ____ Moderate ____ Heavy) ____ NO

Do You Use Drugs? ____ YES (Amount/Type = _____) ____ NO

Primary Insurance Company _____ Policy Number _____

Secondary Insurance Company _____ Policy Number _____

Subscriber's Name _____ Date of birth _____

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Your Medical History

CHECK ONLY THOSE THAT APPLY TO YOU:

Do You Have, Or Have You Had:		YES	
HIGH BLOOD PRESSURE	.....	□	401.9
HEART DISEASE	.....	□	429.9
A STROKE	.....	□	435.9
ASTHMA, EMPHYSEMA	.....	□	493.
GLAUCOMA	.....	□	365.9
CATARACTS	.....	□	366.9
DIABETES	.....	□	250.0
CANCER	.....	□	199.1
KIDNEY STONES	.....	□	592.0
OTHER KIDNEY DISEASES	.....	□	593.9
PROSTATE PROBLEMS	.....	□	602.9
ERECTION PROBLEMS (MEN)	.....	□	607.84
BLADDER CONTROL PROBLEMS	.....	□	596.9
OTHER BLADDER PROBLEMS	.....	□	596.
URINARY TRACT INFECTIONS	.....	□	599.0
BLOOD IN YOUR URINE	.....	□	599.70
LIVER OR GALLBLADDER DISEASES	.....	□	575.9
STOMACH OR INTESTINAL PROBLEMS	.....	□	537.89
SEIZURES OR FAINTING SPELLS	.....	□	780.39

Please explain any "Yes" answers to the above questions:

_____

_____

If You Have Ever Had Surgery Of Any Type, Please List The Procedures And Dates:

_____

_____

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Your FAMILY Medical History

Regarding your Mother, Father, Brother, Sister, do they have or have they had any of the following?

Please check only those that apply.

		Mother	Father	Brother	Sister
HIGH BLOOD PRESSURE	401.9	☐	☐	☐	☐
HEART DISEASE	429.9	☐	☐	☐	☐
A STROKE	435.9	☐	☐	☐	☐
ASTHMA, EMPHYSEMA	493.	☐	☐	☐	☐
GLAUCOMA	365.9	☐	☐	☐	☐
CATARACTS	366.9	☐	☐	☐	☐
DIABETES	250.0	☐	☐	☐	☐
CANCER	199.1	☐	☐	☐	☐
KIDNEY STONES	592.0	☐	☐	☐	☐
OTHER KIDNEY DISEASES	593.9	☐	☐	☐	☐
PROSTATE PROBLEMS	602.9	☐	☐	☐	☐
ERECTION PROBLEMS (MEN)	607.84	☐	☐	☐	☐
BLADDER CONTROL PROBLEMS	596.9	☐	☐	☐	☐
OTHER BLADDER PROBLEMS	596.	☐	☐	☐	☐
URINARY TRACT INFECTIONS	599.0	☐	☐	☐	☐
BLOOD IN YOUR URINE	599.70	☐	☐	☐	☐
LIVER OR GALLBLADDER DISEASES	575.9	☐	☐	☐	☐
STOMACH OR INTESTINAL PROBLEMS	537.89	☐	☐	☐	☐
SEIZURES OR FAINTING SPELLS	780.39	☐	☐	☐	☐

Please explain any "Yes" answers to the above questions:

_____

_____

Please list any surgeries that you are aware of regarding family members above:

_____

_____

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Records Release For Insurance Payment/Request For Direct Payment

Medical Records Release: The undersigned individual authorizes the release of any medical information necessary to process insurance claims for payment to *Pacific Coast Urology Medical Center* for medical services received.

Assignment of Insurance Benefits: The undersigned individual requests that payment for covered services, either from a private insurance company or government entity, be sent directly to *Pacific Coast Urology Medical Center.*

Financial Responsibility Agreement: The undersigned individual agrees that he/she is responsible for all charges incurred for medical care provided to him/her or to any minors for whom he/she is responsible by *Pacific Coast Urology Medical Center.* It is agreed that an insurance plan is a contract between the patient and an insurance company and that the patient being treated by *Pacific Coast Urology Medical Center* is directly and ultimately responsible for payment in full of all charges for medical care rendered, whether or not they are covered by any insurance company or other payment plan.

Agreement To Treat: The undersigned authorizes *Pacific Coast Urology Medical Center* to treat him/her or any minors for whom he/she is responsible.

Contacting *Pacific Coast Urology Medical Center* in an Emergency: The undersigned understands that Dr. Pugach, or a covering physician, is typically available 24 hours/day, 7 days per week, 365 days per year. If, for any reason within or beyond the control of Dr. Pugach or a covering physician, a patient cannot make contact for an urgent or emergency matter, the undersigned understands that prudent judgment should be used and seek care appropriately. This includes calling 911 for a medical emergency, going to a nearby emergency department, urgent care center, etc. In the event of a serious illness 911 should always be called.

_____ _____
Signature Date

_____
Please print your name or the name of a minor receiving care if you are legally responsible

PACIFIC COAST
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Our Payment Policies

June, 2011

1. Patients are responsible for full payment of medical services received at Pacific Coast Urology Medical Center. While we have contracted rates with most insurance companies, you, our patient, are legally responsible for any charges related to your medical care.

2. You must pay all deductibles and co-payments each time you receive medical services.

3. We will bill your insurance company for you, without charge, as long as your account is current for all deductibles, co-payments and there are no past due balances. Otherwise, there is a fee of $10.00 for each insurance company that we bill.

4. If you are not able to show us that you have a current, active health insurance policy, you must pay for all services in full at the time you receive them.

5. If your insurance company has not paid for services within 30 days of the date that you receive them, you must pay the full amount owed. If your insurance company issues a check to us after that, we will refund you promptly.

6. Pacific Coast Urology Medical Center accepts cash, checks with proper identification, VISA, MasterCard and Discover. We do not assess service charges for credit card use. For any returned check, there will be a $25.00 charge plus the current fee charged to us by the bank .

7. Any exceptions to these policies because of financial hardship must be approved before a medical service is provided.

"I have read the payment policies of Pacific Coast Urology Medical Center and I agree to fully comply with them."

PATIENT COPY. PLEASE KEEP FOR YOUR RECORDS.

PACIFIC COAST
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Our Payment Policies

June, 2011

1. Patients are responsible for full payment of medical services received at Pacific Coast Urology Medical Center. While we have contracted rates with most insurance companies, you, our patient, are legally responsible for any charges related to your medical care.

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7. Any exceptions to these policies because of financial hardship must be approved before a medical service is provided.

"I have read the payment policies of Pacific Coast Urology Medical Center and I agree to fully comply with them."

_____
Please Print Your Name Here

_____ _____
Signature Date

OFFICE COPY.

PACIFIC COAST
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HIPAA Privacy Regulation

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that the office of Pacific Coast Urology Medical Center will not reveal to any person information about you or about a family member (i.e. name, address, Social Security number as well as other health information) without your permission. Your information will never be sold, or listed for the purpose of advertisement solicitation or fund raising.

It is however understood, that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the context of your patient care including, but not limited to,

- Patient registration
- Procurement of medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verifications, billing, paper and wire (including e-mail & fax transmissions)
- Insurance company follow-up or interaction with billing services relating to patient care
- Pursuit of collections for unpaid bills
- Hospital workers, nurses, aids and medical records departments
- Emergency officials, Paramedic, Fire personnel, Emergency room physicians, nurses or technicians
- Designated personal religious representatives
- Our office staff
- Pharmacists, drug program personnel/workers
- Completion of disability forms
- Computer and electronically stored information, i.e., related business vendor and service personnel

This constitutes an abridged version of our HIPPA Privacy Regulation Policy. To see our full policy please ask for a copy from our front office reception staff.

I authorize the release of this necessary information.

_____ _____

Patient Signature **Date**

Please clearly **print first and last name** here: _____

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For your convenience, we offer several methods of payment for charges you incur at *Pacific Coast Urology Medical Center.* Please check your preferred method of payment:

I prefer to pay all co-payments, deductibles and other account balances by:

___ Cash or check

___ Credit card*

Credit card type: ___ VISA

___ Mastercard

___ Discover

*We do not add a service charge for credit card use at *Pacific Coast Urology Medical Center*

PACIFIC COAST
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How Did You Hear About Us?

Name: _____ Date_____

At ***Pacific Coast Urology Medical Center*** one of our most important goals is to educate patients about urologic conditions and new, minimally invasive treatments to improve your quality of life. We use a variety of methods to help get our message out to patients. Please fill out this form so that we can learn which methods are the most effective in reaching our patients.
I learned about ***Dr. Robert Pugach and Pacific Coast Urology Medical Center*** from:

Please **PRINT** and **CHECK *ALL*** that apply.

____ Physician referred me (*Doctor's name*) _____

____ Patient/family/friend (*Name*)_____

____ Hospital referral (*Hospital Name*)_____

____ Health Insurance directory (*Company name*) _____

____ Television Show: ___KTLA News ___The Doctors ___Other

____ A newspaper or print ad or article in: *(please check)*
____Leisure World News ____Sorbet Magazine
____Huntington Beach Magazine ____Other, please specify: _____
___ Community Lecture: (specify)_____
___ ENewsletter/EBlast *(Urology Briefs)*

Internet:
___ Pacific Coast Urology Website (www.pacificcoasturology.com)
___ Advanced Vasectomy Website (www.advancedvasectomy.com)
___Western States HIFU (www.hifuprostatecancermd.com)

- Search Engine Used (Google, Yahoo, BING) _____
- Keyword(s) used to search: _____

___Social Media/Review Site(s) (Yelp, Facebook, *please specify)*
_____

Thank you for helping us!

EMAIL CONSENT FORM
Effective 07/23/12

RISK OF USING EMAIL

Pacific Coast Urology Medical Center offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using email. These include, but are not limited to, the following:

1. E-mail can be circulated, forwarded and stored in numerous paper and electronic files.
2. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
3. E-mail senders can easily misaddress an e-mail,
4. E-mail is easier to falsify than handwritten or signed documents.
5. Backup copies of e-mail can exist even after the sender or the recipient has deleted his or her copy.
6. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
7. E-mail can be intercepted, altered, forwarded or used without authorization or detection.
8. E-mail can be used to introduce viruses into computer systems.
9. E-mail can be used as evidence in court.

CONDITIONS FOR THE USE OF EMAIL

Pacific Coast Urology Medical Center will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, *Pacific Coast Urology Medical Center* cannot guarantee the security and confidentiality of e-mail communication and will not be liable for improper disclosure of confidential information that is not caused by *Pacific Coast Urology Medical Center*'s intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

1. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff, billing personnel and payers, will have access to those e-mails.
2. *Pacific Coast Urology Medical Center* may forward e-mails internally to *Pacific Coast Urology Medical Center*'s staff and agents as necessary for diagnosis, treatment, reimbursement and other handling. *Pacific Coast Urology Medical Center* will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
3. Although *Pacific Coast Urology Medical Center* will endeavor to read and respond promptly to an e-mail from the patient, *Pacific Coast Urology Medical Center* cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time sensitive matters.
4. If the patient's email requires or invites a response from *Pacific Coast Urology Medical Center,* and the patient has not received a response within a time considered reasonable by the patient, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
5. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability or substance abuse.
6. The patient is responsible for informing *Pacific Coast Urology Medical Center* of any types of information the patient does not want to be sent by e-mail, in addition to those set out in #5 above.
7. The patient is responsible for protecting his/her password or other means of access to e-mail. *Pacific Coast Urology Medical Center* is not liable for breaches of confidentiality caused by the patient or any third party.
8. *Pacific Coast Urology Medical Center* shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
9. It is the patient's responsibility to follow up and/or schedule an appointment if warranted or desired.

INSTRUCTIONS:

To communicate by e-mail, the patient shall:

1. Limit or avoid use of his/her employer's computer.
2. Inform *Pacific Coast Urology Medical Center* of changes in his/her email address.
3. Put the patient's name in the body of the e-mail.
4. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
5. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to *Pacific Coast Urology Medical Center.*
6. Endeavor to minimize the length of e-mail so that it is concise and to the point.
7. Reply to e-mail receipt requests from *Pacific Coast Urology Medical Center* if requested to do so.
8. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
9. Withdraw consent to the use of e-mail communication only by e-mail or written communication to *Pacific Coast Urology Medical Center.*

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

_____ I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via e-mail between *Pacific Coast Urology Medical Center* and me and I consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that *Pacific Coast Urology Medical Center* may impose to communicate with patients by e-mail. Any questions I may have had were answered to my satisfaction.

_____ I decline to allow communication with me by email

_____
Patient signature

_____
Date

_____
Witness signature

_____
Date