

Desert Radiation Specialists

35800 Bob Hope Drive, Suite 215
Rancho Mirage, CA 92270

Date: _____

Dear _____

We would like to welcome you to our medical practice. Our records show that you have recently scheduled a consultation with Dr. Schreiber on

_____, _____ at _____ a.m. / p.m.

To make your visit to this office pleasant and efficient, we would request that you complete the enclosed forms prior to your appointment. You may fax this completed form at your convenience, bring them to your appointment or mail them in the provided envelope.

It is important that our doctors view any x-rays, scans, or MRI's pertaining to your current diagnosis. We would ask that you obtain any existing films and bring them with you on the day of your appointment.

If there is anything we can do to be of service, please let us know. We look forward to seeing you.

35800 Bob Hope Dr., #215 Rancho Mirage, CA 92270
Phone 760.536.4400 Fax 760.536.4491

Welcome To Our Office
Desert Radiation Specialists

Patient Number _____

Appointment Date _____

THERE WILL BE A \$25 CHARGE FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE
Please print and complete all parts

Language	<input type="checkbox"/> English	<input type="checkbox"/> Other _____	Race	<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Spanish			<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic	
Ethnicity _____		email _____				
Name _____						
Address _____		Last _____	First _____	Middle Initial _____	State _____ Zip _____	
Home _____		Cell _____	Work _____	Date of Birth _____		
Age _____	Sex _____	SSN# _____	Employer _____	Occupation _____		
Spouse _____		Employer _____	Work Phone _____			

Responsible Party: (Person who should receive the bill)

Name _____	Home Phone _____	Work _____
Address _____		City _____ State _____ Zip _____
Primary Care Phys _____	Phone _____	Referring Phys _____ Phone _____

Insurance (Please complete. We will need a copy of your insurance card, front and back)

Primary Insurance _____	Secondary Insurance _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Insured _____	Insured _____
Policy # _____ Group # _____	Policy # _____ Group # _____
Employer _____	Employer _____
Co-pay \$ _____	Co-pay \$ _____

Notify in case of Emergency (Not living with you)

Name _____	Home Phone _____	Cell Phone _____
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I authorize payment of medical benefits to physician or supplier for these services and all future claims as well as the release of any medical information necessary to process this claim and all future claims.
I further understand that if my insurance carrier requires a referral for this or any subsequent office visit, and I have failed to obtain such referral, that I will be solely responsible for any charges incurred.
My signature acknowledges my consent allowing my medical records be sent to any physician administering my care.

Signature (Patient or authorized representative) _____

_____ Date

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Patient Name _____ Date _____

AMERICAN UROLOGICAL ASSOCIATION (AUA) SYMPTOM INDEX

Questions to be answered	AUA Symptom Score (Circle one number on each line)					
	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5
Sum of seven circled numbers (AUA Symptom Score): _____ Scoring: Mild 0-7 Moderate: 8-19 Severe: 20-25						

Adapted from Barry, et al Used with permission

References: 1. Barry MJ, Fowler FJ, O'Leary MP, et al. The American Urological Association symptom index for benign Prostatic hyperplasia. J Urol 1992;148:1549-1557

2. Data on file. Pfizer Inc., New York, NY

Desert Radiation Specialists

David P. Schreiber, M.D.

Name: _____

Date: _____

Please circle those that apply

GENERAL	CHILDHOOD DISEASES	G-INTESTINAL
Unusual fatigue	Measles	Poor appetite
Unusual weakness	Mumps	Hard to swallow
Recent weight loss	Chicken pox	Frequent indigestion
Abnormal thirst	Rubella	Food intolerance
Bruise easily	Diphtheria	Nausea - vomiting
Anemia	Scarlet fever	Yellow jaundice
Swollen nodes	Other	Constipation
Deformity		Take laxatives
Skin rash or sores	UROLOGY	Take antacids
Diabetes - gout	Blood in urine	Black stools
Sexual problems	Get up at night	Diarrhea
	Painful urination	Hemorrhoids
	Slow stream	
HEAD	Urinary frequency	BONES - JOINTS
Frequent headaches	Urinary urgency	Painful joints
Dizziness	Kidney infections	Persistent backache
Loss of balance	Prostate infections	Feet problems
Fainting spells	Vasectomy Yes - No	Broken bones
Head injury		Muscle weakness
Epilepsy	MENTAL	Numbness - tingling
Other	Poor memory	Hard to walk
	Irritable	Date of last colonoscopy
EYES - EARS	Depressed	
Glasses	Emotional stress	WOMEN
Contact lenses	Nervous breakdown	Breast lump - pain
Visual changes	Other	Vaginal discharge
See double		Abnormal bleeding
Hearing loss	HEART - LUNGS	Last Pap smear date
Ringing in ears	Hard to breathe	Pelvic pain
Earache	Persistent cough	Menstrual problems
Other	Cough with blood	Sexual problems
	Chest pain	C-Section
MOUTH - THROAT	Asthma	Pregnancies #
False teeth	High blood pressure	Miscarriages #
Frequent sore throats	Racing heart	Loss of urine
Frequent sinusitis	Leg cramps	
Hoarseness	Swollen feet	
Speech difficulties	Cold feet	
Neck swelling	Varicose veins	
Thyroid problems	Heart murmur	
Other		

Patient Signature _____

Date _____

Physician Signature _____

Date _____

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Patient Name _____ Date _____

Do any of these apply to you?

- High blood pressure
- High cholesterol
- Diabetes
- Smoking

Many common medical conditions and lifestyle choices may lead to another health issue-erectile dysfunction (ED). In men older than 40 years of age, 1 in 2 have ED to some degree. Take the quiz below to see if you may be experiencing ED.

Questions to be answered	Select one response that best describes your situation					
	0	1	2	3	4	5
How do you rate your confidence that you can get and keep an erection?		Very low	Low	Moderate	High	Very High
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No sexual activity	Almost never or never	Few times (less than half)	Sometimes (about half)	Most times (more than half)	Almost always or always
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	No sexual activity	Almost never or never	Few times (less than half)	Sometimes (about half)	Most times (more than half)	Almost always or always
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	No sexual activity	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
When you attempted sexual intercourse, how often was it satisfactory to you?	No sexual activity	Almost never or never	Few times (less than half)	Sometimes (about half)	Most times (more than half)	Almost always or always

If your total score is 21 or less, you may be showing signs of ED. Please consult with your doctor regarding possible treatment options.

Desert Radiation Specialists

PATIENT NAME _____ DATE _____

Please list all medications you are currently taking. This includes prescription and over the counter medications.

MEDICATION	STRENGTH (mg)	DOSAGE

Allergies to medications _____

Pharmacy name _____

Pharmacy phone # _____

Pharmacy fax # _____

Signature _____ Date _____

PROSTATE PATIENTS

Name _____

Date _____

1. Have you ever had rectal bleeding? _____

2. Do you have hemorrhoids? _____

3. Date of your last colonoscopy? _____

4. Where was the procedure performed? _____

5. Who was the Gastroenterologist that performed the procedure? _____

6. Any pertinent findings? _____

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Rancho Mirage, CA 92270

REFERRAL POLICY

Your insurance company may require a referral from your primary care physician. If you are not sure of your insurance requirements, please check first with your insurance company.

Due to this insurance regulation, it is necessary for you to acquire any necessary referral prior to your visit. This will help you avoid any additional out-of-pocket charges.

Please review and comply with the following:

1. Your referral is required prior to the time of your office visit.
2. We cannot accept verbal referrals. Your primary care physician or insurance company can fax your referral to us 24 hours a day at Desert Radiation Specialists 760.536.4491. It is important to tell your primary care physician and/or insurance company the date and time of your appointment.
3. If you do not have a referral, you can be seen for your scheduled visit; however, payment must be made at the time of your visit.
4. Be aware of the expiration date and the number of visits your referral allows. Do not hesitate to ask us to check the remaining number of visits or expiration date at each of your visits.

We hope this information will be helpful during your patient care at Desert Radiation Specialists. It is our goal to assist you in understanding and complying with your insurance carrier's requirements. You may have an insurance that does not require a referral at this time. If your insurance changes to a referral based policy, your signature indicates understanding of our policies and the need for a referral. Your signature also confirms your liability for any medical care received without proper referrals from your primary care physician and insurance company.

Patient Signature

Date

Desert Radiation Specialists

David P. Schreiber, M.D.

ADVANCE DIRECTIVE

The purpose of this advance directive is to inform you of a potential and probable personal financial obligation that you may have for the treatment you will be receiving from Desert Radiation Specialists. Although these are guidelines, it is your responsibility to know the coverage limits of your insurance.

If you are a patient with:

- A. Medicare and no supplement, you would owe 20% of the Medicare allowable (Medicare will pay 80% of their allowable).
- B. Any Medicare replacement plan (Medicare Advantage Plans) such as Aetna, Cigna, Anthem, Secure Horizons, Rocky Mountain Health Plan, the portion owed by you may be the same as stated in A (above).
- C. For any other insurance plan, please be aware of the percentage that your insurance will pay, as well as the deductible or co-insurance assignment that will result in your personal obligation.

We will help you in every way to estimate the balance you are likely to owe. If necessary, payment arrangements can be made with Leslie in our billing office. Please contact her directly at 760.536.4400 between the hours of 8:00 and 4:00 p.m.

Thank you,

David P. Schreiber, M.D.

Date

Patient Signature

Date

35800 Bob Hope Dr., #215, Rancho Mirage, CA 92270
Office: 760.536.4400 Fax: 760.536.4491

Desert Radiation Specialists

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

Desert Radiation Specialists "Practice" is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office; a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. **Treatment:** We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **Payment:** We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **Health Care Operations:** We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit this office.
4. **Appointment Reminders:** We may use and disclose your information to remind you of appointments. We may also email or mail you a reminder postcard for follow-up visits.
5. **Treatment Options:** We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
6. **Business Associates:** We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information.

Practice may disclose your health information without your authorization when permitted or required to by law, Including:

- For public health activities including reporting of certain communicable diseases
- For workers' compensation or similar programs as required by law
- To authorities when we suspect abuse, neglect or domestic violence
- To health oversight agencies

- For certain judicial and administrative proceedings pursuant to an administrative order
- For law enforcement purposes
- To a medical examiner, coroner or funeral director
- For the facilitation of organ, eye or tissue donation if you are an organ donor
- For research purposes under strictly limited circumstances
- To avert a serious threat to your health and safety or that of others
- For governmental purposes such as military service or for national security
- In the event of an emergency or for a disaster relief
- In any other instance required by law

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that action has preceded your revocation. Should you require your records be released, Practice will provide you an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. **Restrictions on Use and Disclosure:** You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals, or entities, involved in our care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. **Confidential Communication:** You have the right to request that we communicate with you in a particular manner or a certain location. For example: You may request that we only contact you at home. We will accommodate reasonable requests.
3. **Access:** You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
4. **Record Amendment:** You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. **Accounting of Disclosures:** You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures Practice has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. **Copy of Notice:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have any questions about this notice, please contact Practice's Privacy Officer at 35-800 Bob Hope Drive, Suite 215, Rancho Mirage, CA 92270 or call 760.536.4400. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

I have had the opportunity to review the Notice of Privacy Practices for Desert Radiation Specialists that outlines how patient confidential information will be used, disclosed and protected.

Printed Patient Name

Name/Relationship if signed by individual other than Patient

Patient Signature

Date

OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual refused to sign

_____ Communication barrier

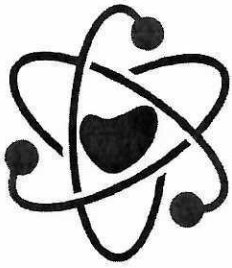
_____ Care provided was emergent

_____ Other

Employee Name

Date

**** PATIENT COPY ****



DESERT PROSTATE SPECIALISTS

35-800 Bob Hope Dr. Suite 215 Rancho Mirage, CA 92270

P:760.536.4400 | F:760.536.4491 | desertprostatespecialists.com

“For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.”

“The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.”

Signature

Date

