DESERT PROSTATE SPECIALISTS

35-800 Bob Hope Dr. Suite 215
Rancho Mirage, CA 92270
P: 760.536.4400 F:760.536.4491
info@desertprostate.com
desertprostatespecialists.com

PATIENT NUMBER:________________________________APPOINTMENT DATE: _________________

THERE WILL BE A $25 CHARGE FOR MISSED APPOINTMENTS WITHOUT 24-HOURS NOTICE.

Please print and complete all parts.

NAME: ____DATE OF BIRTH: ________________
Last First Middle Initial AGE: ________________
ADDRESS: _________________________________CITY: _____________________STATE: ______ZIP: _________

PHONE HOME: ______________________CELL: __________________WORK: ______________________________
EMAIL: ____

GENDER: ________SSN#: ______________________

EMPLOYER: ____OCCUPATION: _______________________________

SPOUSE: ___________________________PHONE: _________________________________

LANGUAGE: O English O Other RACE: O White O Black O Other
O Spanish O Asian O Hispanic

PRIMARY CARE PHYS: _____________________________________PHONE: _______________________________

REFERRING PHYSICIAN: ___________________________________PHONE: _______________________________

PRIMARY INSURANCE NAME: _________________________ID: ____
(We do not accept HMO insurance)
SECONDARY INSURANCE NAME: _________________________ID: _______________________________________

RESPONSIBLE PARTY (Person who should receive the bills)
NAME: ____PHONE: ____
ADDRESS: _________________________________CITY: _____________________STATE: ______ZIP: _________

NOTIFY IN CASE OF EMERGENCY, Not Living with you.

NAME:____PHONE:____

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 and all future claims. I further understand that if my insurance carrier requires a referral for this or any subsequent office visits, 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: __________________

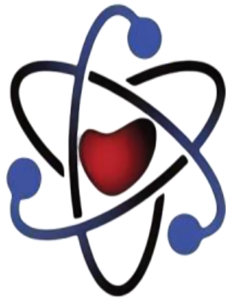
AMERICAN UROLOGICAL ASSOCIATION (AUA) SYMPTOM INDEX

AUA Symptom Score (circle one number on each line)

Questions to be answered	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 N



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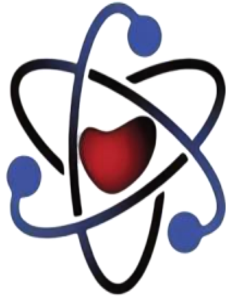
PATIENT NAME:_____________________DATE:_________________

Do any of these apply to you?
*High blood pressure
*High cholesterol
*Diabetes
*Smoking
Many 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	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	Almost never or never	Few times (less than half)	Sometimes (about half)	Most times (more than half)	Almost always or always
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 your doctor regarding possible treatment options.



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Name: ___________________________________ Date: _________________

Please circle those that apply

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

______________________________ __________ ___________________________ ________

Patient Signature Date Physician Signature Date

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PATIENT NAME ___________________________________ DATE ______________

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

MEDICATION	STRENGTH (mg)	DOSAGE

Allergies to medications: ____

____

Pharmacy name: __________________________________

Pharmacy phone number: ______________________________

Pharmacy fax number: _____________________

_____________________________________ _______________________

Signature Date

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PATIENT NAME:________________________________DATE:_________________

1. Have you ever had rectal bleeding? ______________________
2. Do you have hemorrhoids? ______________________________
3. Date of 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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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

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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

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- 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 or 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 NOTIFIY 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 report or 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.

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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 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

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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****

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ADVANCED DIRECTIVE

The purpose of this advanced 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 Denise Stiles in our billing office. Please contact her directly at 760.992.6771 between the hours of 8:00 and 4:00 p.m.

Thank you,

____________________________ ______________________

David P. Schreiber, M.D. Date

____________________________ ______________________

Patient Signature Date

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"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://openpaymentsdataucmsegovu"

______________________________ _________________
Signature Date

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MEDICAL RECORDS RELEASE FORM

Patient's Name: ____

Address: ____

Date of Birth: ____

I hereby authorize: ____

to release my medical records via MAIL/FAX to Desert Prostate Specialists.
35-800 Bob Hope Dr., Suite 215, Rancho Mirage, CA 92270

FAX: 760.536.4491
PHONE: 760.536.4400

Signed: ________________________________Date: ____________________

Relationship to patient: ______________________________