

社會安全號碼#: _____
姓名: _____
地址: _____
城市: _____ 州: _____ 郵遞區號: _____
E-Mail 地址: _____
雇主: _____
工作地址: _____

住家電話: _____
手機號碼#: _____
性別: 男 女 出生日期: _____
婚姻狀態: 單身 已婚 離婚
緊急聯絡人姓名和聯絡號碼:

請選擇下列種族選項:
亞洲
夏威夷
其他太平洋群島
非洲美籍
美國印第安/阿拉斯加原住民
白人
西班牙裔
多種族混血
不提供
使用語言: _____

配偶姓名: _____
配偶出生日期: _____ 電話號碼 #: _____
配偶工作名稱: _____
配偶社會安全號碼: _____

介紹醫生名字: _____ 電話號碼 #: _____
家庭醫生名字: _____ 電話號碼 #: _____
其他專科醫生名字: _____ 電話號碼 #: _____

第一保險名稱: _____	第一保險人名字: _____
與保險人關係: _____	保險人生日日期: _____
第一保險卡號碼: _____	第一保險卡團體號碼: _____
第二保險名稱: _____	第二保險人名字: _____
與保險人關係: _____	第二保險人生日日期: _____
第二保險卡號碼: _____	第二保險卡團體號碼: _____

This form must be completed in order for us to bill your insurance. Failure to do so will mean that you are responsible for all insurance billing.

Assignment of insurance benefits: I hereby authorize my insurance company to pay directly to the doctor the amount due on my claim for services rendered to my dependent or me. Payment for co-pays and deductibles are required at the time services are rendered. I further agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for payment of the difference; and if the nature of the disability were such that it is not covered by the policy, I will be responsible to the doctor for payment of the entire bill.

病人簽名: _____ 日期: _____



Adult Patient Demographics

Social Security#: _____

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

E-Mail Address: _____

Employer: _____

Employer Address: _____

Home Tel: _____

Work Tel: _____

Cell #: _____

Sex: (Female) or (Male)

Date of Birth: _____

Marital Status: _____

Emergency Contact/Name and Tel#

Race: Please choose one:
 Asian
 Native Hawaiian
 Other Pacific Islander
 Black/African American
 American Indian/Alaska Native
 White
 More than 1 Race
 Unreported/Refused to Report

Ethnicity: Please choose one:
 Hispanic/Latino Not Hispanic/Latino
 Unreported/Refused to Report

Preferred Language: _____

Spouse Name: _____

Date of Birth: _____ **Phone #:** _____

Spouse Employer: _____

Spouse SS # _____

Physician Information

Referring Doctor: _____

Primary Care Doctor: _____

Other Physicians: _____

Insurance Information

Name of Insurance: _____ **Subscriber Name:** _____

Relationship to subscriber: _____ **Subscriber Date of Birth:** _____

Policy Number: _____ **Group Number:** _____

Secondary Insurance

Name of Insurance: _____ **Subscriber Name:** _____

Relationship to subscriber: _____ **Subscriber Date of Birth:** _____

Policy Number: _____ **Group Number:** _____

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Patient Signature: _____ **Date:** _____

**Las Vegas Pediatric Urology
Adult Patient Information Sheet**

REASON FOR VISIT: _____

UROLOGIC CONDITIONS: Kidney stones Urinary tract infection Scrotal swelling
 Frequent Urination Blood in urine Incontinence
 Slow urine stream Difficulty with erection Abnormal PSA

ALLERGIES to Medications: None _____
 Medication and reaction Medication and reaction

CURRENT MEDICATIONS: None _____

PHARMACY Name: _____ Phone: _____

Street address: _____ City: _____

MEDICAL HISTORY: Check all conditions for which apply:

___ Diabetes mellitus	___ Hypertension	___ Emphysema/COPD	___ Asthma
___ Heart troubles	___ Thyroid disease	___ Ulcer disease	___ Gout
___ Stroke	___ Diverticulosis	___ Colitis	___ Glaucoma
___ Liver disease/cirrhosis/hepatitis		___ Cancer. Site of origin: _____	
___ Anemia/bleeding disorders		Other: _____	

PRIOR SURGERIES: None

FAMILY HISTORY: Please list medical conditions present in your family.

Mother	Father	Siblings
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY: Check all that apply:

Marital status: ___ Married ___ Single ___ Divorced ___ Widowed ___ Separated
 Smoking: ___ Never Smoked ___ Former Smoker ___ Current Smoker, ___ packs per day
 Alcohol: ___ Never ___ Quit ___ Yes, ___ drinks per day
 Caffeinated drinks: ___ per day
 Blood transfusion in the past: ___ Yes ___ No
 Recreational drug use: ___ Never ___ Former user ___ Current user, drug of choice ___

REVIEW OF SYSTEMS: If you have any of the symptoms below, please circle the condition

<p style="text-align: center;">GENERAL</p> <p>Fever Night sweats Unexpected weight loss Difficulty sleeping Loss of Energy</p>	<p style="text-align: center;">HEAD & NECK</p> <p>Blurry or double vision Temporary blindness Ringing in ears Ear infections Difficulty smelling Nose bleeds easily Difficulty swallowing Sore throat Lump in neck</p>	<p style="text-align: center;">CARDIOVASCULAR</p> <p>Short of breath on exertion Chest pain Irregular heartbeat Leg pain with exertion Swelling in ankles Wake up at night short of breath</p>
<p style="text-align: center;">RESPIRATORY</p> <p>Chronic cough Cough up blood Shortness of breath at rest Wheezing History of pneumonia or bronchitis</p>	<p style="text-align: center;">GASTROINTESTINAL</p> <p>Indigestion or heartburn Stomach ulcers Vomiting blood Blood in stool Tarry stool Chronic diarrhea / colitis Jaundice Chronic constipation</p>	<p style="text-align: center;">HEMATOLOGIC</p> <p>Easy bruising or bleeding tendencies Anemia Poor immune system On blood thinners</p>
<p style="text-align: center;">MUSCULOSKELETAL</p> <p>Pain or swelling in joints Pain in the spine</p>	<p style="text-align: center;">SKIN & BREAST</p> <p>Lumps or pain in breast Nipple discharge Abnormal breast engorgement</p>	<p style="text-align: center;">ENDOCRINE</p> <p>Temperature intolerance Thyroid problems Excessive thirst Steroid use</p>
<p style="text-align: center;">GYNECOLOGIC</p> <p>Abnormal PAP smear Pain with intercourse Vaginal dryness Frequent vaginal infections Hot flashes Prior PID or tubal infections</p>	<p style="text-align: center;">NEUROLOGIC/PSYCHIATRIC</p> <p>Weakness in extremities Numbness or tingling in extremities Pain shooting down extremities Seizures Dizziness Vertigo (room spinning around you) Chronic depression Anxiety disorder</p>	<p style="text-align: center;">GENITOURINARY</p> <p>Blood in urine Kidney or bladder stones Kidney or bladder infections Loss of bladder or bowel control Pain or burning with urination Leak urine with cough, sneeze, or laugh Leak urine with urge</p>

International Voiding Symptom Score

Patient Name _____ Date of Birth _____ Date _____

Please answer the questions below with a ranking of your symptoms.	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.	Your Score:
	0	1	2	3	4	5	
1. Incomplete Emptying 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	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when urinating?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. Nocturia (Night Time) Over the past month, how many times did you usually 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	

Quality of life due to urinary symptoms.	Delighted	Pleased	Mostly Satisfied	Mixed Feelings	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

MEDICAL RECORDS RELEASE FORM

DATE: _____

STAT REQUEST ()

Patient Name: _____

Patient Address: _____

DOB: _____

SSN: _____

Please release all pertinent medical records, imaging studies, and laboratory test results to:

Las Vegas Pediatric Urology
653 N. Town Center Dr., Suite 407
Las Vegas, NV 89144
Tel: 702-728-5686 Fax: 702-628-9030

Signature of Patient or Authorized Patient Representative

Date

Relationship to Patient

(Mother, Father, Legal Guardian, Foster parent, court-appointed case worker, etc.)

**LAS VEGAS PEDIATRIC UROLOGY
AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION**

This form authorizes the release of Protected Health Information pursuant to 45 CFR Parts 106 and 164.

The undersigned authorizes the above-named providers, LAS VEGAS PEDIATRIC UROLOGY, to release contents of medical records to my insurance company for purposes of billing and collecting as requested. The undersigned acknowledges that without this authorization, LAS VEGAS PEDIATRIC UROLOGY may be unable to bill and collect from patient's insurance company.

The information may be disclosed by employees or business associates of LAS VEGAS PEDIATRIC UROLOGY for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

I acknowledge that I have the right to revoke authorization at any time and that it must be requested in writing, and I understand that any use or disclosure that has already occurred prior to the date on which revocation of consent is received will not be affected and may no longer be protected by Federal Privacy Law.

This authorization will remain in effect until terminated in writing by the undersigned patient or legal patient representative.

Notice of Privacy Practices

This acknowledges your receipt and reading of Las Vegas Pediatric Urology Notice of Privacy Practices. You should review the document carefully to learn how your protected health information may be used or disclosed. You should review the notice prior to signing this consent.

Patient Signature	Date	Patient Name	DOB
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Authority: If person signed is other than patient, state authority / relationship to patient

TREATMENT AUTHORIZATION

The persons listed below, in addition to the parents and legal guardians, are authorized to bring

(child's name) _____ to the OFFICE of Las Vegas Pediatric Urology for treatment or consultation.

Please note that a parent or an authorized legal guardian (e.g. court-appointed case worker) must be present to sign hospital or anesthesia consents for SURGERY at the hospital.

Name	Relationship to patient
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Name	Relationship to patient
------	-------------------------

Name	Relationship to patient
------	-------------------------

Name	Relationship to patient
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Las Vegas Pediatric Urology

A BRIEF LOOK AT ARBITRATION FOR THE PATIENT

Introduction

Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association, and noted to be a favored method of resolving disputes by the United States Supreme Court.

If you are unfamiliar with arbitration in general, the information included here provides some of the basic principles of arbitration.

What Is Arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and your doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After a hearing, which is usually less formal than a court proceeding, the arbitrator makes the decision (“award”). Although the procedures are different, generally the same laws and same measure of damages which apply in court proceedings also apply in arbitration.

Does Arbitration Prevent You From Making A Claim?

No. By selecting arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does It Prevent You From Obtaining A Financial Award?

No. Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim, he or she will determine a damage award.

The United States Supreme Court has, in fact previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

May I Be Represented By An Attorney Of My Choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who Is Bound By This Agreement?

If you choose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by the doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by the doctor. Likewise, the doctor or anyone suing on behalf of a doctor is bound.

What Does Arbitration Cost?

In general, arbitration is less expensive than court actions. The arbitrator's fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If Either Party Does Not Like The Arbitration Result, Could There Still Be A Jury Trial In Court?

Generally, the answer is “No”. The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed, and potentially reversed (“vacated”) by a court in limited circumstances.

A Message To Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between healthcare providers and their patients have long been recognized and approved by the courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators) who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article I: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article II: All Claims Must Be Arbitrated: It is the intention of the two parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by the Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article III: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by US Mail, postage prepaid, to all parties, describing the claim against the physician, the amount of damages sought, and the names and addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206-382.48, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9USC 1-4) and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article IV: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or enforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Nevada and Federal law.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE I OF THIS CONTRACT. YOUR SIGNATURE INDICATES THAT OUR OFFICE HAS PROVIDED YOU WITH THE DOCUMENT "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT".

Andrew Hwang 01/01/2015
Physician Signature Date

Andrew H. Hwang, M.D.
Physician Name

Patient Signature Date

Print Patient Name

Patient Representative Signature Date

Print Name of Patient Representative and Relationship to Patient

Translator Signature Date

Print Translator Name

Las Vegas Pediatric Urology

Patient Authorization and Agreement to Office Policies and Fees

DISCLOSURE: Las Vegas Pediatric Urology is a solely-owned for-profit professional Limit Liability Company that provides medical services to the community.

I hereby authorize Las Vegas Pediatric Urology to furnish my insurance carrier(s) with all information upon their request concerning my illness or injury and/or illness or injury of my dependent listed above. I agree to respond to any additional information that the insurance company may request in a timely manner.

I hereby assign to Las Vegas Pediatric Urology all payments to which I am entitled from my insurance carrier(s) for medical and/or surgical expenses related to the services reported. I understand that I am financially responsible for charges not covered by my insurance company at the time of service.

I understand that Las Vegas Pediatric Urology bills the insurance as a courtesy to me. I agree to provide accurate and complete information in a timely manner. If my failure to do so results in payment of the claim being delayed more than 90 days from the date of service, the physician reserves the right to collect the balance in full from me immediately. If I am unable to pay or cannot be contacted, the bills may be sent to a collection agency. In such a scenario, I will be responsible for attorney's fees, collection expenses and interest. I also understand that this account will be listed with local and national credit bureaus.

I understand that all co-payments, co-insurances, deductibles and charges for items and services not covered by my insurance are payable at the time service is rendered. I will be billed a service charge of \$10 if it is paid later. LVPU accepts cash, personal checks, Visa, MasterCard, American Express, and Discover only. I agree to pay a \$25 penalty charge for each dishonored check. Unpaid returned checks will be sent to the District Attorney's office.

I understand that I will be charged a fee of \$35 for all FMLA, Disability, Jury Duty and other extended forms filled out by Dr. Hwang. School or work excuses and permission notes for office visits and operations are free of charge.

I understand that certain lab tests will be sent to an outside laboratory that is not affiliated with this practice and I will be billed separately by the laboratory for those charges.

Unkept Appointment Penalty

I understand that surgery scheduling requires extensive coordination amongst the surgeon(s), the anesthesiologist, the hospital, and if needed, third party equipment companies. Failure to appear at the designated time and date for surgery results in lost time and resources for all providers, and deprives other patients the opportunity to have their surgery done more timely.

I understand that failure to cancel or reschedule a **surgery** appointment at least 24 hours prior will result in a \$100 fee billed to me that is not covered by my insurance. It may also result in my dismissal from the practice.

I understand that if I will be charged \$25 for broken **office** appointment unless 24 hour notice is given.

Medical Records

All requests for the release of records must be submitted to our office in writing either via fax or U.S. mail. Please allow 48-72 hours for all requests for medical records to be processed. Please note that records released to attorneys, insurance companies, or any party other than another doctor's office may be subject to a fee of \$0.60 per page to be remitted upon receipt of medical records. Mailing postage and handling are charged extra.

I may request FREE online access to my personal health records through the electronic health record system (Practie Fusion / Patient Fusion) by providing my email address.

A photocopy of this authorization is as valid as the original.

Signature

Date

Print Name

Social Security Number