# INLAND UROLOGY
## MEDICAL GROUP

**Patient Name (Last, First, MI)** _____

**Date of Birth**_____ **Sex: M ☐ F ☐ Social Security Number** _____

**Address** _____ **City** _____ **State** _____ **Zip Code** _____

**Home Ph #** _____ **2nd Phone Number (☐ Work ☐ Cell)** _____

**Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

**Spouse** _____ **Phone Number**_____**Preferred Language Spoken** _____

**Preferred Communication:** ☐ Home Phone ☐ Work Phone ☐ Cell Phone

**Email** _____

**Patient Occupation** _____ **Employer Name** _____

**Employer Address** _____ **City** _____ **State** _____**Zip** _____

**Work Phone** _____ **May We Contact You at Work?** ☐ Yes ☐ No

**Emergency Contact** _____ **Relationship to Patient** _____

**Emergency Contact Phone #** _____

**Race:** ☐ Declined ☐ Unknown ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ American Indian/Alaska Native ☐ Asian

☐ Black/African American☐ Native Hawaiian/Pacific Islander ☐ White/ Caucasian ☐ Other

**Ethnicity:** Do you identify with any ethnic origin? If Yes, please note: _____

**Pharmacy Name** _____**Pharmacy Phone #** _____

**Pharmacy Address** _____

**Referring Doctor** _____

**Primary Care Physician** _____

# GENERAL OFFICE POLICIES

**CO-PAYMENTS:** Payment for service is required to be made in full at the time of the office visit. We accept cash, checks, and most major credit or debit cards, with the exception of American Express.

**RETURNED CHECKS:** Returned checks will incur a $25.00 fee in addition to check amount. After 2 returned checks, payments must be made by cash or by credit/debit card.

**ARRIVAL FOR APPOINTMENTS:** New patients should arrive 30 minutes before and existing patients should arrive 15 minutes before the scheduled appointment time to complete insurance verification and paperwork. Your appointment may be rescheduled if you arrive more than 15 minutes after your scheduled appointment time and may be considered as a missed appointment.

**CANCELLATION OR MISSED APPOINTMENTS:** A $50.00 "No Show Fee" may be charged to you (this cannot be billed to insurance) if you miss your scheduled appointment or do not call to cancel your appointment within at least 48 hours notice prior to your appointment. This will enable us to free your time allotted to another patient who is waiting to be seen.

I hereby authorize payment directly to **Inland Urology Medical Group, Inc.** of all medical and surgical benefits payable under this claim and I authorize the release of any medical information necessary to process the claim. A photocopy shall be as valid as the original.

**DIAGNOSTIC RESULTS:** When one of our patients has any type of laboratory test, x-ray, or other pathology result pending, it is our office policy that patients that all patients who receive an order for labs/imaging are to schedule a follow up appointment at check-out when picking up lab orders to review results with physician.

This policy was adopted to ensure that we do not overlook any of our patients and to implement a program that gets the patient involved in his or her medical care.

**CONSENT FOR TREATMENT:**

I, the undersigned, hereby consent to the administration and performance of all diagnostic procedures and treatments which, in the judgement of my physician, may be considered necessary or advisable. I further agree that if I decide to leave without receiving treatment or without the consent of my attending physician, neither said physician, nor Inland Urology Medical Group, Inc., shall be liable of such decision.

Please sign below so that our office is aware that you have given your consent for treatment and have been informed of the above policy.

**PATIENT CONDUCT:** We understand that it can be stressful for patients when there are long waits or if you are feeling unwell, but we have a zero-tolerance policy towards aggressive behavior and rudeness to our staff. We expect that you treat our staff, fellow patients, caregivers, and visitors politely and with respect as we strive to treat our patients as family. Violence or verbal harassment will not be tolerated or accepted under any circumstances. You may be asked to seek care by another practice if this behavior occurs.

Patient's Signature or Responsible Party

Date

# AUTHORIZATION FOR USE OF USPS MAIL, ANSWERING MACHINE AND/OR VOICEMAIL as well as ELECTRONIC ACCESS (Patient Portal and Email)

Protected Healthcare Information that we may possibly disclose on your home, work, mobile phone, patient portal account, email and current home address on file would include, but is not limited to: test/lab results, prescription/pharmacy information, patient plans, future orders, appointment instructions for visits and procedures, and clinical information.

_____(Initial) I agree to allow Inland Urology Medical Group, Inc. physicians and healthcare staff to leave messages that include Protected Healthcare Information of the following:

Please initial next to the applicable communication devices:

☐ Home Number ☐ Work Number ☐ Mobile Number ☐ Patient Portal ☐ Email ☐ USPS Mail

_____(Initial) No, I do not agree to allow Inland Urology Medical Group, Inc. physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

**Patient's Signature:** _____ **Date:**_____

# Standard Authorization of Use and Disclosure of Protected Health Information

I authorize **INLAND UROLOGY MEDICAL GROUP, INC.** to disclose any of my health information/medical records to individuals/ facilities listed below:

| | |
|---|---|
| Name of Person/Facility | Name of Person/Facility |
| Name of Person/Facility | Name of Person/Facility |

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to Inland Urology Medical Group, Inc. You should contact the Privacy Officer to terminate this authorization.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Inland Urology Medical Group, Inc, discloses it to another party.

**Rights of the Individual**

- You may inspect or copy information used or disclosed under this authorization
- You may refuse to sign this authorization

**Effect of Refusing Authorization**

If you refuse to sign this authorization, Inland Urology Medical Group, Inc. will not deny you any treatment.

**Signatures**

Name of Patient: _____

Signature of Patient: _____ Date: _____

Signature of Representative: _____ Date: _____

Relationship of Patient Representative to Patient: _____

☐ I do not wish for information to be given to anyone other than myself.

# Patient Acknowledgement of Receipt of Privacy Practices Notice

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information
- My privacy rights with regards to my protected health information
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact **Inland Urology Medical Group, Inc.** by calling (909) 623-3428.

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

### Patient or Personal Representative

Signature: _____ Date: _____

Name: (Last) _____ (First) _____ (MI) _____

Relationship of Patient Representative to Patient: _____

**For Office Use Only**

We made a good-faith effort to obtain an acknowledgement of _____'s receipt of our *Notice of Privacy Practices*. Despite these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

☐ Patient refused to sign. Date of refusal: _____

☐ Communication barriers prohibited obtaining an acknowledgement

☐ An emergency prevented us from obtaining an acknowledgement.

☐ Other: _____

Attempt was made by: _____ Date: _____