Southern California Continence Center
A Medical Corporation

Jill G. Byers M.D.
949.515.3777 fax 949.480.3404
320 Superior Ave, Suite 110, Newport Beach, Ca. 92663

Welcome to our practice and thank you for selecting us for your urologic care. Rest assured that every effort will be made to provide the highest quality treatment for you.

It is our desire to provide for your urologic needs both thoroughly and efficiently. The initial appointment is spent conducting an examination, reviewing a clinical diagnosis, and discussing a treatment plan.

> **We ask your help in gathering pertinent records** so that we can give you the best possible evaluation. If you have had any imaging (ie: CT scans, MRI, Xrays) of your abdomen and pelvis please notify us. We are also including a records request with this paperwork so that you can request appropriate lab work and progress notes be forwarded to our office from the referring physician prior to your first visit. We recognize you have waited for this appointment and would like to provide you with a complete evaluation in a timely manner and having all of the pertinent information available at the time of your visit will help ensure that your urologic concerns are thoroughly evaluated and addressed.

Completing these forms prior to your appointment will help decrease the length of your appointment. Please bring these, and all of your insurance information with you at your scheduled time. If you cannot complete these forms prior to your scheduled appointment time we ask that you arrive at least a half an hour before to allow yourself time to complete them in our office without disturbing the flow of our scheduled appointments. Patients with uncompleted paperwork at the time of their appointment may be required to reschedule for another day.

We look forward to meeting with you.

IMPORTANT:

As a new patient, we require that you use the provided form to obtain pertinent records and have them forwarded to our office in time for your first appointment.
Without this, we will not be able to assess your condition at the time of your appointment and this will result in additional appointments and potential delay of your care.

Men: any and all previous PSA and Testosterone lab levels, urine related labs, imaging of the abdomen or pelvis.

Women: any urine related lab tests done in the last 12 months, all imaging of the abdomen or pelvis.

PRIVACY POLICY STATEMENT

Jill Byers, MD
Southern California Continence Center,
320 Superior Ave, Suite 110, Newport Beach, Ca. 92663

Purpose: *The following privacy policy is adopted to ensure that this medical practice complies fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to this organization. Violations of any of these provisions will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution.*

Effective Date: *This policy is in effect as of November 21, 2005*

It is the policy of this medical practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California law.

Notice of Privacy Practices
It is the policy of this medical practice that a notice of privacy practices must be published, that this notice be provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this organization's notice of privacy practices. It is the policy of this medical practice to post the most current notice of privacy practices in our "waiting room" area, and to have copies available for distribution at our reception desk.

Assigning Privacy and Security Responsibilities
It is the policy of this medical practice that specific individuals within our workforce are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Rule's requirements. Furthermore, it is the policy of this medical practice that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum it is the policy of this medical practice that there will be one individual or job description designated as the Privacy Official.

Deceased Individuals
It is the policy of this medical practice that privacy protections extend to information concerning deceased individuals.

Minimum Necessary Use and Disclosure of Protected Health Information
It is the policy of this medical practice that for all routine and recurring uses and disclosures of PHI (except for uses or disclosures made 1) for treatment purposes, 2) to or as authorized by the patient or 3) as required by law for HIPAA compliance such uses and disclosures of protected health information must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. It is also the policy of this medical practice that non-routine uses and disclosures will be handled pursuant to established criteria. It is also the policy of this organization that all requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.

Marketing Activities
It is the policy of this medical practice that any uses or disclosures of protected health information for marketing activities will be done only after a valid authorization is in effect. It is the policy of this organization to consider marketing any communication to purchase or use a product or service where an arrangement exists in exchange for direct or indirect remuneration, or where this organization encourages purchase or use of a product or service. This organization does not consider the communication of alternate forms of treatment, or the use of products and services in treatment to be marketing. Further, this organization adheres to the HIPAA Privacy Rule that a face to face communication made by us to the patient, or a promotional gift of nominal value given to the patient does not require an Authorization.

Psychotherapy Notes

It is the policy to require an authorization for any use or disclosure of psychotherapy notes, as defined in the HIPAA regulations, except for treatment, payment or health care operations as follows:

A. Use by originator for treatment;

B. Use for training physicians or other mental health professionals as authorized by the regulations;

C. Use or disclosure in defense of a legal action brought by the individual whose records are in issue;

D Use or disclosures as required by law, or as authorized by law to enable health oversight agencies to oversee the originator of the psychotherapy notes

Complaints

It is the policy of this medical practice that all complaints relating to the protection of health information be investigated and resolved in a timely fashion. Furthermore, it is the policy of this medical practice that all complaints will be addressed to Dr. Byers, who is duly authorized to investigate complaints and implement resolutions if the complaint stems from a valid area of non-compliance with the HIPAA Privacy and Security Rule.

Prohibited Activities-No Retaliation or Intimidation

It is the policy of this medical practice that no employee or contractor may engage in any intimidating or retaliatory acts against persons who file complaints or otherwise exercise their rights under HIPAA regulations. It is also the policy of this organization that no employee or contractor may condition treatment, payment, enrollment or eligibility for benefits on the provision of an authorization to disclose protected health information except as expressly authorized under the regulations.

Responsibility

It is the policy of this medical practice that the responsibility for designing and implementing procedures to implement this policy lies with the Privacy Official.

Verification of Identity

It is the policy of this medical practice that the identity of all persons who request access to protected health information be verified before such access is granted.

Mitigation

It is the policy of this medical practice that the effects of any unauthorized use or disclosure of protected health information be mitigated to the extent possible.

Safeguards

It is the policy of this medical practice that appropriate physical safeguards will be in place to reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule. These safeguards will include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection. These safeguards will extend to the oral communication of PHI. These safeguards will extend to PHI that is removed from this organization.

Business Associates

It is the policy of this medical practice that business associates must be contractually bound to protect health information to the same degree as set forth in this policy. It is also the policy of this organization that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate.

Training and Awareness

It is the policy of this medical practice that all members of our workforce have been trained by the compliance date on the policies and procedures governing protected health information and how this medical practice complies with the HIPAA Privacy and Security Rules. It is also the policy of this medical practice that new members of our workforce receive training on these matters within a reasonable time after they have joined the workforce. It is the policy of this medical practice to provide training should any policy or procedure related to the HIPAA Privacy and Security Rule materially change. This training will be provided within a reasonable time after the policy or procedure materially changes. Furthermore, it is the policy of this medical practice that training will be documented indicating participants, date and subject matter.

Material Change

It is the policy of this medical practice that the term "material change" for the purposes of these policies is any change in our HIPAA compliance activities.

Sanctions

It is the policy of this medical practice that sanctions will be in effect for any member of the workforce who intentionally or unintentionally violates any of these policies or any procedures related to the fulfillment of these policies. Such sanctions will be recorded in the individual's personnel file.

Retention of Records

It is the policy of this medical practice that the HIPAA Privacy Rule records retention requirement of six years will be strictly adhered to. All records designated by HIPAA in this retention requirement will be maintained in a manner that allows for access within a reasonable period of time. This records retention time requirement may be extended at this organization's discretion to meet with other governmental regulations or those requirements imposed by our professional liability carrier.

Regulatory Currency

It is the policy of this medical practice to remain current in our compliance program with HIPAA regulations.

Cooperation with Privacy Oversight Authorities

It is the policy of this medical practice that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of health information within this organization. It is also the policy of this organization that all personnel must cooperate fully with all privacy compliance reviews and investigations.

Health Information Exchange

This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law, that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.

If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), We will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE.

To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949/764-8722.

Cancelled or Missed Appointment Policy

In order to provide our patients with timely medical services we have found it necessary to institute this policy regarding missed appointments. A missed appointment prevents us from providing care to other patients with similar needs who could have been scheduled into a cancelled appointment timeslot, and it increases the wait for patients trying to schedule appointments.

1. Patients canceling their appointments within 24 hours of the scheduled visit or not coming to the scheduled appointment will be charged a missed appointment fee.
2. **Our missed appointment fee is $25.00.**
3. Appointments canceled or rescheduled more than 24 hours prior to the date of the scheduled appointment are not affected by this policy.
4. We make every effort to contact each patient one business day prior to their appointment via the telephone number provided at the initial appointment with us. **It is imperative that you notify us if your phone number changes.** We will not be responsible for being unable to contact you with a reminder phone call if you have changed your number and not notified us.
5. Patients arriving late for an appointment will still be seen **if** the schedule permits, after seeing the patients who have arrived on time for their appointments.
6. Excessively or repeated late arrives may be charged a missed appointment fee.

Authorization to use/disclosure of health information

Name: ______________________ Date of Birth: __________

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider: ______________________
Address of Provider: ______________________ Phone: __________
______________________ Fax: __________

Recipient and Address for Delivery of Records:

Dr. Jill Byers/ Southern California Continence Center
320 Superior Ave Suite 110
Newport Beach, CA 92663

Phone: 949-515-3777
Fax: 949-480-3404

Purpose: I understand that the specific purpose of this Authorization is ______________________.

Information to be disclosed: This Authorization permits the above named health care provider to disclose the following medical records:

All my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above mentioned health care provider may hold.

All my health information described above except for the following:

____

Only the following records or types of health information; (insert dates of treatment or other designation):

____

Term: This Authorization will remain in effect for (1) year from the date this authorization is signed.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that the authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt or my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice or revocation.

Questions: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have a right to receive a copy of this authorization from my health care provider.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

______________________ __________ ______________________
Signature date sig of witness

Name: ______________________
Please print

If individual is unable to sign this Authorization, please complete the information below

______________________ __________ ______________________
Sig of Personal Rep date sig of witness

Name: ______________________
Please print

Financial Agreement:

Southern California Continence Center is dedicated to providing you the most efficient medical care and service possible. Your understanding of our financial policy is an essential element of this. If you have any questions regarding any aspect of our policy, please feel free to consult any of our staff.

Full payment is due at the time of service. If you have insurance, and have signed an "Assignment of Benefits" statement, we will bill your insurance carrier for you. Balances after the insurance company has completed processing of your claim are due within thirty (30) days of the billing statement date. Exceptions will be made only if special arrangements have been made with the billing department prior to your visit. Any balance unpaid after ninety days may be turned over to a collection agency. There is a returned check fee of $25 for any returned checks.

It is your responsibility to know the details of your particular insurance policy. Not all services are covered by all carriers. Services which are not covered by your insurance are your responsibility. Diagnoses and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered or falsified in order to obtain coverage by insurance.

If your insurance has a co-payment policy, *the co-payment is due at the time of service*. If you have a deductible, you are responsible for all charges until the deductible is met. You are responsible for any and all allowable charges which remain after your insurance has paid its portion.

If your insurance carrier has a "network" of providers, it is your responsibility to make sure that we are an "in network" provider prior to obtaining services. If we are not "in network," we will still be happy to provide services; however, the percentage of charges for which you are responsible may be greater. It is also your responsibility to make us aware of any restrictions your policy has on ancillary services (such as requiring a specific lab).

It is your responsibility to make sure we have accurate insurance carrier information and billing information. *If a claim is unsuccessful because of flawed insurance or billing information, you will be responsible for the balance*.

We will make every effort to assist you in understanding the above information. We will also assist with any problems arising with your insurance to the extent we can accommodate.

Signature:______________________________ Date: ____________________________
(Patient/Responsible Party)
Print Name: ____

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PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY)

Patient Demographics:

Last Name: ____________ First ______________ MI __________

DOB: ________ Gender : Male ____ Female ___ SSN ____________

Marital Status: Married ____ Single ____ Other ____

Home Address: ____

City: ________________________ State: ______ Zip: ______________

Home #: _____________ Work #: ________ ext _____ Cell #: ____________

Email Address ____

Name of Primary Care Physician ______________________________

Pharmacy Name and Ph # ____________________________________

Employment Information:

Employment Status: Employed ___ Full Time Student ___ Part Time Student ___

Employer Name: _________________________ Phone _______________

Employer Address ____

Employer City ____________ State ___________ Zip __________

Emergency Contact:

Contact Name: _______________ Relationship to Patient ____________

Address ____

City _______________ State ______ Zip ________

Home Phone __________________ Cell Phone __________________

Referred By: Friend _____________________________________

Dr. _______________________________________

Hosp: _________________________

PRIMARY INSURANCE

Company Name:______________________________

Primary Cardholder/subscriber:

Last Name:______________First______________MI____DOB_____________

Patient relationship to Subscriber Self____Spouse____Child_______Other______

Subscriber ID________________________Group ___________________Plan_________

Deductible_____________Visit Copay_________

SECONDARY INSURANCE

Company Name:______________________________

Primary Cardholder/Subscriber

Last Name:______________First______________MI____DOB_____________

Patient relationship to Subscriber Self____Spouse____Child______Other______

Subscriber ID________________________Group ___________________Plan_________

Deductible_____________Visit Copay_________

We do not bill beyond secondary insurance.

Guarantor Information: (if different from primary insured or patient)

Guarantor Last Name________________First__________________MI____________

Responsible Party:______________________

Street: ______________________________ Date Of Birth:________ Age: ___

City:_________________ State/Zip:__________ Home Phone:___________

Employer: ________________________________ Work Phone:____________

Can confidential messages be left on your answering machine or voicemail? Y N

Can info regarding appt scheduling and nonmedical issues be sent to you via email? Y N

Email____

Please list, if any, person(s) whom we may inform about your general medical condition, your diagnosis, and/or your payment operations:

Name:________________________________ Phone #:_________________________

Name: ________________________________ Phone #:_________________________

Assignment of Benefits:
I assign all insurance benefits to **So CA Continence Center.** I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that Dr. Byers' office **is not responsible to know my plan, what it will pay for, or the deductible requirements.** I hereby authorize the doctor to release all information necessary to secure payments of benefits. I hereby give my consent for examination, treatment and insurance billing.

Signature:_______________________ Date: _______________________
(Patient/Responsible Party)
Print Name: ____

Acknowledgement of Receipt of Notice Of Privacy Practices:
I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available upon request, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signature:_______________________ Date: _______________________
(Patient/Responsible Party)
Print Name: ____

If not signed by the patient, Please indicate:

Relationship: _________________________________

Name of Patient: ______________________________

Appointment Policy
We will work hard to accommodate appointments that fit your schedule and medical needs. We ask that you let us know about cancellations or changes twenty-four hours in advance. Habitual missed, cancelled or rescheduled appointments are grounds for dismissal from the practice.

Identity Theft Prevention
Patients are required to present photographic identification or some other form of proof of identity in addition to their insurance eligibility. A copy of this information will be retained in the patient's protected record so as to efficiently verify each established patients identity on return visits. We will also be asking to take a digital picture of the patient to keep with their electronic medical record to further safeguard identity.

Patient Urological Questionaire

Name:______________________________ **Age:**_____ **Occupation:**________________

Your Reason for Todays visit ____

Referring Doctor ____

Past Urological Problems you have had____

____

Recent Imaging done of Abdomen or Pelvis Yes_______ No_______

List any urological medications you have tried, even if briefly (ie: samples)for your symptoms:____

Please Circle all of the following you have had

Hysterectomy
Bladder Surgery
Prostate Surgery
Prostate Biopsy
Scrotal Surgery
Scrotal/GU trauma
Hernia Surgery
Kidney Stones
Kidney Cancer
Prostate Cancer
Bladder Cancer
None

Other____

Please check any of the below which you have had recently (in the last 6 months)

☐Bladder Infection if yes, how many in the last 6 months?____________

☐Urinary leaking when coughing/sneezing/lifting/standing up

☐Urinary leaking with a strong urge to go

☐Urinary leaking without any associated activity or urges to go

☐Visible blood in urine

☐Frequent urination daytime only___ nighttime only___ day and night__

☐Burning with urination

☐A feeling that the bladder is not emptying well after you void

☐Pain in the abdominal area

☐Pain in the sides of your back

Females only

☐A feeling that something is falling down in your vaginal area

☐Dryness and/or itching in the vaginal area

☐Pain in the vaginal area

Please indicate how many children you have had______________ C-Sections____________

Are you or could you possibly be pregnant? Y N LMP__________________

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Review of Symptoms

CIRCLE ALL THAT APPLY:

OVERALL: Fever- Chills- Headache-
EYES: Blurry Vision- Double vision- Pain-
ALLERGY/IMMUNOLOGICAL: Hay fever- Drug allergy-
NEUROLOGICAL: Tremmors- Dizzy spells- numbness/tingling-
RESPIRATORY: Wheezing- Frequent cough- Shortness of breath-
BLOOD/LYMPH: Swollen glands- Clotting problems-
PRACTICING JEHOVAH WITNESS
SKIN: Skin rash Boils- Persistent itch
MUSCULOSKELETAL: Joint pain Neck pain Back pain
EAR/NOSE/THROAT: Ear infections Sore Throat Sinus problems
ENDOCRINE: Excessive thirst Too hot/cold Tired/Sluggish
GASTROINTESTINAL: Abdominal pain- Nausea/vomiting- Indigestion-
CARDIOVASCULAR: Chest pain- Varicose veins- High blood pressure-

PSYCHOLOGICAL
Generally satisfied with life
Severely depressed
Considered Suicide

HEIGHT ____________
WEIGHT____________

ANY FAMILY HISTORY OF (circle if applicable)

Kidney Stones
Breast Cancer
Prostate Cancer
Other____

FAMILY HISTORY: ALIVE/ DECEASED/ AGE /CAUSE OF DEATH
MOTHER____
FATHER____
SIBLINGS____

IMPORTANT: LIST ALL ALLERGIES INCLUDING TO MEDICATIONS AND LATEX AND TYPE OF REACTION (ie NAUSEA, VOMITING, RASH, SWELLING)

____
____
____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

____
____
____
____
____
____
____

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Social History

TOBACCO/ SMOKING HISTORY:
Never Smoked
Smoked cigarettes ____________packs per day for ____________years
Quit smoking ____years ago
Still smoking

ALCOHOL USE:
NO ALCOHOL USE EVER
HISTORY OF ALCOHOL ABUSE, NO LONGER DRINKING
RARELY DRINK ALCOHOL
1 -2 DRINKS PER WEEK
1-2 DRINKS PER DAY

CHILDREN'S NAMES AND AGES:

____

____

____

RECREATIONAL DRUG USE:
NEVER
MARIJUANA - PAST - PRESENT
NARCOTICS - PAST - PRESENT - TYPE____________
SINGLE / SIGNIFICANT OTHER /MARRIED / DIVORCED / WIDOWED
OCCUPATION ________________________

We are required to request the following information:

RACE- Circle one
American Indian / Alaskan Native Eskimo
Asian
Black/ African American
Black Hispanic or Latino
Native Hawaiian or other Pacific Islander
White
White Hispanic or Latino
Refused

ETHNICITY - Circle one
Hispanic or Latino
Not Hispanic or Latino
Refused

LANGUAGE PREFERENCE

____

BARRIERS TO COMMUNICATION - circle if applicable
Hearing
Vision

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Past Medical History

CIRCLE ALL THAT APPLY:

ANEMIA
Anxiety
Appendectomy
ARTHRITIS
ASTHMA
Atrial Fibrillation
Back surgery
BREAST CANCER
Cataract removal
CHEMOTHERAPY
Colon Cancer
COPD/ Emphysema
Coronary Artery Disease
Depression
Diabetes
Diverticulosis
DRY EYES
Endometriosis
FIBROMYALGIA
GALLBLADDER removed (Cholecystectomy)
GERD (Reflux)
Glaucoma
GOUT
HEART ATTACK (MI)
HEART SURGERY
High cholesterol
HIP REPLACEMENT
Hypertension
Hyperthyroidism
Hypothyroidism
HYSTERECTOMY
IBS (Irritable Bowel Disease)
KIDNEY STONE
Knee Replacement
Migraines
NEUROPATHY
Patient denies any significant PMH or PSH.
OSTEOPOROSIS
PACEMAKER
PROSTATE CANCER
RADIATION
Tonsillectomy
Tubal Ligation
Urethral SLING
UTERINE CANCER
VERTIGO
OTHER (Please list)______________________________
____
____
____
____