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.

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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.

SIGN HERE

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.

SIGN HERE

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.

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 acurate 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.

SIGN HERE

Signature:_____ Date: _____
(Patient/Responsible Party)

Print Name: _____

Consent for Release of Medical Records

Southern California Continence Center

Jill Byers, MD.

320 Superior Avenue, Suite #110

Newport Beach, CA 92663

FAX: (949) 480-3404 Telephone: (949) 515-3777

I, _____, do hereby consent to and authorize _____ to discose to Jill Byers, M.D. at 320 Superior Avenue, Suite #110, Newport Beach, CA 92663 information in my medical records including current and previous medical records from other practices and practitioners, hospital, and/or clinic which are part of my medical records.

_____ _____

Patient's Signature Date

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	Hernia Surgery
Bladder Surgery	Kidney Stones
Prostate Surgery	Kidney Cancer
Prostate Biopsy	Prostate Cancer
Scrotal Surgery	Bladder Cancer
Scrotal/GU trauma	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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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)_____

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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

_____
_____
_____
_____
_____
_____
_____

Name: _____ Date: _____

PERSONAL

Married: Yes _____ No_____ How Long?_____ Spouse's name_____
Occupation(past or present)_____
Children's Names and Ages: _____

Tobacco (ever) No___
Yes____for how long_____ How many per day_____
Quit how long ago?_____
Alcohol Yes_____ No_____ How many drinks a day_____or week_____
Recreational Drugs Yes_____ No_____
Height_____ Weight_____

Race:

__American Indian and Alaskan Native Eskimo
__Asian
__Black or African American
__Black Hispanic or Latino
__Native Hawaiian or other Pacific Islander
__White
__White Hispanic or Latino
__Refused

Ethnicity:

__ _____

__Hispanic or Latino
__Not Hispanic or Latino
__Refused

Language Preference

_____

Barriers to Communication:

__Hearing
__Vision

Name

Southern California Continence Center/Dr Jill Byers

Date

PELVIC PAIN and URGENCY/FREQUENCY PATIENT SYMPTOM SCALE

Please circle the answer that best describes how you feel for each question.

		0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1	How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2	a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
	b. If you get up at night to go to the bathroom, does it bother you?	Never Bothers	Occasionally	Usually	Always			
3	a. Do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
	b. Has pain or urgency ever made you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
4	Do you have pain associated with your bladder or in your pelvis (vagina, labia, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
5	a. If you have pain, is it usually		Mild	Moderate	Severe			
	b. Does your pain bother you?	Never	Occasionally	Usually	Always			
6	Do you still have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7	a. If you have urgency, is it usually		Mild	Moderate	Severe			
	b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
8	Are you sexually active? Yes___ No___							

SYMPTOM SCORE = (1, 2a, 3a, 4, 5a, 6, 7a)	
BOTHER SCORE = (2b, 3b, 5b, 7b)	
TOTAL SCORE (Symptom Score + Bother Score) =	

Total score ranges from 1 to 35.

A total score of 10-14 = 74% likelihood of positive PST; 15-19 = 76%; 20 or above = 91% likelihood of positive PST.

Revised 11/17/2003