

NORTHWEST UROLOGICAL CLINIC, P.C.

Physicians and Surgeons

Filling Out Our Forms

This packet includes:

- 1) A Welcome Letter
- 2) **A Registration Form**
- 3) **A History & Physical (H & P) Form**
- 4) A Notice of Privacy Practices (HIPAA)
- 5) **An Acknowledgement and Consent Form (for HIPAA)**

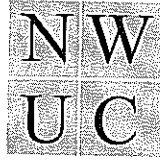
Please fill out the **Registration Form**, the **H & P Form**, and the **Acknowledgement and Consent Form** and bring into the office at the time of your visit.

If you have questions about any part of the forms, leave them blank until your appointment, and a member of our staff will help you.

NORTHWEST UROLOGICAL CLINIC, P.C.

Physicians and Surgeons

General Urology:
Clifford O. Stranburg, M.D.
Thomas M. Pitre, M.D.
Michael T. Lavelle, M.D.
Stanley A. Myers, M.D.



Pediatric Urology:
David B. Lashley, M.D., F.A.A.P.
Daniel A. Hirselj, M.D.
Kelly M. Bartholomew, PA-C

Urologic Oncology:
Bruce A. Lowe, M.D.
Mandy M. Williams, PA-C

WELCOME TO NORTHWEST UROLOGICAL CLINIC, P.C. IT IS IMPORTANT TO COMPLETE AND HAND CARRY THIS PACKET TO YOUR FIRST APPOINTMENT

We are pleased that you have selected our clinic for your care. To help make your first visit with us a little easier, we have prepared an introductory packet for you. Enclosed you will find the following items:

- An appointment card with the date and time of your visit
- A patient registration form
- A medical history form
- A map to our office (located on the back of this cover sheet)

Please complete the patient registration form and the medical history form prior to your visit. If you have medical insurance that you would like us to bill, **you will need to bring your insurance card(s).**

If you have a managed care health plan, please remember to do the following prior to your visit:

- Contact your primary care provider (PCP) to obtain a referral
- Inform your PCP's office of your appointment date so that they can initiate a referral authorizing your insurance company to pay for the services to be rendered
- Contact your insurance company to assure that the visit has been authorized

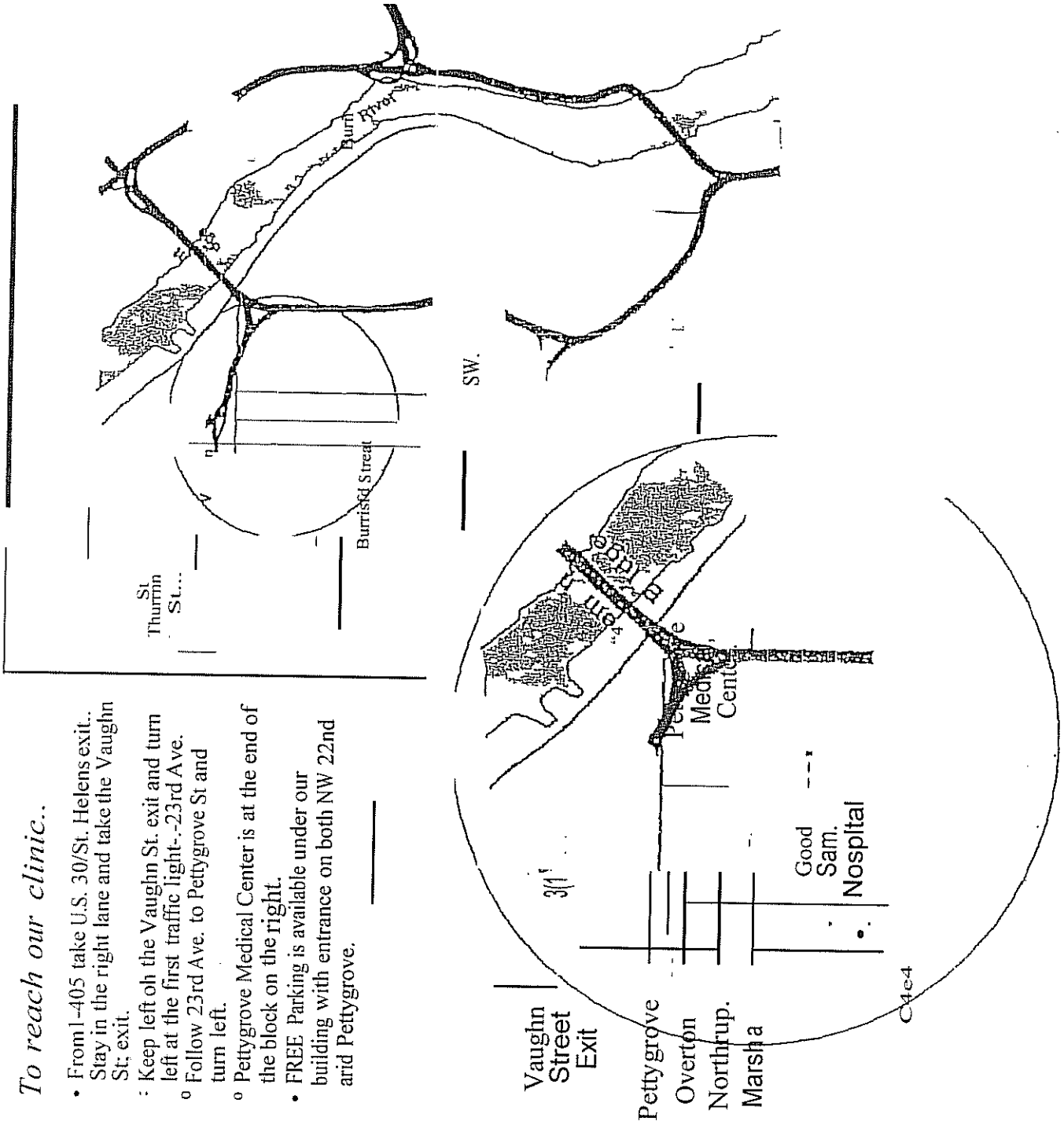
It is your responsibility to make sure an authorization for services is in place. If one is not in place at your scheduled appointment time you will be asked to sign a waiver indicating that you take responsibility for payment of services rendered on that date. In addition, please know which laboratories and hospitals your insurance requires you to use.

Complete medical information is necessary for an accurate consultation with your doctor. Please have your doctor forward to our office any relevant test results, x-ray films, or copies of medical records prior to your visit.

Should you have any further questions prior to your visit, please do not hesitate to contact us. We look forward to serving you!

To reach our clinic..

- From I-405 take U.S. 30/St. Helens exit. Stay in the right lane and take the Vaughn St; exit.
- Keep left on the Vaughn St. exit and turn left at the first traffic light--23rd Ave.
- Follow 23rd Ave. to Pettygrove St and turn left.
- Pettygrove Medical Center is at the end of the block on the right.
- FREE Parking is available under our building with entrance on both NW 22nd and Pettygrove.



C4e4

NORTHWEST UROLOGICAL CLINIC, P.C.

Clifford Stranburg, M.D., Thomas Pitre, M.D., David Lashley, M.D., Bruce Lowe, M.D., Michael Lavelle, M.D.,

Stanley Myers, M.D., Daniel Hirselj M.D., Mandy Williams, P.A.-C, Kelly Bartholomew, P.A.-C.

DATE: _____ ACCOUNT NO: _____ PHYSICIAN: _____
REFERRING DOCTOR: _____ REFERRING DR'S PHONE NO :(____) _____ - _____

Patient Name: _____ Birth date _____ Male/Female
Last First Middle

Marital Status (check one): Single _____ Married _____ Divorced _____ Separated _____ Social Security.#: _____ - _____ - _____
(18 or older)

Home Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

Home Phone: (____) _____ - _____ Daytime Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

May we leave test results/messages on your voice mail or answering machine? ___yes ___no Pharmacy _____ Phone _____

Employer: _____ Occupation: _____

Employer Address: _____
Street City State Zip Code

Spouse/Custodial Parent: _____ M/F _____ Social Security #: _____ - _____ - _____

Address: _____ Birth date: _____
Street City State Zip Code

Parent 2: _____ M/F _____ Social Security #: _____ - _____ - _____

Address: _____ Birth date: _____
Street City State Zip Code

Primary Care Physician: _____ Phone: (____) _____ - _____

Emergency Contact: _____ Relationship: _____
Address: _____ Phone: (____) _____ - _____
Other Person to contact (not relative): _____ Phone: (____) _____ - _____

Primary Insurance Name: _____ Effective Date: _____
Address: _____
Subscriber I.D. _____ Group # _____ Social Security # _____ - _____ - _____
Guarantor: _____ Relationship: _____ Birth date: _____
Secondary Insurance Name: _____ Effective Date: _____
Address: _____
Subscriber I.D. _____ Group # _____ Social Security # _____ - _____ - _____
Guarantor: _____ Relationship: _____ Birth date: _____

Signature: _____ Date: _____

Confidential Medical History-Female-

Date _____
Name _____ Date of Birth _____ Race _____ Chart # _____
Reason for visit: _____

HPI: (for MD only) (Quality _____, Severity _____, Timing _____, Context _____, etc. _____)

Location:

Duration:

Modifying Factors:

Associated Symptoms:

1-3(1 or 2) 4+(3-5) see also progress record this date

Past Medical History: Please list all hospitalization and surgeries you have had and the year if you can remember

None _____

Do you have any **allergies** to medications? Please list: _____ None; Other **allergies** _____

Do you have any **abnormal bleeding** tendencies? yes no

Please list any **other doctors** you are currently seeing: None _____

Please list any ongoing **medical problems** you are being treated for:

None _____

No. of: Pregnancies _____ Children _____ Miscarriages/Abortions _____ Last Menstrual Period _____

Previous Menstrual Period _____ Are you pregnant? yes no

Please list any **prescription medications** you are currently taking: (dosage if you remember)

None _____

_____ see attached list.

Are you taking any **supplements** (non-prescription medication)? Please list:

None _____ see attached list.

Have you ever **smoked**? yes no If yes-how much and for how long? _____ Quit? _____ years

Do you drink **alcohol**? yes no If yes-how much on average? _____

Family History: Among your **blood relations**, is there any history of heart disease strokes cancer diabetes
kidney disease other _____

Social History: what **is** or **was** your occupation for most of your life: _____

Do you have a religious preference yes no. My preference is _____

Marital Status: Married Single Divorced Widowed

Patients Signature _____

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.

If you have any questions about this notice, please contact our HIPAA Privacy Official at (503)223-6223

Northwest Urological Clinic, P.C.
2230 N.W. Pettygrove St. Suite 210
Portland, Oregon 97210

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

- **For payment.** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

- **Appointment Reminders.** We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

- **Treatment Alternatives.** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Products and Services.** We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV, substance abuse, mental health, and genetic testing information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to *Northwest Urological Clinic, P.C., Attention: HIPAA Privacy Official* in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to *Northwest Urological Clinic, P.C., Attention: HIPAA Privacy Official*.

We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization. To obtain this list, you must submit your request in writing to *Northwest Urological Clinic, P.C., Attention: HIPAA Privacy Official*. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to *Northwest Urological Clinic, P.C., Attention: HIPAA Privacy Official*.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to *Northwest Urological Clinic, P.C., Attention: HIPAA Privacy Official*. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

To obtain such a copy, contact our HIPAA Privacy Official.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact *Northwest Urological Clinic, P.C., Attention: HIPAA Privacy Official* (address: 2230 N.W. Pettygrove St., Suite 210, Portland, OR 97210. Phone Number: (503)223-6223. You will not be penalized for filing a complaint.

NORTHWEST UROLOGICAL CLINIC, P.C.

Physicians and Surgeons

General Urology:
Clifford O. Stranburg, M.D.
Thomas M. Pitre, M.D.
Michael T. Lavelle, M.D.
Stanley A. Myers, M.D.



Pediatric Urology:
David B. Lashley, M.D., F.A.A.P.
Daniel A. Hirselj, M.D.
Kelly M. Bartholomew, PA-C

Urologic Oncology:
Bruce A. Lowe, M.D.
Mandy M. Williams, PA-C

TO OUR VALUED PATIENTS:

We would like to thank you for choosing NWUC as your healthcare provider. We are committed to providing you with the best care possible. Please read our policies below and feel free to ask any questions. Your signature at the bottom of this agreement constitutes an agreement to our financial policy.

INSURED:

NWUC participates in most major health plans as well as accepting assignment for Medicare. It is your responsibility as the patient to be aware of your insurance limits and restrictions. If your policy requires a referral, that referral must be established prior to the time of your visit. You must also be aware of the surrounding hospitals and laboratories/ radiological clinics which your insurance plan requires/prefers you to use. Your preparation with this information will assure a smooth encounter with our office. At the time of each visit to our office you are required to present your current insurance card(s). In order to protect your identity we also require photo identification be presented at check in. If your insurance requires a copayment we are bound by contractual agreements with these companies to collect that copayment at the time of service. Failure to provide the correct/current information at the time of your visit may result in you being held responsible for the entire cost of the visit.

UNINSURED:

Except for those continuing care from an initial Emergency Department visit, It is the policy of Northwest Urological Clinic to collect a deposit before scheduling private pay patients in the amount of \$150. This deposit will be applied towards the patient's bill...which may be more than \$150. In the event the patient does not show up for their appointment, the \$150 will be regarded as a no-show fee.

INSURANCE BILLING:

Our business office will submit a claim on your behalf to both your primary and secondary insurances if applicable. It is important to remember that your insurance is a contract between you and your insurer. Although we submit your insurance claims as a courtesy to you, you are still the responsible party for payment of services regardless of the amount your insurance pays. Any remaining balance, after your insurance pays, is due and payable within 30 days of your statement. If this is not possible, it is your responsibility to call the billing office to make payment arrangements. In the case of a dependent being seen, all current insurances must be presented with the appropriate insurance being designated as the primary policy. The person responsible for any supplemental payment must be designated at the time of the visit and their address provided for billing. Once statements are sent from our office we will not act as mediators between guardians. The person who signs the form will be responsible for any balance after insurance has paid.

METHODS OF PAYMENT:

Our office accepts cash, personal check, Visa and MasterCard for payment. We do not currently accept American Express or the Discover card. We can accept your flex pay card if it has the Visa or MasterCard logo on it. Any other type of flex pay policy must be billed by the patient after making a payment and receiving a receipt from us. If you expect your H.S.A./Flex pay/Consumer account to be used for your copay or deductible, you will need to supply that information to our office prior to your visit so that we can verify coverage.

CANCELED APPOINTMENTS: If you fail to show up for an appointment and a cancellation call is not received 24 hours prior to the appointment, you will be responsible for a \$40 no-Show fee. If an interpreter was required and scheduled for your appointment for which you do not show, you will be responsible for the entire billed amount from interpreter. These fees must be paid before another appointment will be scheduled.

BILLING QUESTIONS: Please contact us at: 503-223-6223; follow prompts to Billing.

Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES -ACKNOWLEDGEMENT AND CONSENT:

I understand that Northwest Urological Clinic, P.C. (referred to below as "This Practice") will use and disclose **health information** about me. I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in or to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care

I also understand that I have the right to receive and review written descriptions of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my 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. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

(Patient)

Date: _____
-OR-

(Patient representative) Description of Representative's Authority: _____ Date: _____