Michael S. Kaplan, MD & Brian K. Golden, MD

PATIENT REGISTRATION

PATIENTS NAME: Last ______________________ First ______________________ MI ______

ADDRESS: ______________________ Apt# _____ City ______________ State ______ Zip ______

PHONE# Home ______________ Cell ______________ Alternate(required) ______________

SSN# ______________ **Date of Birth** __________ **Sex** _____ **Marital Status** __________

Employer: ______________________ Addr: ______________________ Phone: ______________

Spouse's Name: ______________________ Spouse's Work/Cell Phone ______________________

Responsible Party: Name ______________________ Relationship to Patient ______________

Resp. Party SSN# ______________ Phone: ______________ Addr: ______________________

Resp. Party Employer: ______________________

Emergency Contact(not living with you) ______________________ Phone: ______________

REFERRED BY: (circle one) Doctor Internet Friend Yellow Pages Hospital Other __________

REFERRING DR. Name ______________________ Phone: ______________ Addr: ______________

INSURANCE (must have cards & ID available)

Primary Ins: ______________________ Phone ______________ Addr ______________________

Policy Holder's SSN ______________ Date of birth ________ Policy# ______________ Rel. to Pat ________

Employer Group Policy Y or N Employer Name: ______________________ Phone: ______________

Second Ins: ______________________ Phone ______________ Addr ______________________

Policy Holder's SSN ______________ Date of birth ________ Policy# ______________ Rel. to Pat. ________

Employer Group Policy Y or N Employer Name: ______________________ Phone# ______________

ASSIGNMENT OF BENEFITS/FINANCIAL POLICY

I hereby authorize the attending physician to furnish my insurance carrier with all information they may request concerning my illness or injury. I additionally assign to the attending physician to which I am entitled for medical and or surgical expenses relative to the services reported.

I agree that it is my responsibility to make sure the attending physician is contracted with my insurance carrier, if for any reason my services are not covered, I will accept complete financial responsibility for my account.

SIGNATURE: ______________________________ Date: ______________

(Patient /Guardian/Responsible party if minor)

Official Use Only: Reviewed by ________ **Cards obtained** ________ **Coverage Verified** ________

MICHAEL S. KAPLAN, M.D. & BRIAN K. GOLDEN, M.D.
4 Sunset Way, Suite B6
Henderson, Nevada 89014
(702) 454-6226 * Fax: (702) 454-7290

Dear Patient,

Welcome to our Practice! Since our goal is to give you the best care possible, we need to have you fill out this questionnaire, as completely as possible. These questions are designed to have all medical information available for your physician *before* you are treated.

Thank you for your Cooperation.

What tests have you had in the last 6 months? Please enter the approximate dates and locations.

YOUR NAME ____________________ DATE OF BIRTH__________

TEST	DATE OF TEST	REASON FOR TEST	PHYSICIAN AND LOCATION
URINE			
BLOOD			
CT SCAN			
MRI			
OTHER			

Uro NV
UROLOGY INSTITUTE OF NEVADA

Urology Institute of Neva[illegible]

Michael S. Kaplan, MD
Main Office
4 Sunset Way, Ste. B-6
Henderson, NV 89014

tel: (702)454-6226
fax: (702)454-7290
www.UroNV.com

Brian K. Golden, MD
St. Rose, San Martin
Medical Office Bldg
8285 Arby Ave., Ste #165
Las Vegas, NV 89113

Patient Medical History

(Medical records are released only with your written authorization)

Name:______________________ **DOB:**__________ **Age:** ______ **Height:** ______ **Wt:** ______

Occupation(s) (past & present):______________________ **Email Address:** ______________________

Primary Care Physician: ______________________ **Referring Physician (if not PCP):** ______________________

Chief Complaint (Describe in detail the main reason for your visit):

HISTORY OF CURRENT PROBLEM	Please Write Your Answer Below:
Describe the location of the problem: abdomen, back, leg, penis, bladder, vagina....	
How severe is the problem, on a scale from 1-10	Mild 1 2 3 4 5 6 7 8 9 10 Disabling
When did you first notice the problem?	
Does anything make the problem worse? or better? e.g. moving more or less, taking cold medicine, certain foods...	
Does anything else occur at the same time? e.g. nausea, fever, urgency, headache, rash...	
What treatment(s) have you had for this problem? Medications, procedures, non-medical...	
Does the problem interfere with your usual activities?	No Yes - Explain:

Which Medical Problems Have You Ever Had?: (please circle and/or fill in blanks)

Diabetes   Coronary Disease/Heart Attack   Arrhythmia   High Blood Pressure   Stroke/TIA   High Cholesterol

Cancer (what kind(s))______________________   Asthma   Emphysema (COPD)   Thyroid Disease

Stomach/GI problems   Hepatitis/Liver disorder   Glaucoma   Spine Injury   Neurologic Disease

List All Other Medical Problems:______________________

Date	Operation Performed (List all surgeries)	Surgeon / Hospital

List *ALL* Medications (Include any herbs, supplements, over-the-counter drugs, aspirin, ibuprofen…)		
Name of Medication	**Dosage**	**Prescribed By**

List or Circle Allergies & reactions: Sulfa __________ Penicillin __________ Iodine Contrast __________

Do you smoke? (circle answer)	**Yes - # packs/day?**	**No – When did you quit?**	**Never**
Do you drink alcohol? (circle answer)	**Yes - # drinks/day?**	**No – When did you quit?**	**Never**

Are you on a special diet? (if yes, please explain)

List all illnesses in your close relatives *(e.g. brother had heart attack at age 47. father has kidney stones & prostate cancer)*

Review of Systems (Have you ever had any problems with the following? If yes, please explain:)		
General Symptoms: *Fever, Chills, Headache, Malaise, Change in Weight*	**NO**	**Yes-Explain:**
Neurologic: *Seizure, Numbness, Tingling, Weakness, Dizziness, Inability to Speak/Move*	**NO**	**Yes-Explain:**
Eyes: *Blurred Vision, Double Vision, Loss of Vision, Pain*	**NO**	**Yes-Explain:**
Ears, Nose, & Throat: *Infections, pain, sinus problems, nose bleeds, sleep apnea*	**NO**	**Yes-Explain:**
Cardiovascular: *Chest Pain/Pressure, Leg/Buttock Ache with Exertion, Leg Swelling, Deep Venous Thrombosis (clot)*	**NO**	**Yes-Explain:**
Respiratory: *Wheezing, Shortness of Breath, Persistent Cough, Coughing up Blood*	**NO**	**Yes-Explain:**
Gastrointestinal: *Abdominal Pain, Nausea/Vomiting, Altered Appetite, Reflux/Heartburn, Constipation, Diarrhea*	**NO**	**Yes-Explain:**
Endocrine: *Excessive thirst, intolerance to heat or cold, altered hair growth*	**NO**	**Yes-Explain:**
Musculoskeletal: *Joint Pain/Swelling, Neck/Back Pain, Injuries*	**NO**	**Yes-Explain:**
Skin: *Rash, Boils, Persistent Itch, Non-healing Wound*	**NO**	**Yes-Explain:**
Blood/Lymphatic: *Swollen Glands, Clotting Problem, Easy Bruising, Excessive Bleeding*	**NO**	**Yes-Explain:**
Psychologic: *Are you dissatisfied with life? Severely depressed? Have you considered hurting yourself?*	**NO**	**Yes-Explain:**
Other (Explain):		

Genitourinary Review (circle/fill-in/explain): Pain (where)____________ Infections (where)____________ Blood in Urine

Kidney/Bladder Stones Incontinence (urine leakage) Urinary Retention Decreased Libido (sex drive) Infertility

Men: Enlarged Prostate Elevated PSA Erectile Dysfunction Used Viagra/Cialis/Levitra Prostatitis/Pelvic Pain

Women: Is there any chance you are pregnant? Y N last period_______ #pregnancies____ #deliveries____ #C-sections____

Have you ever felt bulging of tissue from the vagina (pelvic organ prolapse)?
Is sexual intercourse painful?

How many times do you urinate during an average day?

American Urologic Association Voiding Symptom Score (AUA-SS)	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	**Your Score**
Incomplete Emptying: Over the past month or so, how often have you had the sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
Frequency: Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
Intermittency: Over the past month or so, how often has your urinary stream stopped and started again when you urinated?	0	1	2	3	4	5	
Urgency: Over the past month or so, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak Stream: Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining: Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
Nocturia: Circle the **number of times** you typically get up to urinate from the time you go to bed until the time you get up in the morning?	0	1	2	3	4	≥ 5	
	Total AUA Symptom Score						**/ 35**

PATIENT REVIEW: (sign *once* per visit)	**PHYSICIAN REVIEW:**
Patient Signature______________________ Date_______	Physician Signature______________________ Date_______
Patient Signature______________________ Date_______	Physician Signature______________________ Date_______
Patient Signature______________________ Date_______	Physician Signature______________________ Date_______
Patient Signature______________________ Date_______	Physician Signature______________________ Date_______
Patient Signature______________________ Date_______	Physician Signature______________________ Date_______
Patient Signature______________________ Date_______	Physician Signature______________________ Date_______
Patient Signature______________________ Date_______	Physician Signature______________________ Date_______

Effective Date of Notice: April 14, 2003

Michael S. Kaplan, M.D., Ltd.

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.

Michael S. Kaplan, M.D., Ltd. "Practice" is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office; a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to this information. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location, and you can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. **Treatment:** We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **Payment:** We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **Health Care Operations:** We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.
4. **Appointment Reminders:** We may use and disclose your information to remind you of appointments. We may also mail you a reminder postcard for follow-up visits.
5. **Treatment Options:** We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
6. **Business Associates:** We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as transcription services or quality assurance. Our Business Associates agree to protect the privacy of your information.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it.

YOUR CHART IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. **Restrictions on Use and Disclosure**: You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. **Confidential Communications**: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. **Access**: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
4. **Record Amendment**: You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement.
5. **Accounting of Disclosures**: You have the right to receive an accounting of disclosures. This means you may request a list of certain disclosures Practice has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. **Copy of Notice**: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have questions about this notice, please contact Practice's Privacy Officer at 4 Sunset Way Suite B-6 Henderson, NV 89014 or 702-454-6226. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

MICHAEL S. KAPLAN, M.D. & BRIAN K. GOLDEN, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I have had the opportunity to receive and /or review a copy of the Notice of Privacy Practices that outlines how my confidential information will be used, disclosed and protected by this office.

____
. Print Patient Name

____
Print Name/ Relationship if signed by individual other than Patient

____
Signature

____
DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not because:

- ☐ Individual Refused to Sign
- ☐ Communication Barrier
- ☐ Care provided was Emergent
- ☐ Other (please explain) ____

____

____

______________________ ______________________
Employee Name DATE

Michael Kaplan MD & Brian K. Ge en, MD

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

The following is our financial policy. We believe having financial matters clear from the onset is preferable to encountering difficulties later on. Please initial each line: by doing so you acknowledge that you have read and agree to abide with our policies. Each line MUST be initialed and this form MUST be signed in order to see our physicians.

________ Payment is due at the time of service.

________ All charges are my responsibility whether my insurance company pays or not. Not all services are a covered benefit in all contracts. Fees for these services, along with unpaid deductibles, co-insurance and co-payments are due at the time of treatment. I am responsible for knowing these amounts.

________ There are thousands of plans for employer to choose from and Insurance companies change constantly. It is MY responsibility to know my insurance benefits, such as Do I need a PCP referral Is this doctor a covered provider with my insurance still. No Exceptions. Please do not ask the the office staff, they may not be aware of any recent changes.

________ If for <u>ANY</u> reason my insurance company refuses to pay, this includes the doctor not being on my plan or a missing referral, I will be completely responsible for paying the entire bill, If this occurs I will be given the standard discount for a patient without insurance who is paying cash.

________ I am responsible for any and all collection fees, legal fees and court cost associated with efforts to collect payment on my account. If my balance goes over 30days I will be subject to additional interest and I may be contacted by the collection department for payment

________ I understand no personal checks over $50.00 will be accepted and my personal information must be printed on the check

________ I understand there will be a $35.00 fee for each returned check.

________ I understand there will be a $15.00 fee paid in advance per form that is required to be filled out by by the office this includes any form only requiring a physician signature. Allow 1-7days

NO SHOW/CANCELLATION POLICY

________ You will be charged $75.00 for Surgeries not cancelled or rescheduled 7 days prior to surgery

________ You will be charged $ 50.00 for Office procedures(biopsies,cystos,PVR) not cancelled 3days prior

________ You will be charged $25.00 for any and all other appointments that are missed or not cancelled within 24 hours. You will be given a cancellation Code as your proof. Please keep this number for your records. There will be NO EXCEPTIONS

PLEASE NOTE: NO SHOW/CANCELLATION FEES ARE NOT COVERED BY INSURANCE

________ I authorize the release of any information necessary to obtain reimbursement on any claim

X________________________________ ________________

Print Patient Name DATE

X________________________________ ________________

Patient/Guarantor Signature Relationship to Patient

For official use only: Reviewed by

MUTUAL BINDING ARBITRATION AGREEMENT

Patient's Name: ______________________________

This mutual binding arbitration agreement constitutes an integral part of a contract for medical services by and between ________________________ and ____________________________ who agree to be
(Name of physician) (Name of patient)

bound as described hereunder:

1. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provide in Nevada law, and now by lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2. Such arbitration shall be in accordance with the arbitration rules of the Nevada Revised Statutes. This Mutual Binding Arbitration Agreement shall apply to any legal claim or civil action in connection with any and all medical care of medical services rendered, whether inpatient or outpatient, against Dr. Kaplan/Dr. Golden or any of Dr. Kaplan/Dr. Golden's employees or contracted staff.

3. The Mutual Binding Arbitration Agreement shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITTATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Date: __________________________ Time: ___________________________ A.M./P.M.

Signature: ____
(Patient/parent/legal guardian/legal representative)

If signed by other than patient, indicate relationship: ________________________________

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Michael S. Kaplan, MD & Brian K. Golden, MD

Patient Name____________________ **Birth Date**__________ **SSN#**____________________

Address____________________Apt#______City________________State________Zip________

Other Name________________________**Phone:**________________________

I hereby authorize ____

TO RELEASE ☐ **ALL OF MY MEDICAL RECORDS (Including Insurance Information)**
☐ **ONLY THE FOLLOWING RECORDS** ____________________________

TO: Michael S. Kaplan, MD/ Brian Golden, MD
4 Sunset Way, Suite B6
Henderson, Nv. 89014
Phone: 702-454-6226 Fax: 702-454-7290

I hereby authorize Michael S. Kaplan, MD /Brian K. Golden, MD to release a copy of:

☐ **ALL MY MEDICAL RECORDS(Including Insurance Information and research information)**
☐ **ONLY THE FOLLOWING RECORDS**____________________________________

TO: ______________________________

PHONE:____________________ **Fax:** ______________________

I understand: I may revoke this authorization except to the extent that it has already been acted upon
Once this information is released it may be re-disclosed and may no longer be protected
I may have a signed copy of this authorization

______________________________ ______________

Patient or Personal Representative's Signature Date

____

Description of Representatives' Authority to Act for Patient