UCOSC | The Urology Center of Southern California®

Innovative and Comprehensive Urological Care

Patient Registration Form

PATIENT INFORMATION

Last Name	First	MI	❑ Female ❑ Male	Birth date	Home Phone
Address	Apt#	City		State	Zip
Cell Phone	Social Security: Drivers License:	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑Widowed			
Occupation	Employer Name/ Address				
City	State	Zip	Work Phone		
Emergency Contact		Relationship			Phone
E-Mail		Contact Preference ❑ Home Phone	❑ Cell Phone		

Referred to us/ How did you hear about us?

❑ Dr. ❑ Family/ Friend ❑ Yellow Pages ❑ Hospital: ❑ UCOSC Website ❑ Insurance Plan: ______ ❑ Healthgrades.com ❑ Inland Empire Magazine ❑ Other Website: ______

INSURAN E INFORMATION

Primary Insurance- Name and Address		Phone	
Subscriber Name	Subscriber #	Group#	Subs. DOB
Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
If patient is a minor, person responsible for bill:		Relationship:	
Responsible Party Social Security No:		Responsible Party Birth Date:	
Secondary Insurance- Name and Address		Phone	
Subscriber Name	Subscriber #	Group#	Subs. DOB
Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Urology Center of Southern California Medical Group or insurance company to release any information required to process my claims.

Patient/ Guardian Signature:	Date

The Urology Center of Southern California

Patient History and Review of Systems

Date: ____________________

Name: _________________________

Email: ___________________________________

Referring Physician: ________________________

What is the reason for you visit?

1. _________________________________
2. ___________________________________

Past Medical History:

Past Surgical History:

Family History:

DOB: __________________

Marital Status: _________________

Children: Boy_____ Girl____

Education: _________ **Grade** _____

Sleep: _____**hour(s)**

Exercise___________________

Average per day:

Alcohol (type)_________ **How much**_________
Quit_______

Tobacco __________ **How much**__________
Quit_____

Tea, Caffeine ____________________________

Race: Asian America Indian Alaska Native African American Hispanic/Latino unknown/decline

List of Allergies:

Medication List:

Pharmacy:

Name:

Address:

The Urology Center of Southern California

Patient Name:______________________

DOB: ______________________

Patient History and Review Of System

Have you recently had the following: Circle 'yes 'or 'no': If in doubt, leave blank	
Generals	
Tire easily, weakness	
Persistent fever	
Skin	
Eruptions (rash)	
Change in color	
Ear	
Loss of Heaing	
Eyes	
Trouble Seeing	
Eye Pain	
Nose	
Loss of Smell	
Nosebleeds	
Mouth	
Dental Problem	
Throats	
Hoarseness	
Cardio-Respiratory System	
Cough, Persistent	
Respiratory	
Shortness of Breath	
Cardiac	
Chest pain or discomfort Palpitations	
Gastro-Intestinal System	
Nausea	
Vomiting	
Musculo-Skeletal	
Muscle weakness	
Pain in joints	
Nervous System	
Headaches	
Dizziness	
Infectious Disease	
Hepatitis	
HIV	

Genitourinary System	
Increase in frequency of urination (day) every hours	
Increase in frequency of urination (night) times	
Feel need to urinate without much Urine	
Slow stream	
Hesitancy	
Incomplete voiding	
Pain or burning	
Blood in urine	
Urinary retention	
Urgency	
Urge incontinence	
Leaking Urine when Coughing /Sneezing	
Do you use urinary Incontinence Products ----------- Per Day	
Urethral Discharge	
Vaginal Discharge	
Pain at tip pf penis	
Testicular Pain	
Lump in Testicles	
Impotence	
Lack of Sex Drive	
Pain with intercourse	

UCOSC | THE UROLOGY CENTER of SOUTHERN CALIFORNIA®

Innovative and Comprehensive Urological Care

Patient Communication Consent Form

Patient Name (Last, First, Middle Initial):______________________________

Date of Birth:______________

I authorize The Urology Center of Southern California and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below.

Name	Relationship to Patient	Contact Information

By my signature below, I acknowledge that I have read and understand the information provided on this consent form.

Patient Name:______________________________

Patient Signature:______________________________ Date:____________

Acknowledgement of Receipt of the Notice of Privacy Practices

I hereby acknowledge that I have read and received a copy of the Notice of Privacy Practices, with an effective date of ____________________

Patient Name:______________________________ Date of Birth:____________

Signed:____________________________________ Date:____________________

Telephone: ____________________________________

Patient Address:____

____

____

If not signed by the patient, please indicate name and relationship:

Name:______________________________

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Other authorized personal representative:____________________

FOR INTERNAL USE ONLY

Our office has been unable to obtain a signed acknowledgement of receipt for the following reasons:

- ☐ Patient was unable to sign
- ☐ Patient / Personal representative refused to sign on _________________
  Date of Refusal

- ☐ Other:____

Patient Partnership Plan

Dear Patient,
Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.
Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Name: ______________________________ DOB: _________

______________________________________ ____________
Patient Signature Date

______________________________________ ____________
Physician Signature Date

Privacy Policy

This privacy policy discloses the privacy practices for https://patients.ucosc.com/patientportal/.

This privacy policy applies solely to information collected by this web site. It will notify you of the following:

- What personally identifiable information is collected from you through the web site, how it is used and with whom it may be shared.
- What choices are available to you regarding the use of your data.
- The security procedures in place to protect the misuse of your information.
- How you can correct any inaccuracies in the information.

Information Collection, Use, and Sharing
We are the sole owners of the information collected on this site. We only have access to/collect information that you voluntarily give us via email or other direct contact from you. We will not sell or rent this information to anyone.
We will use your information to respond to you, regarding the reason you contacted us. We will not share your information with any third party outside of our organization, other than as necessary to fulfill your request, e.g. make a payment for services.
Unless you ask us not to, we may contact you via email in the future to tell you about specials, new products or services, or changes to this privacy policy.

Your Access to and Control Over Information
You may opt out of any future contacts from us at any time. You can do the following at any time by contacting us via the email address or phone number given on our website:

- See what data we have about you, if any.
- Change/correct any data we have about you.
- Have us delete any data we have about you.
- Express any concern you have about our use of your data.

Security
We take precautions to protect your information. When you submit sensitive information via the website, your information is protected both online and offline.
Wherever we collect sensitive information (such as credit card data), that information is encrypted and transmitted to us in a secure way. You can verify this by looking for a closed lock icon at the bottom of your web browser, or looking for "https" at the beginning of the address of the web page.
While we use encryption to protect sensitive information transmitted online, we also protect your information offline. Only employees who need the information to perform a specific job (for example, billing or customer service) are granted access to personally identifiable information. The computers/servers in which we store personally identifiable information are kept in a secure environment.

Updates
Our Privacy Policy may change from time to time and all updates will be posted on this page.
If you feel that we are not abiding by this privacy policy, you should contact us immediately via telephone at 951-735-2700 or invoices@ucosc.com.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: 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 provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

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Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

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

By: ________________________________ __________
Patient's or Patient Representative's Signature (Date)

By: ________________________________ __________
Physician's or Authorized Representative's Signature (Date)

By: ____
Print Patient's Name

____
Print or Stamp Name of Physician,
Medical Group or Association Name

____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

Name:_______________________________ DOB: __________________

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

1. **PURPOSE.** The purpose of this form is to obtain your consent for a telemedicine consultation with a health care provider.
2. **NATURE OF TELEMEDICINE CONSULTATION.** Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio, and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken.
3. **RISKS, BENEFITS AND ALTERNATIVES.** The benefits of telemedicine include having access to health care providers and additional medical information and education without having to travel outside of your local health care community. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a health care provider.
4. **MEDICAL INFORMATION AND RECORDS.** All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.
5. **CONFIDENTIALITY.** All existing confidentiality protections under federal and California law apply to Information used or disclosed during your telemedicine consultation.
6. **RIGHTS.** You may withhold or withdraw your consent to a telemedicine consultation at any time Before and/or during the consult without affecting your right to future care or treatment, or risking The loss or withdrawal of any program benefits to which you would otherwise be entitled.

My healthcare provider has discussed with me the information provided above. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility. If your insurance does not cover telemedicine, payment is due prior to telemedicine services. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agree to a telemedicine consultation.

Date: ______________________ Patient's Signature:_____________________________