Robert L. Waguespack, M.D.
A Professional Corporation • Board Certified Urologist
2530 F Street, Suite 101 • Bakersfield, CA 93301
Phone: 661.321.3303 • Fax: 661.321.3308

Patient Information

Welcome to our office! Please help us comply with the rules mandated by the Federal Government by filling out this form. If you have any questions as to why we need this information or you are not sure of an answer, our staff will be happy to assist.

Patient's Name: _____ Marital Status: S M D W Sep

Address: _____ Apt./Sp. _____

City/State/Zip: _____ Phone: (____)_____

Sex: M F Birthdate: _____/_____/_____ Social Security Number: _____-_____-_____

Patient's Employer: _____Address_____

City/State/Zip: _____ Phone: (____)_____

Occupation: _____ Retirement Date: _____/_____/_____

Driver's License #: _____ Primary/Referring Physician: _____

Spouse Information

Spouse's Name: _____Birthdate: _____/_____/_____

Emergency Contact Information

Name of contact **NOT** living with you: _____

Relationship: _____ Phone: (____) _____

Address: _____ City/State/Zip: _____

Insurance Information

Primary Insurance: _____ ID #: _____ GR #: _____

Responsible Party

Please Read and Sign

1. I have completed this form and certify that I am the patient or duly authorized general agent of the patient and am authorized to furnish the information requested.

2. It is my responsibility to make sure that the doctor I am seeing is an authorized provider for my insurance company.

3. In the event of default in payment of any amount due, and/or if this account is placed in the hands of an agency or attorney for collection or legal action, I, the undersigned, hereby agree to pay an additional charge equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

4. It is customary to pay for services and/or co-payments at the time the services are rendered unless other arrangements have been made in advance with the office bookkeeper.

5. It is my responsibility to provide the doctor with any information necessary pertaining to laboratories, hospitals, and radiology facilities that are authorized by my insurance company.

6. It is my responsibility to know the terms and authorized agents of my insurance coverage. If I go to an unauthorized facility, I am responsible for any increase in liability.

7. I authorize the release of any medical information necessary to process an insurance claim.

I have read and fully understand the seven (7) points listed above.

_____ Date: _____

Signature of Patient, Parent, or Responsible Party

Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

All patients must complete our "Patient Information Form" before being seen.

Please be familiar with your insurance coverage regarding your responsibility in the following areas:

- Co-payment
- Deductible
- Non-covered services
- Contracted facilities such as laboratories, hospitals, etc.
- Authorizations, when required, **must** be obtained prior to appointment

Payment is expected at the time of service. We accept cash, checks, Visa, Mastercard or American Express. There will be a $35.00 fee for all returned checks.

Regarding Insurance:

Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will inform you if we are a party to your insurance contract and will handle your claims according to our agreement with the insurance company, if one exists. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance regarding deductibles, co-payments, covered charges, secondary insurance, usual and customary charges, etc., other than to supply factual information as necessary. **You are responsible for the timely payment of your account**. In the event of default of payment of any amount due, and if it becomes necessary to place this account in the hands of an agency or attorney for collection or legal action, an additional charge equal to the cost of collection, including agency and attorney fees and court costs incurred and permitted by laws governing these transactions will be added.

If your insurance company pays more than the balance due, we will issue a refund check to you.

_____ Date: _____

Signature of Responsible Party

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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 read carefully.**

This notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental condition and related services.

Uses and Disclosures of Protected Health Information:

- **Purpose:** Your Protected Health Information may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your case and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

- **Treatment:** We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your Protected Health Information, as necessary, to a home health agency that provides care to you. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

- **Payment:** Your Protected Health Information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

- **Healthcare Operations:** We may use or disclose, as needed, your Protected Health Information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your Protected Health Information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your names and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your Protected Health Information in the following situations without your authorization.

- Public health issues as required by law: communicable diseases, health oversight

- Abuse or neglect
- Food and drug administration requirements
- Legal proceedings
- Law enforcement, criminal activity, inmates
- Military activity and national security
- Workers Compensation
- Coroners, funeral directors, organ donation
- Research
- Required uses and disclosures: under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500

The following is a statement of YOUR RIGHTS with respect to your Protected Health Information:

- **You have the right to inspect and copy your Protected Health Information**: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to law that prohibits access to protected health information.
- **You have the right to request a restriction of your Protected Health Information:**
  - This means you may ask us not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your Protected Health Information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions and to whom you want the restrictions to apply.
  - Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your Protected Health Information, your protected health information will not be restricted. You then have the right to use another healthcare professional.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location:** You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
- **You may have the right to have your physician amend your Protected Health Information:** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You have the right to file a complaint with our office or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our HIPPA Compliance Officer in person, in writing, or by phone at 661.321.3303.

This notice was published and became effective on/or before April 14, 2003.

Patient Acknowledgement of Receipt of Notice of Privacy Practices

Patient's Name: _____(please print) Date: _____

I, _____, have received a copy of Robert L. Waguespack, M.D.

"Notice of Privacy Practices" as required by law.

Patient Urological History

Please answer all the questions that you can by circling YES or NO.

Have you been seen previously in this office?	YES	NO
Have you had recent fevers or chills?	YES	NO
Have you been to a urologist before?	YES	NO
Have you had kidney or bladder x-rays before?	YES	NO
Have you had prior surgery on your bladder or kidneys?	YES	NO
Have you had prior surgery on your uterus, ovaries, or vagina?	YES	NO
If applicable, when was your last period?	_____	
Do you take aspirin or blood thinner drugs?	YES	NO

List all medicines you have taken in the last ten (10) days: _____

_____

List all medicines you are allergic to or cannot take: _____

_____

List all previous operations or surgeries: _____

_____

List any previous serious illnesses or injuries: _____

_____

Do you smoke cigarettes? YES NO If yes, how many packs per day? _____

Do you drink alcoholic beverages? YES NO If yes, how many per week? _____

Circle all that apply. Has anyone in your family had:

Cancer:	Prostate	Bladder	Kidney
Diabetes	Kidney Failure	Kidney Stone	High Blood Pressure

Circle any that you have had problems with:

Weight Loss/Poor Appetite	Dizziness	Vision Problems
Glaucoma	Diarrhea	Sleep Apnea
Stomach Aches	Sinus Problems	Constipation
Skin Rashes	Seasonal Allergies	Nose Bleeds
Shortness of Breath	Cough	Ankle Swelling
Chest Pain	High Blood Pressure	Diabetes
Arthritis	Pain/Numbness	Difficulty Walking
Depression	Swollen Glands	Bleeding

Do you suffer from any other problems that have not been mentioned? YES NO

If yes, please note. _____

_____

_____ Date: _____

Signature of Patient, Parent, or Responsible Party