Male Fertility and Sexual Medicine Specialists

MARTIN BASTUBA, M.D., F.A.C.S.

FOUNDER AND MEDICAL DIRECTOR

NEW PATIENT PERSONAL INFORMATION

Patient Name: LAST FIRST M.I.								**Date:**
Social Security #					**Date of Birth**			
Home #		**Work #**				**Cell Phone #**		
Address								
City, State, Zip Code						**E-Mail:**		
Employer						**Occupation**		
Circle All That Apply: Male Female Minor Single Married Divorced Widowed Separated								
Spouse/ Sig. Other: Name Date of Birth Phone								**Referred By:**
RESPONSIBLE PARTY: Who is responsible for the account? (If other than the patient) Name: Last First								
Relationship to the patient:								
Social Security #					**Date of Birth**			
Address								
City, State, Zip Code								
Employer						**Occupation**		
Home #		**Work #**				**Cell #**		
Where do you prefer to receive calls? (circle one) Home Work Cell								**Is it okay to leave a message?** Yes No
What is the best time to reach you?					**Days?**			
In the case of an emergency whom should we contact? (Not living with you) LAST FIRST								
Relationship		**Home #**		**Work #**			**Cell #**	
INSURANCE INFORMATION								
Name of Insured: Last First M.I.					**Insured Birth Date:**			
Relationship to Patient					**Soc. Sec. #**			
Employer:			**Occupation**				**Date Employed**	
Insurance Company and Address								
Group #			**Employee/Cert. #**					
Deductible			**Amount Already Used**					
Additional Insurance								
Name of Insured	**Relationship**		**Soc. Sec.#**		**Insured Birth Date**			

Authorization and Release:

I authorize this release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and my dependants. I realize that failure to keep this account current may result in you being unable to provide additional services. In the case of default on payment of this account, I agree to pay a processing fee and reasonable attorney fees incurred to collect on this amount any further outstanding balances.

06/11/09

Signature of Patient or parent if patient is a Minor_____ Date_____

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Date: _____

Name: _____ Age: _____Ht: _____Wt: _____

Main Complaint: _____ Referring Physician: _____

History of Main Complaint (Check "yes" or "no" where applicable):

1.) Do you have:	**YES**	**NO**		**YES**	**NO**
a.) Blood in your urine?			**3.) Do you need to get to the toilet quickly when you need to urinate?**		
b.) Burning when you urinate?					
c.) Discharge					
2.) How often do you urinate?			**4.) Do you leak urine/wet underwear?**	**YES**	**NO**
a.) Urinate during the day (____ times)			**a.)** When sneezing, coughing, laughing, or when exercising?		
b.) Wake up at night to urinate (____ times)			**b.)** Anytime?		

Urological History (Check "yes" or "no" where applicable):

5.) Have you had:	**YES**	**NO**	**7.) (Men only) Are you able to get an erection?**	**YES**	**NO**
a.) Previous urological treatment or tests? (i.e. cystoscopy)					
b.) Kidney stones?			**8.) (Women only) Is there a chance you might be pregnant?**		
c.) Urinary tract infections?					
d.) Kidney/Bladder injuries?			**9.) How many times have you been pregnant?** _____		
e.) Sexually transmitted diseases?					
6.) Do you have sexual problems?			**10.) How many vaginal births have you had?** _____		

List all surgeries and medical illnesses you have had:

Past illnesses:	**Year**	**Past Surgeries:**	**Year**

List all known allergies to medicine and food:

Name of Allergy	**Types of Reaction**

Are You Allergic To: IODINE – Yes / No **Are You Allergic To: CONTRAST DYE – Yes / No**

List <u>ALL</u> prescription, non-prescription, and herbal medications you are currently taking:

Name of Medication	**Strength**	**Amount**	**Frequency**	**How Long?**

FAMILY HISTORY:

Name	Age	Cause of death, if deceased or list serious illnesses
Father		
Mother		
Spouse (if married)		
Siblings/Children (list)		
1.)		
2.)		
3.)		

Is there any history of PROSTATE CANCER? YES / NO If so, Relationship: _____

PERSONAL HISTORY:

Occupation: _____ Birth date: ____/____ /____ Marital Status: M S W D Sep.

Do you smoke? Y / N How long? _____ How many per day? _____ Past smoker? Y / N Quit date_____

Do you drink alcohol? Y / N Type? _____ How long? _____ How many per week? _____

Past drinker? Y / N Quit date? _____

Y	N	Constitutional	Y	N	Gastrointestinal	Y	N	Psychiatric
		Fatigue			Nausea or Vomiting			Anxiety
		Fevers			Diarrhea			Depression
		Loss of Appetite			Constipation			Moodiness
					Abdominal Pain			
					Jaundice or Hepatitis			
Y	**N**	**Eyes**	**Y**	**N**	**Musculoskeletal**	**Y**	**N**	**Endocrine**
		Eye Pain			Back Pain			Diabetes
		Loss or Blurring of Vision			Neck pain			Thyroid Disease
		Glaucoma			Joint or Pain Swelling			Weight Loss
Y	**N**	**Cardiovascular**	**Y**	**N**	**Neurological**	**Y**	**N**	**Hematology**
		Chest Pain			Paralysis			Bleeding Disorder
		Shortness of Breath with Exertion			Numbness			Easy Bruising
		Palpitations or Irregular Heartbeat			History of Stroke			Use of Aspirin, Coumadin, or other Blood Thinners.
		High Blood Pressure			Seizures			Past Blood Transfusions
		Heart Attack						
Y	**N**	**Respiratory**						
		Cough						
		Asthma						
		Sputum						
		Coughing Blood						

- All yes responses to above questions need to be thoroughly discussed with your primary care physician. A copy of this list is readily available upon request**.**
- Information from this form may be used with complete confidentiality for Urology research.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Reviewed By: _____ Date: _____

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PATIENT WAIVER

The doctor accepts you as his/her patient with the understanding that you are ultimately responsible for the cost of all professional services rendered by him/her to you and your dependants.

IT MUST BE UNDERSTOOD THAT DEPENDING UPON YOUR INSURANCE CONTRACT BENEFITS, YOU MAY BE RESPONSIBLE FOR PORTIONS OF THE CHARGES NOT PAID FOR OR COVERED BY YOUR INSURANCE. IF YOUR INSURANCE FAILS TO PAY WHEN BILLED, YOU ARE EXPECTED TO MAKE PROMPT, SATISFACTORY ARRANGEMENTS TO SETTLE YOUR ACCOUNT.

I have read and understand the above policy.

_____
PATIENT NAME

_____ _____
PATIENT SIGNATURE DATE

6699 Alvarado Road Suite 2207 San Diego, CA 92120
Telephone (619) 229-2626 Fax (619) 286-5412

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A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hope to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have been long recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You can still call witnesses and present evidence. Each party selects an arbitrator (part arbitrators), who then selects a third neutral arbitrator. These three arbitrators hear the case. This agreement generally helps limit the legal costs and some of the rigors of trial and the publicity, which accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. I know that most problems begin with communication. Therefore, if you have any questions about your care please feel free to ask.

_____

Martin Bastuba M.D.

6699 Alvarado Road Suite 2207 San Diego, CA 92120
Telephone (619) 229-2626 Fax (619) 286-5412

12/22/2003

MALE FERTILITY & SEXUAL MEDICINE SPECIALISTS
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NOTICE OF PRIVACY PRACTICE

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.

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 health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care 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, marketing activities, 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 name 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. These situations include:
As required by Law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, research, criminal activity, military activity and national security, workers' compensation inmates, 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 the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object Unless Required By Law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
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 or, 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 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 restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If Dr. Bastuba 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 of at an alternative location. You have the right to obtain a paper copy of this notice from us, 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 may complain to us 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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **July 30, 2004**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____ acknowledge that I have received a
Patient's Name

copy of the "Notice of Privacy Practices" per HIPAA. This notice describes how Dr. Bastuba, his staff and business associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
Signature of Patient or Personal Representative Date

_____
Relationship to Patient