REGISTRATION FORM

Welcome to our practice! We hope that the following information will be helpful to you.

Medical Information

We would appreciate if you would complete the enclosed Medical Information sheets and bring them with you to your scheduled appointment. Please bring a list of all the medicines you are currently taking. **At the time of your visit a urine sample may be necessary. Please be ready to give a urine specimen.**

Medical Records

We are happy to provide your medical records upon written request. There is a fee of $25.00 for the first 15 pages, thereafter 10 cents per page.

Cancellations

Our office sees patients by appointment only. If you are unable to keep your appointment, please notify us within 24 hours of your scheduled appointment so that we are able to offer the time to another patient.

Medical Insurance

Please bring your current insurance card(s) to your appointment. If your insurance requires a copay it will be collected when you arrive for your appointment. We accept cash, checks, and all major credit cards.

Cameras

Use of a camera or a camera cell phone is not allowed in the exam areas.

Patient Portal

RGU has implemented a Healthtronics Patient Portal system with our electronic medical records with a secure messaging function that supports communication between patients and providers. As mandated by the federal govemment, providers must offer patients secure tirnely electronic access to their health information.

Patient portal is a two-step process

- Patients must provide a valid email address to an RGU staff member during an in-person clinic visit so that the registration can be completed.
- Upon registration a message is instantly delivered to the patient's email address encouraging him/her to complete the second step of the patient portal enrollment process. Please be advised that your temporary password is active for 72hrs only.

No-Show Policy

A fee of $25. 00 may be applied to your account if 24-hour notice of appointment cancelation is not given. Should you miss 3 appointments within a 12-month time frame and not cancel within 24 hours you will only be able to make an appointment at the request of your prirnary provider or treating physician. Your RGU provider reserves the right to terrninate you from his practice.

Telephone Policy

Our staff is available to assist you with any questions regarding your account, appointments, or insurance. Please remember illnesses cannot be diagnosed or treated by phone. If you leave a message for one of the medical providers, please understand that these messages will be retumed as time permits, sometimes not until the end of the business day.

No Lift Policy

If you or a patient require aid to move onto the exam table, you must have a family member or caretaker with you to provide this service. Our employees are not allowed to lift patients. If you do not have someone with you, we will reschedule your appointment.

If you have any questions regarding the above information, please do not hesitate to call our offices at (915) 532-8823 in El Paso or (575) 522-7880 in Las Cruces.

We look forward to meeting you.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to making your treatment as successful as possible. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our Information Form before seeing the doctor. A copy of your insurance identification card and/or picture identification is required to verify eligibility. **Co-payments are due at the time of service.**

Rio Grande Urology will gladly bill your insurance company as a courtesy to you. However, we are not responsible for obtaining payment from your insurance company. **Your policy and coverage is a contract between you and your insurance company and, therefore, it is your responsibility to understand both your policy and its coverage.** You remain responsible for payment of medical services regardless of the status of the claim.

Once the insurance company is billed we will set aside the estimated portion due from the insurance company for 45 days. We do require that the patient's portion be paid at the time of service. If your insurance company does not remit payment within 45 days, the balance will be due in full from you. If you should receive any payments from your insurance for services still due to us, please remit those payments to us immediately. Also, if we receive any payment in excess of the estimated balance due from the insurance company we will promptly refund the credit amount to you.

For our Medicare patients: Rio Grande Urology is a participating provider. Therefore, all covered services will be billed to Medicare for you. You are to pay only the patient co-insurance and/or deductibles at the time of service. Please be aware that some, perhaps all, of the services provided may be non-covered services and/or not considered "reasonable and necessary" under the Medicare Program and/or other medical insurance. You may still be responsible for these charges.

For our HMO/PPO covered patients: co-payments are due at the time of service. This is a requirement of your insurance company. Many insurance plans require a referral/authorization. You must present this at the time of service. If you do not have a valid referral/authorization you will need to reschedule your appointment for another day or pay the charges in full at the time of service. Also, payment for any non-covered services will be due at the time of service.

For Medicaid claims we will bill all services directly. No payment will be expected from the patient unless services are denied for reasons of expired Medicaid eligibility or in cases of a co-pay requirement for Centennial patients. Please note proof of Medicaid eligibility is required at the time of service.

If you have no insurance coverage payment is required at the time of service. A minimum payment of $285.00 will be collected prior to seeing the physician. We expect 50% of the planned cost of any further treatment, including surgery, to be paid in advance. A contract will be signed for further payment arrangements. "Indigent" covers hospital visits only and written proof is required.

A fee of $25.00 may be applied to your account if 24-hour notice of appointment cancelation is not given. Should you miss 3 appointments within a 12-month time frame and not cancel within 24 hours you will only be able to make an appointment at the request of your primary provider or treating physician. Your RGU provider reserves the right to terminate you from his practice.

Patient payment is due when services are rendered unless other arrangements are made in advance. Special arrangements must be discussed in advance of treatment with the Office Manager. Statements are sent monthly and payment is due upon receipt.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's determination of usual and customary rates. For your convenience we accept cash, checks, and all major credit cards.

I have read, understand, and agree to this Financial Policy.

Date:

Signature of Patient

or

Date:

Responsible Party

REGISTRATION FORM

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Sex ☐ Male ☐ Female

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Is this your legal name? ☐ yes ☐ no

If not, what is your legal name?

Birth Date

Age

Social security number

Address

Phone

Occupation

Chose clinic because/Referred to clinic by (please check one) ☐ Family ☐ Friend ☐ Insurance plan ☐ Hospital ☐ Close to home/work ☐ Yellow Pages ☐ Dr. ☐ other

BILLING PARTY (IF DIFFERENT FROM ABOVE)

Person responsible for bill:

Birth Date

Address (if different)

Home phone number

Is this person a patient here? ☐ yes ☐ no

Employer address

Please indicate primary insurance:

Is this person covered by insurance? ☐ yes ☐ no

Subscriber's name:

Birth Date

Subcriber's social security number

Group No.:

Policy No.:

Copayment:

Patient's relationship to subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

Name of secondary insurance (if applicable):

Subscriber's name:

Subcriber's social security number

Group No.:

Policy No.:

Copayment:

Patient's relationship to subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address)

Phone number:

Relationship to patient:

May we release medical information to your spouse or family member? ☐ yes ☐ no

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Rio Grande Urology, P.A., I understand that I am financially responsible for any balance. I also authorize Rio Grande Urology, P.A. or insurance company to release any information required to process my claims.

Patient/Guardian Signature:

Date:

☐ **Westside**
7420 Remcon Circle
Bldg A / Bldg C-3
El Paso, TX 79912

☐ **Eastside**
3100 Lee Trevino,
Suite G
El Paso, TX 79936

☐ **Central**
2201 N. Stanton
El Paso,
TX 79902

☐ **Las Cruces**
2545 Don Roser
Las Cruces,
NM 8801

☐ **RGU East Radiation**
1400 George Dieter Dr.
Suite 170,
El Paso, TX 79936

AUTHORIZATION FOR EXAMINATION AND ACKNOWLEDGEMENT OF TREATMENT
AUTHORIZACION PARA EXAMINACION Y RECONOCIMIENTO DE TRATAMIENTO

Patient's name: Birth Date

Account number:

1) Authorization for examination and treatment: The undersigned will be informed of the examination and/or treatment considered necessary for the patient named on the record and that the treatment and procedures will be performed by Physicians of Rio Grande Urology, P.A., or Employees of Rio Grande Urology, P.A. Authorization is hereby granted for such treatment and procedures and the administration of such local anesthetics, medications, or other treatment deemed necessary. I certify that I have read the above authorization and understand the same, and also certify that no guarantee or assurance has been made as to the results that may be obtained.

Authorizacion para examinacion y tratamiento: El infrascrito sera informado de el examen y/o tratamiento que sea considerado necesario para el paciente nombrado en este archivo y que el tratamiento y las procedimentos seran ejecutados par las doctores de Rio Grande Urology, P.A., o par empleados de Rio Grande Urology, P.A. Par media de la presente, se otorga permiso para tales tratamientos, procedimientos y la administracion de anestesicos locales, medicamentos, otros tratamientos que sean necesarios. Yo certifico que he leido al autorizacion y comprendo la misma y tambien certifico que no he recibido ninguna garantia acerca de las resultados que puedan ser obtenidos.

2) Acknowledgement of outpatient treatment: I hereby acknowledge that the medical care which may be furnished to me in Rio Grande Urology, P.A., will be limited solely to outpatient treatment. I understand that I may be released before all my medical problems are known or treated, and that it will be necessary for me to make arrangements for follow-up care.

Reconocimiento de tratamiento para paciente externo: Par media de la presente, reconozco que el cuidado medico que me puede ser provisto en Rio Grande Urology, P.A. sera limitado solamente a tratamiento para paciente externo. Yo entiendo que puedo ser dado de alta antes de que mis problemas medicos sean conocidos o tratados, y sera necesario que yo me encargue de tomar medidas para cuidados posteriors.

Patient's signature

Date:

Guardian's signature (if patient is a minor)

Date:

Witness by RGU Representative

Date:

ACKNOWLEDGEMENT RECEIPT FOR NOTICE OF PRIVACY PRACTICES

Rio Grande Urology P.A. reserves the right to modify the Privacy Practices outlined in the notice.
I have received a copy of the Notice of Privacy Practices for Rio Grande Urology P.A.

Patient's name (print or type):

Patient's signature

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Date

Relationship to patient:

RECONOCIMIENTO RECIBO DE LA NOTIFICACION DE LA PRIVACIDAD MEDICA

Rio Grande Urology P.A. reserva el derecho de modificar la privacidad medica indicada en esta notificación.
He recibiduna copia de la Notificación de Privacidad Medica de Rio Grande Urology, P.A.

Nombre de (la) Paciente (Impreso o Maquina)

Firma de (la) Paciente

Fecha

Firma del Representante del (la) Paciente
(Se requiere sf paciente es menor de edad o si el adulto no puede firmar esta forma)

Fecha

Relationship to patient:

MEDICATION LIST
LISTA DE MEDICAMENTOS

Date/***Fecha***

Patient's name/*Nombre del Paciente*

Date of Birth/*Fecha de Nacimiento*

Allergies/***Alergias:***

- ☐ Michael Bagg, MD
- ☐ Mark Bieri, MD
- ☐ Mauricio Davalos, MD
- ☐ Lauren N. Eisenberg, DO
- ☐ Emma E. Bendana, MD
- ☐ Thomas Gormley, MD
- ☐ Javier L. Arenas, MD
- ☐ Calvin Han, MD
- ☐ Robert Kolosseus, MD
- ☐ G. Alfonso Latiff, MD
- ☐ Javier E. Lozano, MD
- ☐ Michael Sebesta, MD
- ☐ Jeffrey M. Spier, MD
- ☐ Jeffrey Taber, MD
- ☐ Daniel C. Voglewede, MD
- ☐ Arlette Camacho, FNP-BC
- ☐ Belen Terrazas, CPNP
- ☐ Rosella Vialpando, CNP
- ☐ J. Salvador Saldivar, MD, MPH, FACOG, FACS

Medications/*Medicamentos:*
Please complete prior to your visit with your physician*/Por favor complete antes de su visita con su medico.*

Thank you/***Gracias***

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.

Patient's name:

Birth Date

The information you may release subject to this signed release form as follows:

☐ Complete Records ☐ History & Physical ☐ Progress Notes ☐ Care Plan

☐ Lab Reports ☐ Radiology Reports ☐ Pathology Reports ☐ Treatment Record

☐ Operative Reports ☐ Hospital Reports ☐ Medication Record

☐ Other (please specify)

Release my protected health information to the following physician/person/facility/entity:

Name

Address

Patient's name:

Patient Date of Birth or Social Security Number

Signature of Patient or Personal Representative

Date

Printed name of Patient or Personal Representative

Description of Personal Representative's Authority

CONSENT TO PHOTOGRAPH

The undersigned does herby authorize RGU, the above named facility, and the attending physician to photograph or permit other persons to photograph them.

Name (please print):

While under the care of RGU, the above named facility, I agree that they may use or permit other persons to use the negatives, or prints prepared for such purpose and in such a manner as may be deemed necessary. I also understand that the photographs are not taken by professional photographers and are not for the express purpose of legal litigation.

Signed

Date / Time

Witness

AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient, including patient's representative and heirs or beneficiaries, and health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

1. That all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and

2. In the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choice of the law and forum selection provisions of this paragraph are mandatory and are not permissive.

Signed

Date / Time

REVIEW OF SYSTEMS

Chief complaint: What is the main reason for your visit today?

Patients: Please circle any conditions you have experienced

General/Constitutional:	Fever	Chills	Weight Gain or Loss	Cancer		
Eyes:	Blurred Vision	Double Vision	Cataracts	Glaucoma	Eye Pain	
Immunologic:	Hay Fever/ Allergies					
Neurological:	Frequent Headaches	Light Headed/ Dizzy	Numbness/ Tingling	History of Stroke		
Endocrine:	Diabetes	Thyroid Disorders	Excessive Thirst	Too Hot/Cold	Tired/Sluggish	
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Constipation/ Diarrhea	Indigestion/ Heartburn	Acid Reflux/GERD	
Cardiovascular:	Heart Attack	High Blood Pressure	High Cholesterol	Swollen Feet	Varicose Veins	Chest Pains
Skin:	Rash	Skin Cancer				
Musculoskelatal:	Arthritis	Joint Pain	Neck Pain	Back Pain		
Ears, Nose, Mouth, Throat:	Hearing Problems	Tinnitus/Vertigo	Sinus Problems	Problems Swallowing	Dentures	
Genitourinary:	Blood in Urine	Frequency/ Urgency	Nighttime Urination	Weak Urine Stream		
Respiratory:	Bronchitis/ Emphysema	Asthma	Frequent Cough/ Wheeze	Shortness of Breath		
Hematological/Lyphatic:	Anemia	Swollen Glands	Blood Clotting Problem			
Psychologic:	Stress	Anxiety/ Depression				

Other

List Surgical History

List Past Medical History

List Family Medical History

Do you smoke? ☐ yes ☐ no If yes, how much?

Do you drink? ☐ yes ☐ no If yes, how much?