



ADVANTAGE
UROLOGY

MALCOLM D COSGROVE, MD, FACS
DANIEL J COSGROVE, MD, FACS
MICHAEL J HYMAN, MD

WWW.ADVANTAGEUROLOGY.COM

TEL: 818.906.0635

FAX: 818.906-7303

MALE AND FEMALE UROLOGY • MINIMALLY INVASIVE AND
ROBOTIC SURGERY

16311 VENTURA BOULEVARD #800
ENCINO, CA 91436

Dear New Patient:

Welcome to Advantage Urology. Thank you for choosing our practice for your urological care. We are committed to providing you with the highest quality healthcare.

The forms attached below are for your review in advance of your upcoming appointment. We ask that you read carefully and complete all materials prior to seeing your physician. Please be advised that completion of these forms does not establish a formal physician-patient relationship. It is only after an initial consultation with your physician that you are considered a patient in this medical practice.

- Please ensure that all forms are reviewed and signed where appropriate. You should bring them with you to your appointment. Do not mail or fax them prior to your scheduled visit.
- All forms should be filled out completely, making sure that each question is answered. Should you need more space to elaborate, please write additional information on a separate paper.
- Please bring a photo ID and your insurance card(s) with you on the day of your appointment. If your insurance requires a referral/authorization, please ensure that the referral/authorization has been sent from your referring physician prior to your appointment.
- The HIPAA Notice of Privacy Practices is attached for your records. Please sign the Acknowledgement Receipt and return it at the time of your appointment. Protecting confidentiality of all patients is our goal.

If you have any questions regarding these forms or your appointment, please feel free to contact our office. We look forward to your upcoming visit.

Sincerely,

Daniel J Cosgrove, MD

Michael J Hyman, MD

Malcolm D. Cosgrove, MD



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PATIENT INFORMATION

Date: _____ ☐ NEW PATIENT ☐ UPDATE

Patient Name: _____

LAST FIRST MI PREFERRED TITLE

Sex: ☐ MALE ☐ FEMALE Relationship Status: ☐ SINGLE ☐ MARRIED/PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

Date of Birth: _____ SSN: _____

Ethnicity: ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO

Race: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ WHITE

Preferred Language: _____

Address: _____

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

E-Mail: _____

HOME: _____

CELL: _____

WORK: _____

OTHER: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME

RELATIONSHIP

Tel: _____

Tel: _____

RESPONSIBLE PARTY OTHER THAN PATIENT (GUARDIAN/PARENT ONLY)

Name: _____ SSN: _____

Date of Birth: _____

Address: _____

ADDRESS LINE 1

ADDRESS LINE 2

CITY

HOME: _____

CELL: _____

WORK: _____

E-Mail: _____

PHARMACY INFORMATION

Name: _____

Address: _____

CITY ST ZIP CODE

TEL: _____

FAX: _____

REFERRAL INFORMATION

Referring Physician: _____ TEL: _____

Primary Physician: _____ TEL: _____

By signing below, I acknowledge that the above information is true to the best of my knowledge.

Signature: _____

Date: _____



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NAME: _____ DOB: _____

CHIEF COMPLAINT

WHAT IS THE PRIMARY REASON FOR YOUR VISIT TODAY?

COMMON UROLOGICAL SYMPTOMS:

☐ URINATING TOO FREQUENTLY

☐ URINATING AT NIGHT

☐ BLOOD IN URINE

☐ PAINFUL URINATION

☐ LEAKAGE OF URINE

☐ ERECTILE DYSFUNCTION

HISTORY OF PRESENT ILLNESS

WHERE IS THE PROBLEM LOCATED?

HOW SEVERE IS THE PROBLEM ON A SCALE
OF 1-10, WITH 10 BEING MOST SEVERE
(CIRCLE ONE)?

1 2 3 4 5 6 7 8 9 10

WHEN DID THE PROBLEM START?

WHAT MAKES THE PROBLEM BETTER OR
WORSE?

IS THE PROBLEM CONSTANT OR VARIABLE?

ARE THERE OTHER ISSUES ASSOCIATED
WITH THE PROBLEM?

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ASTHMA

☐ DIABETES

☐ EMPHYSEMA

☐ HEART ATTACK

☐ HEART MURMUR

☐ HEPATITIS

☐ HERNIA

☐ HYPERTENSION

☐ PARKINSON'S DISEASE

☐ STROKE

☐ THYROID DISEASE

☐ PROSTATE CANCER

☐ KIDNEY CANCER

☐ TESTIS CANCER

☐ OTHER _____

SURGICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ APPENDIX REMOVAL

☐ BACK SURGERY

☐ COLONOSCOPY/ENDOSCOPY

☐ CYSTOSCOPY

☐ GALLBLADDER REMOVAL

☐ HEART SURGERY

☐ HERNIA SURGERY

☐ KIDNEY STONE SURGERY

☐ LITHOTRIPSY

☐ PROSTATE BIOPSY

☐ PROSTATE SURGERY

☐ TESTICULAR SURGERY

☐ TONISIL SURGERY

☐ OTHER _____

REVIEW OF SYSTEMS

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY):

☐ NONE

GENERAL/CONSTITUTIONAL:

☐ FEVER

☐ WEIGHT LOSS

☐ CHILLS

EYES:

☐ BLURRY VISION

☐ DOUBLE VISION

☐ CATARACTS

EARS, NOSE, MOUTH, THROAT:

☐ HEARING LOSS

☐ NASAL STUFFINESS

☐ SORE THROAT

CARDIOVASCULAR:

☐ CHEST PAIN

☐ SWOLLEN ANKLES

☐ IRREGULAR HEARTBEAT

RESPIRATORY:

☐ SHORTNESS OF BREATH

☐ WHEEZING

☐ CHRONIC COUGH

GASTROINTESTINAL:

☐ ABDOMINAL PAIN

☐ NAUSEA/VOMITING

☐ CHANGE IN BOWEL HABITS

GENITOURINARY:

☐ INCONTINENCE

☐ PAINFUL URINATION

☐ BLOOD IN URINE

MUSCULOSKELETAL:

☐ CHRONIC BACK PAIN

☐ CHRONIC NECK PAIN

☐ SORE MUSCLES

INTEGUMENTARY/SKIN:

☐ RASH

☐ PERSISTENT ITCHING

☐ SKIN CANCER HISTORY

NEUROLOGIC:

☐ NUMBNESS

☐ TINGLING

☐ DIZZINESS

HEMATOLOGIC/LYMPHATIC:

☐ SWOLLEN GLANDS

☐ ABNORMAL BLEEDING

☐ TRANSFUSION HISTORY



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NAME: _____ DOB: _____

MEDICATIONS

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING:

☐ NONE

ANTIBIOTICS/SULFA DRUGS
BLOOD THINNERS

ANTIHISTAMINES/ALLERGY
CORTISONE/STEROIDS

DAILY ASPIRIN
INSULIN

BLOOD PRESSURE
ORAL CONTRACEPTIVES

DRUG NAME	DOSAGE	REASON PRESCRIBED

ALLERGIES

DO YOU HAVE ALLERGIES TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ PENICILLIN

☐ SULFA

☐ CIPRO

☐ IODINE/CONTRAST

☐ OTHER (PLEASE LIST): _____

FAMILY HISTORY

☐ HEART DISEASE

☐ KIDNEY CANCER

☐ KIDNEY STONES

☐ PROSTATE CANCER

☐ OTHER (PLEASE LIST): _____

SOCIAL HISTORY

MARITAL STATUS:

☐ SINGLE ☐ MARRIED/PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

CHILDREN?

☐ YES ☐ NO HOW MANY? ____ SONS ____ DAUGHTERS

OCCUPATION:

DO YOU SMOKE?

☐ YES ☐ NO IF YES, HOW MANY PACKS PER DAY? _____

DID YOU EVER SMOKE?

☐ YES ☐ NO IF YES, FOR HOW MANY YEARS? _____

DO YOU DRINK ALCOHOL?

☐ YES ☐ NO IF YES, HOW OFTEN DO YOU DRINK? _____

☐ DAILY ☐ WEEKLY

☐ SOCIALLY

DO YOU USE ANY ILLICIT SUBSTANCES? ☐ YES ☐ NO IF SO, PLEASE LIST: _____



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HIPAA 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.

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, 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, Coroner, 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.



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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 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 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. Our 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 your 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 proper 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 **August 1, 2015.**

I, _____, date of birth _____, acknowledge receipt of the HIPAA Notice of Privacy Practices. This notice describes how Drs. Cosgrove and Hyman 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: _____

Date: _____



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RELEASE OF INFORMATION CONSENT

We often get inquiries from spouses/partners, family members and/or friends, and other physicians or medical professionals about the status of our patients. Please be advised that due to Federal Law, we will not release any information about our patients without their prior written consent.

NAME _____ DATE OF BIRTH _____

_____ DO NOT release any information to anyone other than myself.

_____ You may release information ONLY to the following person(s):

_____ Name	_____ Relationship to patient	_____ Phone number
---------------	----------------------------------	-----------------------

_____ Name	_____ Relationship to patient	_____ Phone number
---------------	----------------------------------	-----------------------

_____ Name	_____ Relationship to patient	_____ Phone number
---------------	----------------------------------	-----------------------

_____ Name	_____ Relationship to patient	_____ Phone number
---------------	----------------------------------	-----------------------

Signature: _____

Date: _____



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AUTHORIZATION AND RELEASE

I hereby authorize my physician to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information (including diagnosis and the records of any examination or treatment rendered) needed to substantiate payment for such medical services along with information required for pre-certification, or authorization/referral to other medical providers.

In the event that my health plan determines a service to be not payable, I will be responsible for the complete charge and agree to pay the costs of all services provided. I also agree that should I fail to assume that financial responsibility and credit action is necessary, I will pay any additional costs above the amount of the physician's charges.

FOR MEDICARE/MEDICARE PATIENTS ONLY: EXTENDED PAYMENT REQUEST

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to my physician for any services furnished me by him/her. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents or other insurance carriers any information needed to determine these benefits or the benefits for related services.

This one-time signature will be maintained on file as verification for all subsequent services, which are provided to you by your physician.

A copy of this authorization may be used in place of the original.

Patient Name: _____ **Date of Birth:** _____

Patient or Guardian Signature: _____ **Date:** _____



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ELECTRONIC COMMUNICATION AGREEMENT

Protected Health Information (PHI) is any health information in the medical record that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment. For any health information other than test results, a valid HIPPA compliant release must be completed. You (The Patient) may authorize release of PHI through certain forms of electronic communication. To ensure your privacy, we will not leave messages containing PHI on any device without your permission.

I hereby authorize Malcolm D. Cosgrove, M.D., Daniel J. Cosgrove, MD, and Michael J. Hyman, MD to contact me as defined below.

	DETAILED MESSAGE	PHYSICIAN NAME/NUMBER ONLY	DO NOT LEAVE MESSAGE
CELL PHONE	_____	_____	_____
HOME PHONE	_____	_____	_____
WORK PHONE	_____	_____	_____

By signing below, I consent to the use of this information in providing/coordinating my medical services only.

Name: _____

Date of

Birth: _____

Signature: _____

Date: _____



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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

From (Doctor or Hospital) _____

I hereby authorize the release of my medical records and request release to:

Dr. Malcolm D. Cosgrove

Dr. Daniel J. Cosgrove

Dr. Michael J. Hyman

16311 Ventura Blvd., Suite 800
Encino, CA 91436

Phone (818) 906-0635 • Email: info@advantageurology.com • FAX (818) 906-7303

Please release the following information:

_____ Complete Medical Records

_____ Laboratory Results

_____ Radiology

_____ Consult Notes

_____ Medication List

_____ Other _____

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

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ADMINISTRATIVE POLICY AND ASSOCIATED FEES

In order to ensure our patients receive the highest quality healthcare, certain fees may be assessed and collected at the time of service as indicated below. Patients will be notified about any fees in advance of service. Please read and sign this form to acknowledge your understanding of our administrative and patient financial policies.

WALK-IN POLICY

All patients requesting an unscheduled same-day appointment without previously informing our office will incur a \$50 fee.

CANCELLATION POLICY

We ask that you notify our office of cancellation within 24 hours of your scheduled appointment if you are unable to attend. Failure to notify our office within 24 hours of your scheduled appointment will result in the following fees:

New Patient | Consultation or Follow Up Appointment Cancellation: \$50 fee

Surgical or Procedural Appointment Cancellation: \$200 fee

REQUEST FOR MEDICAL RECORDS POLICY

Any request for copies of your medical record created by your physician will be charged \$25 for the first 25 pages. Any additional pages will be charged at \$1 per page, not to exceed \$50.

REQUEST FOR PRESCRIPTION/SERVICE APPEALS

Any request for your physician to write a letter of appeal on behalf of a denied drug/service will incur a \$25 fee.

ALL INSURANCE COPAYS WILL BE COLLECTED AT THE TIME OF SERVICE

I have read and understand the Administrative Policies and Associated Fees of this medical practice and that all fees are payable at the time of service. I agree to pay such fees as applicable.

Patient Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____



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DENIED SERVICES INSURANCE WAIVER

Commercial insurance companies only pay for services deemed "reasonable and necessary." In some circumstances, insurance companies may not consider testing or treatment prescribed by your physician as "reasonable and necessary."

In such cases, insurance companies may not approve or not adequately reimburse to provide those services.

SERVICES LIKELY TO BE DENIED:

Prostaglandin or papaverine intracavernosal injections

Testosterone, intramuscular injection (\$25 collected at time of service) or Testopel®

Testosterone or other hormonal testing for female sexual dysfunction

Xiaflex® intralesional injection for Peyronie's disease

Semen analysis

HIV testing

Diabetes or cholesterol screening

BENEFICIARY AGREEMENT:

I, _____, date of birth _____, acknowledge that my physician has notified me that my insurance is likely to deny payment, or not adequately reimburse for the services stated above. If my insurance denies payment, or does not adequately reimburse, I agree to be personally and fully responsible for payment.

Signature: _____

Date: _____