MICHAELJHYMANMD
UROLOGY SPECIALIST

16311 Ventura Boulevard • Suite 800 • Encino, California 91436
P: 818-906-1300 • F: 818-906-7303 • www.drhyman.net • drhyman@drhyman.net

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

Diagnostic Tests (Cystoscopy, UDS, Duplex Doppler): $100 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/Other Forms

Any request for your physician to write a letter of appeal on behalf of a denied drug/service or request for disability or leave of absence (e.g. FMLA Forms) 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:** _____

MICHAELJHYMANMD
UROLOGY SPECIALIST

16311 Ventura Boulevard • Suite 800 • Encino, California 91436
P: 818-906-1300 • F: 818-906-7303 • www.drhyman.net • drhyman@drhyman.net

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:** _____

MICHAELJHYMANMD
UROLOGY SPECIALIST

16311 Ventura Boulevard • Suite 800 • Encino, California 91436
P: 818-906-1300 • F: 818-906-7303 • www.drhyman.net • drhyman@drhyman.net

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

From (Doctor or Hospital) _____

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

Dr. Michael J. Hyman
16311 Ventura Blvd., Suite 800
Encino, CA 91436
Phone (818) 906-1300 • Email: info@drhyman.net • 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: _____

MICHAELJHYMANMD
UROLOGY SPECIALIST

16311 Ventura Boulevard • Suite 800 • Encino, California 91436
P: 818-906-1300 • F: 818-906-7303 • www.drhyman.net • drhyman@drhyman.net

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
- ☐ HEART MURMUR
- ☐ PARKINSON'S DISEASE
- ☐ PROSTATE CANCER
- ☐ DIABETES
- ☐ HEPATITIS
- ☐ STROKE
- ☐ KIDNEY CANCER
- ☐ EMPHYSEMA
- ☐ HERNIA
- ☐ THYROID DISEASE
- ☐ TESTIS CANCER
- ☐ HEART ATTACK
- ☐ HYPERTENSION

☐ OTHER _____

SURGICAL HISTORY

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

☐ NONE

- ☐ APPENDIX REMOVAL
- ☐ GALLBLADDER REMOVAL
- ☐ LITHOTRIPSY
- ☐ TONSIL SURGERY
- ☐ BACK SURGERY
- ☐ HEART SURGERY
- ☐ PROSTATE BIOPSY
- ☐ OTHER _____
- ☐ COLONOSCOPY/ENDOSCOPY
- ☐ HERNIA SURGERY
- ☐ PROSTATE SURGERY
- ☐ CYSTOSCOPY
- ☐ KIDNEY STONE SURGERY
- ☐ TESTICULAR SURGERY

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

MICHAELJHYMANMD
UROLOGY SPECIALIST

16311 Ventura Boulevard • Suite 800 • Encino, California 91436
P: 818-906-1300 • F: 818-906-7303 • www.drhyman.net • drhyman@drhyman.net

NAME: _____ DOB: _____

MEDICATIONS

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING: ☐ NONE

ANTIBIOTICS/SULFA DRUGS ☐ ANTIHISTAMINES/ALLERGY ☐ DAILY ASPIRIN ☐ BLOOD PRESSURE ☐
BLOOD THINNERS ☐ CORTISONE/STEROIDS ☐ INSULIN ☐ 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: .....

MICHAELJHYMANMD
UROLOGY SPECIALIST

16311 Ventura Boulevard • Suite 800 • Encino, California 91436
P: 818-906-1300 • F: 818-906-7303 • www.drhyman.net • drhyman@drhyman.net

DENIED SERVICES INSURANCE WAIVER & ADVANCE BENEFICIARY NOTICE

Medicare and 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 may 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 pellets

☐ Testosterone or other hormonal testing for female sexual dysfunction

☐ Xiaflex® intralesional injection for Peyronie's disease

☐ Botox®

☐ 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: .....

MICHAELJHYMANMD
UROLOGY SPECIALIST

16311 Ventura Boulevard • Suite 800 • Encino, California 91436
P: 818-906-1300 • F: 818-906-7303 • www.drhyman.net • drhyman@drhyman.net

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 Michael J. Hyman, M.D. or his staff to contact me and to leave detailed information regarding my care at any contact information I have provided.

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

Name:		Date of Birth:	
Signature:		Date:	

MICHAELJHYMANMD
UROLOGY SPECIALIST

16311 Ventura Boulevard • Suite 800 • Encino, California 91436
P: 818-906-1300 • F: 818-906-7303 • www.drhyman.net • drhyman@drhyman.net

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 my 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.

MICHAELJHYMANMD
UROLOGY SPECIALIST

16311 Ventura Boulevard • Suite 800 • Encino, California 91436
P: 818-906-1300 • F: 818-906-7303 • www.drhyman.net • drhyman@drhyman.net

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 many 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 Dr. 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: .....

MICHAELJHYMANMD
UROLOGY SPECIALIST

16311 Ventura Boulevard • Suite 800 • Encino, California 91436
P: 818-906-1300 • F: 818-906-7303 • www.drhyman.net • drhyman@drhyman.net

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: RJGHKJTR

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:

MICHAELJHYMANMD
UROLOGY SPECIALIST

16311 Ventura Boulevard • Suite 800 • Encino, California 91436
P: 818-906-1300 • F: 818-906-7303 • www.drhyman.net • drhyman@drhyman.net

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: Date: