



Welcome to *Pacific Coast Urology Medical Center*. We are so pleased that you have chosen us for your urology care and look forward to meeting you when you come in for your first appointment.

To get acquainted with you, and to understand your healthcare needs, there are several forms enclosed with this letter. Please fill them out completely and bring them with you at the time of your first visit. Please bring all insurance information with you, too, including your insurance cards, information about co-pays and deductibles, etc. We promise to keep paperwork to a minimum, but these forms help us learn about your medical history and allow us to process bills efficiently for you.

We accept many insurance plans. Most of these are of the fee-for-service type, including PPOs and Medicare. We may also offer limited participation in some managed care plans. We offer courtesy billing of your insurance company without charge. *Pacific Coast Urology Medical Center's* payment policy is to wait up to 1 month for payments to be made by your insurance plan. If no payment is received by that time, you are responsible for the full amount. All co-payments and deductibles must be paid at the time a service is provided to you.

Your first appointment is scheduled for: _____ at _____ in our office located at:

_ 3801 Katella Ave., Suite 110, **LOS ALAMITOS**, CA 90720

_ 16843 Algonquin St., **HUNTINGTON BEACH**, CA 92649

_ 436 North Roxbury Drive, Suite 115, **BEVERLY HILLS**, CA 90210

(For maps and/or directions to each location, please go to our website, www.pacificcoasturology.com). Click on the CONTACT US tab and select the location required to find a map and create directions to our offices.)

We ask that you arrive 15 minutes early for your first appointment to process your paperwork and let us get acquainted. ***If you are unable to keep this appointment, please provide us with 48 hours notice so we can offer the time to other patients who may be waiting.*** If you are not sure how to get to our office please call us for directions.

You can be assured that we will make every effort to ensure that your care and treatment will meet the high standards we have set for ourselves. We always strive to merit your continued confidence in *Pacific Coast Urology Medical Center*

Once again, welcome to *Pacific Coast Urology Medical Center*. We look forward to a long and rewarding relationship with you!

Sincerely,

Robert G. Pugach, M.D.
& the Staff of *Pacific Coast Urology Medical Center*



Your Medical History

<u>Do You Have, Or Have You Had:</u>	<u>YES</u>	<u>NO</u>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
A STROKE	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA, EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>
GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>
CATARACTS	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY STONES	<input type="checkbox"/>	<input type="checkbox"/>
OTHER KIDNEY DISEASES	<input type="checkbox"/>	<input type="checkbox"/>
PROSTATE PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
ERECTION PROBLEMS (MEN)	<input type="checkbox"/>	<input type="checkbox"/>
BLADDER CONTROL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
OTHER BLADDER PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
URINARY TRACT INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD IN YOUR URINE	<input type="checkbox"/>	<input type="checkbox"/>
LIVER OR GALLBLADDER DISEASES	<input type="checkbox"/>	<input type="checkbox"/>
STOMACH OR INTESTINAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURES OR FAINTING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "Yes" answers to the above questions:

If You Have Ever Had Surgery Of Any Type, Please List The Procedures And Dates:



Records Release For Insurance Payment/Request For Direct Payment

Medical Records Release: The undersigned individual authorizes the release of any medical information necessary to process insurance claims for payment to *Pacific Coast Urology Medical Center* for medical services received.

Assignment of Insurance Benefits: The undersigned individual requests that payment for covered services, either from a private insurance company or government entity, be sent directly to *Pacific Coast Urology Medical Center*.

Financial Responsibility Agreement: The undersigned individual agrees that he/she is responsible for all charges incurred for medical care provided to him/her or to any minors for whom he/she is responsible by *Pacific Coast Urology Medical Center*. It is agreed that an insurance plan is a contract between the patient and an insurance company and that the patient being treated by *Pacific Coast Urology Medical Center* is directly and ultimately responsible for payment in full of all charges for medical care rendered, whether or not they are covered by any insurance company or other payment plan.

Agreement To Treat: The undersigned authorizes *Pacific Coast Urology Medical Center* to treat him/her or any minors for whom he/she is responsible.

Contacting *Pacific Coast Urology Medical Center* in an Emergency: The undersigned understands that Dr. Pugach, or a covering physician, is typically available 24 hours/day, 7 days per week, 365 days per year. If, for any reason within or beyond the control of Dr. Pugach or a covering physician, a patient cannot make contact for an urgent or emergency matter, the undersigned understands that prudent judgment should be used and seek care appropriately. This includes calling 911 for a medical emergency, going to a nearby emergency department, urgent care center, etc. In the event of a serious illness 911 should always be called.

Signature

Date

Please print your name or the name of a minor receiving care if you are legally responsible



Our Payment Policies

June, 2011

1. Patients are responsible for full payment of medical services received at Pacific Coast Urology Medical Center. While we have contracted rates with most insurance companies, you, our patient, are legally responsible for any charges related to your medical care.
2. You must pay all deductibles and co-payments each time you receive medical services.
3. We will bill your insurance company for you, without charge, as long as your account is current for all deductibles, co-payments and there are no past due balances. Otherwise, there is a fee of \$10.00 for each insurance company that we bill.
4. If you are not able to show us that you have a current, active health insurance policy, you must pay for all services in full at the time you receive them.
5. If your insurance company has not paid for services within 30 days of the date that you receive them, you must pay the full amount owed. If your insurance company issues a check to us after that, we will refund you promptly.
6. Pacific Coast Urology Medical Center accepts cash, checks with proper identification, VISA, MasterCard and Discover. We do not assess service charges for credit card use. For any returned check, there will be a \$25.00 charge plus the current fee charged to us by the bank .
7. Any exceptions to these policies because of financial hardship must be approved before a medical service is provided.

“I have read the payment policies of Pacific Coast Urology Medical Center and I agree to fully comply with them.”

PATIENT COPY. PLEASE KEEP FOR YOUR RECORDS.



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“I have read the payment policies of Pacific Coast Urology Medical Center and I agree to fully comply with them.”

Please Print Your Name Here

Signature

Date

OFFICE COPY



HIPPA Privacy Regulation

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that the office of Pacific Coast Urology Medical Center will not reveal to any person information about you or about a family member (i.e. name, address, Social Security number as well as other health information) without your permission. Your information will never be sold, or listed for the purpose of advertisement solicitation or fund raising.

It is however understood, that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the context of your patient care including, but not limited to,

- Patient registration
- Procurement of medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verifications, billing, paper and wire (including e-mail & fax transmissions)
- Insurance company follow-up or interaction with billing services relating to patient care
- Pursuit of collections for unpaid bills
- Hospital workers, nurses, aids and medical records departments
- Emergency officials, Paramedic, Fire personnel, Emergency room physicians, nurses or technicians
- Designated personal religious representatives
- Our office staff
- Pharmacists, drug program personnel/workers
- Completion of disability forms
- Computer and electronically stored information, i.e., related business vendor and service personnel

This constitutes an abridged version of our HIPPA Privacy Regulation Policy. To see our full policy please ask for a copy from our front office reception staff.

I authorize the release of this necessary information.

Patient Signature

Date

Please clearly **print first and last name** here: _____



For your convenience, we offer several methods of payment for charges you incur at *Pacific Coast Urology Medical Center*. Please check your preferred method of payment:

I prefer to pay all co-payments, deductibles and other account balances by:

Cash or check

Credit card*

Credit card type: VISA

Mastercard

Discover

*We do not add a service charge for credit card use at *Pacific Coast Urology Medical Center*



How Did You Hear About Us?

Name: _____ Date: _____

At **Pacific Coast Urology Medical Center** one of our most important goals is to educate patients about urologic conditions and new, minimally invasive treatments to improve your quality of life. We use a variety of methods to help get our message out to patients. Please fill out this form so that we can learn which methods are the most effective in reaching and educating our patients.

I learned about **Dr. Robert Pugach and Pacific Coast Urology Medical Center** from:

Please **PRINT** and **CHECK ALL** that apply.

____ Physician referred me (Doctor's name) _____

____ Patient/family/friend (Name) _____

____ Hospital referral (Hospital Name) _____

____ Insurance directory (Insurance company name) _____

____ Radio commercial

____ Television Show - ____KTLA News ____The Doctors

____ A newspaper or print ad or article

____ Leisure World News ____ Leisure World Phone Directory

____ Huntington Beach Magazine ____ Leisure World Bus Schedule

____ Other, please specify: _____

____ Community Lecture: (specify) _____

____ Mailer to my home

Internet:

____ Pacific Coast Urology Website (www.pacificcoasturology.com)

• Search Engine Used (Google, MSN, Yahoo, BING) _____

• Keywords used to search: _____

____ I also used a Referral Website (please check or specify below)

____ www.vasectomy.com

____ www.locateadoc.com

____ www.internationalhifu.com

____ Other referral site or Web resource: _____

Thank you for helping us!