ALVARADO LA MESA UROLOGY MEDICAL GROUP
MOHAMED BIDAIR, M.D./EILEEN BYRNE, M.D.
8881 Fletcher Parkway, Suite 250A, La Mesa, CA 91942
Phone: (619)229-2626 Fax: (619)286-5412

Dear Patient,

Thank you for choosing our practice for your Urological care. My staff and I look forward to providing you with the very best in medical care.

The pre-registration forms are being sent to you in advance to allow you to carefully read and complete them. Please be advised that completion of the demographic and health questionnaire form does not establish a physician-patient relationship. It is only after the initial consultation with the physician or the physician assistance that you are accepted as a patient to the practice.

1. The Pre-Registration form should be completed and signed. Please bring your insurance card(s) as we will ask to copy them for our records. We will also ask for a picture Identification and make a copy for our files. If your insurance requires a referral or authorization, make sure the referral or authorization has been sent from your referring physician prior to the appointment.
2. The Health History Questionnaire should be filled completely, Should you need more space for your medications, please write them on a separate paper. There are two pages to this form. The information you provide gives the doctor introductory medical history at the time of your consultation.
3. The HIPPA Notice of Privacy Practices is for you to read and keep in your personal records. Please sign and return the Acknowledgement Receipt at the time of your appointment. Protecting confidentiality of all patients is our goal. On the HIPPA RELEASE FORM, we will not release any information to anyone without them being listed on this form; regardless of relationship. If no one is listed you will be required to mark this section of the page with an X.
4. The Patient is Responsible for knowing the regulations of their insurance carrier. That would include but is not limited to the need to obtain authorization, the need to use a specific laboratory or radiological facility or treatment facility. Our office does its very best to help the patient maximize their insurance benefits, but it is ultimately the patients responsibility to notify our office if their insurance carrier has specific requirements of if their insurance changes at any time during their treatment at our office.

If a question does not apply to you mark it N/A, please do not leave any line items or boxes blank. Please sign and date all signature lines. Please bring all your completed forms to your appointment. Do NOT mail them to the office or return them prior to appointment. They will only be accepted on the day of your scheduled appointment.

If you have any questions regarding these forms or your appointment, please feel free to contact my staff. They will be more than happy to assist you.

Mohamed Bidair, M.D.
Eileen Byrne, M.D.

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____

Birth Date: _____ Driver License#: _____ Email: _____

Last four SS#: _____ Home#: _____ Cell Phone#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Name of Insured: Last: First: M.I.: Insured Birth Date:
Relationship to patient: Social Security#:
Employer: Occupation: Date Employed:

Insurance Company Name:
Insurance Card#: Group#:

Secondary Insurance:
Secondary Insurance Card#: Group#:

The patient is responsible for knowing the regulations of their insurance carrier. That would include but is not limited to the need to obtain authorization, the need to use a specific laboratory, radiological facility or treatment facility. The patient **must** notify our office if their insurance plan has any specific requirements or if their insurance changes at any time during their treatment. I understand I am responsible for all deductibles, co-insurances and copays.

To avoid "balance billing" the patient is responsible for knowing if a particular physician, including ALMU, consulting physician, referring physician, inpatient/outpatient facility, laboratory, anesthesiologist, radiology facility or any other treatment facility is contracted with their specific insurance plan. If they are not contracted with your insurance plan, you may be balanced billed.

I understand that ALMU may perform some laboratory and diagnostic testing in office, may use LabCorp or PathMD. If my laboratory tests or biopsies need to be sent to a specific laboratory based on my insurance carrier/ plan I agree to notify ALMU or office staff.

My signature below constitutes acknowledgement that **I have read this document and understand** I will be held responsible for reimbursement of any services that do not meet my insurance carrier's requirements including specific diagnosis codes and CPT codes.

Signature of Patient or Guardian:_____ Date: _____

Authorization and Release:

I authorize and consent to the use of ambient listening technology for charting purposes. I authorize and consent to allow electronic review of medications for participating pharmacies. I authorize the release of any information including diagnosis and the records of any treatment of examination rendered to me or my child during the period of medical care to third party payers and to 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 dependents. I realized 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 any processing fees, interest and reasonable attorney fees incurred to collect on this account any further outstanding balances. I further authorize the doctor and office to use my medical information or photos for teaching, research and other purposes as long as my personal information is deleted from such material.

Signature of Patient or Guardian:_____Date:_____

****Failure to notify ALMU of any changes to your insurance (at any time), could result in the patient being financially responsible for services provided.**

ALVARADO LA MESA UROLOGY MEDICAL GROUP

MOHAMED BIDAIR, MD
EILEEN BYRNE, MD

NEW PATIENT PERSONAL INFORMATION

Last Name: First Name: M.I.: Date:

Address: Phone Number:

Preferred Method of Contact: Home Work Cell Is it ok to leave a message?_____

Preferred Pharmacy: Pharmacy Phone Number:

Birth Gender: Male Female Gender Identity: _____

Marital Status: Single Married Divorced Separated Widowed

Ethnicity: _____ Race: _____ Preferred Language: _____

Employment Status: Occupation: Employer:

How did you hear about us? _____ Primary care physician:_____

Emergency Contact

Last Name: First Name: Relationship:

Home#: Work#: Cell#:

Responsible Party: Who is responsible for the account (If other than the patient)

Last Name: First Name: DOB:

Relationship to Patient: Social Security#: Driver's License#:

Address:

Home#: Work#: Cell#:

Employment Status: Occupation: Employer:

ALVARADO LA MESA UROLOGY MEDICAL GROUP

MOHAMED BIDAIR, M.D. / EILEEN BYRNE, MD

Name:_____Age:____ DOB:_____ Ht:_____ Wt:_____ Date:_____

Main Complaint:_____Referred by:_____Primary Care Physician:_____

-Blood in Urine?_____
-Burning when urinating?_____
-How many times do you wake up to urinate at night?_____
-How often do you urinate during the day?_____
-Do you leak urine when you don't want to go?_____
-Any prior kidney stones?_____
-Any prior urinary tract infections?_____
-Sexually Transmitted Diseases?_____
-Sexual function concerns?_____
-Erection Problems (Men)?_____
-Ejaculation Problems (Men)?_____
-Any chance you may be pregnant (Women)?_____
-How Many Prior Pregnancies (Women)?_____
-How many vaginal deliveries (Women)? _____

Past Medical Illness:	**Year:**	**Past Surgeries:**	**Year:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications

Name	**Strength**	**Frequency**	**When Started**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies to Medicines, Food or Environmental	**Type of Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to IODINE? Yes No

Are you allergic to IV Contrast? Yes NO

Family History

Relationship	**Alive/ Deceased**	**Age**	**Medical Conditions**
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling 1	_____	_____	_____
Sibling 2	_____	_____	_____
Child 1	_____	_____	_____
Child 2	_____	_____	_____

Any PROSTATE CANCER in your family? Yes No Relationship:_____

ALVARADO LA MESA UROLOGY MEDICAL GROUP

MOHAMED BIDAIR, M.D.
EILEEN BYRNE, MD

Social History

Current Smoking Status:

Current Every Day Smoker | Current Some Day Smoker | Former Smoker | Never Smoker | Unknown if ever smoked

Please answer if applicable:

When did you start smoking?
_____/ _____/ _____
Month Day Year

When did you quit smoking?
_____/ _____/ _____
Month Day Year

Approx. How many packs per day? _____

For how many years? _____

Do you use smokeless tobacco? _____

Do you use recreational drugs? _____

How many caffeinated drinks do you have each day? _____

Do you drink alcohol? Yes Not anymore No

How Often: Daily/ Weekly/ Monthly/ Yearly

How many drinks? _____

Type of alcohol consumed: Beer Liquor Wine

Drinking habits: Social Light Moderate Excessive

Review of Systems: (Check all that apply)

CONSTITUTIONAL:
___Appetite Decreased
___Chills
___Fatigue
___Fevers

EYES:
___Cataract
___Decreased Vision
___Glaucoma
___Macular Degeneration

Neurological:
___Headaches (Frequent)
___Memory Loss
___Numbness
___Paralysis
___Seizures
___Stroke

ENDOCRINE:
___Excessive Thirst
___Diabetes
___Thyroid Disorder

GASTROINESTINAL:
___Abdominal Pain
___Acid Reflux
___Blood in stool
___Constipation
___Diarrhea
___Jaundice
___Vomiting Blood

Cardiovascular:
___Chest Pain
___Heart Attack
___Heart Disease
___Hypertension
___Cholesterol Elevated
___Palpitations

MUSCULOSKELETAL:
___Arthritis
___Back Pain
___Bone Pain
___Joint Pain
___Neck Pain

RESPIRATORY:
___Coughing Blood
___Difficulty Breathing w/ exercise.
___Frequent Cough
___Pneumonia
___TB

HEMATOLOGY:
___Anemia
___Aspirin Use
___Blood Transfusions
___Easy Bruising
___Hepatitis
___HIV

Psychiatric:
___Anxiety
___Depression
___Hallucinations
___Schizophrenia
___Suicidal Thoughts

Last Pneumovax: _____

Last Colonoscopy: _____

Signature of Patient/ Parent or Guardian: _____ Date: _____

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HIPPA 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 purposed that are permitted or required by law. It also described your rights to access and control your protected health information, that my identify you and that related 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 our physician, our office staff and others outside of our office that are involved in you 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 who 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 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 patient's in 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 on 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 and 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 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, Worker's Compensation, Inmates Required Uses and Disclosure under the law, we 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 PERMITED 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 action to 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 of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law the prohibits access to protected health information.

You have the right to request a restriction on your protected health information. This means you may ask us not to use or disclose any part of your protected health information for 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 of for notification purposes as described in this Notice of Privacy Practices. Our request must states 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 any alternative location.

You have the right to obtain a proper copy of this notice form us, upon request, even if you 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 form amendment you have the right to file a statement of disagreement with is 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 if 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 **APRIL 13, 2003.**

ALVARADO LA MESA UROLOGY MEDICAL GROUP

MOHAMED BIDAIR, M.D. / EILEEN BYRNE, MD

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of the "Notice of Privacy Practices" per HIPAA. This notice describes how ALMU and staff 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

HIPPA RELEASE FORM

(PLEASE FILL OUT IF YOU HAVE AN EMERGENCY CONTACT AND OR IF YOU HAVE A PARTNER, CHILD OR OTHER THAT YOU WOULD LIKE TO HAVE ACESS TO YOUR INFORMATION.)

Patient Name: _____ DOB: _____ SS#: xxx-xx-_____

Privacy regulations require us to have a release signed by our patients so we may speak to family members, friends or other relations regarding your medical treatment. Each Person you wish to be considered must be listed individually by name (including spouse, partner or significant other). An "X" marked across the section indicates patient does not have anyone listed that information should be released to with the exception of continuity of care.

Please print name, relationship and telephone number for each person who you are authorizing release of your private health care information.

Name	Relationship	Telephone Number

This authorization will expire on: _____/ _____/ _____ (fill in date if less than 1 year) or one year after signed.

_____ _____

Signature of Patient or Personal Representative Date

ALVARADO LA MESA UROLOGY

MOHAMED BIDAIR, M.D./EILEEN BYRNE, M.D

8881 FLETCHER PARKWAY, SUITE 250A, LA MESA, CA 91942
PHONE: (619) 229.2626 / FAX: (619)286-5412

No Show/ Late Cancellation Policy

This policy has been established to help us serve you better. When an appointment is made, it takes an available time slot away from another patient. No-shows and late cancellations delay the delivery of healthcare to other patients.

We will be enforcing a $35.00 charge for each no show or late cancellation if less than 24-hour notice is given. *These charges must be paid before you are seen again.*

If the patient "No Show's" for an appointment, they will receive a phone call notifying them of the "No Show" appointment. At that time, the patient will be asked if they would like to reschedule their appointment.

At the providers discretion, if a patient has *three "No Show"* appointments within an 18-month period it will result in the patient being dismissed permanently from the Alvarado La Mesa Urology Medical Group practice.

We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case by case basis.

To cancel or reschedule an appointment, please call office with 24hrs in advance. You may contact the office at (619)229-2626.

Thank You,

Mohamed Bidair, M.D.
Eileen Byrne, M.D.

By signing below I acknowledge my understanding of the context above regarding the Cancellation/No-Show Policy and that I will be responsible for paying these fees accordingly.

_____ _____ _____
(Patient Name Printed) (Signature) (Date)

MR#_____