

# WALSH UROLOGY ASSOCIATES

LANCE P. WALSH, M.D., Ph.D.; GARY LEIFER, M.D.

Completing all forms in their entirety and faxing them to WUA at 760-346-7905, or dropping them off to our office, days prior to your appointment, will decrease your wait time at our office for your appointment.

Patient Name: \_\_\_\_\_

## Personal Information

Social Security #:	DOB:	Marital Status:
Drivers Lic#:	Sex:	Spouse's Name:
Preferred Language*:	Race*:	Ethnicity*:
Do you have children, if so how many:	Emergency Contact Name & Phone #:	
Are you currently working, retired or unemployed:		Employer/ Job:

## Permanent Address

## Second Address

Street:	Street:
City, State, Zip:	City, State, Zip:
My Billing Address is the same as my (circle one) <b>Permanent Address</b> or <b>Second Address</b>	

## Insurance Information

Primary Insurance:	Secondary Insurance:
I.D.#:	I.D.#:
Insured's Name if not Self:	Insured's Name if not Self:

I wish to be contacted in the following manner, please indicate all that apply

Home Phone:	OK to leave detailed message: yes or no
Cell Phone:	OK to leave detailed message: yes or no
Work Telephone:	OK to leave detailed message: yes or no
Written: OK to mail to my home: yes or no	Written: Ok to fax to this number:
WUA has my permission to share my medical information with, indicate name and relation:	

Primary Care Physician:

Referred By:

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\*The Federal Government requires Walsh Urology Associates to gather certain demographic information.

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Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Chief Complaint- please describe your main urological problem:

\_\_\_\_\_

Have you seen a Urologist before? yes or no

If yes, the reason: \_\_\_\_\_

### Medical Problems

1	2
3	4
5	6

### Previous Surgeries with Dates

1	2
3	4
5	6

### Medications You Take

1	2
3	4
5	6

### Allergies You Have

1	2
3	4
5	6

### Social History, please check any that apply and indicate quantity if applicable:

Tobacco Use	Recreational IV Drugs	Exposed to Industrial Dyes or Heavy Pesticides	
Smoke Cigarettes	Drink Alcohol	Blood Transfusion	HIV+ or have AIDS

### Family History, please check any of the following your family has/ has had and indicate who:

Heart Disease	Mental Illness	Cancer	Bleeding Disorder
Stroke	Epilepsy/ Convulsions	Diabetes	Kidney Disease
Prostate Cancer	High Blood Pressure	Thyroid Disease	

Local Pharmacy, name, street or street address and city: \_\_\_\_\_

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Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please check and describe if you have ever had or you now have any of the following.

## Eyes

Decreased Vision
Blurred Vision
Double Vision

## Pulmonary (Lung)

Shortness of Breath
Chronic Cough
Coughing up Blood
Asthma
Emphysema/ COPD
Tuberculosis

## Gastrointestinal

Weight Loss
Decreased Appetite
Change in Bowels
Blood in Stool
Gallbladder Disease
Liver/ Cirrhosis
Hepatitis
Ulcer

## Endocrine

Diabetes
Thyroid Trouble
Goiter
Thyroid Medication

## Urinary Tract

Kidney Trouble/ Disease
Kidney Stones
Bloody Urine
Frequent Urination
Auger/ Albumin Urine
Passing Urine/ Night
Slow Starting Urine
Weak Urine Stream
Incontinence
Frequent Urine Infection

## Ears, Nose, Mouth, Throat

Decreased Hearing
Ringing in Ears
Mouth Pain or Swelling

## Cardiac (Heart)

Heart Attack
Heart Disease/ Failure
High Blood Pressure
Chest Pain or Pressure
Artificial Heart Valves
High Cholesterol
Heart Mummurs
Heart Palpitations

## Muscular/ Skeletal

Back Pain
Arthritis/ Rheumatism
Muscle Pain or Weakness
Artificial Joint(s)
Osteoporosis

## Neurologic

Headaches
Dizzy/ Faint Spells
Nervous Disorders
Epilepsy/ Seizure(s)
Stroke(s)

## Psychiatric

Mental Illness
Depression
Nervous Disorders

## Reproductive System

Venereal Disease
HIV Positive or have AIDS
Lump(s) in Breast
Pain in Breast
Nipple Discharge
Sexual Impotence

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**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

The American Urological Association (AUA) has created this symptom index to give a better understanding of the severity of your urinary symptoms.

Circle a score for each question that best describes your urinary symptoms.

Question	None	Less than 1 time in 5	Less than 1/2 the time	About 1/2 the time	More than 1/2 the time	Almost Always
<b>Incomplete Emptying:</b> Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5
<b>Frequency:</b> Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
<b>Intermittency:</b> Over the past month, how often have you found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
<b>Urgency:</b> Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
<b>Weak-Stream:</b> Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
<b>Straining:</b> Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
<b>Nocturia:</b> Over the past month, how many times did you typically get up at night to urinate?	0	1	2	3	4	5

**Symptom Score**

Add up the points for all questions to determine the severity of your symptoms

**Total Score**

Symptom Score Severity

0 to 7 Mild

8 to 19 Moderate

20 to 35 Severe

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Patient Name: \_\_\_\_\_

Please initial each " \_\_\_\_\_ "

## ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I request that payment of authorized benefits (Medicare, managed HMOs/ IPAs and/or insurance companies) be made either to me or on my behalf to Walsh Urology Associates for any services furnished to me by my provider. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services:

- Division of Family Services
- Centers for Medicare and Medicaid Services
- Insurers and/or agents of these companies
- Responsible person(s) listed
- Other healthcare providers assisting in my medical care

## CONSENT TO TREATMENT

I hereby authorize Walsh Urology Associates and/or any physician or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

## FINANCIAL AGREEMENT

I understand unless other arrangements have been made in advance by either me or my health coverage carrier, payment in full is due at the time of service. Acceptable methods of payment are cash, personal checks, VISA, MasterCard, American Express or Discover card.

Walsh Urology Associates has made prior arrangements with many health plans to accept an assignment of benefits. We will submit a claim to those plans for which we have an agreement and will require you to pay the authorized co-payment, deductible and/ or co-insurance at the time of service. If you have insurance coverage with a plan that we do not have a prior agreement, we will prepare and send a claim for you on an unassigned basis. This means our charges for your care and treatment are due from you at the time of service and your insurer will send their reimbursement directly to you.

If you have questions or concerns regarding your coverage for procedures, screenings services, medications or particular conditions, you are responsible for obtaining this information prior to your appointment from your health plan. You agree to pay in full for all services considered "non-covered" services per your insurance policy if you choose to have the service provided.

If your insurance company does not pay for the services provided, or you do not have insurance, you agree to pay all charges of Walsh Urology Associates. Each bill is due and payable upon presentation or mailing of a statement to you. Should the account become delinquent, you agree to pay all costs of collection applied by a collection agency, interest and attorney fees. Any suit filed may be brought in the county where the services are rendered.

## PHYSICAL FORM COMPLETION

I understand if I, or a person/ entity on my behalf, request Walsh Urology Associates to complete a disability, home health, or other physical form, the practice will assess me a \$35 fee.

## CANCELLATION POLICY

I understand I will be assessed a \$25 fee by Walsh Urology Associates', per their Cancellation Policy, if I:

- Do not show up for my appointment, or
- Do not cancel my appointment with a minimum 24 hour notice.

## RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I have received a copy of, or viewed online at [www.walsh-urology.com](http://www.walsh-urology.com), Walsh Urology Associates' Notice of Privacy Practices.

**I understand and agree to all of the above.**

\_\_\_\_\_  
Signature of Patient (For Patients 17 years of age or younger, a parent or guardian MUST sign)

\_\_\_\_\_  
Date

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**AUTHORIZATION FOR MEDICAL RECORDS RELEASE**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Which Records are needed? \_\_\_\_\_

I, the undersigned, do hereby authorize and direct you to:

Furnish Records to Dr. Lance P. Walsh/Gary Leifer from:

Release records from Dr. Lance P. Walsh/Gary Leifer to:

Facility or Doctor Name: \_\_\_\_\_

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Walsh Urology Associates  
Lance Patrick Walsh, M.D., Ph.D./Gary Leifer, M.D.  
39000 Bob Hope Drive, Wright Bldg, Suite 209  
Rancho Mirage, CA 92270  
Tel: (760) 346-7191 Fax: (760) 346-7905

or any of Walsh Urology Associates agents, associates, or employees, any and all reports, even though marked confidential or considered confidential or privileged, including, but not limited to the following:

Medical records, doctor's office charts, hospital records, consultation reports, laboratory records, test results and reports, x-rays, x-ray reports, radiology films and other forms of diagnostic tests, reports and results, information which they may request including drug/or alcohol treatment records or records of treatment for communicable diseases, including HIV related illnesses, if any psychological testing, reports and records, prescriptions, correspondence, and any hospitalization, history, physical examination, diagnosis, condition, etiology, prognosis, expense, treatment and care.

A copy of this authorization is as valid as an original.

**Patient Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_