

**LANCE P. WALSH, M.D., Ph.D.**

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

**Personal Information**

SS#:	DOB:	Marital Status:
Drivers Lic#:	Age:	Spouse's Name:
Preferred Language:	Sex:	Emergency Contact:
Home Phone:	Race:	Emergency Contact Phone:
Cell Phone:	Ethnicity:	

**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.#:
Address for Claims:	Address for Claims:
Phone #:	Phone #:
Insured's Name if not Self:	Insured's Name if not Self:

**Employment Information**

**Spouse/ Parent Employment Information**

Employer:	Employer:
Work Phone:	Work Phone:
Address:	Address:

<b>Primary Care Physician:</b>	<b>Referred By:</b>
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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



LANCE P. WALSH, M.D., Ph.D.

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_\_

**Medications you take**

**Allergies**

1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

**Social History/Habits**

Are you? Married  Divorced  Never Married

Do you have children?  Yes (how many? \_\_\_\_\_)  No

I am:  currently working as a \_\_\_\_\_  
 retired from work as a \_\_\_\_\_  
 unemployed

Have you ever used tobacco?  Yes  No If yes, how much? \_\_\_\_\_

Do you currently smoke?  Yes  No If yes, how much? \_\_\_\_\_

Do you drink alcohol?  Yes  No How many drinks per day? \_\_\_\_\_

Have you ever had a transfusion?  Yes  No

Have you ever used recreational intravenous drugs?  Yes  No

Are you HIV+ or do you have AIDS?  Yes  No

Have you ever been exposed to industrial dyes or heavy pesticides?  Yes  No

**Family History** If any family member has had any of the following, please indicate which relative. Indicate N/A if Not Applicable.

HEART DISEASE _____	HIGH BLOOD PRESSURE _____
STROKE _____	CANCER _____
PROSTATE CANCER _____	DIABETES _____
KIDNEY DISEASE _____	THYROID DISEASE _____
MENTAL ILLNESS _____	BLEEDING DISORDER _____
EPILEPSY/CONVULSIONS _____	

Local Pharmacy: \_\_\_\_\_

LANCE P. WALSH, M.D., Ph.D.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

CHIEF COMPLAINT: please describe in your main urological problem:

Please check any of the following you have.

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Heart Failure           | <input type="checkbox"/> Heart Attack      | <input type="checkbox"/> Stroke        | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> COPD / Emphysema        | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> High Cholesterol    |
| <input type="checkbox"/> Artificial Heart Valves |  |  |  |

Other Medical Problems:

1.	3.
2.	4.

Previous Surgeries

	Dates
1.	
2.	
3.	
4.	
5.	
6.	

Have you seen a urologist before?  Yes  No

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



# SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

## PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that best describes your own situation. Please be sure that you select one and only one response for each question.

### OVER THE PAST 6 MONTHS:

		VERY LOW	LOW	MODERATE	HIGH	VERY HIGH
1. How do you rate your confidence that you could get and keep an erection?		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	NO SEXUAL ACTIVITY	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	DID NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	DID NOT ATTEMPT INTERCOURSE	EXTREMELY DIFFICULT	VERY DIFFICULT	DIFFICULT	SLIGHTLY DIFFICULT	NOT DIFFICULT
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	DID NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5.

TOTAL: \_\_\_\_\_

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED

8-11 Moderate ED

12-16 Mild to Moderate ED

17-21 Mild ED

## AUA Symptom Score Questionnaire

The American Urological Association (AUA) has created this symptom index to give you and your physician an understanding of the severity of your enlarged prostate symptoms.

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

Question	None	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your score
<b>Incomplete emptying:</b> Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished 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

If you scored 8 points or higher, you should consult your physician.

Symptom Score (Severity) — 0 to 7 (Mild), 8 to 19 (Moderate), 20 to 35 (Severe)

**Lance P. Walsh, M.D., Ph.D.**

## **NOTICE OF PRIVACY PRACTICES**

Lance P. Walsh, M.D., Ph.D. is required by law to protect the privacy of patient information. We will not share your protected health information with vendors, with whom we do business, nor will we share any research program without your specific consent.

Lance P. Walsh, M.D., Ph.D. will limit the use of patient protected health information for treatment, payment and business operations. Examples of such use are:

1. Your protected health information will be shared with your referring MD and any other MDs involved in your treatment.
2. Your protected health information will be shared with your insurance carrier and/or Medicare and any other entity involved in reimbursement.
3. Your protected health information will be shared with a collection agency if it becomes necessary to use their services to collect your delinquent account.

Lance P. Walsh, M.D., Ph.D. will not release your health information to other people unless you have given us written authorization to do so. You may revoke the authorization at any time.

You have the right to place restrictions on your protected health information; however, we do not have to honor your request if it involves treatment, payment or business operations.

You have the right to request amendments to your medical records and the right to receive communication somewhere other than your primary address.

Lance P. Walsh, M.D., Ph.D. does call you for appointment reminders and may leave that reminder message on your answering machine.

This Notice of Privacy Practices may change from time to time and will be re-posted in the reception/lobby area when such changes occur.

If you feel that your protected health information has been used inappropriately, you may file a complaint with Lance P. Walsh, M.D., Ph.D. If your complaint is not resolved, you may file with the Department of Health and Human Services.

# Acknowledgement of Receipt of Notice

LANCE P. WALSH, M.D., Ph.D.

760 346-7191

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

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

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate.

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

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

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## *For Office Use Only:*

1 Signed form received by: \_\_\_\_\_

1 Acknowledgment refused:

Efforts to obtain:

\_\_\_\_\_  
\_\_\_\_\_

Reasons for refusal:

\_\_\_\_\_  
\_\_\_\_\_

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Home Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only<br><br><input type="checkbox"/> Work Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work/office address<br><input type="checkbox"/> O.K. to fax to this number _____<br><br><input type="checkbox"/> Other _____<br>_____ |
|--|---|

Patient Signature	Date
Print Name	Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

**Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

### Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check this box if the disclosure is authorized  
 (2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations; A=Authorization on File; D=Discretionary  
 (3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

# WALSH UROLOGY ASSOCIATES

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Patient Preferred Language / Race / Ethnicity**

## \_\_\_\_\_**ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I request that payment of authorized benefits (Medicaid, Medicare, 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**

Unless other arrangements have been made in advance by either you or your 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.

We have 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 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. 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 including interest applied by a collection agency and attorney fees. Any suit filed may be brought in the county where the services are rendered.

## \_\_\_\_\_**CANCELLATION POLICY**

Walsh Urology Associates' Cancellation Policy states the practice will assess a \$25.00 fee to patients who

- Do not show up for their appointment, or
- Cancel their appointment without a 24 hour notice.

## \_\_\_\_\_**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT**

I have received a copy of Walsh Urology Associates' Notice of Privacy Practices.

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

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

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

(For Patients 17 years of age or younger, parent or guardian MUST sign)

**OFFICE USE ONLY: Patient was offered, but forfeited a copy of Walsh Urology Associates' Notice of Privacy Practices**