David H.C. King, M.D.
Urological Surgeons of Northern Calif. Inc.

Patient Information Sheet (Please Print)

Name: _____ _____ _____
(First) (Middle) (Last)

Address: _____ _____ _____
(number and street) (City) (Zip code)

Birthdate: _____ Home Phone: _____ Cell Phone: _____

Social Security Number: _____ Email Address: _____

Gender: ( )Male ( )Female Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Child

Employed by: _____ Work Phone: _____

Work Address: _____ Occupation: _____

Responsible Party for Payment: ( ) Self ( ) If other than self, then please give information:

Name: _____ Relation: _____ Birthdate: _____

Address: _____ Phone: _____

Method of Payment: ( ) MediCare Insurance ( ) Private Insurance ( ) Secondary Insurance ( ) Cash Pay

Please give receptionist any MediCare or Medical Insurance cards to copy for our records

Who is your Primary Care Physician? _____

Who referred you to our office / How did you find out about our office? _____

_____

***Please indicate any or all methods we can use to communicate with you regarding your personal health information:**

( ) leave message on home phone ( ) leave message on cell phone ( ) leave message at email address

( ) mail information to home address ( ) fax information to _____

***Please list your preferred Pharmacy Name and Location:** _____

***Please list names of any person(s) and their relation to you whom we may discuss your medical information with:**

_____

*** PLEASE READ AND SIGN ***

Cancellation/No show Policy: Please notify us more than 24 hours in advance of any appointment changes or cancellations. For a second missed, cancelled, or changed appointment with less than 24 hours notice, there will be a fee of $50.00 for office visits or $150.00 for procedure appointments payable before another appointment is to be made.

Any copayments, deductible fees and cash pay amounts are due and payable at the time of service. For patients with insurance, we will submit your claim to the insurance company. Any remaining balances after insurance processing will be due from the Responsible Party for Payment. Please remember that the ultimate responsibility for knowing coverage of fees for visits, tests, procedures, surgeries are with the patient or Party Responsible for Payment. Unpaid account balances outstanding after 90 days will be subject to an additional monthly finance charge of 1.5% per month.

Signed: _____ Date: _____

David H.C. King, M.D.

- A Division of Urological Surgeons of Northern California, Inc. -

---

Name: _____

Date of Birth: _____

Date of Appointment: _____

Please describe the reason for your visit today: _____

_____

_____

_____

_____

When did you first notice the problem?_____

Severity of the problem on a scale of 1 to 10 (10 is most severe): _____

How does the problem impact your normal activities?_____

Please list any chronic medical conditions / diagnoses (ex: high bp, diabetes, heart disease, etc.):

_____

_____

Please list any past surgeries / operations: _____

_____

What medicines do you take? (name and dose): _____

_____

_____

Please list any allergies (drug, latex, iodine, xray contrast): _____

How much do you smoke?_____ How much alcohol do you drink?_____

Do you take any recreational drugs? _____ Are you on a special diet? _____

Please list any significant family medical history: _____

_____

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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.

If you have any questions about this notice, please contact: Central Privacy Office at (303) 908-0345

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

TREATMENT. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

PAYMENT. We may use and disclose Health Information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

HEALTH CARE OPERATIONS. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND HEALTH RELATED BENEFITS AND SERVICES. We may use and disclose Heath Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

RESEARCH. Under certain circumstances, we may use and disclose Health Information for research. For example, a re search project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law. We will disclose Health when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your Information.

and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or .similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government -programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Privacy Office at (303) 908-0345. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.urosurgeons.com. To obtain a paper copy of this notice, contact the Privacy Office at (303) 908-0345.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Office at (303) 908-0345. All complaints must be made in writing. You will not be penalized for filing a complaint.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary: 1) for the institution to provide you with health care, 2) to protect your health and safety or the health and safety of others, or 3) for the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the address shown below.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the address shown below.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the address shown below.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the address shown below. ***We are not required to* agree *to your request.*** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to the address shown below. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

You must make all requests in writing addressed to:

Urological Surgeons of Northern California, Inc.
Attn: Privacy Officer
David H.C. King, M.D.
2165 S Bascom Ave
Campbell, CA 95008

David H.C. King, M.D.
A Division of Urological Surgeons of Northern California, Inc.
Adult and Pediatric Urology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____,
(Please Print Name)

have received a copy of this office's notice of privacy practices.

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but acknowledgment cannot be obtained because:

__ Individual refused to sign

__ Communications barriers prohibited obtaining acknowledgment

__ An emergency situation prevented us from obtaining acknowledgment

__ Other (please specify): _____

_____

_____

320 Dardanelli Lane · Suite 23B · Los Gatos, CA 95032
Telephone (408) 866-2500 · Fax (408) 596-7031

Urological Surgeons of Northern California, Inc.

Shahram Shawn Gholami, MD
Wesley Kong, MD
Sari R. Levine, MD
David M. Nudell, MD
Lawrence Y. Hwong, MD
J. Kersten Kraft, MD
Han P. Lo, MD
Robert P. Panvini, MD
Edward Karpman, MD,
Larry H. Kretchmar, MD
David W. Noller, MD
Terrence R. Sullivan, MD
David H. C. King, MD
Frank C. Lai, MD
Mark W. Noller, MD
Patrick E. Wherry, MD

Financial Policy

Welcome to our office. Thank you for choosing us for your care. The following is a statement of our Financial Policy which must be read and signed prior to any treatment. We hope this helps to answer any questions you may have regarding our billing policies.

Insurance:
Our office contracts with most insurance companies. Your Insurance Company provides you with proof of insurance that must be presented prior to all services. We bill all primary insurance plans for our patients. *Payment for co-payments, deductibles, and payment for any non-covered service is required at the time of your visit. Services not considered reasonable or medically necessary by your insurance will be patient responsibility.* If you have no insurance, your account will be treated as a cash account and we will collect payment in full at the time of service. For your convenience we accept check, cash, Visa, and MasterCard.

Your individual insurance plan is an agreement between you and your insurance company. It is necessary for you to know the specific details of your plan. If your plan requires a referral for specialty services, it is especially important to notify us if there are restrictions on referrals to outside facilities for services. It is your responsibility to arrange for all appropriate referrals and authorizations required for insurance payment. You will be liable for all charges billed for outside providers if they are not contracted with your plan and you have not received the proper pre-authorization. It is your responsibility to know if your referral has expired and to obtain a new referral if needed.

Patient Information:
You will be asked to fill out a patient information form at your initial visit and each year thereafter. In order to keep our file up to date, please inform us of any changes to your information such as a new insurance coverage, address, telephone number, medical history, or medications.

Missed Appointments:
Please cancel your appointment at least 24 hours in advance. If you fail to cancel before this time, you may be charged a missed appointment fee of $50 for office visits, and $150 for procedures. Please help us to serve you better by keeping your scheduled appointments.

Returned Checks:
A fee of $25 will be charged for a returned Check

After Hours Services:
All non-emergency services rendered after regular business hours are subject to an additional fee. Our regular business hours are Monday through Friday, 9:00 AM – 5:00 PM excluding holidays.

Your signature below indicates that you have read, understood, and agreed to this Financial Policy.

Signature:_____ Date:_____

Please Print Patient Name: _____

Urological Surgeons of Northern California, Inc.

Shahram Shawn Gholami, MD
David H. C. King, MD
Frank C. Lai, MD
Mark W. Noller, MD
Patrick E. Wherry, MD

Lawrence Y. Hwong, MD
Wesley Kong, MD
Sari R. Levine, MD
David M. Nudell, MD

James Hwong, MD
J. Kersten Kraft, MD
Han P. Lo, MD
Robert P. Panvini, MD

Edward Karpman, MD,
Larry H. Kretchmar, MD
David W. Noller, MD
Terrence R. Sullivan, MD

David H.C. King, M.D.
Phone: (408) 866-2500

ELECTRONIC PAYMENTS AND CONVENIENT PAYMENTS

Urological Surgeons of Northern California, Inc. goal is to provide you with the best, most current medical care available in a positive and supportive environment. Today insurance plans are becoming more complicated in how they determine what the medical practice can collect and what the patient actually owes. Insurance plans now have numerous different co-payments and deductibles that are often confusing to their clients and can even elude the smartest medical practice office manager. What a patient actually owes once insurance pays its portion is a function of the individual's co-payment, deductible, maximum out-of-pocket expenses and where the patient falls within this continuum.

In an effort to streamline this system and make it more cost effective for everybody we are asking every patient to provide us with a credit card, HSA debit card, or a voided check at the time of service. Nothing will be charged to your credit card or checking account until the Explanation of Benefits (EOB) returns from your insurance company and we can enter the contractual write-offs and amount paid by your insurance company into our system. The only amount charged to your credit card or checking account will be the PATIENT RESPONSIBILITY portion as defined on your insurance company's EOB (similar to an invoice). You will receive a statement via mail for any pending balances once insurance has paid. Ten days following the statement an E-MAIL notification with the amount to be charged to your credit card or deducted from your checking account will be sent. You will have 3 days to respond if you need to set up a payment plan, or change your form of payment. This will significantly reduce the costs of repeat statements and collection attempts. As a small business operating on fixed insurance reimbursements with rising costs and expenses, we must do everything possible to reduce the length of time that we extend credit to our patients. Thank you for your cooperation and understanding.

AUTHORIZATION TO CHARGE MY CREDIT CARD, HSA DEBIT CARD, OR CHECKING ACCOUNT FOR THE "PATIENT RESPONSIBILITY" PORTION OF MY INSURANCE PAYMENT

I authorize Urological Surgeons of Northern California, Inc. and Convenient Payments. to charge my credit card, HSA debit card, or my checking account with the balance due (patient responsibility) portion of my insurance explanation of benefits (EOB). I understand that I can dispute the charge at any time with my credit card company or Convenient Payments; however the actual amount of the charge can only be disputed with my insurance company. If I feel the "patient responsibility" portion of the explanation of benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company. Any change in the EOB by the insurance company will be reflected as a credit or additional charge on my credit card, HSA debit card, or directly in my checking account.

PATIENT NAME: _____ SIGNATURE: _____

DATE: _____ DATE OF BIRTH: _____

E-MAIL ADDRESS: _____

Card Holders Name_____

Credit Card/Checking Account Last 4 numbers: _____Expiration Date: _____

__□ Visa □ MC ***Please give card to receptionist for scanning***