

18404 N Tatum Blvd
#207 Phoenix AZ 85032

Chopra Urology

Sameer Chopra MD LLC

Phone: 602-777-3113
Fax: 602-726-3008
ChopraUrology.com

NEW PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

| | | | | | | |
|---|--------------------|--|-------------------------|--|-----------------------|---------------------------|
| PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL) | | ADDRESS | | | | |
| CITY, STATE | | ZIP | HOME PHONE | | CELL PHONE | |
| BIRTHDAY (M/D/Y) | PATIENT SSN | SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____ | | MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____ | | EMAIL (REQ-PORTAL) |
| PATIENT EMPLOYER NAME | | PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP) | | | EMPLOYER PHONE | |
| INSURED/RESPONSIBLE PARTY INFORMATION | | | | RELATION TO PATIENT: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian | | |
| NAME (FIRST -- LAST -- MIDDLE INITIAL) | | ADDRESS (if different from patient) | | | | |
| HOME PHONE | WORK PHONE | SSN | BIRTH DATE | EMPLOYER | | |
| INSURANCE INFORMATION | | | | | | |
| PRIMARY INSURANCE NAME | | ADDRESS (STREET - CITY - STATE - ZIP) | | | PHONE | |
| GROUP NUMBER | ID NUMBER | EMPLOYER | | EMPLOYER PHONE | | |
| SECONDARY INSURANCE NAME | | ADDRESS (STREET - CITY - STATE - ZIP) | | | PHONE | |
| GROUP NUMBER | ID NUMBER | EMPLOYER | | EMPLOYER PHONE | | |
| PRIMARY DOCTOR/FAMILY DOCTOR | | | REFERRING DOCTOR | | | |
| IN CASE OF EMERGENCY CONTACT | | | RELATIONSHIP | PHONE NUMBER | | |

ASSIGNMENT AND RELEASE (Please Initial Before Each Line):

_____ I understand that I have medical insurance which is billed on my behalf should pay for the portion of my office visits, procedure and treatment charges at SAMEER CHOPRA MD PLLC.

_____ I will inform SAMEER CHOPRA MD PLLC of any changes in my insurance coverage(s).

_____ I understand that the billing process may take 4-6 weeks at which time my insurance company will determine and pay for services per my insurance contract.

_____ I understand that it is my responsibility to pay all co-pay, deductible and estimated co-insurance amounts at the time of service rendered and remaining balance as determined by my insurance company.

_____ I understand that if for any reason my insurance company does not pay for the covered services within 90 days of the services provided, I shall assume responsibility for the total amount owed, which may be charged to the credit card on SAMEER CHOPRA MD PLLC assign all medical benefits directly to SAMEER CHOPRA MD PLLC for services rendered.

_____ I understand when CT or PET/CT scan is ordered by my provider, the radiology service provided and billed to me is separate from SAMEER CHOPRA MD PLLC.

_____ SAMEER CHOPRA MD PLLC may request proof of insurance premium payment at times.

| | |
|---|-------------|
| SIGNATURE (Patient or, if minor Signature of parent or guardian) | DATE |
|---|-------------|

PLEASE PRINT AND COMPLETE ALL ENTRIES

| | |
|---|-------------|
| PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL) | Date |
|---|-------------|

Authorization to release health information to:

| | | | |
|-----------------------------------|------------|--|----------------------|
| Name-Emergency Contact (s) | | ADDRESS | |
| CITY, STATE | ZIP | HOME PHONE | DAYTIME PHONE |
| DATES OF SERVICE | | AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) | |
| FROM: | TO: | <input type="checkbox"/> NEVER DATE: | |

Release the following information:

All Records
 Chart Notes
 Radiology Reports
 Operative Reports
 History & Physicals

| | | | |
|------------------------------------|--|----------------|--|
| Name-Additional Contact (s) | | ADDRESS | |
|------------------------------------|--|----------------|--|

| | | | |
|--------------------|------------|-------------------|----------------------|
| CITY, STATE | ZIP | HOME PHONE | DAYTIME PHONE |
|--------------------|------------|-------------------|----------------------|

| | | | |
|-------------------------|------------|--|--|
| DATES OF SERVICE | | AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) | |
| FROM: | TO: | <input type="checkbox"/> NEVER DATE: | |

Release the following information:

All Records
 Chart Notes
 Radiology Reports
 Operative Reports
 History & Physicals

RELEASE OF INFORMATION

I understand that:

- Once SAMEER CHOPRA MD PLLC discloses my health information by my request, I cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission
- I hereby authorize SAMEER CHOPRA MD PLLC to use and disclose my personal health information to the individuals identified on this form. I understand this authorization does not expire unless written notice is mailed to 18404 N Tatum Blvd #207 Phoenix Arizona 85302. I understand this may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist. I understand that SAMEER CHOPRA MD PLLC will treat the individuals identified on this form as individuals involved directly in my care and as such, SAMEER CHOPRA MD PLLC will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations. I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from SAMEER CHOPRA MD PLLC will not be affected if I refuse to sign this authorization.

| | | |
|---|-------------|--------------|
| SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE | DATE | EMAIL |
|---|-------------|--------------|

| | |
|---|---|
| IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT | SIGNATURE OF WITNESS (Optional): |
|---|---|

RECEIPT OF NOTICE OF PRIVACY PRACTICES

- SAMEER CHOPRA MD PLLC share the commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information.
- Please sign the form below to acknowledge that you have received and read our Notice of Privacy Practices.

| | | |
|---|-------------|--------------|
| SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE | DATE | EMAIL |
|---|-------------|--------------|

| | |
|---|---|
| IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT | SIGNATURE OF WITNESS (Optional): |
|---|---|

Chopra Urology

SAMEER CHOPRA MD PLLC

Patient History Form

To prevent medical errors it is critical you complete this form completely and accurately!

First Name: _____ Last Name: _____ DOB: _____ Date: _____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: _____ Preferred Lab: _____

Height: _____ ft _____ in Weight: _____ lbs Age: _____ Occupation: _____

Race: _____ Primary Language: _____ Ethnic Group: _____

How did you hear about our practice:

Referring Physician Friend Internet (which site?) _____ Insurance Company Other, How? _____

Name of Physician who referred you to this Office: _____

| Current Physicians | Address | Phone # | Fax # | Specialty |
|--------------------|---------|---------|-------|-----------|
| | | | | |
| | | | | |
| | | | | |

CHIEF COMPLAINT (Why do you want to see the doctor?) _____

How long have you had this complaint? _____

MEDICATIONS (List all **Prescription** drugs you are taking with dosage and schedule)

See Attached List

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

List all **Non-Prescription** drugs:

Vitamins: _____ Aspirin / Ibuprofen: _____

Other (including supplements): _____

ALLERGIES (List all allergies to drugs or foods (i.e., sulfa, shellfish))

No Known Allergies See Attached List

PATIENT HISTORY (Do you have any of the following:)

Asthma ----- Yes No

Atrial Fibrillation----- Yes No

Cancer----- Yes No

Type: _____

CVA / Stroke----- Yes No

Depression----- Yes No

Diabetes----- Yes No

DVT----- Yes No

Glaucoma ----- Yes No

Heart Disease ----- Yes No

Hepatitis ----- Yes No

Hyperlipidemia ----- Yes No

Hypertension ----- Yes No

Liver Disease ----- Yes No

Myasthenia Gravis ----- Yes No

Neurologic Disorder----- Yes No

Osteoarthritis----- Yes No

Peripheral Vascular Disease ----- Yes No

Thyroid Disorder ----- Yes No

Tuberculosis ----- Yes No

UTI Recurrent ----- Yes No

Vascular Disease ----- Yes No

No Medical Problems----- Yes No

Other Medical Problems: _____

PREVIOUS SURGERIES: Yes No If yes, please complete the below.

| Type | Date | Type | Date |
|------|------|------|------|
| | | | |
| | | | |
| | | | |

Previous Hospitalizations for Medical Problems: No Yes. If yes, type and date: _____

FAMILY HISTORY (Please fill out as complete as possible – # of children, status, check boxes)

| | Status (Alive/Dead) | Age | Prostate Cancer | Kidney Cancer | Bladder Cancer | Breast Cancer | Diabetes | High Blood Pressure | Heart Disease |
|------------------------------|------------------------|-----|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Daughters (#) | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sons (#) | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Father | A/D | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mother | A/D | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Grandparent | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sibling | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Family History?: _____ | | | | | | | | | |

SOCIAL HISTORY

Marital Status: Single Married Widowed Divorced Children: Yes No Boys _____ Girls _____

Exercise? Yes No Type: _____

Current Tobacco use?..... Yes No Prior Tobacco use? Yes No

Alcohol use?..... Yes No Current Drug use? Yes No Type: _____

Caffeine use? (Cups / Day): Coffee: _____ Tea: _____ Cola: _____

REVIEW OF SYSTEMS (Have you currently or recently had)

General

Fatigue Yes No
 Fever Yes No
 Weight Gain Yes No
 Weight Loss Yes No

Allergy

Drug Allergies Yes No
 Seasonal Allergies Yes No

Ophthalmologic

Blurred Vision Yes No

ENT

Dry Mouth Yes No
 Nosebleeds Yes No

Endocrine

Cold Intolerance Yes No
 Excessive Sweating Yes No
 Heat Intolerance Yes No

Respiratory

Shortness of Breath Yes No

Cardiovascular

Chest Pain Yes No
 Edema (swelling) Yes No

Gastrointestinal

Constipation Yes No
 Diarrhea Yes No
 Nausea Yes No

Hematology

Bleeding Problems Yes No

Musculoskeletal

Back Pain Yes No
 History of Gout Yes No

Peripheral Vascular

Blood Clots in Legs Yes No

Skin

Rashes Yes No

Neurologic

Leg or Arm Weakness Yes No
 Balance Difficulty Yes No
 Headaches Yes No

Psychiatric

Depressed Mood Yes No

Date of Last:

Flu Shot _____
 Varicella _____
 Colonoscopy _____
 Dexa Scan _____

Females

Mammogram _____
 Annual Pap _____

Form Completed By: _____ Date: _____

Chopra Urology

SAMEER CHOPRA MD PLLC

Payment Policy

Patient Name: _____ Date of Birth: _____

We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it carefully, ask us any questions you may have, and sign in the space provided. ***A copy will be provided to you upon request.***

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failing to collect co-payments and deductibles could violate our insurance contracts with federal and private insurance companies.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claim submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. **You will receive a total of 3 statements over the period of 90 days, via mail or email. Please be aware that if a balance remains unpaid, your account will be managed by the third-party collection agency and the agency will charge 25% administrative fee in addition to your balance due** (for example, if your balance due is \$100, the collection agency will charge \$25 admin fee, then the total amount due will be \$125.00).

8. Missed appointments. Our policy is to charge in an amount of **\$50.00** for missed appointments, not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Thank you for your understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understood the above information, and agree to accept the conditions:

Signature of patient or responsible party

Date