Newport
Urologic Oncology

☐ ROBERT R. TORREY, III, M.D.

☐ JEFFREY YOSHIDA, M.D.

You have a scheduled appointment with Dr. _____, on _____, at _____ am/pm. We have enclosed our Patient Information sheet and a health questionnaire for you to fill out prior to coming in for your appointment. Please fill out both pages and bring them along with this signed form to your appointment. Also, please bring any insurance cards, driver's license and any records that you have. You will be responsible for any co-payment or deductible at the time of your visit. If you do not have insurance, please be prepared to pay for services at the time you are seen. Our office does accept cash, checks, and Visa/MasterCard/Discover/American Express.

If for some reason you need to cancel your appointment, please notify our office 24 hours in advance. We reserve the right to charge for appointments, procedures, and surgeries cancelled or broken without 24 hours advance notice.

It is our goal in this office to provide our patients with the very best care. This may require certain diagnostic x-rays or lab work. Many insurance plans require that the patient receive services at facilities on an approved provider list. We would like you to be aware that the majority of our lab work is done outside our office. We also send our ultrasounds out to be read by a radiologist. The fact that our office may be a provider for your insurance does not mean that a particular lab or doctor we refer to is covered under your plan. Please be aware of the requirements of your insurance plan. We want to work with our patients to allow them to receive the best insurance coverage for their treatment. If you are required to use a particular lab, please let us know before having any x-rays or lab work done in our office. We are happy to supply you with orders to take to an alternative facility at your request.

We know that you have a choice of medical providers and appreciate that you have trusted us with your care. If you have any questions, please do not hesitate to call our office. We look forward to seeing you soon.

I have read and understand the above information.

_____ _____

Signature Date

_____

Print Name

Newport
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☐ ROBERT R. TORREY, III, M.D.
☐ JEFFREY YOSHIDA, M.D.

PATIENT INFORMATION

Date _____

Name _____ Referred By _____

Male_____ Female_____ Date of Birth_____/_____/_____ Social Sec. # _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ E-Mail _____

Race: _____ Language: _____

Ethnicity: Hispanic or Latin _____ Non Hispanic or Latin _____

Pharmacy Name _____ Number _____

Employer Name _____ Occupation _____

Employer Address _____

Primary Insurance Company _____ Policy # _____

Insured's Name _____ Insured's Date of Birth_____/_____/_____

Secondary Insurance Company _____ Policy # _____

Insured's Name _____ Insured's Date of Birth_____/_____/_____

Marital Status _____ Spouse's Name _____

Emergency Contact _____ Phone (_____) _____

I request that payment of authorized insurance benefits be made either to me or on my behalf to Newport Urologic Oncology for any services furnished to me by these physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. By signing below, I acknowledge my share of costs and agree to be responsible for paying the amount due.

Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that it may be waived by the individual.

_____ I do not authorize the Practice to release any information concerning my medical care.

_____ I authorize the Practice to verbally release any or all information concerning my medical care to the following individuals.

Name	Phone Number	Relationship to Patient
_____	(_____) _____	_____
_____	(_____) _____	_____
_____	(_____) _____	_____

_____ _____

Patient Signature Date

Newport
Urologic Oncology

☐ N Beach ☐ H Beach
☐ Irvine ☐ Redlands

Progress Notes for _____ (date)

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

DATE OF BIRTH: _____ **AGE:** _____ **REFERRING PHYSICIAN:** _____

CHIEF COMPLAINT: (Symptoms or disease causing today's office visit)

_____

_____

_____

HISTORY OF PRESENT ILLNESS: (Location, duration, quality, severity, timing, context, modifying factors, associated signs)

_____

_____

_____

_____

PAST OPERATION AND DATES: _____

_____

_____

_____

_____

_____

ILLNESSES: (Diabetes, High Blood Pressure, Heart or Lung Disease, Glaucoma, Venereal Disease, Other)

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS: _____

_____

_____

_____

_____

_____

_____

ALLERGIES: _____

_____

_____

FAMILY HISTORY: (Cancer, Kidney Stones, Bleeding Disorder)

_____

_____

_____

HABITS: Tobacco _____ Alcohol _____
Coffee _____ Tea _____

CONSTITUTIONAL	**Y**	**N**	**MUSCULOSKELETAL**	**Y**	**N**	**PSYCHIATRIC**	**Y**	**N**
Fatigue	___	___	Back pain or neck pain	___	___	Anxiety	___	___
Fevers	___	___	**GASTROINTESTINAL**	**Y**	**N**	Depression	___	___
Loss of appetite	___	___	Nausea or vomiting	___	___	Moodiness	___	___
CARDIOVASCULAR	**Y**	**N**	Diarrhea	___	___	**NEUROLOGICAL**	**Y**	**N**
Chest pain	___	___	Abdominal pain	___	___	Paralysis	___	___
Shortness of breath with exertion	___	___	**UROLOGICAL**	**Y**	**N**	Numbness	___	___
Pallpitaions or irregular heart beat	___	___	Kidney stones	___	___	History of Stroke	___	___
High blood pressure	___	___	Sexually transmitted disease	___	___	Seizures	___	___
Heart attack	___	___	Blood in urine	___	___	**HEMATOLOGIC**	**Y**	**N**
EYES	**Y**	**N**	Bladder infections	___	___	Bleeding Disorder	___	___
Eye pain	___	___	Problems with erections	___	___	Easy Bruising	___	___
Loss or blurred vision	___	___	Urinary leakage	___	___	Use of aspirin, Coumadin, other	___	___
Glaucoma	___	___	Frequent urination (how often)	___	___	blood thinners	___	___
RESPIRATORY	**Y**	**N**	Pain or burning with urination	___	___	Abdominal pain	___	___
Cough	___	___	Urgency or pressure to urinate	___	___	Past blood transfusions	___	___
Asthma	___	___	Urination at night (how often)	___	___	**ENDOCRINE**	**Y**	**N**
Sputum	___	___	Push or strain to urinate	___	___	Diabetes	___	___
Coughing blood	___	___	Weak urinary stream	___	___	Thyroid disease	___	___
			Incomplete emptying	___	___	Weight loss	___	___

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to the treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdiction limit or the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to healthcare providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered by the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician's or Authorized Representative Signature

NEWPORT UROLOGIC ONCOLOGY
_____
Print or Stamp Name of Physician, Medical Group or Association Name

By: _____ _____
Patient's or Patient Representative Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

Newport Urologic Oncology
1525 Superior Avenue #210
Newport Beach, CA 92663
P: (949) 999-8979 | F: (949) 999-8970

Notice of Privacy Practices Acknowledgment

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law professional accreditation standards and our internal policies and procedures.

Attached is your personal copy of your Notice of Privacy Practice. This notice explains your rights, our legal duties and our privacy practices. It also describes how much medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the notice:

- Our Pledge
- Your personal information
- Our Privacy Practices
- Your written permission
- Other restrictions
- Your rights
- Changes
- Questions or Complaints

We may use your information for:

- Treatment
- Health Information Exchange
- Payment
- Health Care Operations
- Notifications
- Marketing Research
- Special circumstance & the law

Please understand that this summary is not our Notice of Privacy Policies, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, please contact our office manager at the address or phone number above to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining this signed acknowledgment. If, after reviewing the notice, you decide that you do not want to retain your copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices and the office policies & procedures and do with to receive treatment:

Signature _____ Printed Name _____ Date _____

Directions to Newport Urologic Oncology

1525 Superior Avenue, Suite 210
Newport Beach, CA 92663
(949) 999-8979

From Huntington Beach

Take Pacific Coast Highway south to Superior Avenue. Turn left and go up the hill, crossing over Hospital Road and Placentia. Go to the next stop light (with the sign "Hoag Health Center" on it), make a u-turn and turn right into the second driveway. We are upstairs in Suite 210.

From Newport Beach/Corona Del Mar

Take Pacific Coast Highway north to Superior Avenue. Turn right and go up the hill, crossing over Hospital Road and Placentia. Follow the directions above.

From the 405/55 Freeway

Take the 55 (Newport Freeway) south, which turns into Newport Boulevard, heading toward the ocean. Turn right on Industrial Way. Turn left on Superior Avenue. Go past the stop light with the sign "Hoag Health Center" on it and turn right into the second driveway. We are upstairs in Suite 210.