

Patient Registration

Patient Information			
Last Name:		First Name:	
Date of birth:		SSN:	Phone:
Current address:			
City:		State:	ZIP Code:
Email Address:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W		Employment: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled	
Preferred Language:		Race:	Ethnicity:
<i>If employed, please complete the following information:</i>			
Employer Name:		Employer Phone:	
Employer Address:			
City:		State:	ZIP Code:
Spouse or Insured Parent Information			
Last Name:		First Name:	
Current address:		MI:	
City:		State:	Zip Code:
Primary Phone:	Date of Birth:		SSN:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
<i>If employed, please complete the following information:</i>			
Employer Name:		Employer Phone:	
Employer Address:			
City:		State:	ZIP Code:
Referring Physician			
Name:			
Address:			
City:		State:	Referral Phone:
City:		State:	ZIP Code:
Primary Insurance			
Name:			
Address:			
City:		State:	Primary Phone:
Insured's Name:		ID#:	Group#
City:		State:	ZIP Code:
Secondary Insurance			
Name:			
Address:			
City:		State:	Primary Phone:
Insured's Name:		ID#:	Group#
City:		State:	ZIP Code:
Emergency Contact – Not at Same Address			
Name:		Relationship:	
Address:			
City:		State:	Primary Phone:
City:		State:	ZIP Code:
Preferred Pharmacy			
Name:		Address:	
City:		State:	Pharmacy Phone:
City:		State:	ZIP Code:
I hereby authorize and request my insurance company to pay any and all medical benefits directly to: Lamia Gabal, M.D. I understand that I am financially responsible for any charges not paid by my insurance carrier, and hereby authorize Dr. Gabal's office to release any information necessary to process my claim.			
Patient's/Authorized Person's Signature:			Date:

Patient History

Name <i>(Last, First, M.I.):</i>	Date:
How did you hear about us: <input type="checkbox"/> Referring Physicians <input type="checkbox"/> Friend <input type="checkbox"/> Insurance Company <input type="checkbox"/> Facebook <input type="checkbox"/> Google <input type="checkbox"/> Yelp <input type="checkbox"/> WebMD <input type="checkbox"/> Healthgrades	
Why are you seeing the doctor today?	

REVIEW OF SYSTEMS

Please CHECK if you have or have had any of the following diseases or conditions:

Constitutional	<i>Throat/Neck</i>	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Tremors	<input type="checkbox"/> Retention
<input type="checkbox"/> Chills	<input type="checkbox"/> Frequent Sore Throats	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Stones
<input type="checkbox"/> Fever	<input type="checkbox"/> Lumps	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Numbness	<input type="checkbox"/> Bed-Wetting
<input type="checkbox"/> Weakness	Respiratory	Musculoskeletal	<input type="checkbox"/> Strokes	<input type="checkbox"/> Difficulty Starting Stream
<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Unsteady Gait	<input type="checkbox"/> Flank Pain
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Joint Pain	Endocrine	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Short of Breath	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Muscle Cramps	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sexual Arousal Disorder
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Gout	<input type="checkbox"/> Sweats	<input type="checkbox"/> Urgency
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Weakness	<input type="checkbox"/> Diabetes	<i>Male Genitalia</i>
Head	<input type="checkbox"/> Cough	Psychiatric	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Discharge
<input type="checkbox"/> Fainting	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> Impotence
<input type="checkbox"/> Headaches	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Excessive Urination	<input type="checkbox"/> Painful Ejaculation
Eyes	Cardiovascular	<input type="checkbox"/> Depression	<input type="checkbox"/> Increased Thirst	<input type="checkbox"/> Scrotal Masses
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Psychiatric Disorders	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Fertility Problems
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Generally Satisfied	Hematologic/ Lymph	<input type="checkbox"/> Lesions
<input type="checkbox"/> Vision Loss	<input type="checkbox"/> Mitral Valve Prolapse	Breasts	<input type="checkbox"/> Anemia	<input type="checkbox"/> Peyronies Disease
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Swelling of Legs	<input type="checkbox"/> Discharge	<input type="checkbox"/> HIV	<input type="checkbox"/> Sexual Problems
<input type="checkbox"/> Infections	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Self-Examination	<input type="checkbox"/> Bleeding Easily	<input type="checkbox"/> Hernias
<input type="checkbox"/> Eyeglass Use	<input type="checkbox"/> History of Heart Attack	<input type="checkbox"/> Lumps	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Pain
<input type="checkbox"/> Redness	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Blood Clotting Problems	<input type="checkbox"/> Prostate Problems
ENT	<input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> Pain	Allergic/ Immunologic	<input type="checkbox"/> STD
<i>Nose</i>	<input type="checkbox"/> Heart Murmur	Skin	<input type="checkbox"/> Drug Allergies	<i>Female Genitalia</i>
<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hives	<input type="checkbox"/> Bladder Prolapse
<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Mole Increased Size	<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> Menopause
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Recurrent Urinary Tract Infections
<input type="checkbox"/> Sinus Infections	Gastrointestinal	<input type="checkbox"/> Persistent Itching	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Bleeding Between Periods
<input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Lumps	Genitourinary	<input type="checkbox"/> Pain on Intercourse
<i>Mouth</i>	<input type="checkbox"/> Constipation	<input type="checkbox"/> Rashes	<i>Urinary</i>	<input type="checkbox"/> Sexual Problems
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Gallbladder Disease	Neurological	<input type="checkbox"/> Awakening to Urinate	<input type="checkbox"/> Lesions
<input type="checkbox"/> Voice Changes	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Burning	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Recent Pregnancy
<input type="checkbox"/> Change in Dentition	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Frequency	
<i>Ears</i>	<input type="checkbox"/> Decreased Appetite	<input type="checkbox"/> Tingling	<input type="checkbox"/> Infections	
<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Pain on Urination	
<input type="checkbox"/> Infections	<input type="checkbox"/> Nausea	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Hesitancy	
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Black Tarry Stools	<input type="checkbox"/> Speech Disorders	<input type="checkbox"/> Kidney Failure	

FAMILY HISTORY

Please CHECK and indicate which family member has/had any of the following (Father, Mother, Son, Daughter, Sister, Brother, Maternal Grandmother, Paternal Grandfather, Maternal Aunt, Paternal Aunt, Maternal Uncle, Paternal Uncle, First Degree Relative):

Condition/ Disease	Family Member(s)
<input type="checkbox"/> Thyroid Dysfunction	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> Breast Cancer	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> Diabetes	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> MI	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> Arthritis	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> CAD	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> HIV	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> Prostate Cancer	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> BPH	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> Cancer	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> Hypertension	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> Renal Stone	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> Bladder Cancer	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> Cholesterol High	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)
<input type="checkbox"/> Kidney Cancer	_____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased), _____ (<input type="checkbox"/> Alive / <input type="checkbox"/> Deceased)

MEDICAL HISTORY

Please CHECK if you have or have had any of the following diseases or conditions:

<input type="checkbox"/> Lower Urinary Tract Infections	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Migraine	<input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hx of Non-Hodgkin's Lymphoma	<input type="checkbox"/> Retention	<input type="checkbox"/> Mixed Incontinence	<input type="checkbox"/> Low Testosterone
<input type="checkbox"/> Bladder Cancer	<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergy to any Drugs	<input type="checkbox"/> Stroke	<input type="checkbox"/> Overactive Bladder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> BPH	<input type="checkbox"/> Anemia	<input type="checkbox"/> TB
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Cholesterol High	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Back Problem	
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Depression	<input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> COPD	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Congestive Heart Failure	
<input type="checkbox"/> MI	<input type="checkbox"/> Kidney Cancer	<input type="checkbox"/> HIV	<input type="checkbox"/> Erectile Dysfunction	

SOCIAL HISTORY

Please provide the following information:

Tobacco

Cigarettes	<input type="checkbox"/> Current Every Day Smoker	<input type="checkbox"/> Current Some Day Smoker	<input type="checkbox"/> Former Smoker	<input type="checkbox"/> Never Smoked
	<i>If Smoker:</i> <input type="checkbox"/> Heavy Tobacco Smoker (Greater than 10 daily)		<input type="checkbox"/> Light Tobacco Smoker (less than 10 daily)	
Cigars	<input type="checkbox"/> Current Every Day Smoker	<input type="checkbox"/> Current Some Day Smoker	<input type="checkbox"/> Former Smoker	<input type="checkbox"/> Never Smoked
	<i>If Smoker:</i> <input type="checkbox"/> Heavy Tobacco Smoker (Greater than 10 daily)		<input type="checkbox"/> Light Tobacco Smoker (less than 10 daily)	
Pipe	<input type="checkbox"/> Current Every Day Smoker	<input type="checkbox"/> Current Some Day Smoker	<input type="checkbox"/> Former Smoker	<input type="checkbox"/> Never Smoked
	<i>If Smoker:</i> <input type="checkbox"/> Heavy Tobacco Smoker (Greater than 10 daily)		<input type="checkbox"/> Light Tobacco Smoker (less than 10 daily)	
Chewing Tobacco	<input type="checkbox"/> Current Every Day User	<input type="checkbox"/> Current Some Day User	<input type="checkbox"/> Former User	<input type="checkbox"/> Never Used
	<i>If Smoker:</i> <input type="checkbox"/> Heavy Tobacco User (Greater than 10 daily)		<input type="checkbox"/> Light Tobacco User (less than 10 daily)	
Dipping Tobacco	<input type="checkbox"/> Current Every Day User	<input type="checkbox"/> Current Some Day User	<input type="checkbox"/> Former User	<input type="checkbox"/> Never Used
	<i>If Smoker:</i> <input type="checkbox"/> Heavy Tobacco User (Greater than 10 daily)		<input type="checkbox"/> Light Tobacco User (less than 10 daily)	

Alcohol Consumption

Beer	<input type="checkbox"/> Social	<input type="checkbox"/> Occasional	<input type="checkbox"/> Light	<input type="checkbox"/> Heavy
Wine	<input type="checkbox"/> Social	<input type="checkbox"/> Occasional	<input type="checkbox"/> Light	<input type="checkbox"/> Heavy
Hard Liquor	<input type="checkbox"/> Social	<input type="checkbox"/> Occasional	<input type="checkbox"/> Light	<input type="checkbox"/> Heavy

Name (Last, First, M.I.):

Date:

SURGI CAL HI STORY

Please CHECK if you have had any of the following surgeries and date of surgery:

Common Surgeries	<input type="checkbox"/> Prostatectomy Retro	<input type="checkbox"/> Prior Surgery	<input type="checkbox"/> TURBT – Resection of Bladder Tumor	<input type="checkbox"/> Major Orthopedic Surgery
<input type="checkbox"/> Torsion of Spermatic Cord	<input type="checkbox"/> Total Nephrectomy	<input type="checkbox"/> Spermatocele Repair	<input type="checkbox"/> Urinary Stone	<input type="checkbox"/> Rotator Cuff Repair
<input type="checkbox"/> Ablation for Atrial Fibrillation	<input type="checkbox"/> TURBT	<input type="checkbox"/> Vasectomy	<input type="checkbox"/> Bladder Excision Total	<input type="checkbox"/> Spinal Surgery
<input type="checkbox"/> CABG	<input type="checkbox"/> Appendectomy	Other Surgeries	<input type="checkbox"/> Hydroceleotomy	<i>OB/GYN</i>
<input type="checkbox"/> Colectomy	<input type="checkbox"/> Carotid Endarterectomy	<i>Circulatory</i>	<input type="checkbox"/> Prostatectomy Retropubic	<input type="checkbox"/> Hysterectomy Benign Disease
<input type="checkbox"/> Fracture	<input type="checkbox"/> Defibrillator Pacemaker	<input type="checkbox"/> Major Vascular Surgery	<input type="checkbox"/> Ureter Stent	<input type="checkbox"/> Oophorectomy R
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Hernia Abdominal	<input type="checkbox"/> Mitral Valve Repair	<input type="checkbox"/> Calculus Kidney	<input type="checkbox"/> Hysterectomy Total
<input type="checkbox"/> Prostate Biopsy	<input type="checkbox"/> Pacemaker	<i>Digestive</i>	<input type="checkbox"/> Kidney Donation	<input type="checkbox"/> Oophorectomy L
<input type="checkbox"/> TURP	<input type="checkbox"/> Sling for Stress Incontinence	<input type="checkbox"/> Hernia Inguinal	<input type="checkbox"/> Renal Transplant	<input type="checkbox"/> Normal Delivery
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Resection Colon Partial	<input type="checkbox"/> Ureteric Calculus Laser TX	<input type="checkbox"/> Sterilization-Female
<input type="checkbox"/> Aortic Aneurysm	<input type="checkbox"/> AAA Repair	<input type="checkbox"/> Hernia Umbilical	<input type="checkbox"/> Circumcision	<input type="checkbox"/> Oophorectomy BL
<input type="checkbox"/> Cardiac Stent	<input type="checkbox"/> Breast Augmen	<input type="checkbox"/> Major Abdominal Surgery	<input type="checkbox"/> Nephrectomy Partial	<i>Other</i>
<input type="checkbox"/> Cystoscopy	<input type="checkbox"/> Cesarean Section	<i>Genitourinary</i>	<input type="checkbox"/> Stress Incontinence	<input type="checkbox"/> Laparoscopy
<input type="checkbox"/> Heart Valve	<input type="checkbox"/> ESWL	<input type="checkbox"/> Urinary Bladder Stone	<input type="checkbox"/> Urethral Stricture	
<input type="checkbox"/> Insertion of Penile Prosthesis	<input type="checkbox"/> Hip Surgery	<input type="checkbox"/> Genital Prolapse	<i>Musculoskeletal</i>	
<input type="checkbox"/> Basal Cell Carcinoma	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Orchidopexy	<input type="checkbox"/> Artificial Joint	

Current Medications – Please list ALL medications you are currently taking including over the counter meds (attach list if necessary)

Drug Name:	Strength:	Directions/How you take it:

Allergies – Please list ALL types (Drug, seasonal, pets, environmental, foods)

Name *(Last, First, M.I.):*

Date:

Financial and Office Policies

	Please initial next to each section to acknowledge:
	All co-pays, co-insurance, deductibles and cash payments are due at check-in on the day services are rendered. Should you have any remaining balance on your account, you will receive a billing statement in the mail due immediately upon receipt.
	For your convenience we accept cash, check, money order, Mastercard, Visa, Discover, American Express and Care Credit.
	A fee of \$50.00 will be charged to your account for any returned check.
	“No Show for New Patient Appointment” – failure to keep a scheduled appointment fee. \$100.00
	“No Show for procedure” – Failure to keep a scheduled procedure appointment fee. \$100.00
	”Cancellation”- Appointment Cancellation with less than 24 hours’ notice fee. \$50.00
	“Procedure Cancellation” – Procedure cancelled with less than 24 hours’ notice fee. \$100.00
	Surgery Deposits must be paid prior to your scheduled surgery day, usually at the time of your pre-operative appointment
	Dr. Gabal requires a 5 BUSINESS day notice for canceling surgical cases. If you do not cancel your surgery 5 business days in advance, you will be charged \$200.00.
	Completion of disability forms, FMLA, Social Security or insurance forms will be assessed at \$40.00 fee per form to cover the administrative overhead involved in completing these forms. This fee is not covered by insurance.
	Prior Authorizations for medications that are not covered by your insurance company- \$30.00. We will notify you in advance if we believe your insurance company won’t cover your medication. If you wish for us to appeal the decision, the fee will cover the manpower required to attempt the appeal. THERE IS NO GUARANTEE THAT YOUR INSURANCE COMPANY WILL APPROVE ANY APPEAL.
	Peer to Peer Review- \$100.00. If your insurance company denies a procedure, test or medication and requests a peer to peer review, this fee will cover the time required for Dr. Gabal to go through this process. THERE IS NO GUARANTEE THAT YOUR INSURANCE COMPANY WILL GRANT APPROVAL.
	Charges for copies of medical records –twenty five cents per page plus postage. California law has authorized charges up to 25 cents per page. This is to cover the manpower and supply costs of copying and mailing these records. You may access and print your records free of charge from the patient portal.
	Interest Charges for unpaid balances. Unpaid balances due after 60 days will be subject to interest charges. Annual Percentage Rate (APR) of 18%, will be assessed monthly on past due balances.
	Delinquent accounts will be turned over to a collection agency if balances due are not received within 90 days. If your account is turned over to a collection agency, you will be responsible for all collection and legal fees (small claims court).

We appreciate your trust in us and the opportunity to serve your healthcare needs.

Patient’s Signature _____ Date _____

CREDIT CARD AUTHORIZATION / POLICY

We ask that you provide an updated credit card number to have on file upon scheduling your next appointment. Rest assured that all cards on file are added to the system via a secure electronic process that ensures the information is encrypted and remains protected. By signing below, the patient is authorizing Lamia Gabal, MD Inc., to charge the cardholder for no-show fees, unpaid medical services pursuant to the above policies. The no-show fees will be charged to the credit card on the date of the appointment.

Effective Date: April 5th, 2022

Credit Card Information Credit Card Type:

MasterCard Visa American Express Discover Card

Number: _____ Expiration Month: _____

CVV: _____ Expiration Year: _____

Cardholder Signature: _____

Date ____/____/____

Patient's Name (PRINTED)

Signature

Date

Lamia Gabal M.D.
Diplomate American Board of Urology
720 N Tustin Avenue Suite #104 Santa Ana, CA 92705 P:
949-825-7650 Fax: 949-825-7648

RESPONSIBILITY FORM

PLEASE INITIAL BESIDES EACH SECTION TO ACKNOWLEDGE

- _____ 1. I acknowledge that my physician is my partner in health. As an adult, it is my responsibility to keep track of my medical conditions, medications, and all other physicians that are involved in my medical care. It is my responsibility to inform every physician or other health care provider that I encounter about any changes in my medications, medication dosages, any medical conditions or any evaluations in progress
- _____ 2. I acknowledge that to help protect me from identity theft – this medical office participates in the federal regulation program titled the “Red Flags Rule.” As a result, I acknowledge that I will be REQUIRED to present my photo ID and ALL insurance cards at EVERY office visit. Copies of these will be part of my medical record.
- _____ 3. I acknowledge that if I fail to keep an advised follow-up appointment to go over test results, monitor treatment, or evaluate symptoms, then I am responsible if this results in harm to myself, delay in diagnosis, or failure to treat or cure.
- _____ 4. I acknowledge that I am responsible for scheduling my own appointments. As a courtesy – the physician’s office will attempt to contact me one or two days prior to remind me of the appointment, however I may not receive this message for various reasons.
- _____ 5. I acknowledge the importance of making sure the physician’s office has my current address and all phone number contacts. If my information on file is not current, then I acknowledge that my physician’s office will not be able to notify me about abnormal test results, medication recalls, changes in appointment or surgery scheduling, etc.
- _____ 6. I acknowledge that I am responsible to know the insurance benefits provided by my insurance carrier(s). Any questions I have regarding my insurance benefits will be directed to my Insurance carrier or Human Resources department by my guarantor or myself.

Name

Signature

Date

American Urological Association Symptom Score Index

Patient Name: _____

Date: _____

	Never	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
<p>Incomplete Emptying</p> <p>Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?</p>	0	1	2	3	4	5	
<p>Frequency</p> <p>Over the past month, how often have you had to urinate again less than two hours after you finished urinating?</p>	0	1	2	3	4	5	
<p>Intermittency</p> <p>Over the past month, how often have you found you stopped and started again several times when you urinated?</p>	0	1	2	3	4	5	
<p>Urgency</p> <p>Over the past month, how often have you found it difficult to postpone urination?</p>	0	1	2	3	4	5	
<p>Weak Stream</p> <p>Over the past month, how often have you had a weak urinary stream?</p>	0	1	2	3	4	5	
<p>Straining</p> <p>Over the past month, how often have you had to push or strain to begin urination?</p>	0	1	2	3	4	5	
<p>Nocturia</p> <p>Over the past month, how many times did you typically get up to urinate from the time you went to bed at night until the time you got up in the morning?</p>	Never 0	1 time 1	2 times 2	3 times 3	4 times 4	5 times or more 5	

Total Score: 0

<p>Quality of Life Due to Urinary Symptoms</p> <p>If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible

HIPAA OMNIBUS RULE

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this health care facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/ FACILITIES IN THE FUTURE.

Please print name of Patient

Patient Signature / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

Cell Phone Confirmation Home Phone Confirmation
 Work Phone Confirmation **Any of the Above**

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

Cell Phone Confirmation Home Phone Confirmation
 Email Confirmation Work Phone Confirmation
 Any of the Above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Health care Facility via:

Phone Message **Any of the Above**
 Email **Opt Out**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

- It was emergency treatment _____
- I could not communicate with the patient _____
- The patient refused to sign _____
- The patient was unable to sign because _____
- Other (please describe) _____

Signature of Privacy Officer

Possible or Probable Denial of Coverage of Treatment of Diagnostic Test

Some insurance carriers or providers will only pay for tests and services that are covered under the terms of your contract. Each contract is different. Many insurance companies will not pay for certain tests that are excluded by your contract. **Insurance companies may deny payment for the following tests:**

- Urine Culture and Sensitivity
- Urine Analysis Complete
- Free and Total Testosterone
- Semen Analysis
- PSA
- PCA3
- Urine Cytology
- Prostate Biopsy
- Stone Analysis
- STD Tests/Culture
- Penile Doppler

Patient Agreement:

My physician has notified me that my insurance carrier may deny payment for the tests and services identified above. **If my insurance carrier denies payment, I agree to be personally and fully responsible for the payment of these services.**

Patient Signature: _____ Date: _____

Printed Name: _____