Roseville Urology
David Couillard, MD, FACS

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I: _____

DOB: _____ /_____ /_____ Gender: _____ Marital Status: _____

Cell Phone: _____-_____-_____ Home Phone: _____-_____-_____

Mailing Address:_____
Street City State Zip

Emergency Contact: _____

Phone: _____-_____-_____ Relationship to patient: _____

Preferred Pharmacy: _____
Name City State Zip

Email Address: _____

LEGAL GUARDIAN/GUARANTOR INFORMATION

(If different than self)

Last Name:_____ First Name:_____ M.I: ____

DOB: _____ /_____ /_____ Gender: _____Relationship to Patient: _____

Cell Phone: _____-_____-_____ Home Phone: _____-_____-_____

Mailing Address: _____
Street City State Zip

MESSAGES

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call

Signed: _____ Date:_____ /_____ /_____

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Patient Name: _____ Date of Birth: _____ /_____ /_____

Medical Information Release Authorization

As required by thee Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

○ I hereby authorize this medical practice to use and disclose health information to:
(***any family member/friends that may call on your behalf, include first and last name***)

_____ _____
_____ _____
_____ _____

Please mark the type of records that may be disclosed:

_____ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

_____ All psychotherapy notes may be released, except as specifically provided below:
_____ Claims/Billing Records
_____ Other: _____

○ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

I understand that I have a right to receive a copy of this authorization upon request.

Signature: _____ Date: _____ /_____ /_____

Legal Guardian/Guarantor
If not signed by the patient, please indicate the relationship: _____

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Consent Financial and Office Policy

I understand my insurance policy is a contract between my insurance company and myself, and that I am ultimately responsible for the entire bill. I understand that the fees are based on treatment received and have no bearing on outcome. I understand that I may be asked for a deductible deposit every visit for any unmet deductible plans. I understand that Roseville Urology may, at its discretion, change the terms and conditions of this policy, and that I may request a copy of this policy at any time.

I hereby acknowledge I may receive a copy of the Office Policy and Financial Agreement upon request.

Signature: _____ Date: _____ / _____ / _____

Authorization to Pay for Professional Services Rendered

I hereby authorize payment directly to Roseville Urology of the benefits for professional services rendered, otherwise payable to me as determined by my insurance company, but not to exceed the fee as finally determined by my provider. I understand that I am financially responsible for any professional charges not paid by my insurance company to Roseville Urology.

I understand Roseville Urology's Professional Services Rendered Policy.

Signature: _____ Date: _____ / _____ / _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge I may receive a copy of the Notice of Privacy Practices for Roseville Urology. I understand that Roseville Urology may, at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request.

Signature: _____ Date: _____ / _____ / _____

Consent to Treatment

I consent to general treatment, medical procedures, and medications prescribed by Roseville Urology. I understand that all procedures will be explained to me, and any questions I may have will be addressed prior to treatment.

Signature: _____ Date: _____ / _____ / _____