Chart Number

Thomas X. Minor, M.D. / Nadeem Rahman, M.D.
782 Medical Center Dr. E. #311
Clovis CA 93611
Ph: (559) 472-4600 Fax: (559) 472-4601

Patient Information

Last Name		First Name		Middle Name
Street Address		City	State	Zip Code
Home Telephone Number	Cell phone Number	Work Telephone		Patient's Age
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow		Social Security Number		Date of Birth / /
Occupation		Employer		
Emergency Contact Name		Relationship to Emergency Contact	Emergency Contact Telephone	
Email Address		Patient's Pharmacy		

Insurance / Insured Information

Name of Insured / Responsible Party/Guarantor		Telephone Number		Work Phone / Cell Phone	
Street Address		City & State		Zip Code	
Marital Status of Insured ☐ Single ☐ Married ☐ Divorced ☐ Widow	Social Security Number		Sex M F	Age	Date of Birth / /
Patient's Relationship to the Insured ☐ Insured ☐ Spouse ☐ Child ☐ Other	Occupation				
Employer	Employer's Address				

Name of Insurance	ID Number	Group Number	Plan Number

Referring Physician	Primary Care Physician
Name:	Name:
Address:	Address:
Phone Number:	Phone Number:

Assignment of Benefits - I hereby assign all medical and surgical benefits to which I am entitled, including government programs, private insurance, major medical benefits and any other health plan, to California Urology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature of Patient	Date

INSURANCE

California Urology is contracted with most insurance plans. Our staff will make a good faith attempt to determine benefit levels and estimate any charges you may incur. However it is ultimately your responsibility to understand your level of coverage from your insurance company. It is your responsibility to supply us with appropriate billing information, which includes current insurance identification as well as the billing address and anything else required by your insurance carrier for payment of claims. It is your responsibility to be sure that your referral and authorization arrive prior to your visit. If you consent to receive medical services that are considered a "non-covered benefit", you will be held financially responsible for these charges.

PAYMENT

Unless prior arrangements are made all copayments, deductibles and share of costs are due at the time of service. For your convenience our office accepts cash, checks, Visa and MasterCard.

RETURNED CHECKS

If your check is returned for non sufficient funds, you could be liable for three (3) times the amount of the check or $100.00 whichever is greater, plus the face value of the check and any court costs. Our normal charges for a returned check are the check amount plus $25.00 to cover the bank return fees and administrative processing. Depending on the circumstance you may be required to pay cash for all future services if you have returned checks.

FORMS

We will gladly complete your disability forms, however please allow 72 hours for completion. A fee of $ 25.00 will be collected prior to completion for each form.

AFTER HOURS CARE

If you have a medical emergency, please call 911. If you have a non-emergent question or need, you may call our office and the phone service will contact the physician on call.

CANCELLATIONS

We realize that unforeseen circumstances might make it impossible for you to keep your appointment. If this should occur, we ask that you kindly call our office 24 hours prior to your appointment and reschedule for a more convenient time.

MISSED APPOINTMENTS

If you fail to show up for a scheduled appointment you will be charged $25.00.

I understand the above

Patient Name: ______________________________ Patient Signature: ______________________ Date: ________________

NOTICE OF PRIVACY PRACTICES
CONSENT FORM

By my signature below, I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for California Urology, Inc.

____
Name of Patient or Personal Representative

____
Signature of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

Thomas X. Minor, M.D. & Nadeem Rahman, M.D.

Financial Liability

Patient Name: ______________________________

ACCT # ______________________________________

DOB: ____

INSURANCE / BENEFITS / CONSENT

I hereby give consent to release or obtain information to/from physicians and other medical personnel, as may be required in the rendering of treatment. I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action, I shall be responsible for any legal fees incurred. This authorization expires one (1) year from the date of signature.

California Urology makes a good faith attempt to determine benefit levels & estimate any charges you may incur. It is ultimately your responsibility to understand your level of coverage from your insurance company and whatever financial responsibility you will ultimately have. It is your responsibility to supply us with appropriate billing information. This includes current insurance identification as well as the billing address and anything else required by your insurance carrier for payment of claims. It is your responsibility to be sure that your referral and authorization arrive prior to your visit. If you consent to receive medical services that are considered a "non-covered benefit" by your insurance, you will be held financially responsible for these charges.

Patient Signature: ____

Parent or guardian (if patient is under 18 years old) ______________________________________

For office use only, collected by: ____

Note: California Urology is a part of
Community Foundation Medical Group (CFMG).
All billing statements regarding charges incurred by any services
provided by our physicians will come from and be processed by CFMG.

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Patient History Form

NAME: ______________________________________

DATE: ______________________________________

CHIEF COMPLAINT: In your own words, why are you seeing the doctor today?

____

____

How long has this problem been present? Have recent tests been performed for this problem?

____

What facility were these tests performed at? ____

PAST MEDICAL AND SOCIAL HISTORY:

Do you currently smoke? ______Yes ______No How many packs? ____________ How many years? ____________

Have you ever smoked? ______Yes ______No How many packs? ____________ How many years? ______________

Have you ever quit smoking? ______Yes ______No For how long? ______________

Marital Status: ______Single ______Married ______Widowed ______Divorced

Children? ______Yes ______No How many? ________

Do you drink alcohol? _______Never ________Rarely _______ Moderately _______Heavily

Occupation? ____

ALLERGIES TO MEDICATIONS AND REACTIONS:

____

____

____

CURRENT PRESCRIPTIONS MEDICINES YOU TAKE ON A REGULAR BASIS:

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

LIST AND DATE ANY PREVIOUS SURGERIES YOU HAVE HAD:

____

____

____

DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE?

______ Diabetes ______ Bladder Cancer _______ Tuberculosis

______ High Blood Pressure _______ Prostate Cancer _______ Heart Disease

______ Kidney Stones_______ Colon/Rectal Cancer _____ Other: ________________________

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