



*Larry L. Bans, M.D.*  
*Prostate Solutions of Arizona*  
2525 E. Arizona Biltmore Circle  
Suite C-236  
Phoenix, AZ 85016  
(602) 426-9772  
Fax (602) 426-9775

Dear Patient:

I am pleased you have chosen to be a patient of Prostate Solutions of Arizona.

In order for the office to be prepared for your initial visit, the enclosed documents should be reviewed by you and completed, where necessary.

1. General Practice Information.
2. Registration sheet: please fill out entirely and bring a copy of your insurance card, if we participate with your plan.
3. Medical history – questionnaire.
4. Record release: please complete this form if there are other urologic records pertinent to your visit as soon as possible. It is imperative that PSA has all records that are necessary for the initial evaluation.
5. HIPAA policy.
6. Notice of Privacy Practice Acknowledgement.
7. Financial policy.
8. Map of office location, for your convenience.

If you require further clarification, please feel free to contact our staff at (602) 426-9772.

Your anticipated cooperation and courtesy is appreciated in this matter.

Very truly yours,

Larry L. Bans, M.D.



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## General Practice Information

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Thank you for being a patient at Prostate Solutions of Arizona.

Our office hours are 8:00 a.m. to 4:30 p.m. Monday through Friday, and we are closed for lunch from noon to 1:30 p.m.

Our general phone line is (602) 426-9772 and has an auto-attendant for your convenience. When the office is closed, the physician on call can be reached by pressing #6 on the auto attendant. Please reserve this option for important patient issues, and select other options, or call during normal business hours for medication refills, directions to the office, etc. If there is a true life threatening emergency, we advise you call "911" and proceed as directed.

While Prostate Solutions of Arizona participates with some health insurance plans, we are not providers for all available plans. Please inquire as to whether or not we are contracted with your insurance plan in advance. We are happy to see patients who are "out-of-network" or who have insurance that we are not contracted with. In that event, we will advise on general charges, but please understand that exact amounts may be difficult to estimate until the physician can assess what treatment, testing, etc., may be necessary. We will assist, when possible, in securing authorizations, etc., but it is the patient's ultimate responsibility to investigate and understand what his responsibility may be if we are not contracted with your insurance plan. This includes authorizations for hospitalization or surgery if we are not contracted providers, or if Banner Good Samaritan Hospital is not contracted with your insurance.

Dr. Bans utilizes Banner Good Samaritan Regional Medical Center exclusively for all surgery and inpatient procedures. If you have an emergency or hospital admission at another facility, Dr. Bans will be unable to attend your care.

Test results will usually be available on our automated "phone tree" system within two weeks. If you have not heard from us with the test results, or if there is difficulty in obtaining them on this system, please call us and we will inform you of the test results. Dr. Bans personally reviews all test results and makes all recommendations as it pertains to future care.

We at Prostate Solutions of Arizona strive to provide the highest quality of care possible for our patients. We acknowledge that numerous complexities exist in medicine today, and we welcome any comments, suggestions or criticism if you encounter problems with our staff, office, phone system, office policy, etc.



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## PATIENT REGISTRATION

Date: \_\_\_\_\_ Physician: \_\_\_\_\_  New  Update

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ PID#: \_\_\_\_\_  
Last First MI (Office Use Only)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  Single  Married  Other

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**RESPONSIBLE PARTY:**

\_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_  Male  Female  Single  Married Age: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**REFERRAL INFORMATION:**

Physician (or other): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:**

Physician: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PRIMARY INSURANCE:**

Address: \_\_\_\_\_

ID#: \_\_\_\_\_ Group: \_\_\_\_\_ Designated Care Physician: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

**SECONDARY INSURANCE:**

Address: \_\_\_\_\_

ID#: \_\_\_\_\_ Group: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

I accept responsibility; recognizing the need for care, consent, to any and all services as ordered by my physician and agreed to by me. These services include, but are not limited to, laboratory tests, medical or surgical treatment, examination, and other services rendered under specific instructions of my physician.

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## PATIENT MEDICAL HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Today's Date: \_\_\_\_\_

1) What are you being seen for today? \_\_\_\_\_

2) When did the problem begin? \_\_\_\_\_

3) List ANY related diagnoses: \_\_\_\_\_

4) Have you had ANY previous surgery at any time in your life? Yes:  No:

If yes, list here: \_\_\_\_\_

5) Have you seen a physician for any reason in the past year? Yes:  No:

If yes, for what?: \_\_\_\_\_

6) List doctors you have seen within the last 2 years? \_\_\_\_\_

7) List your primary care physician's name and address: \_\_\_\_\_

8) Are you taking any prescribed or over the counter medication? Yes:  No:

If yes, list drug & dosage here (use reverse side if necessary): \_\_\_\_\_

9) ARE YOU ALLERGIC TO ANY MEDICATION? Yes:  No:

If yes, what was the drug and your reaction: \_\_\_\_\_

10) Is there any history of diseases in your family? Yes:  No:  If yes, please circle the appropriate disease and describe.

Diabetes                      Hypertension                      Heart                      Kidney                      Cancer

11) Have you had any problems in any way related to the following? If yes, please circle and GIVE DETAILS ON THE BACK OF THIS FORM.

- |                 |                         |                            |
|-----------------|-------------------------|----------------------------|
| Sinus Infection | Chest Pain              | Hepatitis                  |
| Eye Problems    | Shortness of Breath     | Liver Disease              |
| Nose Bleeds     | Ankle Swelling          | Kidney or Bladder Problems |
| Headache        | Blood Clots / Phlebitis | Seizures                   |
| T.B.            | High Blood Pressure     | Paralysis                  |
| Valley Fever    | Ulcers                  | Diabetes                   |
| Asthma          | Indigestion             | Thyroid                    |
| Emphysema       | Changes in Bowl Habits  | Cancer                     |
| Heart Disease   | Bloody or Tarry Stools  |                            |

12) Do you smoke? Yes  No  How Much? \_\_\_\_\_

Do you drink alcohol? Yes  No  How Much? \_\_\_\_\_

13) CURRENT HEIGHT: \_\_\_\_\_ CURRENT WEIGHT: \_\_\_\_\_

\_\_\_\_\_  
Signature (Patient or Responsible Party)



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## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name: 

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 PID#: \_\_\_\_\_  
Last First MI

Patient's Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PLEASE CHECK THE APPROPRIATE BOX	<input type="checkbox"/> I hereby authorize Prostate Solutions of Arizona, P.C. to send / release photocopies of medical records concerning the above named patient to NAMED RECEIVER LISTED BELOW.
	<input type="checkbox"/> I hereby authorize THE PROVIDER LISTED BELOW to send / release photocopies of medical records concerning the above named patient to Prostate Solutions of Arizona, P.C.

(NAME OF COMPANY / PHYSICIAN / AUTHORIZED PERSON TO RECEIVE / RELEASE RECORDS)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

FOR THE PURPOSES OF: \_\_\_\_\_

FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL:

1. CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-66')
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.)
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION
5. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-1801)

\_\_\_\_\_ MEDICAL RECORDS OF THE LAST TWO YEARS (and / or)

\_\_\_\_\_ THE FOLLOWING DESCRIBED RECORDS (specific types and dates) \_\_\_\_\_

This consent will expire (90) days after the signed date below. I may revoke this authorization at any time providing I notify the above listed doctor(s) in writing to that effect. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentiality. I HEREBY RELEASE PROSTATE SOLUTIONS OF ARIZONA, P.C. FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Parent / Legally Authorized Representative

\_\_\_\_\_  
Relationship to Patient

Reason patient was unable to sign release: \_\_\_\_\_

**PATIENTS 18 YEARS AND OLDER MUST SIGN THEIR OWN RELEASE**



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## Notice of Privacy Practices for Protected Health Information (HIPAA Policy)

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

The Health Information Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

We have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

### **We may use and disclose your medical records only for the following purposes:**

**FOR TREATMENT:** We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, therapists, technicians, or other personnel who are involved in taking care of you. They may work at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, rehabilitation facility, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, physical therapy, prescription refills, or for other treatment purposes.

**FOR PAYMENT:** We may use and disclose health information about you so that the treatment and services you receive from us may be billed and payment collected from you, or an insurance company. Your health carrier may require access to your medical information as a condition to providing your benefits. We may also use health information to determine insurance benefits and eligibility or for utilization review.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose health information about you for operations of our health care practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. We obtain services from business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) for credentialing, medical transcription, and medical review. We will share health information about you with our business associates as necessary to obtain these services. We require our business associates to protect confidentiality of your health information.



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## Notice of Privacy Practices for Protected Health Information (HIPAA Policy)

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**APPOINTMENT REMINDERS:** We may contact you to provide appointment reminders. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

**RESEARCH:** We may collect and review information related to your prostate problem in order to measure the outcomes of treatment. An ongoing critical review of treatment results is an important part of providing excellent medical care. Dr. Bans may wish to describe your case at medical meetings or in medical literature. Your identity will never be disclosed and all identifying information is removed from any description of your case.

**AS REQUIRED BY LAW:** We will disclose health information about you when required to do so by federal, state, or local law.

**SIGN IN SIGHT:** We may use or disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

### **YOUR HEALTH INFORMATION RIGHTS**

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have the right to:

- Request restrictions on certain uses and disclosures of protected health information, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- Request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.



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## Notice of Privacy Practices for Protected Health Information (HIPAA Policy)

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- Inspect and obtain a copy of your protected health information. A request must be submitted in writing to Prostate Solutions of Arizona, 2525 E. Arizona Biltmore Circle, Suite C-236, Phoenix, AZ 85016.
- The right to receive an accounting of disclosures of protected health information.
- Obtain notice. We have the obligation to provide to you a paper copy of the Notice of Privacy Practices for Protected Health Information.
- Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support it to our office using the form we provide to you upon request.

### OUR RESPONSIBILITIES

The office is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with Notice as to our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable requests regarding methods to communicate health information with you.

This notice is effective as of 2/1/04. We reserve the right to amend, change, or eliminate provisions in our privacy and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice upon request.

### TO REQUEST INFORMATION OR FILE A COMPLAINT



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## Notice of Privacy Practices for Protected Health Information (HIPAA Policy)

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If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Frances Rangel, HIPAA Compliance Officer. All complaints must be submitted in writing. We cannot and will not retaliate against you for filing a complaint.



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## Notice of Privacy Practices Acknowledgement

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I hereby acknowledge that I have received and reviewed a copy of Prostate Solutions of Arizona, P.C.'s Notice of Privacy Practices.

Name of Patient: \_\_\_\_\_

Signature (patient): \_\_\_\_\_

Today's Date: \_\_\_\_\_

Please list family members or others with whom you authorize Prostate Solutions of Arizona to discuss your care. Without your authorization, these requests will be denied.

Name of Patient: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



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## FINANCIAL POLICY

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Payment for services provided is due at the time of service. If you are eligible under a medical insurance policy that we participate with, we will bill your medical insurance company for services provided. If we do not participate with your medical insurance company, you will be given appropriate information in order for you to submit your own claim.

We understand most medical insurance companies have a "co-pay"/deductible portion, which is the responsibility of the patient. Payment for the portion due by you, the patient, or responsible party, must be paid at the time of service. This office accepts payments in the form of: Cash, Check, Debit, or Visa/Master Card.

Effective January 1, 2006, we will be a "Non-Participating" Medicare provider and beginning July 1, 2006, we will "opt-out" of Medicare completely. Please inquire as to the details of these changes, and refer to the enclosed letter if it applies to you.

If your medical insurance policy contains a high deductible responsibility, or if you have no medical insurance coverage, amounts due by you, the patient or responsible party, must be paid at the time of service.

As your healthcare provider, we respect your privacy and will limit all disclosures to the minimum necessary to provide for care, treatment and payment of services. The practice of Prostate Solutions of Arizona, P.C., adheres to a policy and procedure protocol to protect the confidentiality of our patient's medical information.

I have read and understand the financial policy of Prostate Solutions of Arizona, P.C.

\_\_\_\_\_ and/or  
Patient Signature

\_\_\_\_\_  
Responsible Party

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Print Responsible Party Name

Date: \_\_\_\_\_



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## DIRECTIONS TO PROSTATE SOLUTIONS OF ARIZONA

### From Camelback Rd. and 24<sup>th</sup> St.

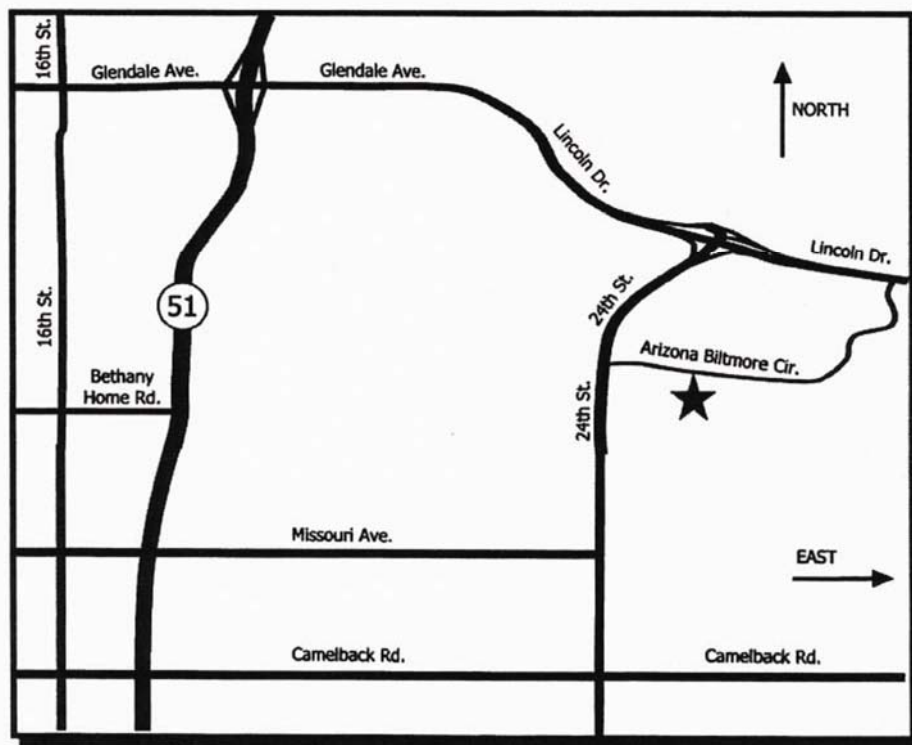
Drive North on 24<sup>th</sup> St. to E. Arizona Biltmore Cir.  
Drive East on E. Arizona Biltmore Cir.  
Office will be on South side of the road  
Park on the EAST side of the building (2<sup>nd</sup> Entrance)

### From Scottsdale Rd. and Lincoln Dr.

Drive West on Lincoln Dr. to 24<sup>th</sup> St.  
Drive South on 24<sup>th</sup> St. to E. Arizona Biltmore Cir. (1<sup>st</sup> Stoplight)  
Drive East on E. Arizona Biltmore Cir.  
Office will be on South side of the road  
Park on the EAST side of the building (2<sup>nd</sup> Entrance)

### From Arizona 51

Exit at Glendale Ave. / Lincoln Dr.  
Drive East on Glendale / Lincoln Dr.  
Glendale Ave. becomes Lincoln Dr.  
Drive East on Lincoln Dr. to 24<sup>th</sup> St.  
Drive South on 24<sup>th</sup> St. to E. Arizona Biltmore Cir. (1<sup>st</sup> Stoplight)  
Drive East on E. Arizona Biltmore Cir.  
Office will be on South side of the road  
Park on the EAST side of the building (2<sup>nd</sup> Entrance)



### Important Notes:

*Suite C-236 is on the EAST side of the building.  
Please park and enter from the EAST parking lot.  
Take the elevator just off the East parking lot to level 2.  
The office is the first suite off the elevator.  
You may park in any "1 Hour" parking space.*

**PLEASE NOTE** – The building will not tow or tag any patient vehicles, regardless of length of stay.