LOURDES HEALTH

Office Policy for New Patients

Thank you for contacting us for your medical needs. We are glad you have entrusted us to be your medical provider. We are enclosing a few guidelines to help you transition your care to us because we have a very high demand for patients to get into our system, and this helps us to be considerate of everyone's time.

1. It is essential that you return the enclosed new patient information sheet **COMPLETED AND SIGNED** to the office prior to your appointment. Without this information we cannot properly register you or set up your chart.
2. We require your insurance cards along with a photo ID to protect your medical Identity.
3. The Health Questionnaire is an essential part of your medical record with us and a requirement for the provider to have prior to beginning any treatment for you. Therefore, it is essential that you bring this **COMPLETED AND SIGNED. Please do not plan to complete this paperwork in the lobby prior to your visit, as there is not enough time.**

Even when you have completed this essential information, it will be necessary for you to show up **30 minutes early** for this visit so that we will have time to get your information into our computer system, establishing a complete chart.

We also pay close attention to our No Show policies, and would like you to know that in consideration for the time we have blocked on the provider's schedule for you; our expectation is that you will show up early.

1. If you do not show up early, we will reschedule your appointment only one more time, once again blocking 60 minutes for you to see one of our providers. If you do not show up early again, you will not be eligible for any further appointments with our provider group.
2. If you no-show your first appointment, we will schedule one more visit for you. However, if you no-show a second time, you will not be eligible for any further appointments with our providers.

Lourdes Urology
1200 N. 14th Avenue Suite 240
Pasco WA 99301
(509)545-1897

LOURDES HEALTH

To Our Valued Patients:

As most of you know, there is a shortage of urologists in the Tri-Cities. That makes our office very busy, often with long waits to obtain a routine appointment. We want to be as efficient as possible to help you, our valued patient, get into the clinic as timely as possible.

Understandably, it can be frustrating when a person doesn't show up for an appointment. This "no-show" problem should be frustrating to you, too, because those are un-used appointments that you or your loved ones could use for important medical help. People who make appointments and don't keep them cause everyone else's appointment to be delayed further In the future.

For this reason, our "no-show" policy is as follows:

1. For the first "no-show" within 12 months, a letter will be sent to the person explaining this policy.

2. For the second "no-show," a warning letter will be sent, Informing of a potential dismissal from our practice.

3. For the third "no-show," a certified letter will be sent, dismissing that person from our practice.

We want to work with you to provide the best, most efficient service possible. If for some reason you are unable to keep an appointment, please provide us 24 hour notice so that we can help you to reschedule. Except in the case of emergencies, giving less than 24 hours' notice is considered a "no-show." Tardiness is also an issue that we have to deal with; therefore our policy is if you are more than 10 minutes late for your appointment you will be considered a "no-show" and the same policies apply.

Respectfully,

The Providers and Staff at
Lourdes Urology
1200 N. 14TH Avenue Suite 240
Pasco WA 99301
(509)545-1897

LOURDES HEALTH

PATIENT INFORMATION SHEET (complete all sections that apply)

Name:_____ AKA(Maiden or Other Name)_____
(Last) (First) (Middle)

Mailing Address:_____ City:_____ State:_____ Zip:_____

Preferred contact number:_____ □ Home □ Work □ Cell DOB: _____ /_____/ _____
(Month) (Day) (Year)

SSN_____ Email_____

☐ Male ☐ Female Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer:_____ **Is this a work related injury? ☐ Yes ☐ No**

Primary Care Physician:_____

Employment status: ☐ Employed ☐ Unemployed ☐ Retired Retirement date_____

Spouse Employment status: ☐ Employed ☐ Unemployed ☐ Retired Retirement date_____

Student Status: ☐ Full time ☐ Part time ☐ N/A Ethnicity:_____

Primary language:_____ **Interpreter needed? ☐ Yes ☐ No** Provided by_____

Have you traveled (outside of the USA) recently? ☐ Yes ☐ No If so, where?_____

If a child with whom does the patient reside? ☐ Mother ☐ Father ☐ Both Parents ☐ Guardian*

***(Guardianship Papers or verbal Parental Permission required prior to examination if parent not present)**

GUARANTOR INFORMATION			
Guarantor name:	DOB:	☐ Male	☐ Female
Guarantor address:			
Telephone:	Employer:	Work telephone:	
INSURANCE INFORMATION			
PRIMARY			
Subscriber name:	**DOB**:	☐ Male	☐ Female
Subscriber address:			
Telephone number:			
Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other Explain other:			
Policy number:			
Group/member number:			
SECONDARY			
Subscriber name:	**DOB:**	☐ Male	☐ Female
Subscriber address:			
Telephone number:			
Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other Explain other:			
Policy number:			
Group/member number:			

EMERGENCY CONTACT INFORMATION		
Name:	Telephone:	Relationship:

Signature:_____ Date:_____

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LOURDES HEALTH

Past Medical History

Condition		Condition	
AIDS/HIV	☐Yes ☐No	Asthma	☐Yes ☐No
Atrial Fibrillation	☐Yes ☐No	Blood Clots	☐Yes ☐No
Cataracts	☐Yes ☐No	Chronic Bronchitis	☐Yes ☐No
Congestive Heart Failure	☐Yes ☐No	COPD Emphysema	☐Yes ☐No
Depression	☐Yes ☐No	Diabetes	☐Yes ☐No
Enlarged Prostate	☐Yes ☐No	Epilepsy	☐Yes ☐No
Fibromyalgia	☐Yes ☐No	Gastritis / Ulcers	☐Yes ☐No
Glaucoma	☐Yes ☐No	Gout	☐Yes ☐No
Heart Attack	☐Yes ☐No	Hepatitis (Type___)	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	High Cholesterol	☐Yes ☐No
Hyperthyroidism	☐Yes ☐No	Hypothyroidism	☐Yes ☐No
Kidney Failure Dialysis	☐Yes ☐No	Kidney Stones	☐Yes ☐No
Liver Disorder	☐Yes ☐No	Lyme Disease	☐Yes ☐No
Lupus	☐Yes ☐No	Neuropathy	☐Yes ☐No
Osteoarthritis	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Pneumonia	☐Yes ☐No	Polio	☐Yes ☐No
Psoriasis	☐Yes ☐No	Pulmonary Embolism	☐Yes ☐No
Recurrent Urinary Infections	☐Yes ☐No	Reflux Disease	☐Yes ☐No
Rheumatoid Arthritis	☐Yes ☐No	Sleep Apnea	☐Yes ☐No
Stroke	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Ulcerative Colitis Crohns	☐Yes ☐No		
Cancer (Specify)			
Other Not Listed Above			

Family History

Condition	Father	Mother	Siblings	Children
Asthma				
Bladder Cancer				
Blood Clots/Pulmonary Embolism				
Diabetes				
Heart Attack/MI				
Heart Failure				
High Blood Pressure				
High Cholesterol				
Kidney Cancer				
Kidney Failure				
Kidney Stones				
Major Anesthesia Problems				
Prostate Cancer				
Stroke				
Other (specify)				

Pharmacy: 1._____ 2. _____
Mail Order Pharmacy:
_____

Tobacco Use: Smoke ☐ Yes ☐ No ☐ Former (quit when?):_____
Chew ☐ Yes ☐ No ☐ Former (quit when):_____
Alcohol: ☐ Yes ☐ Occasional ☐ No ☐ Former (quit when?):_____
Recreational Drug use (Marijuana, Meth, Coke, Heroin, etc.)
Current Use: ☐ Yes ☐ No (If yes what type):_____
Former Use: ☐ Yes ☐ No (If yes what type):_____

List Allergies to Medication(s):_____
_____
_____

MEDICATIONS (If not enough space you can use the back of this page.)

Medication	Dose	Times/day	Reason
Example: Tylenol	*500mg*	*3 times per day*	*Headaches*

Past Surgical History: Please List All Surgeries (Appendix, Tonsils, TURP, Knee, etc.)
_____
_____
_____
_____

Patient Signature:_____ **Date:**_____

Patient Portal Consent and User Agreement

ACCESS, USE OF ONLINE COMMUNICATIONS AND PARTICIPATION CONDITIONS

- *The Patient Portal is an optional service offered as a courtesy to our patients. Use is restricted to current patients and is subject to all terms and conditions of the Patient Portal Consent and User Agreement. Any inappropriate use by the patient or their representative may result in termination.*

- *In addition to Patient Portal communication, you may also be asked to contact us by telephone or in person at any time.*

- *LHN does not guarantee that the Patient Portal will be accessible 24 hours a day, 7 days a week. The Patient Portal may be unavailable, without prior notice, due to routine maintenance or circumstances beyond our control. The Patient Portal may be suspended or terminated without advance notice at any time.*

- *LHN and staff do not have liability or responsibility to any patient or user for their inability to access the Patient Portal. Users will be notified if suspension or termination occurs.*

- *Based on state regulations and LHN policy, LHN does not permit minors to use the Patient Portal.*

- *By logging onto the Patient Portal, you agree to all terms and conditions of the Patient Portal Consent and User Agreement. LHN may amend or rescind its Patient Portal Consent and User Agreement at any time without prior notice. LHN has the right to determine how its Patient Portal Consent and User Agreement apply in a given situation, and its determination will be final and non-reviewable.*

- *LHN is to define the owner of the Patient Portal records, whether in electronic, paper or other form, subject to such access, copying and other rights as may be provided to the patient by federal and state law.*

- *If you receive access to health care information which is not yours, you must immediately stop viewing such information and notify the LHN via a secure message on the Patient Portal or by calling LHN at 509-546-2205.*

By signing below, you acknowledge that you have read and agree to comply with the Patient Portal Consent and User Agreement, which has been provided to you. If you have any questions or need further information, please contact Health Information Management at 509-546-2205.

Email _____

Print Full Name (First, Middle, Last) _____ D.O.B. _____

Patient Signature _____ Date _____

Legal Representative *(if not signed by the Patient)*_____ Relationship _____ Date _____