ORANGE COUNTY UROLOGY ASSOCIATES, INC.

A Medical Group

Paul A. Brower, M.D. • Don Bui, M.D. • Jennifer Gruenenfelder, M.D. • Moses M. Kim, M.D. Ph.D. • James P. Meaglia, M.D. • Josh M. Randall, M.D.
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Patient Name: _____ Birth Date: _____
Last First MI

Sex: *(circle one)* M F Social Security #_____ Drivers License#_____

Address_____ City_____ State_____ Zip_____

Home # _____ Cell # _____ Work # _____

E-mail Address _____

Preferred means of communication (circle one) Cell Phone Home Phone Email USPS Mail Any None

Primary Physician_____ | Employer _____
Referring Physician_____ | Occupation _____

Marital Status *(Circle one)* **S M D W** | Pharmacy Name_____
Spouse's Name_____ | Phone # _____
Spouse Phone#_____ | Pharmacy *(Street, City)*_____

Emergency Contact (***other than spouse***) _____
Relationship to you_____ Phone # _____

Race *(circle one)* • African-American/Black • Asian • Asian/Pacific Islander • Chinese
• Korean • Native Hawaiian • Native American/Alaskan Native • Vietnamese
• White • Other_____ • Decline to State

Ethnicity *(circle one)* • Hispanic/Latino • Non-Hispanic/Non-Latino

Language Choice *(circle one)* • English • Spanish • Chinese • Tagalog •Vietnamese • Korean • Farsi Other_____

RESPONSIBLE PARTY –If other than self or you are a minor.

Name: _____ Relationship:_____

Address_____ City_____ State_____ Zip_____

Home #_____ Work #_____ S.S. #_____

MEDICAL INSURANCE (please present insurance cards for us to photocopy)

Primary Insurance Company: _____ Subscriber's Name_____

Subscriber's Relationship to Patient _____

Insured's ID#_____ Group #_____ Medicare #_____

Secondary Insurance Company: _____ Subscriber's Name_____

Subscriber's Relationship to Patient_____

Insured's ID#_____ Group #_____ Medicare #_____

PLEASE BE ADVISED THAT YOU WILL RECEIVE SEPARATE BILLS FOR ANY LAB TESTS, X-RAYS, ETC. THAT MAY BE ORDERED FOR YOU, AS THEY ARE DONE BY AN OUTSIDE SOURCE.

Assignment of Benefit-Financial Agreement

Assignment and Release. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I hereby assign my benefits to be paid directly to my physician and any assisting physicians. I understand a monthly service fee will be charged on all balance 61 days and older. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I authorize this provider to release any information required to process this claim to my insurance company.

Date:_____ Your Signature X_____

THANK YOU FOR YOUR CAREFUL COMPLETION OF THIS IMPORTANT FORM

Rev. 08/13

Orange County Urology Associates – New Patient Information Form (Male)

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Who referred you? _____

Office Use Only

Date	ROS by

Present Illness

In your own words, what medical problem or concern brings you to our office today?

_____

_____

_____

For how long? _____ Degree of Severity 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Current Urinary Symptoms

- ☐ Incontinence (Involuntary Loss of Urine)
  - ☐ with urgency
  - ☐ with cough or sneeze
  - ☐ Number of pads used per day? _____
- ☐ Blood in urine
- ☐ Pain in testicles
- ☐ Flank Pain
- ☐ Fevers/Chills
- ☐ Frequency of urination
  - Number of voids during the day? _____
  - Number of voids during the night? _____
- ☐ Urgency
  - Number of voids during the day? _____
  - Number of voids during the night? _____
- ☐ Burning/ Painful urination
- ☐ Urethral discharge

Prior Urological History

- ☐ Previous prostate surgery: _____
- ☐ Medication to urinate better
  name of drug: _____
- ☐ Elevated PSA
- ☐ Prostate Inflammation/Prostatitis
- ☐ Prostate Cancer
- ☐ Family history of prostate cancer
  Whom? _____
- ☐ Enlarged Prostate
- ☐ Bladder infections
- ☐ Urethral Stricture
- ☐ Kidney infections/pyelonephritis
- ☐ Kidney stones
- ☐ Family history of kidney stones: *Whom?* _____
- ☐ Hydrocele
- ☐ Other urinary tract disorder: _____
- ☐ Sexual Dysfunction (impotence or ED)
- ☐ Infertility
- ☐ Premature Ejaculation
- ☐ Previous Sexually Transmitted Disease's

Please answer the following questions:	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
1. How often do you urinate again less than 2 hours after a prior urination?	0	1	2	3	4	5	F Freq
2. How often do you find it difficult to postpone urination?	0	1	2	3	4	5	U Urge
3. How often do you have a weak urination stream?	0	1	2	3	4	5	↓ Stream
4. How often do you push or strain to begin urination?	0	1	2	3	4	5	S Strain
5. How often do you find that you stop and start again when you urinate?	0	1	2	3	4	5	I Interm
6. How often do you have a sensation of not emptying your bladder after urination?	0	1	2	3	4	5	PVR
7. How many times do you typically get up to urinate when you go to bed at night?	None	1 time	2 times	3 times	4 times	5 or more	N Next
						TOTAL SCORE	/35

Quality of Life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed, equally satisfied and dissatisfied	Mostly Dissatisfied	Unhappy	Terrible
8. How would you feel about spending the rest of your life with your urinary condition just the way it is now?	0	1	2	3	4	5	6

Current Medications: Please list the medication you are currently taking and the dosage if you know it. Exclude vitamins or other supplements but include over the counter medications you take regularly.

Name of Medication	*Dose*	*Times per Day*	*Name of Medication*	*Dose*	*Times per Day*

Allergies ☐ *NO KNOWN DRUG ALLERGIES*

List medications to which you are allergic.

Drug Name: _____

Drug Name: _____

Please describe the reaction.

Allergic Reaction: _____

Allergic Reaction: _____

Are you allergic to latex? ☐Yes ☐No

Have you had an allergic reaction to IVP dye, iodine, or x-ray contrast? ☐Yes ☐No

Do you require antibiotics to see your dentist? ☐Yes ☐No

Do you have **sleep apnea**? ☐Yes ☐No

Review of Past Medical History Please check previous health problems in the past or active problems at this time. *All conditions should be marked with Yes or No.*

Yes	No	**Eyes**
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Retinal detachment
☐	☐	Other: _____

Yes	No	**Ears, Nose, Throat**
☐	☐	Allergic rhinitis
☐	☐	Neck mass
☐	☐	Thyroid disease
☐	☐	Sinusitis
☐	☐	Other: _____

Yes	No	**Pulmonary**
☐	☐	Asthma
☐	☐	Chronic obstructive lung
☐	☐	Emphysema from smoking
☐	☐	Pneumonia
☐	☐	Pulmonary Edema
☐	☐	Pulmonary Embolism
☐	☐	Sleep Apnea

Yes	No	**Endocrine**
☐	☐	Diabetes
☐	☐	Thyroid problem

Yes	No	**Blood disorders**
☐	☐	Anemia
☐	☐	Clotting problems
☐	☐	Leukemia
☐	☐	Lymphoma

Yes	No	**Neurological/Orthopedic**
☐	☐	Arthritis
☐	☐	Carpal tunnel
☐	☐	Stroke
☐	☐	Fracture

List bones: _____

☐	☐	Chronic migraine/ headache
☐	☐	Spinal disc disease
☐	☐	Parkinson's disease
☐	☐	Seizures
☐	☐	Multiple Sclerosis
☐	☐	Other: _____

Yes	No	**Liver**
☐	☐	Hepatitis

Yes	No	**Gastrointestinal**
☐	☐	Polyps
☐	☐	Crohn's disease
☐	☐	Pancreatitis
☐	☐	Small bowel obstruction
☐	☐	Diverticulitis
☐	☐	Peptic Ulcer
☐	☐	Gallstone
☐	☐	Hemorrhoids

Yes	No	**Cardiovascular**
☐	☐	Congestive heart failure
☐	☐	Heart Attack
☐	☐	Elevated Cholesterol
☐	☐	Rhythm disturbances, irregular heartbeat. List what kind _____
☐	☐	Angina
☐	☐	Heart murmur
☐	☐	Hypertension, high blood pressure
☐	☐	Aneurysm
☐	☐	Aortic valve problem
☐	☐	Mitral valve problem
☐	☐	Peripheral vascular problem
☐	☐	Other: _____

Yes	No	**Psychiatric**
☐	☐	Depression
☐	☐	Bipolar Disease
☐	☐	Anxiety
☐	☐	Other: _____

Yes	No	**Skin**
☐	☐	Skin cancer
☐	☐	Other: _____

Cancers

List any cancers you have had:

_____

_____

Surgical History. Review this list of surgical procedures. Mark those you have had and write your age or the approximate year of the surgery.

Head and Neck

Yes	No	Year	
☐	☐	_____	Cataracts and Lens Implant
☐	☐	_____	Nasal Septum
☐	☐	_____	Laser eye surgery
☐	☐	_____	Thyroidectomy
☐	☐	_____	Tonsils and Adenoids
☐	☐	_____	Other: _____

Cardiovascular/Thoracic

Yes	No	Year	
☐	☐	_____	Abdominal Aneurysm surgery
☐	☐	_____	Angioplasty
☐	☐	_____	Bypass surgery
☐	☐	_____	Heart valve replacement
☐	☐	_____	Cardiac stent
☐	☐	_____	Carotid artery
☐	☐	_____	Defibrillator implant
☐	☐	_____	Lung resection
☐	☐	_____	Pacemaker
☐	☐	_____	Peripheral vascular procedure
☐	☐	_____	Vein stripping
☐	☐	_____	Other: _____

General/Gastrointestinal

Yes	No	Year	
☐	☐	_____	Appendectomy
☐	☐	_____	Bowel Resection Small
☐	☐	_____	Breast biopsy
☐	☐	_____	Breast removal- mastectomy
☐	☐	_____	Gallbladder removed (Open)
☐	☐	_____	Gallbladder removed (Lap)
☐	☐	_____	Colon Resection
☐	☐	_____	Gastrectomy (stomach removal)
☐	☐	_____	Hemorrhoid procedure
☐	☐	_____	Hernia repair – umbilical
☐	☐	_____	Other: _____

Orthopedic/Neurosurgical

Yes	No	Year	
☐	☐	_____	Arthroscopy - knee
☐	☐	_____	Arthroscopy - shoulder
☐	☐	_____	Carpal tunnel repair
☐	☐	_____	Craniotomy
☐	☐	_____	Fracture – surgical repair
☐	☐	_____	Fracture – closed treatment
☐	☐	_____	Laminectomy (spine) cervical
☐	☐	_____	Laminectomy (spine) lumbar
☐	☐	_____	Total hip replacement
☐	☐	_____	Total knee replacement
☐	☐	_____	Other: _____

Plastic/Reconstructive

Yes	No	Year	
☐	☐	_____	Cosmetic
☐	☐	_____	Hand procedure or repair
☐	☐	_____	Rhinoplasty
☐	☐	_____	Skin tag or lesion
☐	☐	_____	Other: _____

Urologic

Yes	No	Year	
☐	☐	_____	Bladder tumor-transurethral
☐	☐	_____	Urethral injections
☐	☐	_____	Kidney stone – removal with scope
☐	☐	_____	Urethral injections
☐	☐	_____	Kidney stone – lithotripsy
☐	☐	_____	Kidney stone – open
☐	☐	_____	Other: _____

Family History

Deceased relation	Age at death	Cause of death	Living relation	Age	Illness

Social History

Occupation? _____ If retired, former occupation? _____

Marital status (optional) ☐ Married ☐ Widowed ☐ Divorced ☐ Single

Number of children? _____ Ages? _____

Smoking Classification

☐ Never smoked

☐ Current smoker — How many years? _____ Packs/day _____

☐ Ex-smoker — How many years? _____ Packs/day _____

What year did you quit? _____

Alcohol Classification

☐ Never drank

☐ Quit — Year you quit _____

☐ Current Drinker — Amount you drink ☐ Beer _____ ounces or 6 packs/week

☐ Wine _____ ounces or liters/week

☐ Liquor _____ ounces week

Social Drug Use

☐ Never used

☐ Past or current usage: *describe* _____

Current Review of Systems: Please check any ***active*** problems at this time.

Yes No **Constitutional**
- ☐ ☐ Fever
- ☐ ☐ Chills
- ☐ ☐ Fatigue
- ☐ ☐ Weight loss
- ☐ ☐ Loss of appetite

HEENT

Yes No **Eyes**
- ☐ ☐ Poor vision
- ☐ ☐ Blurry vision
- ☐ ☐ Double vision

Yes No **Ears**
- ☐ ☐ Hearing loss
- ☐ ☐ Ringing in ears

Yes No **Nose**
- ☐ ☐ Nose bleeds
- ☐ ☐ Nasal obstruction

Yes No **Throat, Mouth**
- ☐ ☐ Sore throat
- ☐ ☐ Dentures

Other: _____

Yes No **Cardiovascular**
- ☐ ☐ Chest pain/angina
- ☐ ☐ Palpitations
- ☐ ☐ Swelling of feet/ankles
- ☐ ☐ Shortness of breath/activity
- ☐ ☐ Trouble sleeping w/1 pillow

Other: _____

Yes No **Respiratory**
- ☐ ☐ Cough
- ☐ ☐ Shortness of breath
- ☐ ☐ Wheezing

Other: _____

Yes No **Gastrointestinal**
- ☐ ☐ Jaundice
- ☐ ☐ Abdominal pain
- ☐ ☐ Diarrhea
- ☐ ☐ Nausea/Vomiting
- ☐ ☐ Bloody or black stools
- ☐ ☐ Constipation
- ☐ ☐ Pancreatitis
- ☐ ☐ Peptic ulcers

Other: _____

Yes No **Musculoskeletal**
- ☐ ☐ Backache
- ☐ ☐ Joint pain
- ☐ ☐ Muscle aches

Other: _____

Yes No **Neurological**
- ☐ ☐ Tremors
- ☐ ☐ Numbness
- ☐ ☐ Dizziness
- ☐ ☐ Headaches
- ☐ ☐ Fainting

Yes No **Psychiatric**
- ☐ ☐ Nervousness
- ☐ ☐ Hallucinations
- ☐ ☐ Anxiety
- ☐ ☐ Depression

Yes No **Endocrine**
- ☐ ☐ Hot flashes
- ☐ ☐ Excessive thirst/sweating
- ☐ ☐ Hot or cold intolerance

Other: _____

Yes No **Skin**
- ☐ ☐ Sores
- ☐ ☐ Rash
- ☐ ☐ Itching

Other: _____

Yes No **Hematologic/Lymphatic**
- ☐ ☐ Easy bruising/bleeding
- ☐ ☐ Swollen lymph nodes/glands

Other: _____

Yes No **Allergic/Immunologic**
- ☐ ☐ Rash
- ☐ ☐ Hives

Other: _____

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of a very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with you doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for each question.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?

Very low	Low	Moderate	High	Very High
1	2	3	4	5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

No sexual activity	Almost Never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Did not attempt sexual activity	Almost Never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Did not attempt sexual activity	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
0	1	2	3	4	5

5. When you attempted sexual intercourse, how often was it satisfactory for you?

Did not attempt sexual activity	Almost Never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

Score: _____

Orange County Urology Associates, Inc.
Financial Policy

Welcome to Orange County Urology Associates, Inc. Your initial visit can range from $200 to $500. Here are some guidelines to help you get your insurance information ready for your visit:

MEDICARE

- Do you have a supplemental plan?
  - YES – We will bill both insurances on your behalf. You will be billed for any balance owed by you after the insurances have paid their amounts.
  - NO –
    i. Have you met your deductible? (2013: $147 Part B)
    ii. You will be required to pay your co-insurance percentage and any portion of the deductible that has not been met.

PPO PLAN

- Are we contracted with your insurance company?
  - YES – You will be required to pay your co-payment and deductible.
  - NO – You will be required to pay in full.

- Do you have a SECONDARY INSURANCE?
  - YES – You will be required to pay your co-payment and co-insurance amounts at the time of your visit.

- If you have a HIGH DEDUCTIBLE PLAN, have you met your deductible?
  - YES – You will be required to pay your co-insurance percentage at the time of your visit
  - NO – You will be required to pay your co-insurance percentage and deductible at the time of your visit

- We will bill your insurance(s) as a courtesy. Payments received in excess of your account balance will be refunded to you.

HMO, EPO, POS OR MANAGED CARE PLANS

- Has your primary care physician AUTHORIZED your visit?
  - Visits with prior approval. If your plan requires a co-payment, you will be required to pay this at the time of your visit.
  - Visits without prior approval. You will be required to pay in full at the time of your visit.

You will be required to PAY IN FULL for your visit if

- You are **OUT OF NETWORK**
- You have **NO INSURANCE**
- We are **NOT CONTRACTED WITH YOUR INSURANCE**

We recommend that you verify your benefits with your insurance plan prior to your visit.

IF YOU FAIL TO PROVIDE COMPLETE, UP-TO-DATE, ACCURATE INSURANCE INFORMATION

- You will be considered a **CASH** patient and will be **required to pay in full** at the time of your visit
- OCUA will not be responsible for billing insurance for this date of service retroactively

Effective May 1, 2009 the Federal Trade Commission (FTC) has implemented a new regulation known as the Red Flag Rule requiring physicians to develop and implement identity theft detection and prevention programs. **TO PROTECT YOU AGAINST IDENTITY THEFT** we are required to ask for a photo ID, and a second type of identification.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY FOR ORANGE COUNTY UROLOGY ASSOCIATES, INC.

Print Name _____ Signature _____ Date _____

Point of Service Option

Welcome to Orange County Urology Associates, Inc. We understand that you have chosen to use your Point of Service **(POS)** option rather than your HMO for our services. The plan you have allows you this flexibility of benefits, and we are pleased you have chosen us as your provider of care.

Please note: **If you choose to use your POS option on your initial visit, all services provided from that point forward will be at the POS option. If at any time you wish to revert to your HMO insurance option for urological service you will be asked to transfer your care to a urology office that accepts your HMO contract.**

Please do not hesitate to discuss any questions you may have with our staff regarding this policy.

I wish to establish a relationship with the physicians of Orange County Urology Associates, Inc. using my Point of Service Insurance Option. I understand that Point of Service becomes the effective contract between Orange County Urology Associates Inc. and me. I further understand that Orange County Urology Associates, Inc. will not contract with me under the HMO option of my insurance.

I understand that choosing to exercise my POS option means that I may have a deductible and/or co-insurance amounts that I am required to pay.

_____ _____

Print Name Sign Name

_____ _____

OCUA Signature Date

****

Failure to Provide Insurance Information

I realize that I did not bring my insurance card to my appointment. I understand that I must provide a copy of my insurance information to Orange County Urology Associates (OCUA) within 48 hours.

I understand and agree that failure to do so will result in today's visit being considered a "CASH" visit, and that I will be responsible for PAYMENT IN FULL. I further understand and agree that OCUA will NOT be responsible for billing my insurance for this date of service retroactively.

The following insurance information, or a copy of my insurance card, must be provided to OCUA with 48 hours:

Insurance Carrier _____ Phone #_____

Subscriber Name_____ Effective Date_____

Identification Number_____ Group Policy #_____

Claims Address_____

_____

_____ _____

Print Name Sign Name

_____ _____

OCUA Signature Date

Orange County Urology Associates

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NOTICE OF PRIVACY PRACTICES

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. In addition, we are required by law to maintain the privacy of Protected Health Information and to provide individuals with notice of our legal duties and privacy practices regarding Protected Health Information.

"Protected Health Information" is information that we keep in electronic, paper or other form, including demographic information collected from you and that is created or received by us that relates to your past, present, or future physician or mental health or condition, the provision of health care services to you, or the past, present, or future payment for the health care services we deliver to you, and that identifies you or which we reasonably believe can be used to identify you.

We are required by federal law to do the following:

- Make sure that your Protected Health Information is kept private
- Give you this Notice of our legal duties and privacy practices related to the use and disclosure of your Protected Health Information
- Follow the terms of the Notice currently in effect
- Describe how we will communicate any changes in this Notice to you
- Tell you if there is a breach of your unsecured Protected Health Information

We reserve the right to make changes in our privacy practices regarding your Protected Health Information. If we change our privacy practices, that change will apply to all Protected Health Information that we maintain about you. However, before we change our privacy practices, we will provide you with written notice of any changes. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

A. We may use and disclose your Protected Health Information for a variety of purposes. For example:

1. **Treatment:** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in provided the care you need. For example, we may share your Protected Health Information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.

2. **Health Care Operations**: We may use and disclose your Protected Health Information to operate the medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competences, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance of health benefits, or their health care fraud and abuse detection and compliance efforts.

3. **Payment:** We may disclose your Protected Health Information to obtain payments. Disclosures for "payment" include (a) disclosure to a health plan to determine your eligibility of coverage under the plan; (b) disclosures to a health plan to obtain reimbursement for delivering medical services to you; (c) disclosures to billing services or collection agencies; (d) disclosures for utilization management and determinations of whether the medical services we deliver to you are necessary or appropriate; or (e) disclosures to determine whether the amount we charge you for medical services are justifiable.

4. **Reminders and Treatment Alternatives**: We may contact you to provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and services that may be of interest to you.

5. **Sign In Sheet**: We may use and disclose Protected Health Information about you 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.

6. **Notification and Communication with Family**: We may disclose your Protected Health Information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. **Marketing**: We may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health

plans we participate in. We will not otherwise use or disclose your Protected Health Information for marketing purposes or accept any payment for marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent that you revoke that authorization.

8. **Required by Law**: As required by law, we will use and disclose your Protected Health Information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings or to law enforcement officials, we will further comply with the requirements set forth below concerning those activities.

9. **Public Health**: We may, and are sometimes required by law to disclose your Protected Health Information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. **Health Oversight Activities**: We may, and are sometimes required by law to disclose your Protected Health Information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

11. **Judicial and Administrative Proceedings**: We may, and are sometimes required by law, to disclose your Protected Health Information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and if you have not objected, or if your objections have been resolved by a court or administrative order.

12. **Law Enforcement**: We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. **Other**: We may, and are often required by law, to disclose your Protected Health Information to coroners in connection with their investigations of deaths; to organizations in procuring, banking or transplanting organs and tissues; to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public; to a school when the law requires the school to have proof of immunization prior to admitting a student if you have agreed to the disclose on behalf of yourself or your dependent; for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody; as necessary to comply with worker's compensation laws or to report cases of occupational injury or occupational illness to the employer or worker's compensation insurer.

14. **Change of Ownership**: In the event that this medical practice is sold or merged with another organization, your Protected Health Information will become the property of the new owner,

although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

15. **Breach Notification**: In the case of a breach of unsecured protected health information, we will notify you as required by law.

16. **Research:** We may disclose your Protected Health Information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

17. **Fundraising**: We may use health information about you to contact you in an effort to raise money for Orange County Urology Associates and its operations, and we may disclose health information to our Business Associates, so that they may contact you in raising money for Orange County Urology Associates. For these purposes, however, the only kind of information we would release is contact information, such as your name, address, and phone number, certain demographic information (e.g., date of birth and gender), dates of services, and certain other limited information permitted by HIPAA. If you do not want to receive these materials, you will have the opportunity to opt-out of each fundraising solicitation. If you opt-out of receiving any further fundraising communications from us, we will treat your notice as a revocation of your authorization to permit us to make fundraising communications to you, and we will obtain permission from you before resuming such communications. Your decision will not impact on your treatment or payment for service.

B. When this Medical Practice May Not use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose Protected Health Information which identifies you without your written authorization. If you do authorize the use or disclosure of your Protected Health Information, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose Protected Health Information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we have already made in reliance on your authorization..

C. Your Health Information Rights

1. **You have the right to request restrictions** on certain uses and disclosures of your Protected Health Information by a written request specifying what information you want to limits and what limitations on our use or disclosure you wish to impose. We do not, however, have to agree to a restriction that you request, unless the requested restriction is on a disclosure to a health plan for a payment or health care operations purpose and the Protected Health Information relates solely to a health care item or service for which we have been paid out-of-pocket in full. If we do comply with your request, we will not use or disclose your Protected Health Information in violation of the restriction unless we must disclose the information for emergency treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. **You have the right to request that you receive your Protected Health Information in a specific way** (such as by mail or email) or at alternative locations (such as your office or business workplace). We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. **You have the right to inspect and copy your health information**, with limited exceptions. To access your medical information you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your request form and format if it is readily producible, or we will provide you will an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by law. If you request an electronic copy of your medical information, our fee will not exceed our labor costs in responding to your request, the costs of electronic media, and postage, if mailed. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. Except in cases where the Protected Health Information is not maintained or accessible on-site, we will act on a request for access no later than thirty (30) days after we receive your request.

4. **You have a right to request that we amend your health information** that you believe is incorrect or incomplete. Your must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and we will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal.

5. **You also have the right to request that we add to your record** a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

6. **You have a right to receive an accounting of all of our disclosures o**f your Protected Health Information in the 6 years prior to the date of your request, except for disclosures: (a) to carry out treatment, payment and health care operations: (b) notification and communication with family or to you: (c) for our directory or to persons involved in your care; (d) for national security or intelligence purposes; (e) for purposes of research or public health which exclude direct patient identifiers; (f) or which are incident to a use or disclosure otherwise permitted or authorized by law; (g) to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official, (h) pursuant to any written authorization that you give to us; or (i) that occurred prior to April 14, 2003

7. **You have a right to request and obtain from us a paper copy of this notice.**

Orange County Urology Associates

D. If You Have a Complaint

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310
(415) 437-8311 (TDD)
(415) 437-8329 Fax
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomlaint.pdf.

You will not be penalized in any way for filing a complaint.

I have read the Notice of Privacy Practices that is posted in your office. I was informed that I may also obtain a printed copy of the notice from your receptionist.

_____
Print Your Name

_____
Signed

_____
Date