



Welcome to MidLantic Urology!

In order to serve you better, please carefully read and complete the attached forms.

Please arrive 15-30 minutes prior to your appointment time so we may process all necessary paperwork. Please bring the following:

- All of the attached patient information and history forms - completed.
- Your insurance card, pharmacy benefit card, and a photo ID.
- Co-payment amounts are due at the time of service.
- If your insurance requires one, a **REFERRAL** from your primary physician.
- The name and phone number of your primary care physician.
- List of all allergies & medications with dosage, including over the counter medications.
- Copies of all recent lab test results, x-rays and medical records.
- Money for parking at our Abington, Chestnut Hill, Lankenau, & Nazareth locations.

If you need to cancel your appointment, please notify us 24 hours in advance. A fee will be assessed for all no-shows or cancellations without 24 hours notice.

Directions to all of our locations can be found on our website at: [www.uhurology.com](http://www.uhurology.com).

If you have any questions prior to your appointment, please call our office.

Thank you,

MIDLANTIC UROLOGY

**MIDLANTIC UROLOGY**  
**PATIENT REGISTRATION FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_

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

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

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

E-mail address: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_ M \_\_\_ F

Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced

Spouse/Partner name: \_\_\_\_\_ DOB: \_\_\_\_\_

If minor, name of Parent/Guardian: \_\_\_\_\_

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

Emergency Contact Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship of Emergency Contact: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Local Pharmacy: \_\_\_\_\_ Phone # \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_

Pharmacy Benefit Plan Name (needed for prior authorizations): \_\_\_\_\_

Explain any special requirements for pharmacy plan – Quantity/Time interval \_\_\_\_\_

Race: \_\_\_ White \_\_\_ Black/African American \_\_\_ Asian \_\_\_ Other

Ethnicity \_\_\_ Hispanic \_\_\_ Not of Spanish/Hispanic Origin

Primary Language \_\_\_\_\_

How did you learn about us: \_\_\_ PCP/other physician \_\_\_ Internet \_\_\_ OUR WEBSITE?

\_\_\_ Family/Friend \_\_\_ Insurance Company \_\_\_ other

**PLEASE SHOW ID CARDS**

**INSURANCE  
PRIMARY**

Primary Subscriber Name: \_\_\_\_\_

Subscriber's Social Security Number: \_\_\_\_\_

DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

**INSURANCE  
SECONDARY**

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

DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

I hereby authorize MidLantic Urology to furnish my medical or other information to insurance carriers, their intermediaries, my attorney, or another physician's office. I understand that sensitive material from my medical history could be included.

I hereby assign to MidLantic Urology all payments for medical services rendered to myself or my dependents. I understand I have financial responsibility for any amount whether or not paid by insurance.

A copy of this authorization is as valid as the original. This assignment will remain in effect until revoked by me in writing.

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

MIDLANTIC UROLOGY  
PATIENT INFORMATION AND HISTORY

HISTORY OF PRESENT ILLNESS

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

When did you first notice the problem?  2 days ago  2 weeks ago  Other \_\_\_\_\_

Are your symptoms getting worse? \_\_\_\_\_

Is the problem  constant or variable  dull then sharp  very sharp then leaves  always

Does the problem interfere with your normal activities?  Yes  No (If yes, explain) \_\_\_\_\_

Is there anything else occurring at the same time?  Yes  No (If yes, explain) \_\_\_\_\_

Nausea  Rash  Headache  Fever  Other \_\_\_\_\_

Have you had this problem before?  Yes  No  I don't know

Have you had prior urological evaluation or surgery?  Yes  No  I don't know

What is your level of pain right now (with 1 being the least bothersome and 10 being severe)? \_\_\_\_\_

Any recent tests related to this problem? (Blood work, urine test, radiology examination) \_\_\_\_\_

HEALTH MAINTANANCE

Have you had a Flu Shot within the last year?  Yes, (approximate date): \_\_\_\_\_  No

Have you ever had a Pneumonia Vaccine?  Yes, (approximate date): \_\_\_\_\_  No

When was your last Colonoscopy/Flex Sigmoid? (approximate date): \_\_\_\_\_  Never

PAST MEDICAL HISTORY-ILLNESSES OR HOSPITALIZATION (List with date first diagnosed)

Cancer \_\_\_\_\_  Hypertension  Coronary Artery Disease/Heart Disease

Diabetes Mellitus  Congestive Heart Failure

Other, please list: \_\_\_\_\_

PAST SURGICAL HISTORY (FOR ANY MEDICAL PROBLEM) List any past surgeries and dates.

**SOCIAL HISTORY**

MARITAL STATUS:  Married  Single  Widowed  Separated  Divorced

WORK STATUS:  Currently working  Unemployed  Part-time  Retired  Student  
 Disabled

DO YOU SMOKE?  Yes  No # PACKS \_\_\_\_ # YEARS \_\_\_\_  CIGARETTES  CIGARS  
 I quit Date stopped: \_\_\_\_\_

DO YOU DRINK ALCOHOL?  Yes  No If yes, how much?  Occasionally  3-4X per week  
 Every day  Other \_\_\_\_\_

CAFFEINE INTAKE:  Yes  No If yes, COFFEE #cups daily \_\_\_\_\_ TEA #cups daily \_\_\_\_\_  
SODA #cups daily \_\_\_\_\_

ARE YOU ON A SPECIAL DIET?  Yes  No

If yes, describe \_\_\_\_\_  Weight loss  Diabetic  Low sodium  Low carbohydrates

SEXUAL HISTORY:  Active  Inactive  None

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL OR OTHER PROCEDURES?  Yes  No

If yes, what do you take? \_\_\_\_\_ If so, why? \_\_\_\_\_

**FAMILY HISTORY**

<u>ILLNESS</u>	<u>FATHER</u>	<u>MOTHER</u>	<u>SIBLING</u>	<u>GRANDPARENT</u>
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Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Gastric Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other	_____	_____	_____	_____
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Family Members that are deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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## REVIEW OF SYSTEMS

Do you presently have any of these problems? Check Yes or No.

Please explain any Yes answers in space provided.

### Constitutional Symptoms

Fever  Yes  No  
Chills  Yes  No  
Headache  Yes  No  
Fatigue  Yes  No  
Other \_\_\_\_\_

### Musculoskeletal

Joint Pain  Yes  No  
Neck Pain  Yes  No  
Back Pain  Yes  No  
Arthritis  Yes  No  
Other \_\_\_\_\_

### Eyes

Blurred vision  Yes  No  
Double vision  Yes  No  
Glaucoma  Yes  No  
Other \_\_\_\_\_

### Integumentary

Skin rash  Yes  No  
Jaundice  Yes  No  
Persistent Itch  Yes  No  
Other \_\_\_\_\_

### Ear/Nose/Throat/Mouth

Ear Infection  Yes  No  
Sore Throat  Yes  No  
Sinus problems  Yes  No  
Other \_\_\_\_\_

### Neurological

Tremors  Yes  No  
Dizzy Spells  Yes  No  
Numbness/tingling  Yes  No  
Headaches  Yes  No  
Other \_\_\_\_\_

### Cardiovascular

Chest Pain  Yes  No  
Varicose Veins  Yes  No  
High blood pressure  Yes  No  
Other \_\_\_\_\_

### Psychologic

Generally satisfied  Yes  No  
Depression  Yes  No  
Suicidal thoughts  Yes  No  
Other \_\_\_\_\_

### Respiratory

Wheezing  Yes  No  
Frequent cough  Yes  No  
Shortness of Breath  Yes  No  
Other \_\_\_\_\_

### Endocrine

Excessive thirst  Yes  No  
Diabetes  Yes  No  
Thyroid disease  Yes  No  
Other \_\_\_\_\_

### Gastrointestinal

Abdominal pain  Yes  No  
Nausea/vomiting  Yes  No  
Indigestion/heartburn  Yes  No  
Other \_\_\_\_\_

### Hematologic/Lymphatic

Swollen glands  Yes  No  
Blood clotting problem  Yes  No  
Other \_\_\_\_\_

### Genitourinary

Urine retention  Yes  No  
Painful urination  Yes  No  
Urinary frequency  Yes  No  
Other \_\_\_\_\_

### Allergic/Immunologic

Hay Fever  Yes  No  
Food Allergies  Yes  No  
Latex Allergy  Yes  No  
Other \_\_\_\_\_

Reviewed by: \_\_\_\_\_

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

**WOMEN ONLY – GYNECOLOGIC/OBSTETRIC HISTORY**

Age at onset of periods \_\_\_\_\_ Frequency \_\_\_\_\_ Length \_\_\_\_\_

Pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Miscarriages \_\_\_\_\_

Prolonged abnormal bleeding  No  Yes (Describe) \_\_\_\_\_

Leakage of urine  No  Yes (Describe) \_\_\_\_\_

Pelvic pain  No  Yes (Describe) \_\_\_\_\_

Abnormal discharge  No  Yes (Describe) \_\_\_\_\_

History of abnormal Pap test  No  Yes (Describe) \_\_\_\_\_

# MIDLANTIC UROLOGY

IN ORDER TO PROVIDE SAFER AND MORE EFFECTIVE CARE, A COMPLETE LISTING AND UPDATE OF ALL OF YOUR MEDICATIONS IS REQUIRED

## MEDICATION AND ALLERGY LIST

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Medication	Dose (mg)	# of pills	How many times a day? (Circle the number)
Example: Tylenol	325	2	1 2 3 (4)
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
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			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4

Check here if more medications are listed on the back of this form.  
(List additional medications on back)

### HERBAL/OVER THE COUNTER/SUPPLEMENTS

Medication	Dose (mg)	# of pills	How many times a day? (Circle the number)
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4
			1 2 3 4

### MEDICATION ALLERGIES AND REACTIONS:

Allergy	Reaction

LATEX ALLERGY    YES    NO    If yes, reaction? \_\_\_\_\_





**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

1. Is this your first visit to our office this year?

Yes \_\_\_\_\_ (If Yes, please go to question 3)

No \_\_\_\_\_

2. Have we asked this year if you have a Medical Advanced Care Directive or Living Will?

Yes \_\_\_\_\_

No \_\_\_\_\_ (If No, please go to Question 3)

3. Do you have a Medical Advanced Care Directive or Living Will?

Yes \_\_\_\_\_ (If Yes, please go to Question 4)

No \_\_\_\_\_

4. Do you have a Healthcare Surrogate Designation? (An official document that appoints an adult to make healthcare decisions for you when you become unable to make them for yourself)

Yes \_\_\_\_\_ (If Yes, go to Question 5)

No \_\_\_\_\_

5. Would you like to give us the name of your Healthcare Surrogate?

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

No \_\_\_\_\_

**MidLantic Urology**  
**BILLING AND PAYMENT POLICY**

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

**Please bring your insurance cards with you to each visit. If your insurance have changed since your last visit please inform the receptionist at the beginning of your visit.**

**Medicare and Managed Medicare Plans**

MidLantic Urology participates in most Medicare and most "managed" Medicare plans. We will directly bill and be paid by Medicare or the other Medicare contract carrier. We will bill our standard fee and will write off the portion of the bill considered to be our "contractual" adjustment. The balance, which is usually 20% is paid by the patient or a supplemental (secondary) insurance. For "managed Medicare plans" there is a co-pay due at each visit. For all Medicare plans there is an annual deductible each year that members are responsible for.

MidLantic Urology will bill your secondary or supplemental insurance for you if we are given all the necessary billing information at the time of service. Your secondary or supplemental insurance is billed once we have received payment from your primary insurance. Medicare does have arrangements with many secondary payers to automatically forward Medicare payment information. The secondary or supplemental insurance pays MidLantic Urology directly. You will receive a bill from MidLantic Urology after Medicare, the Managed Medicare contractor and your supplemental insurance has paid. Medicare will send you an "explanation of benefits". If you have questions about the payment from Medicare, please call Highmark Medicare Services at 1-800-663-4227.

**Private Insurance**

MidLantic Urology will bill your insurance directly for you if supplied with the complete billing information. This includes: name and complete address of insurance company, policy holder name, date of birth, ID and group numbers.

If your insurance company does not pay the bill within sixty (60) days we will hold you responsible for payment. We recommend that you contact your insurance carrier if the bill has not been paid within 30 days to determine what is delaying the claim. Regardless, this office will look directly to you for payment of your services beginning on the 61<sup>st</sup> day from date of service. Co-payments, deductibles and/or co-insurances are due at the time of service. We accept cash, private checks (with proper ID), VISA and MasterCard.

**Self-Pay and Health Savings Account**

Patients with no insurance coverage or have an HSA (Health Savings Account) are asked to pay in full at every visit. To establish a Payment Plan, please contact our Billing Office at 484-530-0203.

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I understand that I am financially responsible for all co-payments, deductibles, co-insurance and all amounts my insurance does not cover. I intend to be legally bound hereby.

Signature: \_\_\_\_\_

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

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

**MidLantic Urology**  
**Policies and Procedures**  
**Identity Theft Prevention and Detection and Red Flags Rules Compliance**

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**Policy**

It is the policy of Urology Health Specialists, LLC to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how Urology Health Specialists, LLC will (1) identify, (2) detect and (3) respond to "red flags." A "red flag" as defined by this policy includes a pattern, practice or specific account or record activity that indicates possible identity theft.

**Procedure**

1. When a patient calls to request an appointment, the patient will be asked to verify their current address or date of birth and their current insurance provider. They will be asked to bring the following at the time of the appointment:
  - Driver's license or other photo ID;
  - Current health insurance card; and
  - Utility bills or other correspondence showing current residence if the photo ID does not show the patient's current address. If the patient is a minor, the patient's parent or guardian should bring the information listed above.
  
2. When the patient arrives for the appointment, the patient will be asked to produce the information listed above. After verifying the patient's identity, the staff will take a photo ID to be entered into the patients EMR. **The photo ID requirement may be waived for patients who have visited the practice and already have a photo ID in the Electronic Medical Record (EMR). If the patient does not have a photo ID in the EMR, photo ID will be required at each visit. Insurance and address will be verified at each visit.**
  
3. Insurance and address will be verified at each visit. Phone call with patients will require the person to verify name, address, and/or date of birth before discussing medical or financial information.

If you have any questions about this policy please ask the administrative assistant at the time of your visit.

**MIDLANTIC UROLOGY**  
**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 THIS NOTICE CAREFULLY.

**About This Notice.**

Our practice is dedicated to maintaining the privacy of your Protected Health Information. We are required to give you this Notice explaining our privacy practices with regard to that information and to notify you following a breach of your Protected Health Information. You have certain rights - and we have certain legal obligations - regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

**What is Protected Health Information?**

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

**How We May Use and Disclose Your Protected Health Information.**

We may use and disclose your Protected Health Information in the following types of circumstances without your prior written authorization:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a primary care physician or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations to run our practice. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our staff in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes or remove information that identifies you from your Protected Health Information so others may use it to study the delivery of health care.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.
- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
- **Research.** We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at your Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.
- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose your Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.
- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation - such as an organ donation bank - as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your Protected Health Information.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose your Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose your Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

**Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out.**

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- **Fundraising Activities.** We do not routinely engage in fundraising. However, if we choose to do so, we may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not wish to be

contacted for fundraising purposes you may notify the Compliance Manager by email, telephone or by mail at the address indicated at the end of this Notice.

#### **Uses and Disclosures that Require Your Written Authorization.**

The following uses and disclosures of your Protected Health Information will be made only with your written authorization unless otherwise permitted or required by law:

1. Most uses and disclosures of psychotherapy notes and/or mental health information;
2. Uses and disclosures of HIV status;
3. Uses and disclosures related to alcohol and substance abuse;
4. Uses and disclosures that constitute marketing; and
5. Uses and disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it (take it back) at any time by submitting a written revocation to our Compliance Manager and we will no longer disclose Protected Health Information under the authorization. But disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

#### **Your Rights Regarding Your Protected Health Information**

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and/or obtain a copy of certain records in which we maintain Protected Health Information that is used to make decisions about your care or payment for your care. This usually includes medical and billing records, but may not include psychotherapy notes. We generally have up to 30 days after receipt of your written request to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional we choose who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request in writing that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable fee associated with copying and transmitting the electronic medical record.

- **Right to be Notified of a Breach.** You have the right to be notified if any of your Protected Health Information is lost, stolen or improperly accessed constituting a breach. We will notify you in writing if there is such a breach.
- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. Your request for amendment must be made in writing to the Compliance Manager at the address provided at the end of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of certain disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, for example a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Compliance Manager. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.
- **Right to Restrict Disclosure to a Health Plan for Out-of-Pocket-Payments.** If you (or someone on your behalf) pays out-of-pocket in full and if you have requested that we not bill your health plan or other third party health insurance for a specific item or service, you have the right to ask us in writing that your Protected Health Information with respect to that item or service not be disclosed to a health plan or other insurance, and we must honor that request. Your written request that we limit such disclosure must be sent by mail to the Compliance Manager at the address indicated at the bottom of this Notice.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time or access a copy on our website ([www.uhurology.com](http://www.uhurology.com)).



**How to Exercise Your Privacy Rights.**

To exercise your rights described in this Notice, send your request, in writing, to our Compliance Manager at the address listed at the end of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Compliance Manager by telephone, mail or email, or you may print out a copy from our website ([www.uhurology.com](http://www.uhurology.com)). You will not be penalized for exercising a privacy right.

**Changes To This Notice.**

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website ([www.uhurology.com](http://www.uhurology.com)) and will be updated to reflect any future changes.

**Complaints.**

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us, contact our Compliance Manager at the address listed at the beginning of this Notice. Complaints submitted to the Secretary must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, [www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/), for more information. There will be no retaliation against you for filing a complaint.

**Foreign Language Version.**

If you have difficulty reading or understanding English, you may request a copy of this Notice in Spanish.

**IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR COMPLIANCE MANAGER:**

Attention: Compliance Manager

140 West Germantown Pike, Suite 250

Plymouth Meeting, PA 19462

Telephone: (484) 530-0205 option #5

Fax Number: (484) 530-0209

Email Address: [privacy@uhsurology.com](mailto:privacy@uhsurology.com)

This notice was revised March 9, 2018