COMPREHENSIVE UROLOGY

Today's Date: _____

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.

Patient's Last Name:	First Name:	Middle Name:
Is this your legal name?	If not, what is your legal/former name?	Sex: ☐ M ☐ F
Date of birth:	Age:	SSN:

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Refuse to Report Preferred Language: _____	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic /Latino ☐ Other: _____

ADDRESSES HOME & WORK

Home Address:	City:	State	Zip code:
Home/Cell Phone Number:	**Email:**		
Employer Address:	City:	State:	Zip code:
Occupation/Position:	Employer/Business Phone Number:		

HOW DID YOU HEAR ABOUT OUR CLINIC?

☐ Family/Friend	☐ Hospital	☐ Online _____
☐ Insurance Plan	☐ Close to home/work	☐ Other _____

Where you referred to us by your doctor? Y / N
If yes, please write your doctor's name and their phone number: _____

Primary Physician's Name & Phone Number:_____

INSURANCE INFORMATION

Define Coverage Type:
☐ Self-Pay (no insurance) ☐ Insurance ☐ Other Insured (spouse) ☐Workers Comp

Insurance carrier:	ID:
Secondary Insurance carrier (if applicable):	ID:
Other Person Responsible for my bill:	
Name:	Relationship to patient:
Date of Birth:	Contact Phone Number:

IF A MINOR ONLY:

Fathers Name:	Mothers Name:

IN CASE OF EMERGENCY

Name of local friend or relative (not living with you)	Relationship to patient:	Phone Number:

COMPREHENSIVE UROLOGY

Name: _____ **Date:** _____

DOB: _____

Welcome to our office or welcome back. We want to provide you with the best possible care, so please take a few moments to complete the following pages. Thank you.

What is the main urologic issue you would like to discuss?

_____
_____
_____

Do you have any other urologic issues you would like addressed?

_____
_____
_____

Please list any medical conditions you have (high blood pressure, diabetes, etc.:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any prior surgeries or procedures: **Date of surgery/procedure:**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

COMPREHENSIVE UROLOGY

Name: _____

DOB: _____

Please list any current medications/herbal supplement:	**Dose:**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

Please list any medications you are allergic to:	**Reaction:**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Please list any serious illness in your family:

Relative: _____	Illness: _____
Relative: _____	Illness: _____
Relative: _____	Illness: _____

COMPREHENSIVE UROLOGY

Name: _____

DOB: _____

FEMALE PATIENTS ONLY:

Ashkenazi Jewish Ancestry?	Yes ☐	No ☐
Have you or any one in your family been diagnosed with ovarian cancer?	Yes ☐	No ☐
Have you or any one in your family been diagnosed with pancreatic cancer?	Yes ☐	No ☐
Have you or any one in your family been diagnosed with breast cancer <50 years old?	Yes ☐	No ☐
Have you or any one in your family been diagnosed with any other type of cancer(s)? If yes, please indicate what type: _____	Yes ☐	No ☐

Number of pregnancies: _____ Number of deliveries: _____

Vaginal or C-section: _____ Birth weights: _____

Age of menopause: _____ Hormone replacement: _____

****

Please indicate your current marital status:

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐

On average, how many alcoholic beverages do you have in a week? _____

Did you ever smoke on a regular basis? Yes ☐ No ☐

If yes, how many packs a day? _____ For how many years? _____

Are you still smoking? Yes ☐ / No ☐ If no, when did you quit? _____

Have you had a colonoscopy in the last 5 years? Yes ☐ / No ☐

Do you have an Advanced Care Plan in place? Yes ☐ / No ☐ /No ☐ (my cultural and/or spiritual beliefs preclude me from having a discussion regarding advance care planning)

If yes… ☐ Living Will ☐ Do Not Resuscitate ☐ Power of Attorney

COMPREHENSIVE UROLOGY

REVIEW OF SYSTEMS

Do you or have you recently had any problems related to the following?
Please circle **Y** for Yes or **N** for No. If your answer is Yes, please explain in the space provided.

Name: _____ **DOB:** _____

Constitutional

Fever	Y	N
Chills	Y	N
Weight Loss	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Glaucoma	Y	N
Other _____		

Ears/Nose/Throat

Difficulty hearing	Y	N
Sinus problems	Y	N
Difficulty swallowing	Y	N
Other _____		

Respiratory

Shortness of breath	Y	N
Chronic cough	Y	N
Other		

Cardiovascular

Chest pain	Y	N
Heart attack	Y	N
High blood pressure	Y	N
Other _____		

Genitourinary

Frequent urination	Y	N
Wake to urinate	Y	N
# of times _____		
Slow stream	Y	N
Push to urinate	Y	N
Retaining urine	Y	N
Painful urination	Y	N
Urinary tract infection	Y	N
Incontinence	Y	N
# of pads per day _____		
Sexual activity	Y	N
Low libido	Y	N
Difficulty reaching orgasm	Y	N
Pain with intercourse	Y	N
Vaginal dryness	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Constipation/diarrhea	Y	N
Other _____		

Musculoskeletal/Neck

Back pain	Y	N
Leg pain	Y	N
Muscle pain	Y	N
Other _____		

Neurological

Migraines	Y	N
Dizzy spells (Lightheadedness)	Y	N
Numbness/tingling	Y	N
Other _____		

Integumentary

Skin rash	Y	N
Skin lesion(s)	Y	N
Breast (lumps, etc.)	Y	N
Other _____		

Allergic/Immunologic

Hay fever	Y	N
Environmental allergies	Y	N
Food allergies	Y	N
Other _____		

Hematologic/Lymphatic

Blood clotting disorder	Y	N
Anemia	Y	N
Swollen glands	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other		

Psychological

Depression	Y	N
Anxiety	Y	N
Other _____		

_____ _____

Physician Signature Date

COMPREHENSIVE
UROLOGY

MEDICAL INFORMATION RELEASE FORM

This form is to allow Comprehensive Urology Medical Group, its physicians, and its staff to release the stated medical information to designated family and/or friends.

I, _____, hereby authorize Comprehensive Urology Group to provide information about my medical information to family or friends that I name in this document. Comprehensive Urology may release information relating to the items checked below.

Please list the persons allowed to receive information and your relationship.

1. _____
2. _____
3. _____
4. _____
5. _____

Information to be released:

☐ Appointment information
☐ Lab results
☐ General health inquiry
☐ Surgery pre-op and post-op instructions
☐ Request copies of medical records
☐ Other _____

By checking the item(s) above, I acknowledge that I have authorized Comprehensive Urology Medical Group to release such information. I have read and reviewed the foregoing release and understand its contents.

I acknowledge that Comprehensive Urology Medical Group is hereby released from any all claims, demands, or liabilities arising out of or in any way related to the disclosure of the information above. I also have the right to change or revoke this request at any time.

_____ _____

Print Patient's Name Date

_____

Patient's Signature

COMPREHENSIVE
UROLOGY

AUTHORIZATION TO PAY MEDICAL & SURGICAL BENEFITS
DIRECTLY TO ATTENDING PHYSICIAN

I hereby authorize _____ to make payments directly to
(INSURANCE COMPANY)

Kiarash Michel, M.D., Robert Sanford, M.D., Dino Deconcini, M.D., Evan Rosen, M.D. and/or Comprehensive Urology Medical Group for all surgical and medical expense benefits otherwise payable to me for this period of treatment. I understand that I am financially responsible for all charges not covered by my insurance benefits.

I also authorize release of my records to the insurance company for purpose of billing.

_____ _____
Print Patient's Name Date

_____
Patient's Signature

COMPREHENSIVE
UROLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices.

Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice.

I, _____, have received a copy of this office's *Notice of Privacy Practices*.

_____
Print Patient's Name

_____
Patient's Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please specify) _____

COMPREHENSIVE UROLOGY

FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** _____

Welcome to Comprehensive Urology Medical Group (CUMG). We are committed to providing you the best urological care possible. For your convenience we have outlined our office financial policy. Kindly review and sign and/or initial in the designated spaces below, indicating you understand the policies. Please feel free to speak with our staff member should you have any questions.

All patients must complete our "Patient Information Form" prior to seeing the doctor.

1. Co-payments. All co-payments need to be paid at the time of service. This arrangement is part of your contract with your insurance company. We accept cash, checks, and most major credit cards. If your referring physician has indicated an alternative payment plan please take the time to notify the business office representative. **Please Initial: _____**

2. Insurance. If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. Please contact your insurance company with any questions you may have regarding your coverage. **Please Initial: _____**

3. *I request that payment of authorized Medicare and/or other insurance company benefits be made to Comprehensive Urology Medical Group on my behalf for any services furnished to me by CUMG. I authorize release of any information needed to determine those benefits to pay for related services.
Please Initial: _____

4. PPOs. Please check your insurance provider booklet to see if we are members of your specific plan. If we are not, you will be responsible for the balance not covered by your insurance plan, regardless of the insurance company's determination of usual and customary rates. If we are a participating provider***, you will only be responsible for non-covered services, co-payments, co-insurance and deductibles.***
Please Initial: _____

5. HMOs. We DO NOT accept any HMO plans. If you have an HMO policy regardless of the payor (i.e., Medicare, HealthNet, etc.) you will be considered a cash patient in the practice and payment at the time of the service is expected. **Please Initial: _____**

6. Medicare. Our medical group accepts Medicare assignment; which means that you will be responsible for the co-insurance and deductibles, and the difference between what we charge and what Medicare approves will be written-off. In the event that you have a secondary carrier, you will only be responsible for the deductible if your secondary carrier does not pay the Medicare deductible. Recent Federal Legislation has made it illegal for physicians to routinely write off co-insurances and deductibles.
Patients who have enrolled in any Medi-Cal plan as their secondary insurance will be responsible for the 20% co-insurance/share of cost & deductible (if applicable). **Please Initial: _____**

7. Advance Beneficiary Notice or Waiver of Liability (Non-Covered Services). Medicare or your insurance (including Medi-Cal) may **not** pay for all your healthcare services. They may pay only for services they deem "covered services". The fact that they will not pay for a particular service does not mean that it is not medically necessary. You will be informed of how much these services may cost and will be asked to sign the waiver of liability forms. **Please Initial: _____**

COMPREHENSIVE UROLOGY

Patient Name: _____ Date of Birth: _____

8. Insurance Verification. Upon completion of verification of your insurance if it is deemed that your benefits are ones which we are not a participating provider, ***you will be financially responsible for all services provided to you.*** **Please Initial: _____**

9. Claim submission. We cannot bill your insurance unless you bring in all insurance information. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract. **Please Initial: _____**

10. Insurance Cards. Photocopies of the front and back of all insurance cards will be obtained at the time of the visit. If this information changes at any time you are responsible for providing us with the updated information. If we do not receive your complete insurance information, your account will be assigned a cash status, and payment in full will be required at the time of the visit. **Please Initial: _____**

11. Authorization to release information. CUMG physicians and staff may give out written or verbal information concerning my medical records to any insurance carrier or agent that is authorized to have access to and make copies of my medical records. **Please Initial: _____**

12. Self-Pay/Balance After Insurance Payment. Self-pay patients are required to pay 100% fee for service at the time of the visit. In addition, once the insurance company has paid their contractual portion of the bill, the balance is the patient's responsibility. **Please Initial: _____**

13. Non-payment. If your account is over 60 days past due, you will receive a letter stating you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. If a balance remains unpaid, we may refer your account to a collection agency. Should the account be referred to an attorney or collection agency, the undersigned agrees to pay the actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. **Please Initial: _____**

14. Missed appointments. It is important to give us at least 24 hours notice if you will not be able to make an appointment. You will be charged if cancellation does not occur within 24 hours (weekday) of your appointment. Established patient office visits $65.00/ Special Procedures $200.00 (UD, Cysto, PNS or PFR). All CT scans will be charged at a rate of $250.00 if not given a 24 hour notice. Please note that bonafide emergencies may be exempt from this policy. **Please Initial: _____**

15. Special letters and Healthcare related form completion (i.e., DMV, disability, life insurance & jury duty). Any requests for a letter describing any medical conditions and/or treatments will be charged at a rate of $40.00. **Please Initial: _____**

16. Copy of medical records, CD copies. Any request for copies of medical records is a charge of $40 and CD copies will be charged $25 each (request will be completed within 5 to 7 business days from request). Rush request will be charged an additional fee (to be determined by office based on number of pages in chart - expedited within 48 hours of request) **Please Initial: _____**

COMPREHENSIVE
UROLOGY

Patient Name: _____ Date of Birth: _____

17. Submission of authorizations and/or appeals for medications and/or services exceeding the normal scope of care. Should your insurance require an authorization for medication and/or services due to special circumstances outside the range of normal expectation a charge of $55.00 will be incurred. This charge is applied due to the amount of time that is required to expedite your medication and/or services to obtain the best results for your medical care. Please note that this request for authorization does not guarantee that your insurance will approve the medication/service being requested.

Please Initial: _____

18. Special Service(s). There will be particular moments in which a phone consultation and/or telemedicine will be completed versus an in-office visit. These services are not covered by insurance and are defined as discussions that exceed the "normal" conversations following laboratory services and/or ancillary services.

Please Initial: _____

ACKNOWLEDGEMENT OF RECEIPT OFCOMPREHENSIVE UROLOGY MEDICAL GROUP (CUMG)
NOTICE OF FINANCIAL POLICIES

By signing this document, I acknowledge that I understand and agree with CUMG's Financial Policies

Name (printed): _____ Date: _____

Signature: _____

A. Notifier: Comprehensive Urology Medical

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance doesn't pay for **D.** *Phone and/or on-line Services* below, you may have to pay.

Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect yourinsurance may not pay for the **D.** *Phone and/or on-line services* below.

This agreement provides the availability for telephone appointments with our providers without having to come to the office to discuss things that do not require a visit to the office.

D. Phone and/or On-Line Services	E. Reason Blue Shield Of California May Not Pay:	F. Estimated Cost
99441 - Phone conversation w/physician 5 to 10 minutes of medical discussion	**Non-Covered Service**	**99441 - $55**
99442 - Phone conversation w/physician 11 to 20 minutes of medical discussion		**99442 - $65.00**
99443 - Phone conversation w/physician 21 to 30 minutes of medical discussion		**99443 - $85.00**
98966 - Phone conversation w/physician extender (nurse, NP or PA) 5 to 10 minutes of medical discussion		**98966 - $50.00**
98967 - Phone conversation w/physician extender (nurse, NP or PA) 11 to 20 minutes of medical discussion		**98967 - $60.00**
98968 - Phone conversation w/physician extender (nurse, NP or PA) 21 to 30 minutes of medical discussion		**98968 - $80.00**
99444 - Email or some other on-line services to discuss a medical problem w/a physician		**99444 - $50.00**
98969 - Email or some other on-line services to discuss a medical problem w/a physician extender		**98969 - $40.00**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** *Phone and/or on-line services* listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** phone and/or on-line services listed above. You may ask to be paid now, but **I** also want my insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my insurance doesn't pay, **I** am responsible for payment, but **I can appeal to** my insurance by following the directions on the EOB**.** If my insurance does pay, you will refund any payments **I** made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** phone and/or on-line services listed above, but do not bill my insurance. You may ask to be paid now as **I** am responsible for payment. **I cannot appeal if my insurance is not billed**.

☐ **OPTION 3.** I don't want the **D.** phone and/or on-line services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

H. Additional Information:

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**

Pulse 4 Pulse

COMPREHENSIVE UROLOGY

RISK ASSESSMENT FOR CARDIOVASCULAR WELLNESS

Patient Name **Date of Birth**:

Provider:

1. Do you have erectile dysfunction (if applicable)?	**YES**	**NO**
2. Do you experience urinary dysfunction (such as incontinence, urgency, frequency, nocturnal enuresis, etc.)	**YES**	**NO**
3. Do you frequently experience pelvic pain?	**YES**	**NO**
4. Do you have chronic kidney disease?	**YES**	**NO**
5. Have you been diagnosed with low testosterone, a thyroid or hormonal disorder?	**YES**	**NO**
6. Do you have sleep apnea?	**YES**	**NO**
7. Do you have diabetes?	**YES**	**NO**
8. Do you have heart disease?	**YES**	**NO**
9. Do you smoke or have a history of smoking?	**YES**	**NO**
10. Do you ever have pain or numbness in your fingers, hands, toes or feet or do they ever feel cold?	**YES**	**NO**
11. Do you ever get pain in your legs when you walk, have trouble walking, or have an unsteady gait?	**YES**	**NO**
12. Do you experience excessive sweating (hyperhidrosis)?	**YES**	**NO**
13. Do you have high cholesterol?	**YES**	**NO**
14. Do you experience digestive dysfunction (such as abdominal distention, pain, constipation, loss of voluntary bowel control, GERD, IBS, etc.)?	**YES**	**NO**
15. Do you frequently experience lightheadedness/dizziness?	**YES**	**NO**
16. Do you have high or low blood pressure?	**YES**	**NO**

If the patient answers yes to the following, **DO NOT PERFORM SUDOMOTOR:** (circle one)

Does patient have pacemaker, defibrillator?	**YES / NO**
Cardiac stents and/or hip replacement in past 3 months?	**YES / NO**

If the patient answers yes to the following, **DO NOT PERFORM ANS:** (circle one)

Has the patient had Laser Retinopathy Surgery in past 3 months?	**YES / NO**
Has the patient been told they have an Atrioventricular (AV) block?	**YES / NO**
Is the patient pregnant?	**YES / NO**

PATIENT NAME: _____ **PATIENT SIGNATURE:**_____ **DATE:** _____	Did the patient have COVID-19 or were they exposed? YES / NO MA INITIAL: _____

COMPREHENSIVE UROLOGY

SLEEP DISORDER ASSESSMENT

Your physician is requesting that you complete this Sleep Assessment Form.
This form determines the need for you to have a sleep test, which will evaluate if you have a sleep disorder. Sleep Disorders negatively affect your cardiovascular health and well being, but can be effectively treated.

Date: **Name:**

Phone Number: **Physician Name:**

Home Address:

Part 1.

1. Have you ever been told you have Congestive Heart Failure? Yes ☐ No ☐
2. Have you ever been told you have Coronary Artery Disease? Yes ☐ No ☐
3. Have you ever had a stroke? Yes ☐ No ☐
4. Do you take medications for high blood pressure? Yes ☐ No ☐
5. Have you ever experienced irregular heart rhythms? Yes ☐ No ☐
6. Have you ever been told that you stop breathing at night? Yes ☐ No ☐
7. Do you have diabetes? Yes ☐ No ☐

Part 2.

1. Have you been told that you snore? Yes ☐ No ☐
2. Do you awaken from sleep with chest pain or shortness of breath? Yes ☐ No ☐
3. Does your family have a history of premature death in sleep? Yes ☐ No ☐
4. Is your neck size larger that 15.5 inches (female) or 17.0 inches (male)? Yes ☐ No ☐
5. Have you ever been diagnosed with Obstructive Sleep Apnea? Yes ☐ No ☐
6. Are you currently being treated for sleep apnea? Yes ☐ No ☐

6a. If yes, are you using your apparatus every night? Yes ☐ No ☐

Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale:
0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

Part 3.

1. Being a passenger in a motor vehicle for an hour or more	0	1	2	3
2. Sitting and talking to someone	0	1	2	3
3. Sitting and reading	0	1	2	3
4. Watching TV	0	1	2	3
5. Sitting inactive in a public place	0	1	2	3
6. Lying down to rest in the afternoon	0	1	2	3
7. Sitting quietly after lunch without alcohol	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Score: _____

Scoring Methodology: One "Yes" in Part 1 and one "Yes" in Part 2 order the sleep study or Part 3 score greater than 8 order sleep study

_____

Physician Signature **Date:**

COMPREHENSIVE UROLOGY MEDICAL GROUP

Effective January 1, 2005

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. Our practice uses health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our practice.

HOW OUR PRACTICE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

For Treatment. Our practice may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as physicians, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and not how you respond to these actions.

For Payment. Our practice may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. Our practice may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to member of the medical staff, risk or quality improvement personnel, and others in order to:

evaluate the performance of our staff;

assess the quality of care and outcomes in your case and similar cases;

learn how to improve our facilities and services; and

determine how to continually improve the quality and effectiveness of the health care we provide

Appointments. Our practice may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required by Law. Our practice may use and disclose information about as required by law. For example, our practice may disclose information for the following purposes:

for judicial and administrative proceedings pursuant to legal authority;

to report information related to victims of abuse, neglect or domestic violence; and

to assist law enforcement officials in their law enforcement duties.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be used to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donations. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research. Our practice may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and Safety. Your health information may be disclosed to avert a serious threat to health or safety of you or any other person pursuant to applicable law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Worker's Compensation. Your health information may be used or disclosed in order to comply with

laws and regulations related to Worker's Compensation.

Other Uses. Other uses and disclosures will be made only with your written authorization, and you may revoke the authorization except to the extent of our practice has taken action in reliance on such.

YOUR HEALTH INFORMATION RIGHTS

You have the right to:

request a restriction on certain uses and disclosures of your information as provided by 45 C.F.R. 164.522; however, our practice is not required to agree to a requested restriction;

obtain a paper copy of the notice of information practices upon request;

inspect and obtain a copy of your health record as provided for in 45 C.F.R.164.524;

request that your health record be amended as provided in 45 C.F.R. 164.526;

request communications of your health information by alternative means or at alternative locations; and

receive an accounting of disclosures made of your health information as provided by 45 C.F.R. 164.528.

COMPLAINTS

You may complain to our Privacy Officer and/or to the Department of Health and Human Services if you believe your privacy right have been violated. You will not be retaliated against for filing a complaint.

OBLIGATIONS OF OUR PRACTICE

Our practice is required by law to:

maintain the privacy of protected health information;

provide you with this notice of its legal duties and privacy practices with respect to your health information;

abide by the terms of this notice;

notify you if we are unable to agree to a requested restriction on how your information is used or disclosed; and

accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.

notify you if a breach in the security of your Protected Health Information (PHI) occurs

Our practice reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by in-office handouts or via our website.

CONTACT INFORMATION

If you have any questions of complaints, please contact:

Privacy Officer:
Lina Barricello