UROLOGICAL Associates of Savannah, P.C.

Dr._____
Date of Appt_____

PATIENT INFORMATION FORM

Last Name _____First Name_____ MI___
Home Address (**NO PO BOXES**)_____
City _____ State_____ Zip_____ Is your mailing address same as home? ▢ Y ▢ N
Mailing Address _____
City_____ State_____ Zip_____
Home Phone _____ Work _____Ext_____ Cell_____
Email_____
How would you like for us to contact you? (appt reminders) ▢ **Email** ▢ **Text** ▢ **Cell** ▢ **Home**
Date of Birth____/_____/_____ Social Security#_____ Sex: ▢ M ▢ F
Race ▢African American/Black ▢American Indian/Alaskan Native ▢Asian
▢Caucasian/White ▢Declined ▢Other Race _____ ▢Unknown
Ethnicity ▢Declined ▢Hispanic or Latino ▢Not Hispanic or Latino ▢Unknown
Marital Status: ▢ Single ▢ Widowed ▢ Divorced ▢ Married
Employer_____ Occupation_____
Employer's Address_____ Main Office #_____

Spouse or Guardian's Information

Name_____ Relationship_____ SSN _____
Employer_____ Work phone_____

Emergency Contact

Name _____ Relationship_____ Phone_____
Name _____ Relationship_____ Phone_____
Referring Physician_____ Phone_____
Primary Care Physician_____ Phone_____

Insurance Information

Name of Insured_____ Relationship to Patient _____
Insured Date of Birth ___/____/_____ SSN_____ Date employed _____
Name of Employer _____ Work #_____
Address of Employer_____ City _____State____ Zip_____
Insurance Company_____ Member ID_____ Group #_____
Insurance Company Address_____ City _____State____ Zip_____
Plan Information: Specialist co-pay_____ Deductible_____
Do you have additional insurance? Yes ▢ No▢ If yes, complete the following:
Name of Insured_____ Relationship to Patient _____
Insured Date of Birth ___/____/_____ SSN_____ Date employed _____
Name of Employer _____ Work #_____
Address of Employer_____ City _____State____ Zip_____
Insurance Company_____ Member ID_____ Group #_____
Insurance Company Address_____ City _____ State ____ Zip_____

If your visit today involved an on-the-job work injury, please give the receptionist a letter of authorization from your employer <u>prior to</u> services being rendered today.
See Reverse for our Payment Policy.

Payment Policy

The doctors and staff of Urological Associates of Savannah, P.C. are committed to providing our patients with the best possible care. If you have medical insurance, we want to be sure you receive your maximum benefits. In order to achieve this, we need your assistance and understanding of our payment policy.

All services are provided for a fee-for-service basis, unless you are associated with a managed care plan in which we participate. In this case, you will be required to pay your co-pay. Payments for office visit, insurance co-payments and deductibles are expected when the service is rendered. We accept cash, personal checks and all major credit cards.

Auto Accidents/ Other Accidents

We will not get involved in Third Party billing. When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, the patient is still responsible for payment of the bill. Urological Associates cannot be expected to wait for the conclusion of long-term court cases or settlements of a disputed insurance claim before being paid.

Worker's Compensation

Patients injured on the job should report their injury directly to their employer. The employer is responsible for directing the employee to their Panel of Physicians. Before we see you, we require a letter from your employer verifying that they are responsible for your charges. Patients cannot be seen without this verification. Your appointment will be rescheduled. This is necessary to avoid the patient being responsible.

Medicaid

Please bring your Medicaid Card to each visit; otherwise you will be directly responsible. You are responsible for any services not covered by Medicaid. South Carolina Medicaid requires a referral from your Primary Care Provider. Any appointments made without a referral will be rescheduled.

Insurance

Your insurance coverage is a contract between you and your insurance. We file your insurance as a courtesy to you. You will be asked to pay your unmet deductibles and co-pays prior to any surgery or procedure.

You may receive monthly statements even though your insurance is pending. Urological Associates cannot accept the sole responsibility for collecting your claim or negotiating a settlement on a disputed claim since we are not a party to your insurance contract. If you have a question regarding your account or the filing of your insurance, call our Insurance Department and they will be happy to assist you: (912)790-4060.

If you need to set up extended financial arrangements, please contact us before your appointment.

Consent for Treatment*: The signature below serves as consent for services/treatment to be rendered by Urological Associates of Savannah, P.C. for the below named patient. This authorizes the practice to release or receive protected health information for the purpose of treatment, payment, or healthcare operations necessary for services.*

IT IS THE PATIENT'S RESPONSIBILITY TO CONTACT OUR OFFICE FOR <u>ALL</u> TEST RESULTS IF NOT NOTIFIED OF RESULTS WITHIN FOURTEEN (14) DAYS OF TEST.

Authorization for Assignment of Benefits*: The signature below assigns benefits from the patient's insurances to Urological Associates of Savannah, P.C. The patient understands that he/she is financially responsible for any balance not covered by the insurance carrier. A copy of this signature is as valid as the original.*

*Patient Name*_____*Date*_____

*Signature*_____

UROLOGICAL ASSOCIATES OF SAVANNAH, P.C.

230 E. DeRenne Avenue • Savannah, Georgia 31405
(912) 790-4000 • (912) 352-9031
www. urologysavannah.com

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Thomas E. Shook, M.D.
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James L. Liu, M.D.
Melissa Porter, PA-C
Whitney Rintelman, PA-C
Tulsi B. Patel, PA-C
Lindsay N. Miller, PA-C
Erika Burke, FNP-C
Bailey Stephenson, FNP-C
Madison Voss, FNP-C

PATIENT FINANCIAL POLICY 2024

We are dedicated to providing you with the best possible care and service and anticipate your understanding of our financial policies as an important part of your care and treatment. To maintain this relationship, we find it necessary to implement the following financial policy.

Payment is due at the time service is rendered. For your convenience we accept cash, check, money order, Visa, MasterCard, Discover, American Express, Care Credit, Papaya and Apple Pay.

Co-payments must be paid **prior** to seeing the physician on the date service is rendered. We reserve the right to reschedule your appointment due to non-payment of your co-pay or any patient due balances currently owed. Patients are responsible for their deductibles and/or charges not reimbursed by insurance. As a courtesy to you, we file your insurance claim therefore it is **your responsibility** to provide our office with any address, phone number changes, up-to-date billing information and a **copy of your insurance cards, and a picture ID at each visit.**

Please understand that your insurance is a contract between you and your insurance company and you are ultimately responsible for the bill. If we have not received payment, we will work with your insurance company for 90 days then the balance will be transferred to patient responsibility.

Attention: It is the patient's responsibility to contact their insurance company to verify covered benefits and in network participation status.

We are specialists. If your insurance requires a **referral number** from your primary care physician, it is **your responsibility** to obtain that number prior to your visit. If you do not have a referral number, your visit may be delayed, rescheduled, or you will be asked to sign a waiver indicating that you are aware you are being seen without a referral number and will be required to pay **$175.00** prior to being seen by the physician.

Self-pay patients are required to pay **$175.00** prior to being seen for their visit and **will be balance billed for the remainder of the fees** at the time of charge posting.

Regardless of whether you receive a reminder call, message or text the below policy will remain in effect:

There will be a **$35.00 "No Show Fee"** for appointments not cancelled within 24hours.
There will be **a $100.00 "No Show Fee"** for any testing appointments not cancelled within 24hours.
There will be a **$250.00 "No Show Fee"** for any procedure scheduled at **Urology Surgery Center of Savannah** not cancelled/rescheduled within 24hours.
There will be a **$36.00** fee for checks returned for non-sufficient funds.

I consent to receive calls/texts from Urological Associates and their agents, including collection agencies or attorneys for my protected healthcare and any other reason at any phone number(s) provided, including my wireless number. I understand I may be charged for such calls/texts by my wireless carrier and that such calls/texts may be generated by an automated dialing system.

I have read and understand the financial policy of the practice and any other owned entity and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended by the practice. I authorize the release of any medical information necessary to process my insurance claim.

Signature of Patient or Responsible Party Date

Account #_____

PATIENT ACKNOWLEDGEMENT FORM

_____ _____ _____

Patient's Last Name First M Date of Birth Social Security Number

I understand that the patient's health information is private and confidential. I understand that Urological Associates of Savannah, P.C., (UAS) works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that UAS may use and disclose the patient's personal health information to help provide health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that the law may require the release of this information without permission. These situations are very unusual. An example would be if a patient threatened to hurt someone.]

UAS has a detailed document called the "Notice of Privacy Practices". It is posted in their lobby and a copy is available to me upon request. It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgement.

UAS may update this Acknowledgement and "Notice of Privacy Practices" at any time. If that occurs, the practice will provide me with the most current "Notice of Privacy Practices".

Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, accessing my medical records, restrictions on certain specified methods of communications, and/or alternative locations.

This practice has established procedures which help them meet their obligations to patients. These procedures may include: other signature requirements, written acknowledgements and authorization; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist UAS by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Urological Associates of Savannah's "Notice of Privacy Practices".

_____ _____ _____

Patients Signature **Date** **Time**

_____ **Witness**_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

FOR OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Staff Signature:	Reason:

HIPAA (Authorization for Release of Information)

I hereby authorize Urological Associates of Savannah, P.C., 230 East DeRenne Avenue, Savannah, Georgia to release the following information from the health records of:

Patient Name: _____ SS# _____ DOB: _____

TO BE RELEASED TO:

NAME _____Relationship: _____DOB: _____

NAME _____Relationship: _____DOB: _____

NAME _____Relationship: _____DOB: _____

INFORMATION TO BE RELEASED: (check all that apply)

▢ Entire Record	▢ Lab Results	▢ Nursing Notes	▢ Demographics
▢ Emergency Room Notes	▢ X-ray Results	▢ Physician's Orders	
▢ Dictated Reports (H&P, discharge summary, Op notes)	▢ Medication Administration Record	▢ Other _____	

FOR THE PURPOSE OF:

▢ Anything on behalf of the patient

▢ Creating/Changing/Cancelling appointments

▢ Viewing or correcting demographic information to include signing in on my behalf

▢ Speaking to Urological Associates' staff regarding my protected health information including but not limited to billing and insurance information on my behalf

▢ Receiving documents containing my protected health information with an authorization for release of information signed by me

▢ Picking up prescriptions, forms, and/or medications on my behalf

▢ Other _____

I understand that I can revoke this authorization by providing written notice to the address listed above or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relaying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATION ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within one year from the date listed below.

Patient Signature _____ Date _____

Patient's Guardian or Capacity _____ Date _____

Relationship to Patient _____

UROLOGICAL Associates of Savannah, P.C.

NEW PATIENT HISTORY & PHYSICAL FORM

Date: _____
Name _____
Date of Birth _____/_____/_____
Primary Care Physician: _____
Referring Physician: _____
Person Completing Form: _____
*Nurse/MA Reviewing Form: _____

NOTE: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

REASON FOR YOUR VISIT TODAY? _____

Has any physician treated you for this? ▢ Yes ▢ No Date of Last Treatment: ___/___/_____
Have you had any x-rays, CT scans or MRI's in the past year? ▢ Yes ▢ No

If yes, what type, and where was it completed? _____

_____

History of Present Illness:

On a scale of 1-10, (Circle) the number that best describes problem?

No pain 0 1 2 3 4 5 6 7 8 9 10 **The most intense pain.**

When did you first notice the problem? _____ days ago _____ weeks ago_____ months ago
Other_____

How long does the problem last? ___ minutes ___hours All the time Other_____

Does the problem interfere with your normal functions? ▢ Yes ▢ No

If yes, please explain_____

For Women Only:
How old were you when your period started? _____years of age
When was your last period? _____
Do you use any form of birth control? ▢ Yes ▢ No
Is there a possibility you are pregnant? ▢ Yes ▢ No
Who is your OB/GYN physician? _____

Past Medical and Surgical History: (Please fill out completely)

Are you allergic to any Medications? ▢ Yes ▢ No (if yes, please list and describe reaction)

Cipro	▢ Yes	▢ No	Latex	▢ Yes	▢ No	Shellfish	▢ Yes	▢ No
Erythromycin	▢ Yes	▢ No	Levaquin	▢ Yes	▢ No	Sulfa	▢ Yes	▢ No
Gentamicin	▢ Yes	▢ No	Macrobid	▢ Yes	▢ No	Tetracycline	▢ Yes	▢ No
IV Iodine (x-ray dye or contrast)	▢ Yes	▢ No	Penicillin	▢ Yes	▢ No			

Other Medication Allergies _____

Preferred Pharmacy: _____ Location _____

Pharmacy Phone_____

UROLOGICAL Associates of Savannah, P.C.

NEW PATIENT HISTORY & PHYSICAL FORM

Is it ok for us to contact your Pharmacy? ▢ Yes ▢ No

Please list all medications/supplements: (**PLEASE LIST NAME, DOSAGE, and HOW OFTEN**)

____________________	____mg	___ x a day	____________________	____mg	___ x a day
____________________	____mg	___ x a day	____________________	____mg	___ x a day
____________________	____mg	___ x a day	____________________	____mg	___ x a day
____________________	____mg	___ x a day	____________________	____mg	___ x a day
____________________	____mg	___ x a day	____________________	____mg	___ x a day
____________________	____mg	___ x a day	____________________	____mg	___ x a day
____________________	____mg	___ x a day	____________________	____mg	___ x a day
____________________	____mg	___ x a day	____________________	____mg	___ x a day
____________________	____mg	___ x a day	____________________	____mg	___ x a day
____________________	____mg	___ x a day	____________________	____mg	___ x a day
____________________	____mg	___ x a day	____________________	____mg	___ x a day
____________________	____mg	___ x a day	____________________	____mg	___ x a day

Please (Circle) if you have any of the following **medical problems** in the past or if you are currently taking medications for any of them:

None

Anxiety	Diverticulitis	Kidney Disease
Asthma	Elevated Cholesterol	Kidney Stones
Atrial Fibrillation	Emphysema	Multiple Sclerosis
Bipolar	Glaucoma	Pulmonary Embolism
Bleeding Tendency	Gout	Reflux
Cataracts	Heart Disease	Seizures
Chronic Obstructive Pulmonary Disease (COPD)	Heart Attack	Sleep Apnea
Congestive Heart Failure (CHF)	Hepatitis C	Stroke
Depression	High Blood Pressure	Thyroid Disease
Diabetes	HIV	Tuberculosis
DVT/Blood Clots	Indigestion	Ulcer

Cancer (TYPE)____

Have you had any problems with anesthesia? ▢ Yes ▢ No If yes, explain__________________

Are you currently on any blood thinners or aspirin? ▢ Yes ▢ No
If yes, for what condition? ____

Name:________________________________

UROLOGICAL Associates of Savannah, P.C.

NEW PATIENT HISTORY & PHYSICAL FORM

PLEASE LIST ANY SURGICAL PROCEDURES THAT YOU HAVE BEEN TREATED FOR IN THE PAST AND DATES OF PROCEDURE:

SURGICAL PROCEDURE	DATE OF PROCEDURE

DO YOU HAVE ANY IMPLANTED DEVICES? ▢ Yes ▢ No If YES, what type _____

IS THERE IS ANYTHING ELSE IN YOUR MEDICAL HISTORY THAT YOU THINK YOUR DOCTOR SHOULD BE AWARE OF THAT IS NOT INCLUDED ABOVE, PLEASE LIST IT HERE:

_____

Family History:

Do your parents/siblings/grandparents have any of the following health problems? **(check and list who)**

	Anesthesia Problems	
	Bleeding Tendencies	
	Cancer (type) _____	
	Diabetes	
	Elevated Cholesterol	
	Heart Attack	
	High Blood Pressure	
	Kidney Disease	
	Kidney Stones	
	Sickle Cell Disease	
	Tuberculosis	
	Other _____	

Social History:

Do you use tobacco? *CURRENT FORMER NEVER*
If current, how many packs a day? _____
How long have you been a smoker? _____
Have you quit smoking YES *or NO What* year? _____

Do you drink alcohol? *CURRENT EVERYDAY SOMEDAY FORMER NEVER*
If yes, how much? _____
How long? _____

Do you exercise regularly? ▢ Yes ▢ No If YES, how much? _____

Do you use any illicit drugs? ▢ Yes ▢ No If YES, please list _____

Occupation: _____

Name:_____

UROLOGICAL Associates of Savannah, P.C.

NEW PATIENT HISTORY & PHYSICAL FORM

Review of Systems:

Do you now or have you had any problems related to the following systems? check Yes or No

CONSTITUTIONAL SYMPTOMS

Fever	▢ Yes	▢ No
Chills	▢ Yes	▢ No
Headache	▢ Yes	▢ No

EYES

Blurred Vision	▢ Yes	▢ No
Double Vision	▢ Yes	▢ No
Pain	▢ Yes	▢ No

EAR/NOSE/THROAT/MOUTH

Ear Infection	▢ Yes	▢ No
Sore Throat	▢ Yes	▢ No
Sinus Problems	▢ Yes	▢ No

CARDIOVASCULAR

Chest Pain	▢ Yes	▢ No
Varicose Veins	▢ Yes	▢ No
High Blood Pressure	▢ Yes	▢ No
Rheumatic Fever	▢ Yes	▢ No
Heart Attack	▢ Yes	▢ No

RESPIRATORY

Wheezing	▢ Yes	▢ No
Frequent Cough	▢ Yes	▢ No
Shortness of Breath	▢ Yes	▢ No

GASTROINTESTINAL

Abdominal Pain	▢ Yes	▢ No
Nausea/Vomiting	▢ Yes	▢ No
Indigestion/Heartburn	▢ Yes	▢ No
Jaundice	▢ Yes	▢ No

INTEGUMENTARY

Skin Rash	▢ Yes	▢ No
Boils	▢ Yes	▢ No
Persistent Itch	▢ Yes	▢ No

NEUROLOGICAL

Tremors	▢ Yes	▢ No
Dizzy Spells	▢ Yes	▢ No
Numbness/Tingling	▢ Yes	▢ No

MUSCULOSKELETAL

Joint Pain	▢ Yes	▢ No
Neck Pain	▢ Yes	▢ No
Back Pain	▢ Yes	▢ No
Gout	▢ Yes	▢ No

ENDOCRINE

Excessive Thirst	▢ Yes	▢ No
Too hot/cold	▢ Yes	▢ No
Tired/Sluggish	▢ Yes	▢ No
Diabetes	▢ Yes	▢ No

HEMATOLOGIC/LYMPHATIC

Swollen Glands	▢ Yes	▢ No
Blood Clotting Problems	▢ Yes	▢ No
Anemia	▢ Yes	▢ No

ALLERGIC/IMMUNOLOGIC

Hay Fever	▢ Yes	▢ No
Drug Allergies	▢ Yes	▢ No
Asthma	▢ Yes	▢ No

GENITOURINARY

Do you get up at night to void?	▢ Yes	▢ No	Painful urination?	▢ Yes	▢ No
Do you feel as though you are empty?	▢ Yes	▢ No	Urinary frequency	▢ Yes	▢ No
Do you ever leak urine?	▢ Yes	▢ No	Sexually Transmitted Disease	▢ Yes	▢ No
Do you have urine retention?	▢ Yes	▢ No	Frequent Infections	▢ Yes	▢ No

Are you generally satisfied with your life? ▢ Yes ▢ No
Do you feel severely depressed? ▢ Yes ▢ No
Have you considered suicide? ▢ Yes ▢ No

Physician use only: (Comments/Notes)
All other systems reviewed are negative _____ (Physician's Initials)

Name:_____

UROLOGICAL ASSOCIATES OF SAVANNAH, PC
UROLOGY SURGERY CENTER OF SAVANNAH, LLLP

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

At Urological Associates of Savannah, PC and Urology Surgery Center of Savannah, LLLP (UAS), we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information or PHI.

Effective Date: September 23, 2013
This Notice was revised on March 21, 2014

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer
Mailing Address: 230 E. DeRenne Avenue, Savannah, GA 31405
Telephone: 912-790-4000
Fax: 912-790-4077

About This Notice
We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that 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 circumstances:

- **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 specialist 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. 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 team members 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.

- **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. *(Optional, only included if applicable.)*

- **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 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 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 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) 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 health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose 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 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 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.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:
1. Most uses and disclosures of psychotherapy notes
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. 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 at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice may not apply to these types of information.

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 copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days 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 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 agrees 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 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, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **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. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning 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 the 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, like 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 Privacy Officer. 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, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. 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.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **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.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning 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 Privacy Officer by phone at 912/790-4000 or mail at 230 E. DeRenne Avenue, Savannah, GA 31405.

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.

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 Privacy Officer at the address listed at the beginning of this Notice. All complaints 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/, for more information. There will be no retaliation against you for filing a complaint.

UROLOGICAL ASSOCIATES OF SAVANNAH, P.C.
230 E. DeRenne Avenue • Savannah, Georgia 31405
(912) 790-4000 • Fax (912) 352-9031

PATIENT/PROVIDER AGREEMENT

This is to advise you that Urological Associates of Savannah, P.C. is privately owned and operated. As providers of care and owners of this corporation, we reserve the right to discontinue services to patients who:

1. Are unwilling to follow medical recommendations or treatment plans
2. Are unwilling to schedule recommended follow-up visits or tests as prescribed by our providers or repeatedly miss scheduled appointments
3. Use vulgar, demanding, threatening or abusive speech towards our staff, providers, or other visitors to our facility,
4. Demonstrate abuse of medication, equipment or supplies
5. Damage our property or grounds
6. Display threatening behavior (by phone or in person) of any kind towards staff, providers, or other visitors to our facility. *(Note: Police will be called to remove unruly individuals from our premises and we will press charges to the fullest extent allowed by law.)*
7. Enter the clinical areas unescorted or otherwise violate patients' privacy rights as outlined under HIPAA
8. Are disrespectful of the needs of other patients visiting our facility

In addition to the above, should any visitor accompanying a patient display any of these behaviors, we reserve the right to discontinue service to the patient.

We feel the above actions are necessary to ensure a professional, safe, and secure environment and to ensure respectful and efficient business operations.

COVID-19 STATEMENT

Your signature below indicates that you understand that the 2019 novel coronavirus, which causes the disease COVID-19, has been declared a pandemic by the World Health Organization, is extremely contagious, and is believed to be spread by person-to-person contact. You recognize that Urological Associates of Savannah, P.C. has put in place reasonable preventative measures aimed at reducing the spread of COVID-19. However, you recognize and accept the risk of becoming infected by virtue of seeking services in-person at our facility.

NO PROVIDER TRANSFER REQUESTS

All of our physician urologists here cross-cover for each other when on call and often assist each other with difficult surgeries and hospital rounding. For these reasons, the physician ownership of Urological Associates will not allow patients to transfer their care to another provider within Urological Associates. We regret any inconvenience this may cause.

PATIENT'S SIGNATURE _____ DATE SIGNED _____