NORTH ATLANTA UROLOGY ASSOCIATES PC

Howard C. Goldberg; M.D. Douglas A. Nyhoff; M.D. Paul L. Rubin; M.D. Jin S. Yeoh M.D.

PATIENT INFORMATION SHEET

First Name: _____ Last Name: _____ Date: _____
Mailing Address: _____
City: _____ State: ____ Zip:_____
Home Number: _____
Cell Number:_____
Work Number: _____
Fax Number: _____

Sex: Male / Female (circle one) Age:_____ Date of Birth:_____Marital Status: _____
Race:_____Ethnicity: _____ Primary Language: _____
Social Security Number: _____-____-_____ Email: _____

Emergency Contact Name: _____
Phone Number: _____

Preferred Pharmacy Name: _____Address: _____
City:_____State:___ Zip: _____Phone Number: _____
Referring / Primary Care Physician: _____
Phone Number:_____

Are you a resident of a Nursing Home facility? (Yes / No) If answered yes, What is the Facility Name & Address:_____ City: _____
State: _____ Zip:_____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID#: _____
Policy Holder: _____DOB:_____

Secondary Insurance: _____ Member ID#: _____
Policy Holder: _____ DOB: _____

Patient / Guardian Signature:_____ Date: _____

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PATIENT HISTORY

Please answer all questions to your fullest ability, if there is no answer, please write N/A. If you have medications, please list them or provide your own list.

First Name: _____ Last Name: _____ DOB: _____

Reason for visit today:_____

Surgical History with dates:

_____

_____

_____

List all medical conditions that you have and had:

_____

_____

_____

List all your current medications you are taking:

_____

_____

_____

List all your drug allergies:

_____

_____

_____

FAMILY HISTORY

Do any of your immediate family members have or have had the following conditions? If yes. Please explain who has or had the illness.

Bladder Cancer_____ Prostate Cancer_____

Kidney Cancer_____ Testicular Cancer_____

Other Medical Illnesses and Conditions:

_____

SOCIAL HISTORY

Do you smoke? (Y / N) If yes, how many do you smoke per day? _____ When did you start smoking?

_____

Do you drink alcohol? (Y / N) If yes, how many drinks per day?_____

Do you drink caffeinated drinks? (Y / N) If yes, How many drinks per day?_____

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REVIEW OF SYSTEMS

Please circle or check the problems in each body system.

CONSTITUTIONAL: ___fever ___chills___weight loss

EARS, NOSE, THROAT: ___ hearing loss ___nasal stuffiness ___ sore throat

RESPIRATORY: ___ shortness of breath ___ wheezing ___coughing

CARDIOVASCULAR: ___chest pain ___ swollen ankles ___ irregular heartbeat

HEME/LYMPH: ___ swollen glands ___ abnormal bleeding ____ transfusion history

GASTROINTESTINAL: ___ abdominal pain ___change in bowels ___ nausea/vomiting

GENITOURINARY: ____incontinence ___ painful urination ___ blood in urine

MUSCULOSKELETAL: ___ chronic back pain ___chronic neck pain ___sore muscles

NEUROLOGICAL: ___ tingling ___ dizziness ___ numbness

INTEGUMENTARY/SKIN: ___ rash___ persistent itching ___history of skin cancer

PSCHOLOGICAL: ___depression ___ difficulty sleeping ___ suicidal thoughts

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RELEASE OF INFORMATION

Please initial each release of information and add an authorized contact person, with your signature.

Last Name:_____ First Name:_____ Date: _____

_____**Initials:** ASSIGNMENT OF BENEFITS: I request that payment of authorized benefits for myself and/or my dependents be paid directly to North Atlanta Urology for services rendered. I agree that my medical information may be released to my insurance company and its agents as needed for payment and health care operations. I agree that a copy of my authorization may be used in place of the original.

_____**Initials:** RELEASE OF INFORMATION BY PAYERS AND NETWORKS: I authorize my insurance company or health care maintenance organization, other payers, payer network organizations, including accountable care organizations and their contractors and third party administrators to share my health records and information obtained from my health care provider and any other provider, with my health care provider whom I have received services, or any other payer, payer network organization, including accountable care organization, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

_____**Initials:** HIPAA-NOTICE OF PRIVACY PRACTICES: I acknowledge that I have reviewed North Atlanta Urology's HIPAA policy and I understand the full HIPAA policy is available for review at the front desk and on North Atlanta Urology's website. I have read and understand that my protected health information may be used for normal health care business, scheduling appointments, planning my treatment, and obtaining payment from insurance companies.

_____**Initials:** LAB BILLING/OUTSIDE LAB BILLING: When having lab work performed at North Atlanta Urology, some testing may be sent to an outside lab for further analysis and you may receive a separate statement from the outside lab. By signing below you are agreeing to pay for these services if your insurance does not provide coverage or applies these charges to your deductible, co-pay, or co-insurance. Applicable insurance adjustments will be applied per your insurance policy.

_____**Initials:** CONSENT TO LEAVE MESSAGES: I agree that North Atlanta Urology may communicate with me concerning myself and/or my dependents treatment (lab results and appointment reminders) via fax/voice messaging and email. If I have agreed to this statement, then I agree that the following person can discuss my medical/financial information on my behalf.

Authorized Contact:_____ Relation: _____

Patient Signature:_____Date: _____

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CONSENT FOR DISCLOSURE

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means.

I hereby authorize the following person(s) to receive information pertaining to my medical care provided by North Atlanta Urology:

_____ / _____
Name Relationship to Patient

_____ / _____
Name Relationship to Patient

_____ / _____
Name Relationship to Patient

Patient Signature:_____ Date: _____

Print Name:_____DOB:_____

The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of any requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

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FINANCIAL POLICY

North Atlanta Urology is pleased that you have selected our practice to provide urological care for you and/or family. In order to better serve your needs and avoid confusion, it is important for you to understand our financial policy. North Atlanta Urology will process any and all U.S. based insurance claims on behalf of our patients. Since it is impossible for us to keep track of every insurance plan and how it works, we expect you to know your insurance coverage, co-pay and/ or deductible levels. North Atlanta Urology will assist you with your insurance card or information at the time of service. Without current insurance information you will be entered into our system as a self-pay patient. As a new self-pay patient you are required to pay $175.00 for your first consultation. Once you are a established patient, the self-pay rate is $85.00 per visit.

Co-pay/coinsurance/deductibles: All co-pay/coinsurance/deductible required by your insurance plan are collected at the time of service. Patients receiving urodynamic services should be aware that although theses services are diagnostic in nature, they may be considered surgical by your insurance company and therefore may require separate co-pay or coinsurance.

Referrals/pre-certification/prior-authorization: If an insurance referral from your primary care physician is required, you must present it at the time of service. If your choose to be seen without the appropriate referral in hand, you agree to be responsible for the charges should they not be covered by your insurance.

Disputes: If for any reason you dispute coverage or payments made by your insurance company, it is your responsibility to contact your insurance company and to resolve the matter based on your insurance company's arbitration or resolution process. We will provide documentation (providing your signature of authorization is on file) to assist in the dispute resolution process. During this time, you will be asked to pay in full the balance or schedule payment arrangements by contacting the business office at 770-995-0424.

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance of my account for any services rendered. I acknowledge that I have read and understand all of the foregoing and authorize North Atlanta urology to treat me and/ or my dependents.

Patient Signature:_____Date:_____

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclose and how you can gain access to this information. Please review it carefully.

Protected Health Information (PHI) about you is maintained as a written and/ or electronic record of your contacts or visits from you healthcare services with our practice. Specifically , PHI is information about you, including demographic information (name, address, phone numbers, etc), that may identify you and relates to your past, present, and future physical or mental health condition and relates health services. Our practice is required to follow specific rules to maintain the confidentiality of your PHI, using your information and disclosing or sharing this information with other healthcare professionals involved in your care and treatment, obtain payment for services you receive, manage our healthcare operations and for all other purposes that are permitted or require by law.

Your rights under the Privacy Rule: Following is a statement of you rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff. You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices, if you call our office or at your next appointment. The notice will also be posted in conspicuous location within the practice, and if such is maintained by the practice on it website.

You have the right to authorize other use and disclosures: This means you have the right to authorize any use or disclosure of your PHI that is not specified within the notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses and disclosures of psychotherapy note, or if we intended to sell your PHI.

You have the right to request alternative means of confidential communication: This means you have the right to ask us to contact you about medical matters using an alternative method (email/telephone), and to a destination (cellphone number/alternative address) designated by you. You must inform us in writing, using a form provided by our office, how you wish to be contacted if other than the address/phone number(s) that we have on file for you. We will follow all reasonable request. You have the right to inspect and copy your PHI. That means you may obtain and inspect a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in a electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state or federal guidelines.

You have the right to request restriction of you PHI: This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific

treatment or service that you, or someone on your behalf, has paid in full, out of pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information: This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny you request. You have the right to request disclosure accountability. This means that you may request a listing of disclosures that we have made, of you PHI, to entities or persons outside of our office. You have the right to receive to receive a privacy breach notice, you have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required. If you have questions regarding you privacy rights, please feel free to contact information is provided on the following page under Privacy Complaints. How we may use or disclose protected health information. Following are examples of uses and disclosures of you PHI that we are permitted to make. These examples are not meant to be exhausted, but to describe possible types of uses and disclosures.

Treatment: We may use and disclose you PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose you PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other healthcare providers who may be involved in your care and treatment.

Payment: Your PHI will be used, as needed , to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommended for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations: We may use or disclose, as needed, your PHI in order for business planning and development, quantity assessment and improvement, medical review, legal services, auditing functions and patient safety activities and other permitted and patient safety activities.

Required Uses and Disclosures: We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in case of abuse or neglect; to apply with food and drug administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; workers compensation; when an inmate is in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the privacy rule.

Privacy Complaints: You have the right to complain to us or directly to the secretary of the Department of Health and Human Services if you believe you privacy rights have been violated by us.

You may file a complaint with us by notifying the Practice Manager, Jennifer Cannell, at 770-995-0424