Jeffrey A. Dann, MD

Terrence C. Regan, MD

AUI
ADVANCED UROLOGY
INSTITUTE

We would like to take this time to welcome you to our office as a new patient.

Enclosed are patient information forms for you to complete. Some of these questions may seem unrelated to your problem. However, your cooperation in completing these forms will help us in diagnosing and treating your illness, as well as understanding the relation to other problems you may have had. Please answer **ALL** questions and return the completed forms to our office. Once your forms are received and entered into the computer system, we will contact you to schedule an appointment.

It is important to bring your insurance card and a picture ID with you on the day of your appointment.

We accept Medicare assignment; however, you are responsible for any deductible and the 20% difference between the Medicare allowable and the Medicare payment. Payment of your portion is expected at the time services are rendered. If your insurance plan requires a co-pay, please be prepared to pay it at the time services are rendered.

Please be advised that our office sees patients by appointment only. We do not see walk-in patients. If you feel it is an emergency, please call 911. If you are having an issue that you don't feel is an emergency, please call our office at the number listed below so we can route your message appropriately. All messages are addressed by the next business day.

PLEASE BRING A LIST OF YOUR CURRENT MEDICATION WITH YOU.

Thank you,

Advanced Urology Institute, LLC
Palm Coast

21 Hospital Drive
Suite 140
Palm Coast, FL 32164
Phone (386) 445-8530 Fax (386) 446-5087

Jeffrey A. Dann, MD

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ADVANCED UROLOGY INSTITUTE

Terrence C. Regan, MD

Date: _____ SSN: _____

Date of Birth: _____ Age: _____ Sex: ❑ M ❑ F Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino

Race: ❑ White ❑ Black/African American ❑ American Indian/Alaskan ❑ Native Hawaiian ❑ Other_____

Primary Language: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient Name: _____ _____ _____
Last Name First Name Middle
Address: _____ City: _____ State: _____ Zip_____

Summer/Winter Address: _____ City: _____ State: _____ Zip_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Employer: _____
Would you like to participate in the Patient Portal? ❑ Yes ❑ No

Primary Care Physician: _____ Referring Physician: _____
Pharmacy: _____ Location: _____ Phone Number: _____

Emergency Contact:
Name:_____Address:_____Phone:_____Relation:_____
Spouse's Name: _____Date of Birth: _____ SSN: _____
Address (if different from above): _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Financially Responsible Party: _____ Relation: _____

Primary Insurance Co. _____ Phone: _____
Policy Subscriber Name: _____ DOB: _____
Relation: _____ SSN _____ Policy #_____ Group # _____

Secondary Insurance Co. _____ Phone: _____
Policy Subscriber Name: _____ DOB: _____
Relation: _____ SSN _____ Policy #_____ Group # _____

Third Insurance Co. _____ Phone: _____
Policy Subscriber Name: _____ DOB: _____
Relation: _____ SSN _____ Policy #_____ Group # _____

Authorization to Release Medical Information: I hereby authorize the above physician to release any information necessary to process my insurance claim.
Authorization to Pay Benefits: I authorize lifetime payment of medical benefits to the above named physician/medical group.
Payment for services is expected at the time of service, unless advance payment arrangements have been made. Insurance is filed as a courtesy. It does not eliminate the patient's responsibility for payment. I certify the information I have provided is correct.

_____
Patient Signature Date

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Date: _____ Name: _____ DOB: _____

GENERAL REVIEW OF PERSONAL HISTORY: (a copy of this may be added to your hospital record)
Describe any non-urological symptoms you presently have:

Depression or anxiety: _____

Nerologic (e.g. weakness, numbness, dizziness, seizures): _____

Eyes (e.g. glaucoma, double vision): _____

Ears, nose, throat, sinuses: _____

Respiratory (e.g. shortness of breath, asthma, bronchitis, bloody sputum):_____

_____

Cardiovascular (e.g. angina, palpitations, congestive failure): _____

_____

Gastrointestinal (e.g. stomach, intestines, gallbladder, liver): _____

_____

Other: _____

_____

Are you an "easy bleeder"? ❑ Yes ❑ No Have you ever had a blood transfusion? ❑ Yes ❑ No
List any past operation or immunizations and their approximate dates:
Colonoscopy ❑ Yes ❑ No Date: _____ Pneumonia Vaccine ❑ Yes ❑ No Date: _____

Operation: _____ Date: _____ Operation: _____ Date: _____
Operation: _____ Date: _____ Operation: _____ Date: _____
Operation: _____ Date: _____ Operation: _____ Date: _____

List any past serious illnesses and approximate dates:

Illness: _____ Date: _____ Illness: _____ Date: _____
Illness: _____ Date: _____ Illness: _____ Date: _____
Illness: _____ Date: _____ Illness: _____ Date: _____

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Date: Name: DOB:

List all present medications, dosages and reasons for use (include non-prescription drugs taken frequently also (e.g. Aspirin):

Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____

List all allergies, particularly medication and food allergies:

Allergic to iodine? ❑ Yes ❑ No Reaction: _____
Allergic to seafood? ❑ Yes ❑ No Reaction: _____
Allergic to Latex? ❑ Yes ❑ No Reaction: _____
Allergic to: _____ Reaction: _____
Allergic to: _____ Reaction: _____
Allergic to: _____ Reaction: _____

Smoking Status:

❑ Current everyday smoker ❑ Current someday smoker
How many per day? _____ How many years? _____
❑ Former Smoker – Year quit? _____ How many years? _____
❑ Never Smoker
Do you drink alcohol? ❑ Yes ❑ No Type: ❑ Wine ❑ Beer ❑ Liquor How may per day? ___
What is your present or former occupation? _____

FAMILY HISTORY

Cancer:	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandmother	❑ Grandfather
Diabetes:	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandmother	❑ Grandfather
Nephritis (Bright's Disease):	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandmother	❑ Grandfather
Kidney Stones:	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandmother	❑ Grandfather
Bleeding Tendencies:	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandmother	❑ Grandfather
Heart Trouble:	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandmother	❑ Grandfather
High Blood Pressure:	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandmother	❑ Grandfather

Other: _____

Mother: ❑ Living age: ____ ❑ Deceased/age of death: ____ Cause of death: _____
Father: ❑ Living age: ____ ❑ Deceased/age of death: ____ Cause of death: _____
Sisters: number living: _____ age(s): _____
number deceased: _____ age(s) at death: _____ Cause of death: _____
Brothers: number living: _____ age(s): _____
number deceased: _____ age(s) at death: _____ Cause of death: _____
Children: number living: _____ age(s): _____
number deceased: _____ age(s) at death: _____ Cause of death: _____

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Date: Name: DOB:

MUST BE COMPLETED PRIOR TO SEEING THE PROVIDER

Height: _____ Weight: _____

PLEASE CHECK OFF ANY OF THE FOLLOWING SYMPTOMS THAT YOU HAVE:

- ❑ Fever
- ❑ Chills
- ❑ Weight Loss
- ❑ Blurry Vision
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Hearing Loss
- ❑ Sinus Congestion
- ❑ Sore Throat
- ❑ Chest Pain
- ❑ Irregular Heartbeat
- ❑ Swollen Ankles
- ❑ Shortness of Breath
- ❑ Wheezing
- ❑ Cough
- ❑ Abdominal Pain
- ❑ Nausea/Vomiting
- ❑ Oxygen use
- ❑ Blood in Urine
- ❑ Diarrhea/Constipation
- ❑ Vaginal Dryness
- ❑ Chronic Back Pain
- ❑ Urinary Leakage
- ❑ Skin Lesions
- ❑ Rashes
- ❑ Erectile Dysfunction
- ❑ Decreased Libido
- ❑ Numbness
- ❑ Joint Pain
- ❑ Walks with Cane/Walker
- ❑ Depression
- ❑ History of Skin Cancer
- ❑ Current Skin Lesion
- ❑ Tingling
- ❑ Dizziness
- ❑ Headaches
- ❑ Panic Attacks
- ❑ Poor Memory

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rev. 10/2018

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Date: Name:

DOB: Referring Physician:

Have you ever been seen by a Urologist? ❑ Yes ❑ No Urologists name?

Symptoms or problems which lead you to seek help:

How many times is your sleep interrupted to urinate?

Do you have pain during urination?

When awake do you urinate:
❑ an appropriate frequency
❑ more often than usual, but not a problem
❑ enough to be a problem

When you need to urinate do you feel:
❑ you can wait if necessary
❑ you can wait a brief time
❑ you must urinate immediately

How long do you have to wait to start urination after you reach a bathroom?
❑ not at all
❑ some delay but not a problem
❑ enough to be concerned

Do you notice slowing or weakness of your urinary stream?
❑ not at all
❑ some delay but not a problem
❑ enough to be concerned

Any abnormality in urine such as:
❑ blood
❑ cloudy urine
❑ strong odor to urine

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Date: Name: DOB:

Any pain felt related to urinary tract?
❑ Yes ❑ No
Location: _____
Describe Pain (e.g. burning, sharp, ache, etc): _____
_____

Any incontinence (urinary leakage) enough to be a problem?
❑ Yes ❑ No
❑ get warning but can't wait
❑ leak without warning (e.g. with coughing, sneezing, laughing)

Check any of the following that apply:
❑ must strain or bear down to start your urinary stream
❑ intermittent urinary stream
❑ must return to the bathroom to completely empty your bladder
❑ a history of kidney stones
❑ a history of urinary tract infections
❑ a history of sexually transmitted disease

Have you ever had a catheter or cystoscopy (procedure where a scope is passed to look at your bladder) performed?
❑ Yes ❑ No If yes, when? _____

FEMALES ONLY (check all that apply):

❑ Menstrual irregularities
❑ Vaginal discharge
❑ Urinary symptoms after intercourse
❑ Post menopausal bleeding
❑ Pain with intercourse

MALES ONLY (check all that apply)

❑ Pain in testes
❑ Pain with ejaculation
❑ Difficulty obtaining an erection, maintaining an erection or both
❑ Swelling of testes
❑ Blood in semen

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ADVANCED UROLOGY INSTITUTE

Check the Facts

ABOUT YOUR URINARY ACTIVITIES

NAME AGE

Circle your score for each below.

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always
1 Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2 Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3 Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
4 Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5 Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6 Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5

	None	1 time	2 times	3 times	4 times	5 or more times
7 Over the last month or so, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

From the American Urological Association (AUA) Symptom Index for BPH.

Total Symptom Score = Sum of Questions 1 to 7 = ____

SYMPTOM SCORE = 1-7 Mild 8-19 Moderate 20-35 Severe

Quality of Life How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
	0	1	2	3	4	5	6

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record

- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- Sale of your information

In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

We can use your health information and share it with other professionals who are treating you.

We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. Your information may be shared w/ other providers, labs and radiology groups through our EHR system as listed:

1) Lab Corp 2) Quest Diagnostic 3) Dianon Pathology

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Preventing or reducing a serious threat to anyone's health or safety
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence
- Reporting adverse reactions to medications

Do research, Comply with the law, Respond to organ and tissue donation requests, Work with a medical examiner or funeral director.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions as military, national security, and presidential protective services

Respond to lawsuits and legal actions

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

You Have A Right To File A Complaint If You Feel Your Privacy Has Been Violated

- If you feel your Privacy Rights have been violated, please ask our staff for a Privacy Complaint Form. Our Security Officer will review the form and promptly notifiy you of the actions our office will take.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Advanced Urology Institute LLC

HIPAA Compliance Officer: Jerri Creggar

Phone: 386-239-8500

This Notice of Privacy Practices is effective December 1, 2015

Jeffrey A. Dann, MD

ADVANCED UROLOGY INSTITUTE

Terrence C. Regan, MD

Date: _____

Name: _____ Date of Birth: _____

Advanced Urology Institute, LLC is authorized to release protected information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information: Please mark each person/entity that you approve to receive any personal or medical information	**Description of Information to be Release:** Please mark each area of information that may be given to the person/entity listed on the left in the same section.
❑ Answering Machine	❑ Messages regarding appointments, lab tests/x-rays or procedures ❑ Any other information regarding treatment ❑ Any information regarding Medications
❑ Spouse (please provide name, DOB and phone #) _____ _____	❑ Billing Information ❑ Financial/Insurance Information ❑ Medical Information (treatments, results, etc.)
❑ Parents/Children (please provide name(s), DOB and phone#): _____ _____ _____ _____	❑ Billing Information ❑ Financial/Insurance Information ❑ Medical Information (treatments, results, etc.)
❑ Other (please provide name(s), DOB and phone #) _____ _____	❑ Billing Information ❑ Financial/Insurance Information ❑ Medical Information (treatments, results, etc.)

Expiration Date: Provide an expiration date that this authorization will expire: _____

If no expiration date is given, this authorization will expire 1 year from the below signature date!

RIGHTS OF THE PATIENT: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Advanced Urology Institute, LLC. I understand that revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned or signing. This authorization will be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority: _____

Acknowledgment of Privacy Notice

In compliance with HIPAA regulations, I have been given the opportunity to review the Joint Privacy Notice for Advanced Urology Institute, LLC. I understand a copy of this policy is available for me to take home for my records.

_____ _____

Signature of Patient or Personal Representative Date

21 Hospital Drive
Suite 140
Palm Coast, FL 32164
Phone (386) 445-8530 Fax (386) 446-5087

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ADVANCED UROLOGY INSTITUTE

Terrence C. Regan, MD

Date: Name: DOB:

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials	Reason:

21 Hospital Drive
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ADVANCED UROLOGY
INSTITUTE

Terrence C. Regan, MD

Date: Name: DOB:

FINANCIAL POLICY OF ADVANCED UROLOGY INSTITUTE, LLC

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, personal checks, MasterCard, Visa and Discover. Returned checks are subject to a service charge of $25.00 and you may lose your privilege to write checks in our office.

PRIVATE INSURANCE COMPANIES THAT WE "ARE" A PROVIDER WITH. Co-payment and deductible must be paid at the time of service. If we are unable to verify your insurance coverage, you may be responsible for full payment at the time of the service. Because we are under contract with the insurance company, we will file your insurance claim. If payment is not received from your insurance company within a reasonable time, the full balance will be transferred to the responsibility of the patient (or guardian).

If you provide us with incorrect or invalid insurance information and we need to re-enter and resubmit your corrected insurance information, there may be a $20 administrative charge for each claim that has to be refiled.

PRIVATE INSURANCE COMPANIES THAT WE "ARE NOT" A PROVIDER WITH. You will be responsible for payment in full at the time of service and our office will file the claim form as a courtesy with your insurance company.

MEDICARE. Your deductible and 20% of the allowable charges are due at the time of service. Since we are a Medicare provider, we will file your Medicare. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare processes the claim. If you have a secondary insurance policy, we will file the claim as a courtesy.

CHILDREN OF DIVORCED PARENTS. Payment will be due from the person who is with the child today no matter who is responsible by divorce decree.

MISSED APPOINTMENTS. We ask for 24 hours notice to cancel an appointment. Patients who do not call to cancel an appointment may be charged $25. A third no-show may result in the patient being discharged from the practice.

FORMS AND RECORDS. For completion of disability and cancer policy forms, there will be a $10 charge for a one-sided form and a $15 charge for a two-sided form. Medical records requested will have a charge of $1 per page for the first 25 pages, and twenty-five cents for every page thereafter. Forms and records will be released only after the payment has been collected.

FINANCIAL AGREEMENT. We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you and the insurance company. We are not privy to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (such as elective sterilization, infertility evaluation, screening lab tests, etc.)

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account after 90 days, including those that your insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our billing department at (386) 274-1947.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the Financial Policy.

Signature (Patient, Guardian, or Power of Attorney

Date

21 Hospital Drive
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SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

ADVANCED UROLOGY INSTITUTE

ADDENDUM
TO THE STATE OF FLORIDA PATIENT BILL OF RIGHTS

YOU HAVE THE RIGHT TO:

Chose a health care provider

Be informed of any financial benefits when referred to an organization