ADVANCED UROLOGY INSTITUTE

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MAIN OFFICE
80 Doctors Drive
Panama City, FL 32405

AdvancedUrologyInstitute.com

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Dear Patient:

We would like to take this opportunity to welcome you to our practice. We look forward to meeting you and providing the highest quality urological care. In order to facilitate your appointment, we ask that you please take a few moments and complete the enclosed forms. By doing this before your visit, we hope to make your visit as efficient as possible.

We need you to bring the following to your appointment:

- Completed forms
- Insurance cards
- Driver's license or picture ID
- Insurance co-pay
- List of medications and allergies
- CD (disk) or x-ray forms, if performed, relating to your current problem.

If your insurance requires a referral or pre-authorization when seeing a specialist, please contact your primary care physician and confirm this has been completed.

We appreciate you taking the time to help us streamline your visit and serve you as efficiently as possible. If you have any questions or need any assistance, please call our office. We will be happy to help you in any way we can.

We are looking forward to meeting you,

Sincerely,
Advanced Urology Institute
Panama City

Advanced Urology Institute ▪ Adult Patient History

Name:_____ Chart #:_____

Date of Birth:_____ Age:_____ Today's Date:_____

Reason for visit: _____ Problem for how long? _____

Referring Provider: _____ Other Treating Providers: _____

Past Medical History

Heart and Blood Vessels
- ☐ Anemia
- ☐ Angina (Chest Pain)
- ☐ Aortic Aneurysm
- ☐ Atrial Fibrillation
- ☐ Arrhythmia (Irregular beat)
- ☐ Bleeding Problem
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ DVT or Blood Clots
- ☐ Endocarditis
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Valve Problem
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Heart Valve Replacement

Endocrine and Hormones
- ☐ Diabetes (Not on insulin)
- ☐ Diabetes (On insulin)
- ☐ Gout
- ☐ Hyperthyroidism (High)
- ☐ Hypothyroidism (Low)

General
- ☐ Hernia (Location:_____)
- ☐ Lupus
- ☐ Malaise (Weak and Fatigued)
- ☐ Sleep Apnea

Abdomen and Intestines
- ☐ Cholelithiasis (Gall Stones)
- ☐ Colitis (Colon Inflammation)
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Gastritis
- ☐ GERD (Acid Reflux)
- ☐ Hemorrhoids
- ☐ Hepatitis-Type A B or C ____
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Peptic Ulcer
- ☐ Ulcerative Colitis

Urinary
- ☐ AIDS or HIV
- ☐ Bladder Cancer
- ☐ Bladder Stone
- ☐ Bladder Infections
- ☐ BPH (Enlarged Prostate)
- ☐ Chronic Kidney Failure
- ☐ Chronic Prostatitis
- ☐ Condyloma (Genital Warts)
- ☐ Erectile Dysfunction
- ☐ Hematuria (Bloody Urine)
- ☐ Interstitial Cystitis
- ☐ Kidney Cancer
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Nerve Damaged Bladder
- ☐ Orchitis (Testicle Infection)
- ☐ Polycystic Kidney Disease
- ☐ Prostate Cancer
- ☐ Transplant (Kidney)
- ☐ Undescended Testicle
- ☐ Venereal Disease

Gynecology
- ☐ Endometriosis
- ☐ Ovarian Cyst
- ☐ Uterine Fibroids
- ☐ Vaginal Prolapse/Bulge
- ☐ Vaginal Inflammation

Head and Neck
- ☐ Blindness
- ☐ Deafness
- ☐ Glaucoma (Open or Closed?)
- ☐ Mumps

Muscles and Bones
- ☐ Arthritis
- ☐ Back Pain
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis

Brain and Psychiatric
- ☐ Alzheimer's Disease
- ☐ Anxiety or Depression
- ☐ Bipolar Disorder
- ☐ Epilepsy or Seizure Disorder
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Spinal Cord Injury
- ☐ Stroke

Lungs
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema (COPD)
- ☐ Pneumonia
- ☐ Pulmonary (Lung) Blood Clot

Tumors and Cancer
- ☐ Bladder Cancer
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Renal (Kidney) Cancer
- ☐ Testicle Cancer

List Any Other Medical Problems Here: _____

_____

_____

_____

_____

Past Surgical History

Kidneys/Ureters
- ☐ ESWL lithotripsy (R or L)
- ☐ Nephrectomy (Kidney Removal)
- ☐ Nephrolithotomy
- ☐ Pyeloplasty
- ☐ Renal Kidney Transplant
- ☐ Ureteroscopy

Bladder/Urethra
- ☐ Artificial Urinary Sphincter
- ☐ Bladder Surgery
- ☐ Cystolithopaxy (Bladder Stone)
- ☐ Cystoscopy (Bladder Scope)
- ☐ Interstim (Spinal Stimulator)
- ☐ TURBT (Bladder Tumor)

Prostate
- ☐ Biopsy of Prostate
- ☐ Brachytherapy (Prostate Seeds)
- ☐ Cryotherapy (Prostate Freezing)
- ☐ Prostate Radiation
- ☐ Radical Prostatectomy
- ☐ TUIP (Incision of Prostate)
- ☐ TURP (Resection of Prostate)

Penis
- ☐ Circumcision
- ☐ Meatotomy
- ☐ Penile Implant

Scrotum
- ☐ Epididymis excision (R or L?)
- ☐ Hydrocele excision (R or L?)
- ☐ Testicle excision (R or L?)
- ☐ Varicocelectomy (R or L?)
- ☐ Vasectomy

Heart and Vascular Surgery
- ☐ AICD (Implanted Defibrillator)
- ☐ Angioplasty / Stent
- ☐ Aortic Aneurysm Repair
- ☐ CABG (Heart Bypass)
- ☐ Carotid Bypass
- ☐ Pacemaker
- ☐ Valve Replacement

General
- ☐ Laminectomy
- ☐ Parathyroidectomy

Gastrointestinal Surgery
- ☐ Abdominal Hernia Repair
- ☐ Appendectomy
- ☐ Cholecystectomy (Gall Bladder)
- ☐ Colectomy (Colon Removal)
- ☐ Colostomy
- ☐ Hemorrhoidectomy
- ☐ Inguinal Hernia Repair (R or L?)
- ☐ Laparoscopy
- ☐ Liver Surgery
- ☐ Colonoscopy (Date:_____)

Gynecologic Surgery
- ☐ Breast Implants
- ☐ Cystocele Repair
- ☐ C-Section x _____
- ☐ Vaginal Delivery x _____
- ☐ D and C x _____
- ☐ Hysterectomy
- ☐ Mastectomy (R or L)
- ☐ Ovarian Cyst Removal (R or L)
- ☐ Rectocele Repair
- ☐ Tubal Ligation

Head And Neck Surgery
- ☐ Ear Surgery
- ☐ Eye Surgery
- ☐ Facial Surgery
- ☐ Nasal Surgery
- ☐ Sinus Surgery
- ☐ Thyroid Surgery
- ☐ Tonsillectomy

Musculoskeletal Surgery
- ☐ Amputation
- ☐ Arm Surgery (R or L?)
- ☐ Arthroscopy Knee (R or L?)
- ☐ Carpal Tunnel Surgery
- ☐ Cervical Spine Surgery
- ☐ Knee Replacement (R or L?)
- ☐ Hip Replacement (R or L?)
- ☐ Hip Pin / Rod (R or L?)
- ☐ Leg Surgery (R or L?)
- ☐ Lumbar Spine Surgery
- ☐ Shoulder Surgery (R or L?)

Repiratory Surgery
- ☐ Lung Surgery

Skin Surgery
- ☐ Basal Skin Cancer
- ☐ Melanoma
- ☐ Squamous Cell Cancer

List Any Other Surgeries Here: _____

_____

_____

_____

Sexual History: Sexual Activity: ☐ Not Sexually Active ☐ Active, Single Partner ☐ Active, Multiple Partners

HIV/AIDs Risk or Exposure? ☐ Yes ☐ No

Sexually Transmitted Disease: ☐ Chlamydia ☐ Gonorrhea ☐ HPV ☐ Condyloma ☐ Herpes ☐ HIV/AIDS

Females: Number of Pregnancies: _____ Number of Live Births: _____ Miscarraiges: _____ Abortions: _____

Family History:
- ☐ Arthritis
- ☐ Alzheimers
- ☐ Bedwetting
- ☐ BPH (Enlarged Prostate)
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ COPD
- ☐ Dementia
- ☐ Diabetes Mellitus
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Stones
- ☐ Renal (Kidney) Failure
- ☐ Stroke
- ☐ Thyroid Disease

Other Family History: _____

_____

Pneumococcal Vaccination? ☐ Yes ☐ No Approximate Date: _____

 Name: _____ ***Date:*** _____

Social History: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Common Law Spouse

Education: ☐ Primary School ☐ High School ☐ College Degree ☐ Professional Degree

Occupation: _____ Hobbies: _____

Living Situation: ☐ Lives at home alone ☐ Lives at home with others ☐ Nursing Home / Assisted Living

Alcohol Use: ☐ None ☐ Occasional ☐ Liquor (ounces per day: _____) ☐ Beer (how many per day: _____)

Tobacco Use: ☐ None ☐ Previously smoked (_____ packs a day, quit in _____) ☐ Current Smoker (_____ packs a day)

Recreational Drugs: ☐ None ☐ Previous user (_____) ☐ Current user (_____)

Caffeinated Beverages: ☐ None ☐ Low ☐ Moderate ☐ Excessive ☐ Coffee (_____ cups a day)

Foreign Travel: ☐ None ☐ Canada ☐ Mexico ☐ Central America ☐ South America ☐ Europe ☐ Far East ☐ Other_____

Review of Systems

Constitutional:
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Generalized Weakness
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Weight Loss

Eyes:
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Glaucoma

Allergies:
- ☐ Drug Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies

Neurological:
- ☐ Balance Problems
- ☐ Dizzy Spells
- ☐ Fainting Spells
- ☐ Headache
- ☐ Leg or Arm Weakness
- ☐ Memory Loss
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizures

Endocrine:
- ☐ Diabetes
- ☐ Pituitary Disease
- ☐ Thyroid Disease
- ☐ Too hot/cold

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Acid Reflux
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomitting
- ☐ Trouble Swallowing

Cardiovasular:
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Shortness of Breath
- ☐ Swelling of Ankles

Integumentary / Skin:
- ☐ Acne
- ☐ Boils
- ☐ Changing Moles
- ☐ Persistent Itch
- ☐ Skin Rash

Musculoskeletal:
- ☐ Back Pain
- ☐ Bone Pain
- ☐ Joint Pain
- ☐ Muscle Cramps
- ☐ Neck Pain/Stiffness

Ear/Nose/Throat/Mouth:
- ☐ Congestion
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Sinus Problems
- ☐ Sore Throat

Genitourinary:
- ☐ Blood in Urine
- ☐ Burning Urination
- ☐ Erection/Ejaculation Problem
- ☐ Flank Pain
- ☐ Infertility
- ☐ Loss of Sexual Interest
- ☐ Nocturia/Urinating at Night
- ☐ Painful Ejaculation
- ☐ Premature Ejaculation
- ☐ Phimosis (Tight Foreskin)
- ☐ Scrotal Pain
- ☐ Suprapubic/Bladder Pain
- ☐ Urgent Urination
- ☐ Frequent Urination
- ☐ Urine Leakage
- ☐ Weak Urine Stream

Respiratory:
- ☐ Coughing up Blood
- ☐ Frequent Coughing
- ☐ Shortness of Breath
- ☐ Wheezing

Hematologic/Lymphatic:
- ☐ Aspirin or Blood Thinner Use
- ☐ Bleeding Problems
- ☐ Swollen Lymph Nodes/Glands

Psychological:
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal Thoughts

Medications: _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies (Medicines, Latex, IVP dye): _____

_____

Advanced Urology Institute

RAMOS, HEALEY, KARAMAN, JENKINS, HITT, JAMES WILKINS, PA-C, JENNA HURLEY, PA-C
80 Doctors Drive – Panama City, FL. 32405 – Phone 850-785-8557 – Fax 850-771-0111

Patient Name:_____ Age:_____ Date of Birth:_____

LAST FIRST MI

Please Circle: Male / Female **Marital Status:** Single Married Divorced Surviving Spouse

Address:_____ Home Phone:_____

City / State / Zip:_____ Work Phone :_____

Social Security #:_____ Cell Phone:_____

Email:_____

Employer Address:_____ Occupation Dept. :_____

Employer Address:_____

Do you live in a Nursing Home:_____ Name of Facility:_____

Address of Facility:_____ Phone:_____

Emergency Contact:_____ Relationship:_____

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

Spouse Name:_____ Date of Birth:_____

LAST FIRST MI

Social Security #:_____ Employer:_____ Occupation:_____

Address:_____

Person Responsible for Charges?_____

(if patient has a legal Guardian) Name Home Phone Work Phone

Primary Insurance:_____ Insurance ID #:_____ Group #:_____

Address:_____

Subscriber's Name:_____ Subscriber's Date of Birth:_____

Secondary Insurance:_____ Insurance ID #:_____ Group #:_____

Address:_____

Subscriber's Name:_____ Subscriber's Date of Birth:_____

Family Physician:_____ Reason for Appointment:_____

Referring Physician:_____ Address:_____

Drug Allergies:_____ Latex Allergy:_____

Pharmacy:_____ Phone:_____

Today's Date:_____

General Consent to Diagnosis and Treatment

I, the undersigned, for myself or another person for whom I have authority to sign, hereby consent to medical care (including disclosing my history, having a physical exam performed upon me, diagnostic testing, and treatment with medication or minor surgery), as ordered by a provider, while such medical care and treatment is provided through Advanced Urology Institute (AUI) on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary. This consent extends to all AUI providers and office locations. I understand that this consent is continuing in nature- even after a diagnosis has been made or treatment begun.

Specific Consent for Genital or Pelvic Examination:
I specifically consent to have a genital exam performed on me if my AUI provider so recommends. For males, this consent includes an examination of the external genitals and the prostate gland; for females, this consent includes a pelvic exam: the external genitals and the internal genitalia (vagina, cervix, uterus, fallopian tubes, ovaries, and rectum). I understand that I will sign a separate consent that is specific to a provider and date, and I may withdraw this consent at any time.

Consent for Specific Procedures
I understand that some specific office or hospital procedures involve additional benefits and risks, and I may be asked to sign a separate consent form for those procedures- if deemed necessary by my AUI provider. I understand that I have the right to discuss a treatment plan with my provider, and I have the right to refuse specific diagnostic tests or treatment procedures.

Consent for Health Information Exchange
I grant permission to my AUI Provider to download and exchange medical information about me- including but not limited to past and current medications, lab and radiology test results, hospitalizations, and visits to other providers participating in such exchanges- in order to ensure that my medical history is complete and accurate. This authorization will remain in effect until my death or the day I withdraw my permission. I understand that AUI may only disclose my protected health information (PHI) according to federal and state laws and the separate authorization to use and disclose PHI.

Consent for Disposal of Medical Waste (biological specimens)
I further understand during the course of my care it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis that does <u>not</u> involve the examination of your DNA, but from which DNA could potentially be extracted to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements. It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal. By signing this document, I affirmatively state that it is my intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with AUI to a third party as set forth above.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required):

_____

DATE:_____TIME:_____A.M./P.M.

MEN'S HEALTH ASSESSMENT QUESTIONNAIRE

Sponsored by GlaxoSmithKline, Makers of

AVODART (dutasteride)

Name _____ *Date* _____

American Urological Association Symptom Index (AUA-SI)*[1]

Circle the answer that best describes your symptoms.

Urinary symptoms during the past month	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. How often have you had a sensation of not emptying your bladder completely?	0	1	2	3	4	5
2. How often did you urinate more than once within a 2-hour period?	0	1	2	3	4	5
3. How often have you stopped and started several times while urinating?	0	1	2	3	4	5
4. How often have you had difficulty postponing urination?	0	1	2	3	4	5
5. How often have you had a weak urinary stream?	0	1	2	3	4	5
6. How often did you strain to begin to urinate?	0	1	2	3	4	5

7. How many times did you get up during the night to urinate?	0 TIMES	1 TIME	2 TIMES	3 TIMES	4 TIMES	5 TIMES

*Adapted from the AUA-SI

Total Score: _____

BOTHER ASSESSMENT QUESTION

Overall, how bothersome has any trouble with urination been during the last month?

❑ *Not at all bothersome* ❑ *Bothers me a little* ❑ *Bothers me some* ❑ *Bothers me a lot*

Sexual Function Question

Would you like to talk to the doctor about sexual function? ❑ yes ❑ no

AVODART is indicated for the treatment of symptomatic benign prostatic hyperplasia (BPH) in men with an enlarged prostate to improve symptoms, reduce the risk of acute urinary retention, and reduce the risk of the need for BPH-related surgery.

Only your doctor can tell if your symptoms are from an enlarged prostate and not a more serious condition such as prostate cancer. See your doctor for regular exams.

Women and children should not take AVODART 0.5mg Soft Gelatin Capsules. Women who are, or could become pregnant, should not handle AVODART due to the potential risk to a developing male fetus.

Men treated with AVODART should not donate blood until at least 6 months after their final dose. Tell your doctor if you have liver disease. AVODART may not be right for you.

Possible side effects include sexual side effects, breast tenderness and/or swelling. These side effects occur infrequently.

Please see Patient Information on the reverse side.

GlaxoSmithKline

Reference: 1. Barry MJ, Fowler FJ Jr, O'Leary MP, et al, and the Measurement Committee of the American Urological Association. The American Urological Association symptom index for benign prostatic hyperplasia. J Urol. 1992;148:1549-1557.

Advanced Urology Institute

RAMOS, HEALEY, KARAMAN, JENKINS, HITT,
JAMES WILKINS, PA-C, JENNA HURLEY, PA-C
80 Doctors Drive – Panama City, FL 32405 – Phone 850-785-8557 – Fax 850-785-1123

Financial Policy

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, Discover, and American Express as payment for office services deductibles, copays and co-insurance.

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).

Please note that if you do not provide us with the correct, current insurance information at each date of service, you will be responsible for any charges incurred.

PRIVATE INSURANCES 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.

Self Pay- **For our patients who do not have insurance coverage, we will require a $175 deposit each visit that will go towards your date of service. The patient is solely responsible for all charges from the date of service rendered. Our billing office is available to discuss your account and setup up payment options after all charges have been processed.**

Surgical Services: Payment of co-pays, deductibles and co-insurances will be collected prior to surgery. If requested, a written estimate of charges will be given to you along with the patient's estimated balance owed after insurance has paid. We will file with third payers for the assigned insurance balance only.

Hospital Services: Payment of co-pays, deductibles and co-insurances will be collected before hospitalization. If requested, a written estimate of charges will be given to you along with the patient's estimated balance owed after insurance has paid. We will file with third payers for the assigned insurance balance only.

Non-Payment Accounts: Any insurance balance will be billed to the insurance carrier. If the insurance carries does not pay, you will be responsible for the payment. Any balances with no payment activity will be forwarded to a collection agency.

Missed Appointment: We ask for 24 hours' notice to cancel an appointment. Patients who do not call to cancel an appointment may be charged $25.00. 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 $10.00 charge for a one-sided form and $15.00 charge for a two-sided form. Medical records requested will have a charge of $1.00 per page for the first 25 pages, and twenty-five cents for every page thereafter. Forms and records will be released only after payment has been received.

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 party 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 test, 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 over 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 occur, please contact our billing department at (850)785-8557.
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.

My signature below certifies that I have read and understand the terms of the financial policy.

Print (Patient, Guardian, or Power of Attorney)	**Date of Birth**
Signature (Patient, Guardian, or Power of Attorney)	**Date**
Witness	**Date**

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80 Doctors Drive – Panama City, FL. 32405 – Phone 850-785-8557 – Fax 850-785-1123

Cancellation Policy / No Show Policy for Doctor Appointments and Surgery

1. *Cancellation/ No Show Policy for Doctor Appointments*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call or cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advanced you will be charges a twenty five dollar ($25) fee; this will not be covered by your insurance.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Patients who NO-SHOW three (3) or more times in a 12 month period may be dismissed from the practice thus they will be denied any future appointments.

2. *Scheduled Appointments*

We understand that delays can happen, however, we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we may have to reschedule the appointment.

3. *Cancellation / No Show Policy for Surgery*

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 3 days in advance for minor surgery and 7 days in advance for major surgery, you will be charged a seventy five dollar ($75) fee; this will not be covered by your insurance company.

4. *Account balances*

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100.00 must make payment arrangements prior to future appointments being made.

_____

Print Name Patient

_____

Signature Patient / Guardian

_____ _____

Today's Date Patient Account # (Office Use)

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80 Doctors Drive – Panama City, FL. 32405 – Phone 850-785-8557 – Fax 850-785-1123

Authorization for Release of Medical Records

Patient: _____ DOB: _____

Phone: _____ Acct #: _____

By signing this authorization, I authorize Advance Urology Institute to use, receive, or disclose certain (PHI) Protected Health Information about myself.

Release Records To:

Primary Doctor: _____Phone/Fax:_____

Oncologist: _____Phone/Fax:_____

Radiologist: _____Phone/Fax:_____

Other: _____Phone/Fax:_____

Please have my physician send the following information. (Mark all that apply)

- o Complete Record
- o Radiology (CT,US, X-ray)
- o PET CT
- o Labs
- o Operative notes
- o Pathology / Biopsy

Purpose of Disclosure: Further Medical Treatment

This release will expire one (1) year from the signed date.

I understand that I have the right to revoke this authorization at any time by providing written notice to this practice.

- o Call patient to pick up records.
- o Mail to patient or other. Address: _____

_____ _____

Signature of patient or legal guardian **Date Signed**

_____ _____

Patient Name or legal guardian (Please Print) **Relationship to the patient**

----------For Office Use----------

Date requested: _____ Date released: _____

Date Copied: _____ Employee: _____

Privacy Notice

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

This joint notice applies to the staff, volunteers, business associates, and physicians who provide services on behalf of any Advanced Urology Institute office location, outpatient diagnostic or treatment center, laboratory, or affiliated ambulatory surgery center. Advanced Urology Institute locations and providers are located throughout Florida. This notice describes how we will use and share your information, how we are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your health or condition and related health care services. We will tell you if your PHI has been breached. We are required to abide by the terms of the notice currently in effect. If you have questions about any part of this notice or if you want more information about our privacy practices, contact our Privacy Officer at the privacyofficer@auihealth.com.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of your medical information to the extent required by state and federal law.
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you.
- Notify affected individuals following a breach of unsecured medical information under federal law.
- Notice that is currently in effect.

HOW WE (Including Our Affiliated Entities and Other Physicians Who Are Treating You) MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We are committed to protecting the privacy of your health information. The law permits us to use or share your health information for the following purposes:

- **Treatment**: We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice).
- **Payment**: We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. For example, obtaining approval for payment of services from your health plan may require that your PHI be shared with your health plan. We may also provide your PHI to our business associates or other providers' business associates, such as billing companies, transcriptionists, collection agencies, and vendors who mail billing statements. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Your Rights Regarding Medical Information About You, we will follow that restriction on disclosure unless otherwise required by law.
- **Health Care Operations**: We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers. In addition, we may also provide your PHI to accountants, attorneys, consultants, accrediting agencies, outside funding sources and others to make sure we're complying with the laws that affect us.

- **Notification and Communication with Family**: Unless you object, we may release to a relative, close friend or any other person you identify, information that directly relates to that person's involvement in your health care or who helps pay for your care. We may also use or release PHI to notify or assist in notifying a family member, personal representative or any other person responsible for your care to tell them your location or general condition. If you are unable to provide written authorization, agree or object to the release, we may release information as necessary if we determine that it is in your best interest based on our professional judgment, such as emergency situations. Finally, we may use or share your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and releases to family or other individuals involved in your health care.
- **Required by Law, Court or Law Enforcement**: We may release PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence, when dealing with crime or when ordered by a court.
- **Quality Assurance**: We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.
- **Utilization Review**: We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.
- **Credentialing and Peer Review**: We may need to use or disclose your medical information for us to review the credentials, qualifications and actions of our health care providers.
- **Treatment Alternatives**: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.
- **Public Health**: As required or permitted by law, we may release PHI or a limited data set to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.
- **Health Oversite Activities**: We may release PHI to health agencies for activities authorized by law. These oversight activities include audits, investigations and inspections, as necessary for our licensure and for the government to monitor the health care system, government programs and compliance with civil rights laws. For example, we may release PHI to the Secretary of the Department of Health & Human Services so they can determine or compliance and privacy.
- **Deceased Person Information**: We may release your health information to coroners, medical examiners and funeral directors. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.
- **Organ and Tissue Donation**: If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- Research: We may, in certain situations, release your health information or limited data set to researchers conducting research. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."
- **Specific Government Functions**: We may share your health information for military or national security purposes or in certain cases if you are in law enforcement custody.
- **Law Enforcement, National Security and Intelligence Activities**: In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary, to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates**: If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.
- **Workers' Compensation**: We may share your health information as necessary to comply with workers' compensation laws. We report any injuries referred to us from an employer to the Department of Workers' Compensation and any work-related deaths to OSHA. All employers are given health information regarding work-related injuries they have referred to us.
- **Appointment Reminders and Health Related Benefits and Services**: We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone; leaving a message

on an answering machine; sending a text or email message) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

- **Fundraising, Marketing and the Sale of PHI**: We may contact you to participate in fundraising activities. You have a right to opt out of receiving such fundraising communications. We will not sell your PHI or use or disclose it for marketing purposes without your specific permission.
- **Florida State-Specific Requirements**: When Florida's laws are stricter than federal privacy laws, we are required to follow the state law.
- **Affiliated Covered Entity**: PHI will be made available to staff at local affiliated entities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to PHI at their locations to assist in reviewing past treatment information as it may affect treatment at this time. You may contact the Privacy Department for more information on specific sites included in this affiliated covered entity.
- **Treatment of Sensitive Information**: Psychotherapy notes and diagnostic and therapeutic information regarding mental health, drug/alcohol abuse or sexually transmitted diseases (including HIV status) will not be disclosed without your specific permission, unless required or permitted by law.
- **Military and Veterans**: If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.
- **Fundraising**: We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

OTHER USES OF MEDICAL INFORMATION

- **Authorizations**: There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.
- **Right to Revoke Authorization:** If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights:

- **Right to Inspect and Copy**. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's Privacy Officer at the address listed in below. If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law. If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you. In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will

review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

- **Right to Amend**. If you feel the medical information, we have about you 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 the Practice. To request an amendment, your request must be in writing and submitted to the Privacy Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), is not part of the information kept by the Practice, is not part of the information which you would be permitted to inspect and copy, or is accurate and complete. If we deny your request, we will notify you of that denial in writing.

Your Health Information Rights

- **Right of an Accounting of Disclosure.** You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations or disclosures made pursuant to your specific authorization, or certain other disclosures. If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's Privacy Officer at PrivacyOfficer@auihealth.com for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations. To request a list of accounting, you must submit your request in writing to the Practice's Privacy Officer at the address at the bottom of this Notice. Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical 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. Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's Privacy Officer at the address listed below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply. As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).
- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such

confidential communications, you must make your request in writing to the Practice's Privacy Officer at the address listed below. We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's Privacy Officer at the address below.
- **Right to Breach Notification.** In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's Privacy Officer at the address listed below or by asking the office receptionist for a current copy of the Notice.

COMPLAINTS

If you believe that your privacy rights as described in this Notice have been violated, to file a complaint to the Privacy Officer, send a written letter to the address or email address below:

Advanced Urology Institute
Attn: Privacy Officer
26750 US Highway 19 North
Suite 200
Clearwater, FL 33761
PrivacyOfficer@auihealth.com
Ph# 727-287-4586

The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's Privacy Officer at the address email address above.

Advanced Urology Institute

RAMOS, HEALEY, JENKINS, HITT, KARAMAN,
JAMES WILKINS, PA-C, JENNA HURLEY, PA-C
80 Doctors Drive – Panama City, FL. 32405 – Phone 850-785-8557 – Fax 850-785-1123

Acknowledge of Receipt of Notice of Privacy Practice

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

Advanced Urology Institute 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.

My signature below certifies that I have read and understand the terms of the policy.

I _____ **acknowledge that either (Please check appropriate box):**

☐ I have received a copy of Advanced Urology Institute's Notice pf Privacy Practices;

☐ I declined the offer copy of Advanced Urology Institute's Notice pf Privacy Practices. A copy of that notice a copy of that Notice of Privacy Practices is available at our website advancedurologyinstitute.com.

This notice describes how Advanced Urology Institute may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Entity to Receive Information: Check each person / entity that you approve to Receive any personal or medical information.	**Description of Information to be released:** Please check each area of information that may be given to the person/entity listed on the left in the same section.
☐ Answering Machine	☐ Message regarding appointments, lab test / x-rays or other procedures. ☐ Any other information regarding traetment. ☐ Any information regarding medications.
☐ Spouse (provide name & date of birth) _____	☐ Billing information ☐ Financial / Insurance information ☐ Medical information (treatments, results,etc)
☐ Parents/Children (provide name & date of birth) _____ _____	☐ Billing information ☐ Financial / Insurance information ☐ Medical information (treatments, results,etc)
☐ Other (provide name & date of birth) _____ _____	☐ Billing information ☐ Financial / Insurance information ☐ Medical information (treatments, results,etc)

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 written notification to Advanced Urology Institute.

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 subjected 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 on signing this authorization shall be in effect until revoked by the patient.

_____ _____ _____

Signature (Patient, Guardian, or Power of Attorney) **Date** **Date of Birth**

_____ _____

Witness **Date**

AUI
ADVANCED UROLOGY
INSTITUTE

Manage Your Healthcare Online, Anytime

Patient Portal

24/7 Access

- Request Appointments
- Request Prescription Refills
- Educational Materials
- View Your Medical Profile
- Send Messages to Clinical Staff

Sign Up Today!

Ask any member of our valuable team, how to access the patient portal.