

SUMMARY OF NOTICE OF PRIVACY PRACTICES

THIS SUMMARY IS PROVIDED TO ASSIST YOU IN UNDERSTANDING THE ATTACHED "NOTICE OF PRIVACY PRACTICES".

THE ATTACHED NOTICE OF PRIVACY PRACTICES CONTAINS A DETAILED DESCRIPTION OF HOW OUR OFFICE WILL PROTECT OUR HEALTH INFORMATION, YOUR RIGHTS AS A PATIENT AND OUR COMMON PRACTICES IN DEALING WITH PATIENT HEALTH INFORMATION. PLEASE REFER TO THAT NOTICE FOR FURTHER INFORMATION

USES AND DISCLOSURES OF HEALTH INFORMATION:

WE WILL USE AND DISCLOSE YOUR HEALTH INFORMATION IN ORDER TO TREAT YOU OR TO ASSIST OTHER HEALTH CARE PROVIDERS IN TREATING YOU. WE WILL ALSO USE AND DISCLOSE YOUR HEALTH INFORMATION IN ORDER TO OBTAIN PAYMENT FOR OUR SERVICES OR TO ALLOW INSURANCE COMPANIES TO PROCESS INSURANCE CLAIMS FOR SERVICES RENDERED TO YOU BY US OR OTHER HEALTH CARE PROVIDERS. FINALLY, WE MAY DISCLOSE YOUR HEALTH INFORMATION FOR CERTAIN LIMITED OPERATIONAL ACTIVITIES SUCH AS QUALITY ASSESSMENT, LICENSING, ACCREDITATION AND TRAINING OF STUDENTS.

USES AND DISCLOSURES BASED ON YOUR AUTHORIZATION:

IN THE FOLLOWING CIRCUMSTANCES, WE MAY DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION:

- ❖ TO FAMILY MEMBERS OR CLOSE FRIENDS WHO ARE INVOLVED IN YOUR HEALTH CARE.
- ❖ FOR CERTAIN LIMITED RESEARCH PURPOSES.
- ❖ FOR PURPOSES OF PUBLIC HEALTH AND SAFETY.
- ❖ TO GOVERNMENT AGENCIES FOR PURPOSES OF THEIR AUDITS, INVESTIGATIONS AND OTHER OVERSIGHT ACTIVITIES.
- ❖ TO GOVERNMENT AUTHORITIES TO PREVENT CHILD ABUSE OR DOMESTIC VIOLENCE.
- ❖ TO THE FDA TO REPORT PRODUCT DEFECTS OR INCIDENTS.
- ❖ TO LAW ENFORCEMENT AUTHORITIES TO PROTECT PUBLIC SAFETY OR TO ASSIST IN APPREHENDING CRIMINAL OFFENDERS.
- ❖ WHEN REQUIRED BY COURT ORDERS, SEARCH WARRANTS, SUBPOENAS AND AS OTHERWISE REQUIRED BY LAW.

PATIENT RIGHTS:

AS OUR PATIENT, YOU HAVE THE FOLLOWING RIGHTS:

- ❖ TO HAVE ACCESS TO AND/OR A COPY OF YOUR HEALTH INFORMATION.
- ❖ TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE OF YOUR HEALTH INFORMATION.
- ❖ TO REQUEST THAT WE COMMUNICATE WITH YOU IN CONFIDENCE.
- ❖ TO RECEIVE NOTICE OF OUR PRIVACY PRACTICES.

IF YOU HAVE A QUESTION, CONCERN OR COMPLAINT REGARDING OUR PRIVACY PRACTICES, PLEASE REFER TO THE ATTACHED NOTICE OF PRIVACY PRACTICES FOR THE PERSON OR PERSONS WHOM YOU MAY CONTACT.

ADVANCED UROLOGY OF SOUTH FLORIDA

LAWRENCE M. YORE, M.D., F.A.C.S. ❖ EDWARD M. SCHECKOWITZ, M. D., F.A.C.S. ❖ EMANUEL E. GOTTENGER, M.D., F.A.C.S.

5130 LINTON BOULEVARD ▪ SUITE F-6 ▪ DELRAY BEACH ▪ FLORIDA ▪ 33484 ▪ PHONE: 561-496-4444 ▪ FAX: 561-496-2001

HIPPA Privacy Acknowledgement

I, _____ have received a copy of
Advanced Urology of South Florida's Summary of Notice of Privacy Practices.

Signature of Patient

Date

Optional Disclosures:

Telephone messages may be left on my:

Home Phone _____

Cell Phone _____

Work Phone _____

Advanced Urology of South Florida has my permission to release information
regarding my medical condition to the following:

My Spouse _____
Print Name Contact Number

My Children _____
Print Name Contact Number

Other _____
Print Name Contact Number

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PATIENT INFORMATION FORM ~ PLEASE PRINT CLEARLY

PATIENT NAME		TODAY'S DATE
LOCAL ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	BUSINESS PHONE
OUT OF TOWN ADDRESS		
CITY, STATE, ZIP CODE		OUT OF TOWN PHONE NUMBER
EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE NUMBER
PATIENT'S DATE OF BIRTH	AGE	PATIENT'S SOCIAL SECURITY NUMBER
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		SPOUSE'S NAME
OCCUPATION	EMPLOYER	EMPLOYER PHONE NUMBER
REFERRED BY	PRIMARY CARE DOCTOR	DOCTOR'S PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE <input type="checkbox"/> MEDICARE <input type="checkbox"/> OTHER:	POLICY NUMBER / GROUP NUMBER
INSURED PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER:	SOCIAL SECURITY NUMBER OF INSURED PARTY
SECONDARY INSURANCE	POLICY NUMBER / GROUP NUMBER
INSURED PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER:	SOCIAL SECURITY NUMBER OF INSURED PARTY

AUTHORIZATION AND ASSIGNMENT

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND ACCURATE. I HERBY AUTHORIZE ADVANCED UROLOGY OF SOUTH FLORIDA. TO RELEASE ANY INFORMATION ACQUIRED DURING MY EXAMINATION TO MY INSURANCE COMPANIES. I FURTHER AUTHORIZE PAYMENT DIRECTLY TO ADVANCED UROLOGY OF SOUTH FLORIDA. FOR SERVICES RENDERED. I UNDERSTAND AND ACCEPT THAT I AM FINANCIALLY RESPONSIBLE TO ADVANCED UROLOGY OF SOUTH FLORIDA FOR ALL INSURANCE DEDUCTIBLES AND ALL FEES NOT COVERED BY MY INSURANCE. IN THE EVENT THAT I HAVE NO INSURANCE OR MY INSURANCE IS REJECTED, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES INCURRED. IF MY INSURANCE REQUIRES A REFERRAL FROM MY PRIMARY CARE DOCTOR, I UNDERSTAND THAT I AM RESPONSIBLE FOR OBTAINING THE REFERRAL AND I UNDERSTAND THAT ADVANCED UROLOGY OF SOUTH FLORIDA CANNOT SEE ME WITHOUT IT. I FURTHER UNDERSTAND THAT I WILL BE HELD RESPONSIBLE FOR ALL FEES INCURRED IF THE REFERRAL IS NOT OBTAINED. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE AND THAT IF COLLECTION SERVICES ARE REQUIRED ON MY ACCOUNT, I WILL BE RESPONSIBLE FOR ALL FEES INCURRED.

PATIENT SIGNATURE	DATE
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PATIENT HISTORY FORM

Today's Date: _____ Date of Birth: _____ Age: _____ Primary Dr.: _____

Last Name: _____ First Name: _____ M.I. _____ Male Female

Chief Complaint

What is the main reason for your visit? _____

When did you notice the problem? _____

How long does the problem last? _____

Where is the problem located? _____

What makes it better or worse? _____

How severe is the problem on a 0 to 10 scale? (Least Severe) 0 1 2 3 4 5 6 7 8 9 10 (Most Severe)

Does it interfere with normal functions? _____

Past Medical History and Social History

Marital Status Single Married Divorced Widow

Race Caucasian African-American Hispanic Other _____

Education High School/GED College Graduate Degree Other _____

Occupation _____ Part-Time Full-Time

Use of Tobacco Yes No Former If yes, how many packs? Per Day _____ Per Week _____

Use of Alcohol Yes No Former If yes, how many drinks? Per Day _____ Per Week _____

Do you take antibiotics prior to dental work or other procedures? Yes No

If yes, Why? _____

Have you needed chemotherapy or radiation? Yes No

If yes, Why? _____

Are you taking any blood thinners? Yes No Aspirin Coumadin Other _____

List Any Surgeries/Including Dates:

List Any Medical Illness / Including Dates:

Family History

History of Prostate Cancer? Yes No If yes, Who? _____

Father Alive Deceased at Age _____ Medical Problems? _____

Mother Alive Deceased at Age _____ Medical Problems? _____

Siblings Medical Problems: _____

Children Medical Problems: _____

Remarks:

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Review of Systems

Who is your family physician? _____

If applicable, who is your cardiologist? _____

Do you now, or have you had problems related to the following:

General:

Fever Yes No

Chills Yes No

Weight Loss Yes No

Other: _____

Eyes:

Vision Difficulties Yes No

Glaucoma Yes No

Other: _____

Allergic:

Penicillin Yes No

Sulfa Yes No

IV Contrast Yes No

Other: _____

Neurological:

Dizzy Spells Yes No

Strokes (CVA) Yes No

Tremors Yes No

Other: _____

Endocrine:

Diabetes Yes No

Thyroid Disease Yes No

Excess Thirst Yes No

Heat / Cold Intolerance Yes No

Other: _____

Gastrointestinal:

Nausea / Vomiting Yes No

Ulcers / Heartburn Yes No

Hepatitis Yes No

Other: _____

Cardiovascular:

Chest Pain / Angina Yes No

Heart Attack Yes No

High Blood Pressure Yes No

Heart Murmur Yes No

Other: _____

Integumentary:

Skin Rash Yes No

Persistent Itch Yes No

Other: _____

Musculoskeletal:

Arthritis Yes No

Back Pain Yes No

Other: _____

Ear/Nose/Throat:

Dry Mouth Yes No

Sinus Problem Yes No

Other: _____

Respiratory:

Emphysema (COPD) Yes No

Shortness of Breath Yes No

Wheezes Yes No

Other: _____

Hematological/Lymphatic:

Immune Disorder Yes No

Blood Clotting Problem Yes No

Other: _____

Urological/Renal:

Erectile Dysfunction (men) Yes No

Urinary Infections Yes No

Kidney Disease/or Failure Yes No

Kidney Stones Yes No

Other: _____

Psychological:

Depression Yes No

Anxiety Yes No

Other: _____

