Associated Urologists PA

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1133 College Avenue, Bldg G, Suite 100, Manhattan, KS 66502
Telephone (785) 537-8710 Fax (785) 537-0562

To new patient or current patient:

Our Physicians and staff would like to welcome you to our practice. We appreciated your decision to select our practice to serve you with your health care needs. Our board-certified clinicians are determined to provide services at multiple locations to best serve your needs. Our main office is in Manhattan, with outpatient clinics in Abilene, Clay Center, Council Grove, Junction City, Marysville, Seneca, Onaga and Smith Center.

Appointment date _____ Time _____ Location _____

We are including paperwork that is essential to be completed and taken to your next appointment.

Our billing staff is here to assist you with your account and help with any issues you may encounter. We will make every effort to keep down the cost of your medical care. Our office and surgical fees are determined by the complexity of the procedure, time involved and the fee that is customary for our area.

- All patients need to bring in a photo ID and the most current up to date Insurance Cards, current medication list, (Drug name, dosage, and frequency). **Failure to bring photo ID and Insurance Cards** will result in a rescheduling of your appointment.

- All Self-pay patients and patients who present without proof of insurance are required to pay $100.00 in cash, money order, check, or credit card at the time of service. Failure to bring your expected payment will result in a rescheduling of your appointment. This will be applied to any other fees incurred during your care.

- Your insurance requires that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at EACH visit. There will be an additional service charge of $10.00 on all co-pays not paid at the time of service.

- If Tricare/Healthnet or Veterans Administration (VA) is your primary insurance, it is your responsibility to make sure you have a valid referral and Military issued ID for Tricare and VA issued ID for VA, otherwise your insurance will deny your visit and the payment will be your responsibility.

- All minors (under the age of 18) must have a parent or legal guardian present at the time of service (if guardian please bring the supporting legal documentation)

- If patient has DPOA then they must be present at the time of the service

If you have been referred to us, please make sure that your doctor referring you has for has forwarded your records to us. Remember to bring medical records to include x-rays, and lab work. If you need to have a radiological study or lab work ordered, it is your responsibility to make sure you contact your insurance to make sure that the study is performed by an in-network provider. If the procedure is performed by a provider that is out of Network, you will be responsible for out-of-pocket costs.

- You may need to be prepared to provide a urine specimen at the time of your appointment.

If you have any questions or concerns, please don't hesitate to get in touch with the clinic. Thank you!

Associated Urologist, P.A.

Notice of Privacy Practices for Protected Health Information
Effective Date: January 1, 2003 and revised February 04, 2011

This notice describes how medical information about you may be used and disclosed and how you get access to this information and exercise your rights regarding this information. ***Please review it carefully.***

Associated Urologist, P.A. is permitted by federal privacy laws to make uses and disclosures of your health information for purpose of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing out services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for the service.

Examples of uses of your health information for treatment purposes are:

- ☐ A nurse obtains treatment information about you and records it in a health record
- ☐ Required to disclose for: Public health, law enforcement, legal proceedings. (cases of abuse/neglect, health oversight, and as required by state and or federal law)
- ☐ During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input, and to further coordinate your care & treatment with other covered entities.
- ☐ We may use and disclose health information by telephone for appointments, treatment or medical care at Associated Urologist P.A. unless you direct us otherwise we may leave messages on your answering machine, voice mail, or with the person answering the telephone if you are not available.

An example of use of your health information for payment purposes:

- ☐ We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.
- ☐ Share certain patient health information with third party agencies for collection purposes.

An example of use of your health information for health care operations:

- ☐ We obtain services for our insurers or other business associates. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of Associated Urologist P.A. The information in it, however, belongs to you. You have the right to:

- ☐ Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office-we are not required to grant the request but we will comply with any request granted.
- ☐ Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at Associated Urologist, P.A.
- ☐ Right to inspect and copy your health records and billing record-you may exercise this right by delivering the request in writing to our office; copies will require a nominal fee.
- ☐ Appeal a denial of access to your protected health information except in certain circumstances.
- ☐ Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. We may deny your request if you ask us amend information that was not created by us; is not part of the health information kept by or for Associated Urologist, P.A.: is not part of the information that you would be permitted to inspect and copy; or, is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- ☐ Request that communication of your health information confidential and be made by alternative means or an alternative location by delivering the request in writing to our office.
- ☐ Obtain an accounting of disclosures of your health information as required to maintained by law by delivering a written request to our office; and accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to you action has already been taken by delivering a written revocation to our office.
- ☐ Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact the Privacy Officer at the Associated Urologist, P.A. at 1133 College Ave., Bldg G, Suite 100, Manhattan, KS 66502, 785-537-8710, in person or in writing, during normal hours. They will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

Associated Urologist, P.A. is required to:

- ☐ Maintain the privacy of your health information as required by law;
- ☐ Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you:
- ☐ Abide by the terms of this notice:
- ☐ Accommodate your reasonable requests regarding methods to communicate health info with you in the rights section.
- ☐ We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our “Notice” or by visiting our office and picking up a copy.

To request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information; you may contact the privacy officer at 785-537-8710.
Additionally, if you believe your privacy right has been violated, you may file a written complaint at our office by delivering the written complaint to the privacy officer. You may also file a complaint by mailing it to the Secretary of Health and Human Services whose street address is 444 SE Quincy, Topeka, Kansas.

- ☐ We will not require you to waive the right to file a complaint with the Secretary of Health and Human Resources (HHS) as a condition of receiving treatment from Associated Urologist, P.A.
- ☐ We cannot and will not retaliate against you for filing a complaint with the secretary.

Other Disclosures and Uses

Business Associates

- ☐ We have associates with whom we may share your protected health information. For example, in preparing our annual financial statement, auditors may need to review samples of the medical care given. We may disclosure your health information to the accounting firm to prepare this material.

Notification

- ☐ Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

- ☐ Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Research

- ☐ We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- ☐ We may use and disclose your protected health information to assist in disaster relief efforts

Food and Drug Administration (FDA)

- ☐ We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- ☐ If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- ☐ As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability: to report person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse and Neglect

- ☐ We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

- ☐ We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct and evaluation relating to medical surveillance of the workplace or to evaluate whether you have work related illness or injury. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

- ☐ If you are an inmate of a correctional institution for law enforcement purpose as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent and individual is in the custody of law.

Health Oversight

- ☐ Federal law allows us to release your protected your protected health information to appropriated health oversight agencies or for health oversight activities

Judicial/Administrative Proceedings

- ☐ We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- ☐ To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- ☐ We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other uses

- ☐ Other uses and disclosures besides those identified in the Notice will be only otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Changes to the Notice

- ☐ We reserve the rights to change this notice. We reserve the right to make the revised or changed notice effective for health 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 at Associated Urologist, P.A. The notice will contain on the first page the effective date.

Acknowledgement

- ☐ You will be asked to provide a written acknowledgement of your receipt of this Notice of Privacy Practices.

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Your Rights Regarding Electronic Health Information Technology

Associated Urologists PA participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything.

Second, you may restrict access to **all** of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only you choice is to permit or restrict access to all of your information.

If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information.

If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of- state health care provider regarding those rules.

PLEASE PRINT **Today's Date**: _____/_____/_____

Name: _____ Social Security #_____
Home Address: _____ Home Phone: (____) _____ -_____
City _____ State _____ Zip _____ Cell Phone: (____) _____ -_____
Email Address: _____
Sex: M F Age: _____ Birthdate_____ Single ____ Married____ Widowed ____ Divorced _____
Primary/Referring Medical Doctor: _____

Please circle which apply:
Ethnicity: Hispanic /Latino Non-Hispanic /Non-Latino Race: American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Hawaiian/Another Pacific Islander White

Language: Dutch English French Japanese Spanish

Employed By: _____ Occupation: _____
Employment Address: _____ Business Phone: (____) _____ -_____
Referred By: _____ Are you seeing us due to an injury? _____

INSURANCE INFORMATION

Person Responsible for Account _____Social Security Number _____
Relationship to Patient _____Responsible Person Birthdate _____
Address (if different from patient's) _____Phone _____
City _____ State _____ Zip_____

Primary Insurance _____ Identification Number: _____
Group Number: _____ Policyholder Name: _____ DOB: _____

Secondary Insurance _____ Identification Number: _____
Group Number: _____ Policyholder Name: _____ DOB:_____

Tertiary Insurance _____ Identification Number: _____
Group Number: _____ Policyholder Name: _____ DOB:_____

Please circle the Lab your insurance requires: Irwin Quest Lab Corp Peterson Lab

ASSIGNMENT AND RELEASE

€ I, the undersigned, hereby authorize **Associated Urologists** to **Discuss/Disclose** a report of my medical condition to or contact in case of emergency:

Name: _____ Relationship: _____Phone: _____
Name: _____ Relationship: _____Phone: _____
Name: _____ Relationship: _____Phone: _____
(Spouse, family member, caregiver, friend, durable power of attorney) **and to release my medical records to any referring or consulting physicians OR covered entity for continuation of care.**

€ I, the undersigned, certify that I (or my dependent) have insurance coverage _____

(Name of Insurance Company(ies)and assign directly to **Associated Urologists, PA** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

€ I acknowledge the receipt of Notice of Privacy Practices for Protected Health Information.
€ I agree to recurrent payment agreement for any outstanding balances, if so requested by patient.
_____ monthly _____ biweekly _____ amount to be paid

Print Patient Name: _____ **Relationship to Patient**: _____
Signature of Patient/Representative _____**Date:** _____/_____/_____

I hereby authorize medical information can be relayed to me via:

_____ Home Phone/Answering Machine Phone _____

_____ Work Phone or Voice Messaging System Phone _____

_____ Cell Phone/Answering Machine Phone _____

_____ _____
Signature of Patient/Patient Representative Date

Advance Directive is a written document, which communicates your health care wishes clearly.
There are two types of advance directive documents:

1. A Durable power of Attorney for Health Care
2. A living Will or Health Care Directive

____I **do** have an Advance Directive
Name of Person listed on my Advance Directive_____

____I **do NOT** have an Advance Directive

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have received a copy of the Provider's

Notice of Privacy Practices for Protected Health Information
Effective Date: January 1, 2003
And revised February 04, 2011

_____
Print Patient Name

_____ _____
Signature of Patient/ Patient Representative **Date**

_____
Relationship to Patient

Associated Urologists PA

Medical History Summary Today's Date: _____/_____/_____

To ensure you receive the best care possible, please fill out this form completely

Name:_____DOB:_____ Age:_____ Marital Status:_____

Height:_____Weight_____Please list your current Pharmacy:_____Location_____

Primary Care Doctor: _____

Please circle the Lab your insurance requires you to use: Quest Lab Corp Peterson Lab NA

Reason for your visit/Chief Complaint: _____

Please List Any **Medical Issues** you have (example: high blood pressure, high cholesterol, diabetes)

☐ Please check box if you don't have any medical issues

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any **surgeries** you have had: (type and date)

☐ Please check box if you haven't had any surgeries.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Medication (names, dosage, & how often do you take your medication)

☐ Please check the box if you don't take any medications.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Personal History:

Do you currently smoke? Yes No Never

If so, how long:_____

How many packs per day:

If former smoker, when did you quit?

Do you Drink alcohol? Yes No If so, how much per day:

Family Medical History (parents, grandparents, and sibling only):

Urinary Cancer (circle one and specify who): Prostate Kidney Bladder

Other cancers, please specify type and family member:

Anesthesia problems:

******PLEASE SEE OTHER SIDE******

Medication Allergies: ☐ Please check box if you don't have any medication allergies

_____ _____ _____

_____ _____ _____

Do you have a LATEX allergy? Yes or No

Do you have an IODINE allergy (topical or IV)? Yes or No

Do you have any Anesthesia Problems? Yes or No
If yes, please explain:

A. Patient Chart Number **DOB:**

B. Patient Name:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If you have no insurance or have a Medi-share plan, you are considered to be self-pay. You are required to pay $100 before each appointment.

New Patient Visits	Established Patient Visits
99202-$175	99211-$63
99203-$200	99212-$75
99204-$240	99213-$136
99205-$300	99214-$140
	99215-$200

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive or deny the **service** listed above.
- This signed form will need to be brought with you at the time of your appointment.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **service** listed above. I also understand that my payment of $100 will be applied towards my visit. I understand that I am also responsible for payment for any other charges on my account for services or procedures received.

☐ **OPTION 2.** I don't want the service listed above. I understand with this choice I am not responsible for payment and will not receive care.

H. Additional Information:

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**