HIPAA Compliance Patient Consent Form

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However such a revocation will not be retroactive.

By signing this form, I understand that:

_____The practice reserves the right to obtain and/or release copies of my medical records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on myself, for insurance/billing purposes or healthcare operation.

_____The practice reserves the right to change the privacy policy as allowed by law

_____The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions

_____The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease

_____The practice may condition receipt of treatment upon execution of this consent

May we phone you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell? YES NO

May we leave a message at your employment? YES NO

May we email to your specified email address personal private health information including but not limited to laboratory reports, treatment recommendations, relevant scientific articles and medical forms? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

____

____

This consent was signed by: ____

(PRINT NAME PLEASE)

Signature:______________________________________Date:___________________________

Witness:____Date:___________________________

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NOTICE OF PRIVACY PRACTICES

(Medical)

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

**Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
**Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
**Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we already have taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Offer.

**The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any person identifiable by you.
We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
**The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alterative locations.
**The right to inspect and copy your protected health information.
**The right to amend your protected health information.
**The right to receive an accounting of disclosures of protected health information.
**The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 1, 2003 and we are required to abide by the terms of this Notice of Privacy Practice currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint:

The US Dept of Health and Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington, DC 20201 202-619-0257 or 1-800-696-6775

The Urology Group, P.C.
Registration Form

Date: ____________________

Last Name ________________________________ First Name ____________________________

Date of Birth_____________________ Gender (circle): Male Female

Ethnicity (optional) please circle

Caucasian African American Hispanic/Latino Asian Other: ________________________

Preferred Language: ________________________

Street Address ____

City: ____ State________ Zip___________

Social Security No.: ___________________________

Patient's Employer ____

Marital Status: (circle) Married Single Divorced Widowed Separated Partner

Home Phone __________________________________Cell Phone___________________________

Work Phone__________________________________

****May we leave messages/results for you on your voice mail/answering machine/email/text message*****

I am fully aware that a cell phone is not a secure and private line.

Home: Yes □ No □ **Work:** Yes □ No □ **Cell:** Yes □ No □ **Email:** Yes □ No □

Email Address: ____

* In emergency notify: (person not living with you) _______________________________________

Relationship_________________________ Phone __________________________

Pharmacy Name and Location____

Pharmacy Phone#: ____

Mail Order Pharmacy____

Care Team

Primary Care Provider: ____

Referring Physician____

The Urology Group, P.C.
Registration Form

Insurance or Responsible Party Information

PRIMARY INSURANCE ____

Effective Date______________ Group No.: ______________________________

Subscriber No. or ID No.__________________ Subscriber Name: ________________

DOB: ____________________ Soc. Sec. No.:______________________

***PRIMARY INSURANCE'S PREFERRED LAB: ______________________________

If you do not specify which lab is in network for your insurance, you are accepting responsibility for any and all services that may be sent out for analysis by your physician during your treatment plan.

SECONDARY INSURANCE____

Effective Date: __________________ Group No.:__________________________

Subscriber No. or ID No.:____________________ Subscriber Name: ______________

DOB: ____________ _____ Soc. Sec. No.: _____________________

***** Insurance Authorization: I hereby authorize The Urology Group PC to furnish information to insurance carriers concerning my illness and treatment. I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

*****You will receive a statement upon receipt of your explanation of benefits (EOB) from your insurance company and will be required to make prompt payment in a timely fashion to avoid your account being turned over to an outside collections agency.

*****Letters / Form completion: At the discretion of the physician, letters and forms requiring medical review and physician signature are subject to a $20.00 fee per form.

*****Referrals: If your insurance company requires a referral to see a specialist, you are responsible for obtaining the referral. If the referral is not processed BEFORE your visit you will need to reschedule.

Signature of Patient or Responsible Party ______________________________

HEALTH HISTORY FORM

Please list any medication allergies and reactions:

____

____

____

If you have a latex allergy, is it a true medically diagnosed allergy?

____

Please check to indicate if you have ever had the following conditions:

____ Diabetes ____ Kidney Disease ____On dialysis

____ Coronary Artery Disease

____ High blood Pressure ____ Congestive Heart Failure

____ Heart Stent/ When? __________

____ Stroke/ When? __________

____ Heart Attack/ When? __________

____ Pacemaker or ICD if so, what brand? ____________________________

____ Pulmonary issues ____ Emphysema ____COPD

____ Hepatitis ____ HIV ____Seizures ____Sleep Apena

List of any surgeries and their approximate date/year:

Surgery:	Date/year:
____	______________
____	______________
____	______________
____	______________

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

____

____

(revised 10/2018)

What Pharmacy do you use for your prescription medications:

Please list all current medications and dosage:

Who is your Primary Care doctor/Medical doctor?

Who is your Cardiologist/Heart doctor?

Who is your Pulmonologist/Lung doctor?

Who is your Nephrologist/Kidney doctor?