We would like to take this opportunity to welcome you to the Urology Institute of Central Florida and thank you for allowing us to participate in your medical care. Urology Institute of Central Florida is office-based. Our doctors do not admit patients to hospitals or do hospital consultations or procedures. All procedures performed in the office are with local anesthesia and oral sedation. If a patient needs to be admitted, they will be referred to an admitting physician. Enclosed is a medical release form. Please complete, mail or fax back to us at your earliest convenience so we can have your records during your appointment.

Also enclosed is our new patient packet. Please complete and bring with you to your appointment along with the following:
- Insurance cards
- Photo ID
- Updated list of medications and supplements
- Any medical records, labs, diagnostic reports/films that will assist the physician with your urological care

Please be prepared to give us a urine sample.

Our office will be calling you to confirm your appointment a day or two before your scheduled appointment. We ask that you please notify our office at least 24 hours in advance if you are unable to keep this appointment by calling the office marked here between the hours of 9 a.m. and 4 p.m.

Best Regards,
Patient Services Representative
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: ________________________________

You are hereby authorized to furnish Urology Institute with copies of the medical records compiled during my treatment in your facility and are hereby released from any legal liability that may arise from the release of the information requested, including any sensitive information or genetic testing. A photo-static copy or facsimile of this authorization is to be considered as valid as the original. Information may be transmitted by fax, in person or e-mail and I am aware of the potential dangers of electronically transmitted information.

I understand that state law prohibits the re-disclosure of the information disclosed to the persons or entities listed above without my further authorization but that Urology Institute cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Medical Records Specialist to the address marked below. I further understand that any such revocation does not apply to information already released in response to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization.

Requested medical information authorized to be released: (Check items authorized to be released)

☐ Consult/H&P
☐ OP Report/Procedure Report
☐ Follow-Up Notes
☐ Progress Notes
☐ Discharge Summary
☐ Weekly CBC Reports
☐ PSA Scores
☐ All Labs
☐ Tumor Markers
☐ Pathology Reports
☐ Pathology Slides
☐ EKG
☐ All CT Scans/X-rays/Ultrasound
☐ Mammograms
☐ Entire Chart
☐ Radiotherapy Treatment Records
☐ Chemotherapy Flow Sheet
☐ Other __________________________

Patient’s Name: ____________________________  Patient’s Date of Birth: __________________

Signed: ____________________________________  Date: __________________

Relationship to Patient: ____________________________  Date: __________________

Jeffrey R. Thill, MD
Emily Perry-Hartlein, APRN • Rosemary Cavan, APRN
Phone: 352-751-0040  Fax: 352-751-2825
Mail to: 808 Highway 466, Lady Lake, FL 32159

Charles King, MD
Erin Zimmer, APRN • John A. Somers, APRN
Phone: 352-732-6474  Fax: 352-732-7205
Mail to: 2850 SE 3rd Court, Ocala, FL 34471
CELL PHONES
To avoid being distracted, please turn off your cell phone while in the exam room.

URINALYSIS
A urinalysis is performed for patients at each and every visit. Please be prepared to give a urine specimen upon arrival to the office for each visit.

PRESCRIPTIONS & REFILLS
Your prescriptions can be filled at any pharmacy or by mail unless noted otherwise. If you should need a refill, please call the pharmacy and ask them to contact our office for authorization of the refill. Please make sure you allow ample time for the request to be processed so there will be no interruption in your medication. If it has been more than 6 months to a year since your last visit, chances are a refill will not be authorized without an examination first.

TELEPHONE CALLS
Every attempt is made to return all calls on the day they are received. If you need to speak with the doctor or nurse and they are not available, know your call will be delivered to them and returned as soon as possible.

CREDIT POLICY
To avoid misunderstandings, we invite early discussion of financial questions or problems. Our requirements are as follows:
1. Payment is due at the conclusion of each visit, unless arrangements have been made prior to the visit or if you:
   A. Have Medicare: We DO accept Medicare assignment. Patients will be responsible for 20% of the allowed charges and when applicable, the annual Medicare deductible. The balance will be due once Medicare and supplemental insurance carriers, if applicable, have paid.
   B. Have other insurance: you will be responsible for your co-payments, co-insurance and deductibles.
2. Under certain circumstances payment in advance may be required.
3. Payment plans can be arranged when balances cannot be paid in full in one payment.

INSURANCE
Your insurance policy is a contract between you and the company you chose. It is important that you understand its limitations and benefits. WE CANNOT GUARANTEE PAYMENT OF YOUR CLAIM. Reductions for rejection of your claim by the insurance company may not relieve the financial obligation you have incurred, except in the instance of contract deductions of participating plans.

BILLING
An itemized statement for all outstanding services will be mailed to you on a monthly basis. If a date of service has been paid in full, it will not appear on the following statement. Balances not paid after receiving a monthly statement are subject to a billing charge.

FOLLOW UP APPOINTMENTS
Be prepared to:
1. Arrive at the office at your scheduled time. Call if you will be delayed.
2. Give a urine sample at all visits.
3. You may be asked to have a reasonably full bladder, please drink lots of fluids prior to arrival so you can comply with the request.
4. Give a list of all current prescription medications.
5. Advise of any changes in address, phone number or medical insurance.

ANESTHESIA
All procedures performed in the office are with local anesthesia and oral sedation.

OUR GOAL IS TO PROVIDE YOU WITH THE BEST POSSIBLE MEDICAL CARE
We have an uncompromising commitment to provide very personal healthcare for all our patients. You’ll always receive thorough and professional attention from everyone here; physicians, nurses and staff alike.

We encourage our patients to discuss any questions regarding our policies with us. If problems arise, please discuss them with us promptly. Every attempt is made to keep our schedule on time. We are prompt in seeing our patients and we request you arrive on time for your appointments. If you did not receive the new patient packet by mail, you should arrive 30 minutes early to complete paperwork.
# PATIENT REGISTRATION

Date: ____________________________

<table>
<thead>
<tr>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Date of Birth</th>
<th>Age</th>
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<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>County</th>
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<tr>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>E-mail</th>
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</table>

Primary Preferred Phone          Secondary Preferred Phone

Attention: We will use all phone numbers listed above to contact you as necessary for treatment and payment purposes unless you place a restriction on the use of these numbers in writing.

SSN: ____________________________  Sex: M  F  Marital Status: S  M  W  D

Race:  □ American Indian or Alaskan Native  □ Asian  □ Black or African American  □ Native Hawaiian or Pacific Islander  □ White

Ethnicity:  □ Hispanic/Latino  □ Non-Hispanic/Latino  □ Do not want to provide  □ Do not know

Preferred Language: ____________________________

Employed: No  Yes  Retired: No  Yes  Date  Disabled: No  Yes  Date

Employer: __________________________________________  Occupation: __________________________________________

Primary Care Physician

Phone  Fax

Referring Physician

Phone  Fax

Additional Physicians:

________________________________________

________________________________________

________________________________________

________________________________________

EMERGENCY CONTACT

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Relationship</th>
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</table>
**PATIENT REGISTRATION CONT.**

**PHARMACY INFORMATION**

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
</table>

Are you currently staying in a SNF, Convalescent Home or enrolled in Hospice?  
No  Yes  
*Note: If NO, Patient or Caregiver must immediately notify staff if patient is admitted to a hospital, SNF, Convalescent Home or Hospice.*

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Phone</th>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

**INSURANCE INFORMATION**

**Primary Insurance**

<table>
<thead>
<tr>
<th>Medical Group (HMO)</th>
<th>ID#</th>
<th>Group#</th>
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<table>
<thead>
<tr>
<th>Name</th>
<th>Relation to Policy Holder</th>
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<table>
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<tr>
<th>SSN of Policy Holder</th>
<th>Date of Birth for Policy Holder</th>
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**Secondary Insurance**

<table>
<thead>
<tr>
<th>Medical Group (HMO)</th>
<th>ID#</th>
<th>Group#</th>
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<tr>
<th>Name</th>
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<table>
<thead>
<tr>
<th>SSN of Policy Holder</th>
<th>Date of Birth for Policy Holder</th>
</tr>
</thead>
</table>

Patient/Guardian Signature: ________________________________ Date: ________________
Patient Name: ___________________________ DOB: ___________________________

CHIEF COMPLAINT: What is the reason for your visit today?

________________________________________________________________________

HISTORY OF PRESENT ILLNESSES
Please answer all questions.

Do you have...
Frequent daytime urination? Yes No
  If yes, how often?_________________________
Frequent nighttime urination? Yes No
  If yes, how often?_________________________
Decrease in urinary flow? Yes No

Other:

Have you had a flu shot within the last year? Yes No

Have you had a pneumonia vaccine? Yes No
  Recently
  In the past 5 years

ALLERGIES
Do you have allergies to any drugs or medications? Yes No
If yes, list all: ______________________________________________________________

Are you allergic to Iodine? Yes No
Are you allergic to Latex? Yes No
Are you allergic to any antibiotics? Yes No
If yes, list all: ______________________________________________________________

MEDICATIONS
Please list all medications even if taking only as needed.

Medication Name
Dosage
Times per day

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Supplement Name
Dosage
Times per day

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Select any of the following that you have received medication for:  ○ TB  ○ Heart Disease  ○ High Blood Pressure  ○ Emphysema
  ○ Ulcers  ○ Nervous Disorders  ○ Stroke  ○ Glaucoma  ○ Cancer  ○ Rheumatic Fever  ○ Diabetes  ○ Other

Please explain: ____________________________________________________________
FAMILY MEDICAL HISTORY
Do your parents or siblings have any of the following? Circle all that apply.

- Prostate cancer
  - Yes
  - No
  - Father
  - Brother

- Kidney cancer
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister

- Bladder cancer
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister

- Colon cancer
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister

- Bleeding disorder
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister

- Polycystic kidneys
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister

- Kidney failure
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister

- Kidney or bladder stones
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister

- Urinary tract infections
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister

- Interstitial cystitis
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister

- CX
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister

- Other types of cancer
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister
  - Type:

- History of blood transfusions
  - Yes
  - No
  - Mother
  - Father
  - Brother
  - Sister

Are parents currently living? Yes No
If deceased, cause of death and age at time of death:

SOCIAL HISTORY
Circle all that apply.

- Have you ever smoked? Yes No
  - If yes, how long? ____________
  - If yes, how many packs per day? ____________

- Have you quit smoking? Yes No
  - If yes, when did you quit? ____________

- Smokeless tobacco? Yes No
  - If yes, how long? ____________

- Have you quit? Yes No
  - If yes, when did you quit? ____________

- Recreational drugs? Yes No
  - If yes, how long? ____________
  - If yes, what kind? ____________

- Have you quit? Yes No
  - If yes, when did you quit? ____________

- Alcohol? Yes No
  - Beer
  - Wine
  - Liquor
  - Amount per week: ____________
  - If yes, how long? ____________

- Have you quit? Yes No
  - If yes, when did you quit? ____________

- Are you sexually active? Yes No

I hereby authorize consent for treatment and release any necessary information acquired in the course of examination and treatment by my physician for processing of my medical claim.

Signature of Patient/Insured/Legal Guardian: ________________________________

Date: ________________________________
PAST MEDICAL HISTORY

Have you ever been to a urologist before?  
Yes  No

If yes, why?  

PAST SURgeries
Check all that apply.

☐ Appendectomy  Date: ___________________________
☐ Back Surgery  Date: ___________________________
☐ Basal Cell Carcinoma  Date: ___________________________
☐ Cataracts  Date: ___________________________
☐ Colon Resection  Date: ___________________________
☐ Gall Bladder  Date: ___________________________
☐ Heart Surgery (CABG)  Date: ___________________________
☐ Heart Stent  Date: ___________________________
☐ Heart Valve Replacement  Date: ___________________________
☐ Hernia  Date: ___________________________
☐ Hip Replacement  Date: ___________________________
☐ Hysterectomy  Date: ___________________________
☐ Kidney or Bladder Stones  Date: ___________________________
☐ Knee Replacement  Date: ___________________________
☐ Arthroscopic  Date: ___________________________
☐ Lung  Date: ___________________________
☐ Nephrectomy  Date: ___________________________
☐ Pacemaker  Date: ___________________________
☐ Squamous Cell Carcinoma  Date: ___________________________
☐ Thyroid  Date: ___________________________
☐ Tonsillectomy  Date: ___________________________
☐ Other surgeries not listed: ___________________________

Select any of the following pertaining to your past medical history:

Cardiovascular
☐ Heart attack
☐ Heart murmur
☐ High blood pressure
☐ Deep vein thrombosis
☐ Heart valve problems
☐ Anemia
☐ Irregular heart beat
☐ Bleeding tendency
☐ Coronary artery disease
☐ Congestive heart failure

Endocrine
☐ Insulin dependent
☐ Diabetes/diet
☐ HYPERthyroid
☐ HYPOTHYroid
☐ Gout disease

GI
☐ Acid reflux
☐ Irritable bowels
☐ Peptic ulcers
☐ Diverticulitis
☐ Constipation/diarrhea

GU
☐ Kidney stones
☐ Bladder stones
☐ Frequent UTIs
☐ Elevated PSA
☐ BPH
☐ Prostatitis
☐ Overactive bladder

HEENT
☐ Glaucoma
☐ Cataracts
☐ Hay fever
☐ Vertigo
☐ Ear infection

Musculo-skeletal
☐ Arthritis
☐ Low back pain
☐ Fibromyalgia
☐ Joint replaced

Neurologic
☐ Stroke
☐ Seizures
☐ Migraines
☐ Polio
☐ Parkinson’s
☐ Spinal cord injury
☐ Chronic headaches
☐ Spina bifida
☐ Multiple Sclerosis
☐ Unsteady gait

Pulmonary
☐ Emphysema
☐ Asthma
☐ Bronchitis
☐ COPD
☐ Lung cancer

Hematology/Oncology
☐ Prostate cancer
☐ Uterine cancer
☐ Bladder cancer
☐ Lymphoma
☐ Kidney cancer
☐ Leukemia
☐ Testicle cancer
☐ Ovarian cancer
☐ Other
SYMPTOMS
Have you experienced now or in the past any of the following? Circle “yes” or “no” on all.

**Constitutional**
- Chronic fevers: Yes No
- Poor Appetite: Yes No
- Chills or night sweats: Yes No
- Bruises easily: Yes No

**Cardiovascular**
- Chest pains: Yes No

**Ears/Nose/Throat/Mouth**
- Hearing loss: Yes No
- Sinus infections: Yes No
- Difficulty swallowing: Yes No

**Hematologic/Lymphatic**
- Swollen glands: Yes No
- Blood clots: Yes No
- Bleeding problems: Yes No

**Endocrine**
- Difficulties getting or maintaining an erection: Yes No
- Difficulties maintaining energy level: Yes No
- Tired/Sluggish: Yes No
- Decreased libido: Yes No

**Skin**
- Skin rashes: Yes No

**Genitourinary**
- Weak stream: Yes No
- Awaken to urinate: Yes No
- Not emptying bladder: Yes No
- Dribbling: Yes No
- Problems urinating: Yes No
- Blood in urine: Yes No

**Allergic/Immunologic**
- Animal: Yes No
- Environmental: Yes No
- Food: Yes No
- Seasonal: Yes No

**Gastrointestinal**
- Constipation: Yes No
- Diarrhea: Yes No
- Indigestion/heartburn: Yes No
- Abdominal pain: Yes No

**Reproduction**
- Children: Yes No
  - If yes,     ○ vaginal     ○ c-section

**Other concerns:**

________________________________________________________________________

I hereby authorize consent for treatment and release any necessary information acquired in the course of examination and treatment by my physician for processing of my medical claim.

Signature of Patient/Insured/Legal Guardian: _________________________________________

Date: __________________________________________________________________________
ASSIGNMENT OF BENEFITS

Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to Urology Institute of Central Florida (the "Provider") for any services furnished me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian Signature: ________________________________ Date: ______________

Medigap (Medicare supplemental insurance) Assignment of Benefits

I request payment of authorized Medigap benefits be made to the Provider and also authorize any holder of medical information about me to release to the Medigap insurer listed below any information needed to determine benefits payable for services from the Provider.

Medigap Insurance Name: ________________________________

Patient/Guardian Signature: ________________________________ Date: ______________

General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature: ________________________________ Date: ______________

Receipt of HIPAA Patient Privacy Rights Notification

My signature below indicates that I have received the HIPAA Patient Privacy Rights Notification and that I have been made aware of my privacy rights and how I may exercise those rights. I understand that all contact phone numbers listed on the Patient Registration Form may be used to contact me for treatment or payment purposes unless I submit a written request to restrict the use of any/all contact phone numbers listed.

Patient/Guardian Signature: ________________________________ Date: ______________

Fundraising Communications Op-Out

By checking the box below I indicate that I do not want to receive any fundraising communications from my Provider.

☐ I do not want to receive any fundraising communications

Patient/Guardian Signature: ________________________________ Date: ______________
How We May Use and Disclose Your Medical Information: The following describes the different ways we may use and disclose your medical information.

1. **Treatment:** In order to treat you we may disclose information to others who are involved in your care or treatment.

2. **Payment:** In order to bill and collect payment for services you receive from us, we may use and disclose information to obtain payment from third parties that may be responsible for such costs such as insurance companies or family members. We may use your medical information in order to bill you directly for services and items.

3. **Health Care Operations:** To operate our business to ensure you receive quality care and to assure our organization is well run.

4. **Appointment Reminders & Test Results:** To remind you that you have an appointment or change an appointment we will use all daytime phone numbers supplied on the Patient Information form you completed.

5. **Treatment Alternatives:** To inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

6. **Fundraising:** We may use or disclose your demographic information, including name, address, age, gender, and date of birth, as well as dates of health service information, department of service, treating physician, outcome information, and health insurance status for fundraising purposes. With each fundraising communication you will be provided the opportunity to opt-out of receiving such communication and we will provide you with an opportunity to opt back in to receive such communication if you should choose to do so.

7. **Marketing:** To make a marketing communication to you that occurs in a face-to-face encounter with you; concerns, products or services of nominal value; however, we may disclose your health information for marketing purposes if we will receive direct or indirect financial remuneration not related to our cost of making the communication unless we receive your authorization to do so.

8. **Coroners. Medical Examiners. Funeral Directors:** As needed to carry out their duties required by law.

9. **Organ and Tissue Donation:** To organizations that handle organ and tissue procurement, banking or transplantation.

10. **Sale of PHI:** We will not sell your PHI to third parties. However, this does not include disclosure for public health purposes, research where we only receive remuneration for our cost to prepare and transmit the PHI, for treatment and payment purposes, for sale, transfer, merger or consolidation of our practice, for a business associate or its subcontractor to perform health care functions on our behalf, or for purposes as required or permitted by law.

11. **Required By Law:** When required by applicable law regarding crime or criminal conduct; warrant, summons, subpoena or legal process. If served with a legal subpoena for records (contains a release or records signed by you or verbal authorization obtained from you or your attorney of record or proof of service from the requesting party) we must honor the request.

12. **Public Health Activities:** To control disease, injury or disability; maintain vital records such as birth or death; cancer reporting; child abuse or neglect; exposure to communicable disease; drug reactions or FDA warnings; recalling devices or medications. To notify appropriate government agencies and authorities regarding potential abuse or neglect of an adult patient including domestic abuse if the patient agrees or we are required by law to do so. Under limited circumstances to your employer for related workplace injury or illness or medical surveillance.

13. **Research:** Subject to special approval process, information may be used on research projects or studies. The information will not leave our premises without your authorization.

14. **Serious Threats to Health or Safety:** To reduce or prevent a serious threat to your health and safety or that of another individual or the general public. We will only disclose to persons or organizations able to help prevent the threat.

15. **Specialized Government Functions:** If you are a member of the U.S. or foreign military forces (including veterans) and if required by appropriate military command authorities; or to federal officials for intelligence and national security.

16. **Workers Compensation:** Our organization will release your medical information for workers’ compensation and similar programs to all parties as required by state and federal law.
Your Rights Regarding Your Medical Information: You have the following rights regarding the medical information that we maintain about you. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when necessary to treat you. In order to request a restriction on the use or disclosure of your medical information, you must make your request in writing to the address below.

Requesting Restrictions: The right to request a restriction on our use and disclosure of your medical information for treatment, payment, or healthcare operations. You have the right to limit our disclosure to individuals involved in your care or the payment for your care such as family members and friends. We will use all contact phone numbers and addresses listed on the Patient Information form unless you place a restriction. You may restrict disclosure to your health plan if you have paid for the service in full, and the disclosure is not otherwise required by law. This type of request for restriction will only be applicable to the particular service. You will have to request a restriction for each service thereafter. The request for restriction must be submitted in writing and sent to the address below.

Confidential Communications: The right to request how our organization communicates with you about your health and related issues in a particular manner or certain locations without stating a reason for your request. We will use all contact phone numbers and addresses listed on the Patient Information form unless you place a restriction. The request for restriction must be submitted in writing and sent to the address below.

Notification of a Breach: The right to be notified if there is a probable compromise of unsecured medical information within 60 days of the discovery of the breach.

Inspections and Copies: The rights to inspect and obtain paper or electronic copies of the medical information that may be used to make decisions about you, including medical records, billing records, but not including psychotherapy notes. In order to inspect or obtain records, you must submit the request in writing to the address below. If you would like an electronic copy of your health information, we will provide you with a copy in the form and format as requested as long as we can readily produce such information in the form requested. Otherwise, we will cooperate with you to provide a readable electronic form and format as agreed.

Amendment: The right to ask us to amend your medical information if you believe it is incorrect or incomplete and you may request an amendment for as long as the information is kept by or for our organization. You must provide us with a reason that supports your request. The reason for your request needs to be in writing to the address below. Also, we may deny the request if you ask us to amend information that is accurate and complete; not part of the information you are permitted to inspect and copy; not created by our organization, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosure: The right to request an accounting of disclosures made of your medical information to entities with which you do not have an established relationship. In order to obtain an accounting, you must submit your request in writing to the address below. All requests may not be longer than 6 years and may not include dates prior to October 16, 2003. The first request in a 12 month period is free of charge. You may be charged for any additional lists requested in a 12 month period.

Right to File a Complaint: If you believe your rights have been violated, you may file a complaint with our organization or with the secretary of the Department of Health & Human Services. You will not be penalized for filing the complaint. All complaints must be submitted in writing at the address below.

Right to Provide an Authorization of Other Uses and Disclosures: Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or are not permitted by applicable law, such as the use and disclosure of HIV/AIDS, sexually transmitted diseases, genetic information, mental or behavioral health, and drug/alcohol abuse. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your medical information for reasons described on the authorization. Of course, we will not be able to take back any disclosures that we have already made with your permission.

Right to Paper Copy of This Notice: You are entitled to receive a paper copy of this notice. You will be asked to sign an acknowledgment proving receipt of this Notice of Privacy Practices. A more detailed notice that contains examples is available upon request at the office listed below.

Right to Request Email Communication: You may request that we communicate with you via email. You may be asked to provide your email address for the sole purpose of sending you information about events, educational seminars, reminders about your questionnaire, etc. If you wish to not receive information from us via email you may decline to provide your email address. You may also ask to have your email address removed from our mailing list at any time by contacting our office.

If you have any questions regarding this notice, your privacy rights, or our privacy policies please contact:

Norman H. Anderson, M.D., P.A.
Dania Neveau - HIPAA Privacy Officer
Drew Anderson - HIPAA Compliance Officer
2020 SE 17th Street, Ocala, FL 34471
(352) 861-2400
AUTHORIZATION FOR THE RELEASE OF PRIVATE HEALTH INFORMATION (PHI)

While under the care of the physicians at Urology Institute of Central Florida, I hereby give authorization for the release of private health related information to the following authorized persons.

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<th>Physicians</th>
<th>Family Members (Relation)</th>
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This information may be given to the above mentioned people either by phone, fax or in person should the need arise for this information to be released for my proper care while a patient here. Should any unforeseen incident arise that I wish not to inform any or all of the above named persons, I will notify Urology Institute of Central Florida in writing of such names.

I authorize Urology Institute of Central Florida and staff to leave medical information pertaining to my care using the following methods and will assume responsibility to notify Urology Institute of Central Florida and staff whenever this information changes.

- [ ] Home Phone
- [ ] Home Phone Voice-mail
- [ ] Work Phone
- [ ] Work Phone Voice-mail
- [ ] Cell Phone
- [ ] Cell Phone Voice-mail
- [ ] Mail
- [ ] Post Card

Patient Signature: ___________________________________________________ Date:____________
NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt

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

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly or indirectly
- Electronically exchange records with other healthcare providers and organizations
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis
- Access drug benefit coverage and medication history

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

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

I understand that I may revoke this consent at any time except to the extent that you have taken action relying on this consent.

Patient Name: ________________________________

Patient Signature: ________________________________

Date: ________________

Inability to Obtain Acknowledgment

To be completed only if no signature is obtained. If it is not possible to obtain the individual’s acknowledgment, describe in good faith efforts made to obtain the individual’s acknowledgment and the reasons why the acknowledgment was not obtained.

UICFLA Rep. Signature: ________________________________

Date: ________________

Norman H. Anderson, M.D., P.A.
Dania Neveau - HIPAA Privacy Officer
2020 SE 17th Street, Ocala, FL 34471
(352) 732-0277