TOWER UROLOGY, INC. **Women's New Patient Forms**

PLEASE PRINT AND COMPLETE EVERY BLANK ON THIS FORM

DATE

ACCOUNT # LAB #

PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE	HOME PHONE
ADDRESS / LANGUAGE		PATIENT'S USUAL PHYSICIAN	WORK PHONE
CITY	STATE	ZIP CODE	CELL PHONE
SOCIAL SECURITY NO. / SEX / RACE / MARITAL ST.		DATE OF BIRTH / AGE	E-MAIL ADDRESS
EMPLOYED BY	EMPLOYER ADDRESS		OCCUPATION
EMPLOYER CITY	EMPLOYER STATE / EMPLOYER ZIP	HOW LONG EMPLOYED?	PREVIOUSLY TREATED THIS OFFICE?
EMERGENCY CONTACT PERSON/ PARENT OR GUARDIAN	RELATION	PHONE	YOUR NAME AT THAT TIME
NAME OF REFERRING OR PRIMARY PHYSICIAN	REFERRING PHYSICIAN ADDRESS		REFERRING PHYSICIAN PHONE
IF CHILD, RESPONSIBLE PARTY NAME			RELATIONSHIP
ADDRESS	CITY / STATE / ZIP CODE		TELEPHONE NUMBER
PHARMACY NAME	PHARMACY PHONE	PHARMACY FAX	

DO YOU HAVE MEDICAL INSURANCE? YES ☐ NO ☐

IS YOUR INSURANCE AN HMO? YES ☐ NO ☐

HAS YOUR VISIT BEEN PREAUTHORIZED? YES ☐ NO ☐

DO YOU HAVE HEALTH SAVINGS ACCOUNT? YES ☐ NO ☐

METHOD TO CONFIRM YOUR FUTURE APPOINTMENT:

TEXT ☐ **E-MAIL** ☐ **VOICEMAIL** ☐

THIS INFORMATION MUST BE COMPLETE OR WE WILL REQUIRE PAYMENT AFTER SERVICES HAVE BEEN RENDERED.

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE CARRIER			ADDRESS	TELEPHONE
CITY / STATE	ZIP		INSURED PARTY	DATE OF BIRTH
IDENTIFICATION NO.	EMPLOYER COVERAGE?	EFFECTIVE DATE	GROUP	PATIENT'S RELATIONSHIP TO INSURED (Check One) ☐ SELF ☐ SPOUSE ☐ CHILD ☐ PARENT ☐ OTHER
NAME OF SECONDARY INSURANCE CARRIER			ADDRESS	TELEPHONE
CITY / STATE	ZIP		INSURED PARTY	DATE OF BIRTH
IDENTIFICATION NO.	EMPLOYER COVERAGE?	EFFECTIVE DATE	GROUP	PATIENT'S RELATIONSHIP TO INSURED (Check One) ☐ SELF ☐ SPOUSE ☐ CHILD ☐ PARENT ☐ OTHER

PLEASE NOTE: YOU ARE RESPONSIBLE FOR ALL CO-PAYS AND DEDUCTIBLES.
PLEASE BE PREPARED TO PAY FOR CO-PAYMENTS AT THE TIME OF YOUR VISIT.

Please sign the attached Assignment of Benefit

TU ASSIGNMENT OF BENEFITS AND ACKNOWLEDGEMENTS REGARDING PAYMENT

ASSIGNMENT OF ALL RIGHTS AND BENEFITS: I understand and acknowledge that Tower Urology, Inc. ("TU") is an out-of-network provider for all third-party payors, except Medicare. In exchange for and in connection with any and all of the medical and related services provided to me ("Services") by TU and its physicians, I hereby assign to TU all of my rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever, without limitation, that I had, have or may have in the future pursuant to or in connection with any out-of-network insurance policy or plan, health benefit plan, health management agreement, risk-bearing agreement, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively, "OON Health Coverage"). This assignment includes, without limitation, direct payment by my insurance carrier or health plan directly to TU and/or its designated associates for the Services, appeal rights (both internal and external), fiduciary rights, rights to sue, rights to payment, rights to full and fair claims review, rights to penalties or interest, rights to plan documents and plan information, and rights to notices and disclosures from any source (collectively, "Rights"). I am hereby transferring to TU all of these Rights under any OON Health Coverage to which I am now, previously, or may be entitled to in the future with respect to the Services. Unless otherwise agreed between me and TU, this assignment is irrevocable.

ACKNOWLEDGEMENT OF PATIENT RESPONSIBILITY FOR ALL CHARGES: I understand and agree by signing below that I am financially responsible for all charges regarding the Services, and that TU reserves the right to require that I pay any deductible or co-payment required by my OON Health Coverage or other deposit prior to services. In the event that my OON Health Coverage refuses to cover any portion of the charges submitted by TU for payment, I understand and agree that I shall be liable for any remaining unpaid charges and, unless TU and I agree otherwise, I agree to pay such charges timely upon receiving an invoice for payment from TU. In the event that my insurance plan pays me for the Services, then I will forward such payment to TU. I further understand and agree that TU reserves the right to charge me an administrative fee for obtaining, on my behalf, prior authorization for prescription medication and/or for performing other non-covered services. I further understand and agree that TU reserves the right to charge me an administrative fee for obtaining, on my behalf, prior authorization for prescription medication and/or for performing other non-covered services.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE: Subject to and without waiver of my agreement to be financially responsible for all charges regarding the Services, I hereby designate TU and/or its designated agents and representatives as my duly authorized representative(s) in connection with all matters arising from or relating to Rights and OON Health Coverage, such that TU has the right, for so long as it chooses to exercise it or until revoked by me, to completely and without reservation "stands in my shoes" and takes my place for all applicable purposes, and is granted absolute power and legal authority to seek, claim and directly receive payment or reimbursement for Services; challenge or appeal any adverse benefit determination of any kind whatsoever; or take any other action or obtain anything that I would have been entitled to do, seek, claim, appeal or obtain in my own capacity pursuant to or in connection with the Rights in any legal, private, administrative, formal or informal process or forum whatsoever and without limitation, including any internal or external appeal, review, grievance or any other process, procedures or entitlement. **Notwithstanding the foregoing, TU shall not be obligated to pursue payment and appeals from my insurance, but rather will do this as a courtesy as my authorized representative for up to 60 days after the claim for Services is submitted to insurance.**

AGREEMENT TO COOPERATE: I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by TU (or its designated associates) to effectuate, perfect, confirm, validate or enforce my Assignment of Rights and Benefits to TU or authorization of TU as my authorized representative, as provided above. I promise to make my best efforts to assist and cooperate with TU as needed or reasonably requested by TU in connection with any action in any forum, whether legal, formal or informal, without limitation, commenced or maintained by TU in order to exercise, secure or enforce any Rights.

ATTORNEY'S FEES: If my account is referred to TU's legal counsel or a collection agency to obtain payment, or if legal action is brought against me, I agree to pay the total amount due with applicable late charges or interest as well as all reasonable attorney's fees or collection fees or related expenses incurred in collecting or recovering payment on my debt.

Patient Name (please print): _____

Patient's Guardian (if applicable, print): _____

Patient or Guardian Signature: _____ **Date:** _____

NEW / CONSULTATION VISIT – FEMALE

E/M CODE:

PATIENT NAME_____ **DATE OF VISIT**_____

NEW PATIENT ☐ **CONSULTATION (New/Estab)** ☐ **OFFICE ACCOUNT #**_____

DOB / AGE_____ **SEX**_____ **OCCUPATION**_____

REFERRED BY DR. _____ **SPOUSE NAME**_____ **PHONE**_____

CHIEF COMPLAINT/REASON FOR VISIT:_____

HISTORY OF PRESENT ILLNESS: ***Brief*** *(problem focused) 1-3 elements;* ***Extended*** *(detailed/comprehensive) ≥ 4*

Pertinent *(Detailed) 1 from any 3 areas;* ***Complete*** *(Comprehensive) Established Patient: 1 from 2 of the 3 areas - New Patient/Consultation: 1 from each of the 3 areas*

Patient – please answer all questions below this line on this page

PAST MEDICAL / SURGICAL / GYNECOLOGICAL HISTORY (illnesses, operations, injuries and hospitalizations):

FAMILY HISTORY (health status, diseases or cause of death of immediate family):

	ALIVE	AGE	DECEASED	ILLNESSES
FATHER				
MOTHER				
BROTHERS				
SISTERS				
CHILDREN				

SOCIAL HISTORY (drug, alcohol, tobacco use):_____

ALLERGIES/REACTIONS (are you allergic to medications, x-ray dye, iodine, or shellfish?):_____

CURRENT MEDICATIONS (include non-prescription e.g. Aspirin):

NAME	DOSE	FREQUENCY

Problem Pertinent*: 1* ***Extended*** *(Detailed): 2-9* ***Complete*** *(Comprehensive): ≥ 10*

Constitutional: ☐ weight change ☐ chills ☐ fevers ☐ sweats ☐ other:	**Respiratory:** ☐ shortness of breath ☐ chronic cough ☐ other:	**Skin:** ☐ skin lesions ☐ rashes ☐ other:
Eyes: ☐ Glaucoma ☐ Cataracts ☐ glasses/contact lens ☐ other:	**Gastrointestinal:** ☐ frequent heart burn ☐ diarrhea ☐ black/bloody stools ☐ constipation ☐ other:	**Neurologic:** ☐ numbness ☐ memory loss ☐ headaches ☐ fainting ☐ other:
Ears, Nose, Mouth, Throat: ☐ ringing ears ☐ sore throat ☐ sinus trouble ☐ bleeding gums ☐ other:	**Endocrine:** ☐ excessive sweating ☐ excessive thirst ☐ other:	**Psychiatric:** ☐ anxiety ☐ depression ☐ other:
Cardiovascular: ☐ chest pain ☐ ankle swelling ☐ palpitations ☐ other:	**Musculoskeletal:** ☐ muscular ☐ joint pain ☐ weakness ☐ other:	**Hematologic/Lymphatic:** ☐ easy bruising ☐ bleeding ☐ other:

Genitourinary:

☐ painful urination	☐ straining to urinate	☐ lower abdominal pain	☐ pelvic/vaginal infections
☐ blood in urine	☐ pus or cloudy urine	☐ bladder infections	☐ other genital/urinary problems
☐ urinary leakage	☐ vaginal discharge, itching	☐ kidney infections	How many pregnancies_____
☐ weak or slow urination	☐ frequent urination___day___night	☐ urethral stricture	Last pap smear_____
☐ hesitation before starting	☐ back pain	☐ currently pregnant	Last menstrual period _____

EXAM - GENITOURINARY FEMALE *(1997 Level 1 (1-5), Level 2 ≥ 6, Level 3 ≥ 12, Levels 4&5 ≥ 21)* **POSITIVE FINDINGS**

☐ CONST:	Vital signs BP Pulse Temp
☐ GEN:	No apparent distress.
☐ GU:	External genitalia normal. Meatus normal. Urethra normal.
	Bladder normal position and nontender.
	Vagina normal mucosa with no discharge and no prolapse.
	Adnexa no tenderness or mass. Anus and perineum normal.
	Cervix ____. Uterus _____.
☐ RECT:	Normal sphincter tone. No hemorrhoids or rectal masses.
☐ GI:	No abdominal masses or tenderness.
	No hernia. Liver & spleen not palpable.
☐ BACK:	Nontender.
☐ NECK:	Normal appearance without masses.
☐ RESP:	Normal effort.
☐ CV:	Good peripheral pulses with no significant edema.
☐ LYMPH:	No palpable nodes.
☐ SKIN:	No lesions.
☐ NEURO:	Fully oriented with normal mood and affect.

TEST / PROCEDURES OR DATA REVIEWED:

TEST / PROCEDURE NAME	MD SIGNATURE	RESULT (NORMAL, ABN.,ETC.)	COMMENTS

Screening for Aerosol Transmissible Diseases (ATD)

Do you have (circle): History of Tuberculosis or symptoms of Tuberculosis (Productive cough, Bloody Sputum, Fever, Malaise, Night Sweats, Unexplained Weight Loss)? No _____

Do you have (circle): Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis, MRSA (Body Aches, Runny Nose, Sore Throat, Nausea, Vomiting, Diarrhea, Fever & Respiratory Symptoms, Severe Coughing Spasms, Painful-swollen Glands, Skin Rash-blisters, Stiff Neck)? No _____

ASSESSMENT:

Renal Stones: ☐ Infected ☐ Uninfected ♦ Post Treatment Stone Status: ☐ No improvement ☐ No fragmentation ☐ Residual fragments and size_____ ☐ Stone free

Incontinence: Type:_____ # of pads used/day: _____

UTI: Type:_____

Other Diagnosis: _____

_____

CO-MORBIDITIES.	STABLE	UNSTABLE	COMMENTS

PLAN:

☐ Medications

☐ Tests/Procedures *(List scheduled procedures)*:

☐ Watchful Waiting

☐ Records Reviewed / Content

☐ Counseling (indicate **time spent if counseling > 50%)** ☐ Return Visit

X_____

Provider's Signature

TOWER UROLOGY, INC.

NOTICE OF PRIVACY PRACTICES

Effective Date: September 6, 2013

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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our medical group, its medical staff and affiliated health care providers who jointly perform health care services with our medical group, including physicians and physician groups who provide services at our facilities. A copy of our current notice will always be posted at all registration and/or admission points. You will also be able to obtain your own copies by accessing our website at www.towerurology.com or calling the Privacy Officer at (310) 854-9898.

If you have any questions about this notice or would like further information, please contact the above referenced individuals.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information include information indicating that you are a patient of our medical group or receiving health-related services from our facilities, information about your health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information, such as your name, address, social security number or phone number.

REQUIREMENT FOR WRITTEN AUTHORIZATION

Generally, we will obtain your written authorization before using your health information or sharing it with others outside of our medical group. There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Marketing. We may not disclose any of your health information for marketing purposes if our medical group will receive direct or indirect financial remuneration not reasonably related to our medical group's cost of making the communication.

Sale of Protected Health Information. We will not sell your protected health information to third parties. The sale of protected health information, however, does not include a disclosure for public health purposes, for research purposes where our medical group will only receive remuneration for our costs to prepare and transmit the health information, for treatment and payment purposes, for the sale, transfer, merger or consolidation of all or part of our medical group, for a business associate or its subcontractor to perform health care functions on our medical group's behalf, or for other purposes as required and permitted by law.

If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our medical group. You may also initiate the transfer of your records to another person by completing a written authorization form.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

1. Treatment, Payment and Health Care Operations.

Treatment. We may share your health information with doctors or nurses at the medical group who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A doctor in our medical group may share your health information with another doctor to determine how to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care.

Payment. We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Health Care Operations. We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the

performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you.

2. Appointment Reminders, Treatment Alternatives, Benefits and Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment, services or refills or in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

3. Business Associates. We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company, or we may share your health information with an accounting firm or law firm that provides professional advice to us. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information. If our business associate discloses your health information to a subcontractor or vendor, the business associate will have a written contract to ensure that the subcontractor or vendor also protects the privacy of the information.

4. Friends and Family Designated to be Involved In Your Care. If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

5. Proof of Immunization. We may disclose proof a child's immunization to a school, about a child who is a student or prospective student of the school, as required by State or other law, if a parent, guardian, other person acting in loco parentis, or an emancipated minor, authorizes us to do so, but we do not need written authorization.

6. Emergencies or Public Need.

Emergencies or As Required By Law. We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you. We may use or disclose your health information if we are required by law to do so, and we will notify you of these uses and disclosures if notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities under law, such as controlling disease or public health hazards. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if permitted by law. We may disclose a child's proof of immunization to a school, if required by State or other law, if we obtain and document the agreement for disclosure from the parent, guardian, person acting in loco parentis, an emancipated minor or an adult. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws.

Victims Of Abuse, Neglect Or Domestic Violence. We may release your health information to a public health authority authorized to receive reports of abuse, neglect or domestic violence.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facilities. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Lawsuits And Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if required judicial or other approval or necessary authorization is obtained.

Law Enforcement. We may disclose your health information to law enforcement officials for certain reasons, such as complying with court orders, assisting in the identification of fugitives or the location of missing persons, if we suspect that your death resulted from a crime, or if necessary, to report a crime that occurred on our property or off-site in a medical emergency.

To Avert A Serious And Imminent Threat To Health Or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security And Intelligence Activities Or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Military And Veterans. If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates And Correctional Institutions. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners And Funeral Directors. In the event of your death, we may disclose your health information to a coroner or medical examiner. We may also release this information to funeral directors as necessary to carry out their duties.

Organ And Tissue Donation. In the event of your death or impending death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

7. Completely De-identified Or Partially De-identified Information. We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

8. Incidental Disclosures. While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

9. Changes to this Notice. We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. We will notify you of any changes.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

You have the following rights to access and control your health information:

1. Right To Inspect And Copy Records. You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. If you would like an electronic copy of your health information, we will provide you a copy in electronic 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.

2. Right To Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is kept in our records by writing to us. Your request should include the reasons why you think we should make the amendment. If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records.

3. Right To An Accounting Of Disclosures. You have a right to request an "accounting of disclosures," which is a list with information about how we have shared your health information with others. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer. You have a right to receive one list every 12-month period for free. However, we may charge you for the cost of providing any additional lists in that same 12-month period.

4. Right to Receive Notification of a Breach. You have the right to be notified if there is a probable compromise of your unsecured protected health information within sixty (60) days of the discovery of the breach. The notice will include a description of what happened, including the date, the type of information involved in the breach, steps you should take to protect yourself from potential harm, a brief description of the investigation into the breach, mitigation of harm to you and protection against further breaches and contact procedures to answer your questions.

5. Right To Request Restrictions. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. You also have the right to request that your health information not be disclosed to a health plan if you have paid for the services in full, and the disclosure is not otherwise required by law. The request for restriction will only be applicable to that particular service. You will have to request a restriction for each service thereafter. To request restrictions, please write to the Privacy

Officer. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so.

6. **Right To Request Confidential Communications.** You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home, by notifying the registration associate who is assisting you. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

7. **Right To Have Someone Act On Your Behalf.** You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

8. **Right To Obtain A Copy Of Notices.** If you are receiving this notice electronically, you have the right to a paper copy of this notice. We may change our privacy practices from time to time. If we do, we will revise this notice and post any revised notice in our registration area and on our website

9. **Right To File A Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us by calling the Privacy Officer at (310) 854-9898, or with the Secretary of the Department of Health and Human Services. The hospital will not withhold treatment or take action against you for filing a complaint.

10. **Use and Disclosures Where Special Protections May Apply.** Some kinds of information, such as HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

11. **Notice from Medical Board.** Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint, please visit www.mbc.ca.gov, email: licensecheck@mbc.ca.gov, or call (800) 633-2322.

TOWER UROLOGY, INC.

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this notice, and how I may obtain access to and control of this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information from my Health Care Provider. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Request for Confidential Communication

Please select **ONE** of the following:

_____ I, hereby authorize Tower Urology to leave messages/results on this telephone number: _____

_____ I do not authorize Tower Urology to leave messages/results on my voicemail.

_____
Signature of Patient

I, hereby, authorize Tower Urology to discuss my Protected Health Information ("PHI") with the following representative:

_____ _____
Name (Print or Type) Relationship to Patient

_____ _____
Name (Print or Type) Relationship to Patient

Furthermore, I understand that it is my responsibility to notify Tower Urology in writing of any changes.

TOWER UROLOGY

ACKNOWLEDGMENT AND CONSENT TO PRIOR AUTHORIZATION FEES

"Prior authorization" (also known as "pre-authorization" or "pre-approval") is a process used by some insurance companies and payors whereby advance permission must be granted for certain services or medications before they will be covered by a patient's insurance. Obtaining prior authorizations is typically the responsibility of the patient. Upon our patient's request, Tower Urology physicians and staff are able to assist with obtaining prior authorization by calling, faxing, and otherwise communicating with insurance companies.

Because obtaining prior authorizations can be time-consuming and cuts into time spent on patient care, it is Tower's policy to charge a **twenty-five dollar ($25.00) administrative fee** for each prior authorization. Patients will be reminded of this fee at the time they request Tower Urology to obtain each prior authorization and will be charged upfront. Please note that as an administrative fee unrelated covered services, this $25 administrative charge is not reimbursable by insurance. If you or we learn that your insurance will separately reimburse for the prior authorization process, then we will refund you the $25 administrative fee.

Tower also reserves the right to charge a reasonable "administrative fee" for other non-medical, non-covered patient requests as they may arise in the course of treatment, and we will always notify the patient of these upfront.

****

By signing below, I acknowledge that I am responsible for paying the prior authorization fee at the time of my request, and that such administrative charge is out-of-pocket and not reimbursable by my insurance.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Tower Urology

PATIENT:_____ DOB_____DATE:_____

B/P: _____ PULSE: _____ ALLERGIES: _____

SMOKING: _____ YES _____ NO HEIGHT: _____ WEIGHT _____

Medication List	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	