



ADVANCED UROLOGY INSTITUTE
PATIENT INFORMATION FORM

TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL/OTHER PHONE \_\_\_\_\_

Primary Address \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_

Secondary Address \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_

(If Applicable)

Dates residing at SECONDARY ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ SPOUSE/NEAREST RELATIVE \_\_\_\_\_ CONTACT # \_\_\_\_\_

EMERGENCY CONTACT OTHER THAN SPOUSE/RELATIVE \_\_\_\_\_ CONTACT # \_\_\_\_\_

YOUR RACE: Please check one: [ ] AFRICAN AMERICAN [ ] ASIAN [ ] CAUCASIAN [ ] HISPANIC [ ] OTHER \_\_\_\_\_

YOUR ETHNICITY: Please check one: [ ] HISPANIC / LATINO [ ] NON-HISPANIC/NON LATINO [ ] OTHER \_\_\_\_\_

YOUR PREFERRED LANGUAGE: [ ] ENGLISH [ ] SPANISH [ ] RUSSIAN [ ] OTHER \_\_\_\_\_

YOUR EMAIL ADDRESS: \_\_\_\_\_ Preferred Methods of Contact: \_\_\_\_\_

EMPLOYMENT STATUS: [ ] FULL TIME [ ] PART TIME [ ] DISABLED [ ] RETIRED [ ] STUDENT [ ] UNEMPLOYED [ ] OTHER \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK TELEPHONE NUMBER \_\_\_\_\_

How do you plan to pay for your medical treatment with us? [ ] Self pay (Cash/Check/Visa/MC) [ ] Medicare [ ] Medicare Supplement [ ] Medicare HMO [ ] Private Insurance (HMO, PPO, Indemnity) [ ] Worker's Compensation

PRIMARY INSURANCE \_\_\_\_\_ SECONDARY INSURANCE \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Policyholder Name \_\_\_\_\_

Policyholder DOB & SS# \_\_\_\_\_ Policyholder DOB & SS# \_\_\_\_\_

Relationship to Policyholder \_\_\_\_\_ Relationship to Policyholder \_\_\_\_\_

Primary care physician's name and phone number: \_\_\_\_\_

Pharmacy name and phone number \_\_\_\_\_

PLEASE READ AND SIGN:

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I AGREE TO PAY ALL AMOUNTS NOT PAID BY MY INSURANCE CARRIER ACCORDING TO MY POLICY PROVISIONS AND THE PROVIDER CONTRACT. IN THE EVENT OF A DISPUTED PAYMENT, IT IS MY RESPONSIBILITY TO PAY FOR THE CHARGES AND DISPUTE THE PAYMENT WITH MY INSURANCE CARRIER. IT IS ALSO MY RESPONSIBILITY TO RECEIVE AUTHORIZATION/REFERRALS FOR ANY OFFICE VISITS TO ADVANCED UROLOGY INSTITUTE.

I HEREBY AUTHORIZE MY PHYSICIAN TO ACCESS MY PRESCRIPTION HISTORY IN ORDER TO DETERMINE THE CORRECT FORMULARY IN ACCORDANCE WITH MY HEALTH INSURANCE BENEFITS.

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

CHIEF COMPLAINT/ REASON FOR VISIT \_\_\_\_\_

REFERRED TO OUR PRACTICE BY \_\_\_\_\_

(AUA Symptom Score) In the past month:	Not at all	<1 in 5 times	< ½ times	About ½ the time	> ½ times	Almost always	Your score
How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
How often have you had to urinate less than every 2 hours?	0	1	2	3	4	5	
How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
How often have you had a weak urinary stream	0	1	2	3	4	5	
How often have you had to strain to start urination	0	1	2	3	4	5	
How many times did you typically get up at night to urinate?	0 times	1 time	2 times	3 times	4 times	5 times	
TOTAL SCORE: 1-7 mild; 8-19 moderate; 20-35 severe	///////	///////	///////	///////	///////	///////	

If you were to spend the rest of your life with your current urinary condition just the way it is now, how would you feel about that?

Circle your response: DELIGHTED----PLEASED----MOSTLY SATISFIED----MIXED----MOSTLY DISSATISFIED----UNHAPPY----TERRIBLE

FOR MEN ONLY (SHIM SCORE): ( ) Please check here if you are not sexually active

CIRCLE the number that best describes your own situation. Select only 1 answer for each question.

Over the past 6 months:	1	2	3	4	5
How do you rate your confidence that you could get and keep an erection?	Very low	low	moderate	high	Very high
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
SCORE ( If < 21, speak to your doctor):	//////////	//////////	//////////	//////////	//////////

Please complete your most current medication list:

Name of Medication/Over the counter meds/Vitamins/Herbal meds	Strength	# of Times Taken per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

LIST YOUR PHARMACY NAME AND LOCATION: \_\_\_\_\_

ALLERGIES TO ANY MEDICATIONS OR FOODS OR IV CONTRAST/X-RAY DYE: \_\_\_\_\_

PAST MEDICAL HISTORY: (CHECK all that apply to you)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> High blood pressure                        | <input type="checkbox"/> Kidney stones           | <input type="checkbox"/> Asthma                   |
| <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> Cancer: Type: _____     | <input type="checkbox"/> sleep apnea              |
| <input type="checkbox"/> Heart Attack                               | <input type="checkbox"/> Enlarged prostate (BPH) | <input type="checkbox"/> Mitral valve prolapse    |
| <input type="checkbox"/> Stroke                                     | <input type="checkbox"/> Erectile dysfunction    | <input type="checkbox"/> Blood clot in legs (DVT) |
| <input type="checkbox"/> Atrial Fibrillation (irregular heart rate) |  | <input type="checkbox"/> Anemia                   |
| <input type="checkbox"/> Arthritis                                  | <input type="checkbox"/> Kidney failure          | <input type="checkbox"/> chronic back pain        |
| <input type="checkbox"/> Glaucoma                                   | <input type="checkbox"/> High cholesterol        | <input type="checkbox"/> Depression/Anxiety       |
| <input type="checkbox"/> hypothyroid                                | <input type="checkbox"/> Emphysema (COPD)        | <input type="checkbox"/> Neurologic problem       |

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE \_\_\_\_\_

PREVIOUS SURGERIES:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Appendectomy                           | <input type="checkbox"/> Pacemaker or AICD defibrillator   | <input type="checkbox"/> Hysterectomy                 |
| <input type="checkbox"/> Gall Bladder/Cholecystectomy           | <input type="checkbox"/> Kidney stones surgery Type: _____ | <input type="checkbox"/> Hernia repair                |
| <input type="checkbox"/> Tonsillectomy                          | <input type="checkbox"/> Prostate surgery: Type: _____     | <input type="checkbox"/> Bladder surgery: Type: _____ |
| <input type="checkbox"/> Heart Surgery                          | <input type="checkbox"/> Bypass surgery (CABG)             | <input type="checkbox"/> Heart Valve surgery          |
| <input type="checkbox"/> Joint replacement surgery: Type: _____ |  |   |

OTHER SURGERIES NOT LISTED ABOVE \_\_\_\_\_

FAMILY HISTORY: Has anyone in your family had? (Circle if yes) Prostate Cancer    Kidney Stones    Kidney Cancer

Is your mother living? YES    NO    If NO, year deceased \_\_\_\_\_

Is your father living? YES    NO    If NO, year deceased \_\_\_\_\_

**SOCIAL HISTORY:**

**TOBACCO/ ALCOHOL USAGE:**

Do you smoke cigarettes? YES NO      How many packs per day? \_\_\_\_\_  
 If NO, have you ever smoked? YES NO      When did you quit? \_\_\_\_\_  
 Do you drink alcohol? Never Occasional Daily      # Drinks per day \_\_\_\_\_

ARE YOU:    \_\_\_ MARRIED    \_\_\_ DIVORCED    \_\_\_ SINGLE (NEVER MARRIED)

NUMBER OF CHILDREN: \_\_\_\_\_

**G. REVIEW OF SYSTEMS: Please check Yes or No**

**General/Constitutional**

Headache            ( ) Yes ( ) No  
 Chills                ( ) Yes ( ) No  
 Fever                 ( ) Yes ( ) No

**Ophthalmologic**

Blurring of vision    ( ) Yes ( ) No  
 Double vision        ( ) Yes ( ) No  
 Eye Pain             ( ) Yes ( ) No  
 Glaucoma             ( ) Yes ( ) No

**HEENT/Neck**

Ear Infection        ( ) Yes ( ) No  
 Sinus Problems     ( ) Yes ( ) No  
 Sore Throat         ( ) Yes ( ) No

**Endocrine**

Excessive thirst     ( ) Yes ( ) No  
 Too hot/too cold    ( ) Yes ( ) No  
 Fatigue              ( ) Yes ( ) No

**Respiratory**

Cough                ( ) Yes ( ) No  
 Shortness of Breath ( ) Yes ( ) No  
 Wheezing            ( ) Yes ( ) No

**Cardiovascular**

Chest Pain          ( ) Yes ( ) No  
 High Blood Pressure ( ) Yes ( ) No  
 Varicose Veins     ( ) Yes ( ) No

**Gastrointestinal**

Abdominal Pain     ( ) Yes ( ) No  
 Heartburn/Indigestion ( ) Yes ( ) No  
 Nausea/Vomiting    ( ) Yes ( ) No

**Urologic**

Urinary Retention    ( ) Yes ( ) No  
 Painful Urination    ( ) Yes ( ) No  
 Urinary Frequency    ( ) Yes ( ) No

**Neurologic**

Dizziness            ( ) Yes ( ) No  
 Numbness/Tingling    ( ) Yes ( ) No  
 Tremor                ( ) Yes ( ) No

**Musculoskeletal**

Neck pain            ( ) Yes ( ) No  
 Back pain            ( ) Yes ( ) No  
 Joint pain            ( ) Yes ( ) No

**Dermatologic**

Boils                 ( ) Yes ( ) No  
 Itching                ( ) Yes ( ) No  
 Rash                  ( ) Yes ( ) No

**Hematology**

Swollen Glands      ( ) Yes ( ) No  
 Blood Clotting problem ( ) Yes ( ) No

**Psychiatric**

Insomnia             ( ) Yes ( ) No  
 Anxiety                ( ) Yes ( ) No  
 Depression            ( ) Yes ( ) No

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of your last Flu Shot \_\_\_\_\_

Date of your last Pneumonia Shot \_\_\_\_\_



ADVANCED UROLOGY INSTITUTE NOTICE OF PRIVACY PRACTICES  
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act  
of 1996 (HIPAA) and modified by the HIPAA Omnibus Final Rule of 2013

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY**

**A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information, also described as "protected health information" (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. Some of these records may be on paper and some may be electronic media. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that were in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

Advanced Urology Institute Privacy Officer, 1744 N. Belcher Rd. Clearwater, FL 33765 Telephone: 727-474-3716

**C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS (SUBJECT TO CERTAIN RESTRICTIONS THAT YOU HAVE THE RIGHT TO REQUEST & WE MAY GRANT)**

The following categories describe the different ways in which we may use and disclose your PHI.

**1. Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

**2. Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

**3. Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

**Business Associates** — Our health care operations may involve the use of other contractors to assist us in billing, collection, record-keeping or other facets of our business operations. Our business associates are required to protect the privacy of your PHI and are not allowed to use or disclose my information other than as specified in our Business Associate contract with them.

**D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

**1. Public Health Risk.** Our practice may disclose your PHI to public health authorities authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled



- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this Information if the patient agrees or we are required or authorized by law to disclose this Information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Notifications of Data Breaches. Our practice may use and disclose your PHI to meet the requirements under the HIPAA rules to notify you and government agencies of any data breach that could potentially result in unintended disclosures of your PHI.

4. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

5. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

6. Marketing of our Services. Our practice may use and disclose your PHI for purposes of marketing our services to others but only if we have obtained your written authorization to use specified information for this purpose. You have a right to revoke this authorization at any time in writing. Any transaction that occurs prior to such revocation will not be considered an unauthorized disclosure.

7. Sale of Aggregate Data. Our practice may sell and disclose your PHI to other covered entities but only if we have obtained your written authorization prior to doing so. You have a right to revoke this authorization at any time in writing. Any transaction that occurs prior to such revocation will not be considered an unauthorized disclosure.

8. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary; (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI: You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to AUI Privacy Officer 727-474-3716 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request with certain exceptions (see below). If we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the Information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to AUI Privacy Officer 727-474-3716. Your request must describe in a clear and concise fashion:



- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

You have a right to revoke such restrictions in writing to the same representative of our practice.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. This includes your right to an electronic copy of any electronic medical records that we maintain. You may request this electronic copy be transmitted to you or to any other individual or entity that you designate. We will make reasonable efforts to transmit this electronic copy in the format you request however, if the PHI is not readily producible in this format, we will provide your record in our standard electronic format or in hard copy. You must submit your request in writing to AUI Privacy Officer 727-474-3716 in order to inspect and/or obtain a copy of your PHI. We have 30 days to comply with your request. Our practice may charge a reasonable fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health 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 practice. To request an amendment, your request must be made in writing and submitted to AUI Privacy Officer 727-474-3716. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI, outside of those for treatment, payment or health care operations purposes. Use of your PHI B3 part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to: **AUI Privacy Officer 727-474-3716**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) year from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same-12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to Notice of Data Breach.** In accordance with specifications of the U. S. Department of Health and Human Services, you have the right to be notified by us of a data breach that unintentionally discloses any or all of unsecured electronic PHI to an unauthorized party.

7. **Right to Restrict Disclosure: of Services Paid "Out of Pocket".** You have a right to forego a filing of insurance claims and restriction of disclosures to your health plan for any specific service that you pay for out of pocket. This request will be honored by us as long as the full payment is received at the time of service.

8. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact AUI Privacy Officer 727-474-3716

9. **Right to File a Complaint** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **AUI Privacy Officer 727-474-3716**. All complaints must be submitted in writing. You will not be penalized for filing a complaint

10. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact AUI Privacy Officer 727-474-3716.

PRINT NAME \_\_\_\_\_ Signature \_\_\_\_\_ DATE \_\_\_\_\_

May we leave a message on your answering machine? Yes \_\_\_\_\_ No \_\_\_\_\_

Names, of family members and telephone numbers we may contact \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**NOTICE OF PRIVACY PATIENT ACKNOWLEDGEMENT**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I understand that, under The Health Insurance Portability Accountability of 1996 and HIPAA Omnibus Final Rule of 2013, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understand The Notice of Privacy Practices. I agree that my signature will be valid as long as I am a patient of Advanced Urology Institute.

The practice reserves the right to change the terms of this Notice of Privacy Practices. I understand the practice will provide current Notice of Privacy Practice upon request.

I authorize AUI to release my PHI to the following individuals or service providers:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

I was unable to obtain the patient's signature.

Date \_\_\_\_\_ Name \_\_\_\_\_

# Consent to Share My Health Information with BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange (BayCare eHX) is designed to improve your health care and make office visits easier and more convenient. Giving your consent allows all your doctors who participate in BayCare eHX to enroll you in BayCare eHX and to disclose your demographic, insurance and medical information (collectively your "health information") to BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses and health professionals, and hospitals and other health care facilities. Only health care providers and authorized personnel who participate in BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of BayCare eHX, will be able to access your health information. BayCare eHX allows your providers access to your health information more quickly and accurately than paper charts.

You may use this consent form to note whether or not to allow BayCare eHX to see and obtain access to your health information in this way. This form may be filled out now or at a later date. Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on BayCare eHX for your medical treatment.

If you check the "YES" box below, you are saying "Yes, members of BayCare eHX may see and get access to all of my health information through BayCare eHX."

If you check the "NO" box below, you are saying "No, members of BayCare eHX may not see or get access to my health information through BayCare eHX for any purpose."

Read the information on the back of this form carefully before making your decision.

## Your Consent Choices

- YES, I give consent for my doctors to enroll me in BayCare eHX and for the members of BayCare eHX to access ALL of my health information as set forth in this Consent Form.
- NO, I deny consent for my doctors to enroll me in BayCare eHX and for the members of BayCare eHX to access ALL of my health information as set forth in this Consent Form.

Printed name of patient/representative \_\_\_\_\_

Signature of patient/representative \_\_\_\_\_

Date \_\_\_\_\_

Authority of Representative

I, \_\_\_\_\_, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_



# Details About Your Health Information in BayCare eHX and the Consent Process:

## 1. How Your Health Information Will Be Used

Your health information will be used by members of BayCare eHX only:

- To provide you with medical treatment and related services
- To check whether you have health insurance and what it covers
- To evaluate and improve the quality of medical care provided to all patients
- For administrative management of BayCare eHX

## 2. What Types of Health Information About You Are Included

If you give consent, members of BayCare eHX may access ALL of your health information available through BayCare eHX. This includes information created before and after the date of this consent form. Your health information available through BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries (such as diabetes or a broken bone), test results (such as X-rays or blood tests), and lists of medications you've taken. As part of this consent form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:

- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Psychiatric/mental health conditions
- Sexually transmitted diseases
- Substance abuse

## 3. Where Health Information Comes From

Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health information electronically.

## 4. Who May Access Information About You, If You Give Consent

Access to BayCare eHX will be limited to only those members of BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth in this consent form and who have agreed to the overall terms and conditions established for use and operation of BayCare eHX.

## 5. Improper Access to, or Use of, Your Information

If at any time you suspect that someone who should not have seen or received access to your health information has done so, contact the BayCare Privacy Department at (727) 820-8024.

## 6. Re-Disclosure of Information

Any electronic health information about you may be re-disclosed by members of BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in paper form. You understand that the protected health information disclosed pursuant to this consent form may not be protected by federal law once it is disclosed by your physician.

## 7. Effective Period

This consent form will remain in effect until the day you withdraw your consent.

## 8. Withdrawing Your Consent

You can withdraw your consent at any time by giving written notice to the Population Health Administrator (eHX) of BayCare Health System at 2995 Drew Street, Clearwater, FL 33759. Organizations that access your health information through BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.

## 9. Copy of Form

You are entitled to receive a signed copy of this consent form after you sign it.



**ADVANCED UROLOGY  
INSTITUTE**

**MEDICAL RECORDS RELEASE**

Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Number City State Zip

Social Security#: \_\_\_\_\_

I authorize \_\_\_\_\_  
(Doctor's Name)  
\_\_\_\_\_  
(Address) (City) (State) (Zip)

to furnish protected health information (PHI), including:

\_\_\_\_\_ Office Notes \_\_\_\_\_ Lab/Radiology \_\_\_\_\_ Test Results

To: Advanced Urology Institute or \_\_\_\_\_  
Address: \_\_\_\_\_  
of location \_\_\_\_\_  
\_\_\_\_\_

I release and hold harmless \_\_\_\_\_ MD and the providers' medical practice and employees, from all liability, including negligence that may arise from complying with this authorization. I understand that the medical record maintained may contain protected health information (PHI) from other health care professionals. I also understand that Advanced Urology Institute office policy requires prepayment of duplication costs incurred. As authorized by Florida law, fees for copying medical records are: \$1.00/page for the first 25 pages, \$.25 thereafter. (Chart review \_\_\_\_\_ pages is \$ \_\_\_\_\_ )

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_\_

**THIS AUTHORIZATION AND SIGNATURE WILL REMAIN VALID AS LONG AS I  
AM A PATIENT OF ADVANCED UROLOGY INSTITUTE.**

minimal risk of side-effects due to low absorption of the medication into the blood stream. Compounded topicals prepared by a pharmacist can be customized to the patient's specific needs.

**Interventional pain management.** "Interventional" procedures might include an injection of an anesthetic medicine or steroid around nerves, tendons, joints or muscles; spinal cord stimulation; insertion of a drug delivery system; or a procedure to stop a nerve from working for a long period of time.

**Non-opioid anesthesia.** Non-opioid anesthesia. Non-opioid anesthesia refers to the anesthetic technique of using medications to provide anesthesia and post-operative pain relief in a way that does not require opioids. Anesthesiologists can replace opioids with other medications selected for their ability to block surgical and post-surgical pain. By replacing opioids and incorporating the variety of anesthetic and analgesic medications that block the process of pain, anesthesia providers can provide a safer anesthetic that avoids the adverse effects of opioids.

Discuss these alternatives with your healthcare practitioner and talk about the advantages and disadvantages of the specific options being considered. Different approaches work better on different types of pain. Some treatments for pain can have undesirable side effects while others may provide benefits beyond pain relief. Depending on your insurance coverage, some options may not be covered, resulting in substantial out-of-pocket costs. Other options may require a significant time commitment due to the number of treatments or the time required for the treatment. Good communication between you and your healthcare practitioner is essential in building the best pain management plan for you.

## Helpful Hints and Links

When you are selecting a healthcare practitioner, you can verify their license and find more information at: <https://apps.mqa.doh.state.fl.us/MQASearchServices/Home>

You can find more information at these links.

National Institutes of Health: <https://ncch.nih.gov/health/pain/chronic.htm>  
Centers for Disease Control and Prevention: [https://www.cdc.gov/drugoverdose/pdf/nonopioid\\_treatments-a.pdf](https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf)

# Information on Nonopioid Alternatives for the Treatment of Pain

A guide to working with your healthcare practitioner to manage pain

Prescription opioids are sometimes used to treat moderate-to-severe pain. Because prescription opioids have a number of serious side effects, it is important for you to ask questions and learn more about the benefits and risks of opioids. Make sure you're getting care that is safe, effective, and right for you.



This pamphlet provides information about nonopioid alternative treatments to manage pain. You and your healthcare practitioner can develop a course of treatment that uses multiple methods and modalities, including prescription medications such as opioids, and discuss the advantages and disadvantages of each approach.

Pain management requires attention to biological, psychological, and environmental factors. Before deciding with your healthcare practitioner about how to treat your pain, you should consider options so that your treatment provides the greatest benefit with the lowest risk.





## General Consent to Diagnosis and Treatment

### General Consent to Care:

I, the undersigned, for myself or another person for whom I have authority to sign, hereby consent to medical care (including disclosing my history, having a physical exam performed upon me, diagnostic testing, and treatment with medication or minor surgery), as ordered by a provider, while such medical care and treatment is provided through Advanced Urology Institute (AUI) on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary. This consent extends to all AUI providers and office locations. I understand that this consent is continuing in nature- even after a diagnosis has been made or treatment begun.

### Specific Consent for Genital or Pelvic Examination:

I specifically consent to have a genital exam performed on me if my AUI provider so recommends. For males, this consent includes an examination of the external genitals and the prostate gland; for females, this consent includes a pelvic exam: the external genitals and the internal genitalia (vagina, cervix, uterus, fallopian tubes, ovaries, and rectum).

### Consent for Specific Procedures

I understand that some specific office or hospital procedures involve additional benefits and risks, and I may be asked to sign a separate consent form for those procedures- if deemed necessary by my AUI provider. I understand that I have the right to discuss a treatment plan with my provider, and I have the right to refuse specific diagnostic tests or treatment procedures.

### Consent for Health Information Exchange

I grant permission to download and exchange medical information about me- including but not limited to past and current medications, lab and xray test results, hospitalizations, and visits to other providers participating in such exchanges- in order to ensure that my medical history is complete and accurate. I understand that may only disclose my protected health information (PHI) according to federal and state laws and the separate authorization to use and disclose PHI.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required):

Print: \_\_\_\_\_ Sign: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_