AU | **Urology Center of Chester County, P.C.**
a division of **Academic Urology LLC**

Donald H. Andersen, M.D., F.A.C.S.
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William G. Merriam, M.D.

Dear Prospective Patient,

Welcome to our practice. We are honored that you choose us to provide you with your urologic care. An appointment has been scheduled with Dr. ____________ at __________ office location.

Our Mission Statement is to utilize the latest technology available to provide the highest level of care to all patients in a cost efficient manner.

MEDICAL INFORMATION:

Please complete the enclosed history form. We request that you bring copies of any laboratory tests, X-Ray reports or X-Ray films that would be helpful in our evaluation.

MEDICAL INSURANCE:

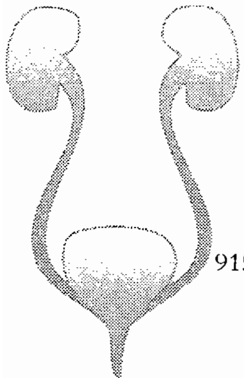
Please complete the patient information enclosed form. This will assist us in maintaining an accurate record of both personal and insurance information. Please bring any referrals, insurance cards, & co-payments with you at the time of your visit to assure accurate submission of any charges incurred. Please make sure that we are a participating provider with your health insurance carrier. Regardless of your insurance, payment remains your responsibility and we do accept cash, credit cards and personal checks. We are participating providers with Medicare, Medicare Advantage, Independence Blue Cross & Blue Shield and US Health Care among others.

APPOINTMENT POLICY:

Our offices are open Monday through Thursday, 8:30 A.M. to 4:30 P.M., and Friday 8:30 A.M. to 3:00 P.M. The office is closed on Saturdays, Sundays and Holidays. We request that if you cannot keep a scheduled appointment, you call to cancel at least 72 hours in advance. After hours or weekends, one of the doctors is available for emergencies through an answering service, by calling the office phone number. We request that routine prescription refill requests be made during our available office hours, and we require 48 hours notice. A 72 hour notice is required from patients requesting any records from our office; a copying fee may apply.

We look forward to meeting you.

Ellen W. Hamilton, RN, Administrator



Urology Center of Chester County, P.C.
915 Old Fern Hill • Building B, Suite 202 • West Chester, PA 19380 • t: 610.692.4270 • f: 610.692.2566
213 Reeceville Road • Suite 21 • Coatesville, PA 19320 • t: 610.383.7663 • f: 610.383.6377
15 Industrial Boulevard • Suite 201 • Paoli, PA 19301 • t: 610.647.3660 • f: 610.644.2165
www.urologyccc.com

Patient Information

Please answer all questions fully

Date: ______________________________

Account Number: ______________________

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PATIENT

Name (Last, First, MI)	Social Security	Birthdate	Sex	Home Phone

Mailing Address	City	State	Zip	Marital Status
Employer	City	State	Zip	Work Phone

RESPONSIBLE PARTY

Name (Last, First, MI)	Social Security	Birthdate	Sex	Home Phone

Mailing Address	City	State	Zip	Marital Status
Employer	City	State	Zip	Work Phone

PRIMARY PHYSICIAN	REFERRING PHYSICIAN

INSURANCE INFORMATION

Primary Insurance Company	Subscriber's Name	Relationship	Policy Number	Group #
Second Insurance Company	Subscriber's Name	Relationship	Policy Number	Group #
Third Insurance Company	Subscriber's Name	Relationship	Policy Number	Group #

EMERGENCY CONTACT INFORMATION

Contact Name	Relationship	Primary Phone Number	Secondary Phone Number

PATIENT RELEASE:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

SIGNATURE:____ DATE: ____________

(SIGNATURE OF INSURED OR AUTHORIZED PERSON, PATIENT OR PARENT IF MINOR)

THE UROLOGY CENTER OF CHESTER COUNTY, P.C.

NEW PATIENT QUESTIONNAIRE

Date: ____________________

Name: ____________________ Age: ________ Referring Doctor: ____________________

What is the main reason that you are seeing the doctor today?

____

____

____

____

____

____

____

PAST MEDICAL HISTORY:

Illnesses: (List any medical conditions you have such as High Blood Pressure, Diabetes, Heart Disease, High Cholesterol, etc...)

____

____

____

____

____

____

____

Surgeries: (List any operations you have had and approximately when they were done.)

____

____

____

____

____

____

____

Allergies: (List all allergies to Medications, Anesthetics, Contrast agents, etc...)

____

____

____

____

____

Occupation: ____________________

Marital Status: ____________________

Ages and Sex of Children: ____________________

____

____

____

Cigarettes: (Packs per day) ____________________

Alcoholic Beverages: (Drinks per day) ____________________

Family History: List your parents' age and medical condition if living. If parents deceased, list age and cause of death.

Father ____________________

Mother ____________________

Is there a family history of?:

Prostate Cancer	☐ Yes	☐ No
Kidney Cancer	☐ Yes	☐ No
Bladder Cancer	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No

REVIEW OF SYSTEMS

Do you have any problems now or have you had any related to the following systems? Please check Yes (Y) or No (N)

Constitutional Symptoms (Comments)

Weight change ☐ Y ☐ N
Chills ☐ Y ☐ N
Fever ☐ Y ☐ N
Other:

Eyes

Glaucoma ☐ Y ☐ N
Cataracts ☐ Y ☐ N
Other:

Cardiovascular

Chest pain ☐ Y ☐ N
Irregular heartbeat ☐ Y ☐ N
Swelling in ankles ☐ Y ☐ N
Other:

Psychologic

Do you feel depressed? ☐ Y ☐ N
Do you feel anxious? ☐ Y ☐ N

Endocrine

Excessive thirst ☐ Y ☐ N
Too hot/cold ☐ Y ☐ N
Other:

Hematologic/Lymphatic

Swollen glands ☐ Y ☐ N
Blood clotting problem ☐ Y ☐ N
Bruising ☐ Y ☐ N
Other:

Genitourinary (Comments)

Change in stream ☐ Y ☐ N
Nocturia (getting up at night) ☐ Y ☐ N
Urinary frequency >8 times/day ☐ Y ☐ N
Burning with urination ☐ Y ☐ N
Other:

Musculoskeletal

Muscle weakness ☐ Y ☐ N
Joint pain (swelling) ☐ Y ☐ N
Other:

Neurological

Tremors ☐ Y ☐ N
Dizzy spells ☐ Y ☐ N
Numbness/tingling ☐ Y ☐ N
Stroke ☐ Y ☐ N

Respiratory

Wheezing ☐ Y ☐ N
Frequent cough ☐ Y ☐ N
Shortness of breath ☐ Y ☐ N
Other:

Gastrointestinal

Abdominal pain ☐ Y ☐ N
Nausea/vomiting ☐ Y ☐ N
Indigestion/heartburn ☐ Y ☐ N
Constipation/diarrhea ☐ Y ☐ N

Sexual History

Change in sex drive? ☐ Y ☐ N
Sexual performance satisfactory? ☐ Y ☐ N
Other:

Male Only — **AUA Symptom Score: Circle one number in each line**

Questions to be answered	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More then half the time	Almost always
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. On a nightly basis, how many times do you typically get up to urinate?	0	1	2	3	4	5

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Sum the seven circled numbers (AUA Symptom Score): **Scoring:** Mild 0 - 7 Moderate 8 - 19 Severe 20 - 35

Physician Signature: ______________________________ Date: ________________

Patient Medication List

Patient Name	DOB	Today's Date
Medication	**Dosage**	**Frequency**

<u>**NOTICE OF PRIVACY PRACTICES FOR THE UROLOGY CENTER OF CHESTER COUNTY, PC.**</u>

Effective date: April 14, 2003

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

If you have any questions regarding this notice, you may contact our privacy officer at:

The Urology Center of Chester County, PC, Attention Privacy Officer
915 Old Fern Hill Road, Building B, Suite 202
West Chester, PA 19800
610-692-4270 (telephone)
610-692-2566 (facsimile)

I. YOUR PROTECTED HEALTH INFORMATION

The Urology Center of Chester County, PC is required by the federal privacy rule to maintain the privacy of your health information that is protected by the rule, and to provide you with notice of our legal duties and privacy practices with respect to your protected health care information. We are required to abide by the terms of the notice currently in effect.

Generally speaking, your protected health information is any information that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for health care provided to you, and individually identifies you or reasonably can be used to identify you.

Your medical and billing records at our practice are examples of information that will usually be regarded as your protected health information.

II. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. Treatment, payment, and health care options

This section describes how we may use and disclose your protected health information for treatment, payment, and health care operations. The descriptions include examples. Not every possible use or disclosure for treatment, payment, and health care operations purposes will be listed.

1. Treatment

We may use and disclose your protected health information for our treatment purposes as well as the treatment purposes of other health care providers. Treatment includes the provision, coordination, or management of health care services to you by one or more health care providers. Some examples of treatment uses and disclosures include:

- During an office visit, practice physicians and other staff involved in your care may review your medical record and share your medical information with each other.
- We may share and discuss your medical information with an outside physician to whom we have referred you for care.
- We may share and discuss your medical information with an outside physician, whom we are consulting regarding you.
- We may share and discuss your medical information with an outside laboratory, radiology center, or other health care facility where we have referred you for testing.
- We may share and discuss your medical information with an outside home health agency, durable medical equipment agency or other health care provider to whom we have referred you for health care services and products.
- We may share and discuss your medical information with a hospital or other health care facility where we are admitting or treating you.
- We page patients by name in the waiting room when it is time for them to go to an examining room.
- We may contact you to provide appointment reminders.

2. Payment

We may use and disclose your protected health information for our payment purposes as well as the payment purposes of other health care providers and health plans. Payment uses and disclosures include activities conducted to obtain payment for the care provided to you or so that we can obtain reimbursement for that care. Examples of payment uses and disclosures include:

- Sharing information with your health insurer to determine whether you are eligible for coverage or whether proposed treatment is a covered service.
- Submission of a claim form to your health insurer or insurance clearinghouse.
- Providing supplemental information to your health insurer so that your health insurer can obtain reimbursement from another health plan under a coordination of benefits clause in your subscriber agreement.

- Sharing your demographic information (for example, your address) with other health care providers who seek this information to obtain payment for health care services provided to you.
- Mailing you bills in envelopes with our practice name and return address.
- Provision of a bill to a family member or other person designated as responsible for payment for services rendered to you.
- Providing medical records and other documentation to your health insurer to support the medical necessity of a health service.
- Allowing your health insurer access to your medical record for a medical necessity or quality review audit.
- Providing consumer reporting agencies and credit information (your name and address, date of birth, social security number, payment history, account number, and our name and address).
- Providing information to a collection agency or our attorney for purposes of securing payment of a delinquent account.
- Disclosing information in a legal action for purposes of securing payment of a delinquent account.

3. Health care operations

We may use and disclose your protected health information for our health care operation purposes as well as certain health care operation purposes of other health care providers and health plans. Some examples of health care operation purposes include:

- Quality assessment and improvement activities.
- Population based activities relating to improving health or reducing health care costs.
- Reviewing the competence, qualifications, or performance of health care professionals.
- Conducting training programs for medical and other students.
- Accreditation, certification, licensing, and credentialing activities.
- Health care fraud and abuse detection and compliance programs.
- Conducting other medical review, legal services, and auditing functions.
- Business planning and development activities, such as conducting cost management and planning related analyses.
- Sharing information regarding patients with entities that are interested in purchasing our practice and turning over patient records to entities that have purchased our practice.
- Other business management and general administrative activities, such as compliance with the federal privacy rule and resolution of patient grievances.

4. Communication from our Office

We may contact you to remind you of appointments or to help you schedule studies or procedures. We may also contact you to obtain payment for services provided.
Some examples are:

- Phoning you at home or at work.
- Leaving a message or voice mail on an answering machine; identifying us as a medical practice and requesting a return call.
- Reminder postcards for appointments that include the name and address of our practice.
- Letters addressed to you mailed by regular or certified mail that include the name and address of our practice on the envelope.

B. Uses and disclosures for other purposes

We may use and disclose your protected health information for other purposes. This section generally describes those purposes by category. Each category includes one or more examples. Not every use or disclosure in a category will be listed. Some examples fall into more than one category – not just the category under which they are listed.

1. Individuals involved in care or payment for care

We may disclose your protected health information to someone involved in your care or payment for your care, such as a spouse, a family member, or close friend. For example, if you have surgery, we may discuss your physical limitations with a family member assisting in your post-operative care.

2. Notification purposes

We may use and disclose your protected health information to notify, or to assist in the notification of, a family member a personal representative, or another person responsible for your care, regarding your location, general condition, or death. For example, if you are hospitalized, we may notify a family member of the hospitalization and your general condition. In addition, we may disclose your protected health information to a disaster relief entity, such as the Red Cross, so that it can notify a family member, a personal representative, or another person involved in your care regarding your location, general condition, or death.

3. Required by law

We may use and disclose protected health information when required by federal, state, or local law. For example, we may disclose protected health information to comply with mandatory reporting requirements involving

births and deaths, child abuse, disease prevention and control, vaccine-related injuries, medical device–related deaths ands serious injuries, gunshot and other injuries by a deadly weapon or criminal act, driving impairments, and blood alcohol testing.

4. Other public health activities

We may use and disclose protected health information for public health activities, some examples include:

- Public health reporting, for example, communicable disease reports.
- Child abuse and neglect reports.
- FDA – to report reactions to medications or problems with products or devices regulated by the Food and Drug Administration (FDA) or other activities related to the quality, safety or effectiveness of FDA regulated products or activities.
- Public health warnings to third parties at risk of a communicable disease or condition.
- OSHA requirements for workplace surveillance and injury reports.

5. Victims of abuse, neglect or domestic violence

We may use and disclose protected health information for purposes of reporting of abuse, neglect or domestic violence in addition to child abuse, for example, reports of elder abuse to the Department of Aging or abuse of a nursing home patient to the Department of Public Welfare.

6. Health oversight activities

We may use and disclose protected health information for purposes of health oversight activities authorized by law. These activities could include audits, inspections, investigations, licensure actions, and legal proceedings. For example, we may comply with a Drug Enforcement Agency inspection of patient records.

7. Judicial and administrative proceedings

We may use and disclose protected health information disclosures in judicial and administrative proceedings in response to a court order or subpoena, discovery request or other lawful process. For example, we may comply with a court order to testify in a case at which your medical condition is at issue.

8. Law enforcement purposes

We may use and disclose protected health information for certain law enforcement purposes including to:

- Comply with legal process, for example, a search warrant.
- Comply with a legal requirement, for example, mandatory reporting of gun shot wounds.
- Respond to a request for information for identification/location purposes.

- Respond to a request for information about a crime victim.
- Report a death suspected to have resulted from criminal activity.
- Provide information regarding a crime on the premises.
- Report a crime in an emergency.

9. Coroners and medical examiners

We may use and disclose protected health information for purposes of providing information to a coroner or medical examiner for the purpose of identifying a deceased patient, determining a cause of death, or facilitating their performance of other duties required by law.

10. Funeral directors

We may use and disclose protected health information for purposes of providing information to funeral directors as necessary to carry out their duties.

11. Organ and tissue donation

For purposes of facilitating organ, eye and tissue donation and transplantation, we may use protected health information and disclose protected health information to entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue.

12. Threat to public safety

We may use and disclose protected health information for purposes involving a threat to public safety, including protection of a third party from harm and identification and apprehension of a criminal. For example, in certain circumstances, we are required by law to disclose information to protect someone from imminent serious harm.

13. Specialized government functions

We may use and disclose protected health information for purposes involving specialized government functions including:

- Military and veterans activities.
- National security and intelligence.
- Protective services for the President and others.
- Medical suitability determinations for the Department of State.
- Correctional institutions and other law enforcement custodial situations.

14. Workers' compensation and similar programs

We may use and disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault. For example, this would include submitting a claim for payment to your employer's workers' compensation carrier if we treat you for a work injury.

15. Business associates

Certain functions of the practice are performed by a business associate such as a billing company, an accountant firm, or a law firm. We may disclose protected health information to our business associates and allow them to create and receive protected health information on our behalf. For example, we may share with our billing company information regarding your care and payment for your care so that the company can file health insurance claims and bill you or another responsible party.

16. Creation of de-identified information

We may use protected health information about you in the process of de-identifying the information. For example, we may use your protected health information in the process of removing those aspects which could identify you so that the information can be disclosed to a researcher without authorization.

17. Incidental disclosures

We may disclose protected health information as by-product of an otherwise permitted use or disclosure. For example, other patients may overhear your name being paged in the waiting room.

18. Disclosure required by HIPAA Privacy Rule

We are required to disclose protected health information to the Secretary of US Dept. of HHS when requested by the secretary to review our compliance with the HIPAA Privacy Rule

C. Uses and disclosures with authorization

For all other purposes, which do not fall under a category listed under sections II.A and II.B, we will obtain your written authorization to use or disclose your protected health information. Your authorization may be revoked at any time except to the extent that we have relied on the authorization.

III. PATIENT PRIVACY RIGHTS

A. Right to request restrictions

You may also request additional restrictions on our disclosure of protected health information to certain individuals involved in your care that otherwise are permitted by the Privacy Rule. **We are not required to agree to your request.** If we do agree, we are required to comply with our agreement except in certain cases, including when the information is needed to treat you in the case of an emergency.
To request a further restriction, you must submit a written request to our privacy officer. The request must tell us: (a) what information you want restricted; (b) how you want the information restricted; and (c) to whom you want the restriction to apply.

B. Right to receive confidential communication
You have a right to request that we communicate your protected health information to you by a certain means or at a certain location. For example, you might request that we only contact you by mail or at work. We are not required to agree to requests for confidential communications that are unreasonable.
To make a request for confidential communications, you must submit a written request to our privacy officer. The request must tell us how or where you may want to be contacted. In addition, if another individual or entity is responsible for payment, the request must explain how payment will be handled.

C. Right to request an accounting of disclosures
You have the right to request, an "accounting" of certain disclosures that we have made of protected health information about you. This is a list of disclosures made by us during a specified period of up to six years other than disclosures made for treatment, payment and health care operations; for use in or related to a facility directory; to family members or friends involved in your care; to you directly; pursuant to an authorization you or your personal representative; or for certain notification purposes; and disclosures made before April 14, 2003. If you wish to make such a request, please contact our privacy officer. The first list you request in a 12-month period will be free, but we will charge you our reasonable cost of providing additional lists in the same 12-month period.

D. Right to request inspection and copying
You have the right to request the opportunity to inspect and obtain a copy of your protected health information that we maintain in a designated records set. Record retrieval may take up to 60 days, if records stored off site.
This right is subject to limitations.
To exercise your right of access, you must submit a written request to our privacy officer. The request must: (a) describe the health information to which access is requested, (b) state how you want to access the information, such as inspection, pick-up copy, mailing of copy, and (c) include the mailing address, if applicable.
If you request a copy of your records, you will be charged a reasonable fee for the copying, postage, labor and supplies used in meeting your request.

E. Right to amendment
You have a right to request that we amend protected health information that we maintain about you in a designated records set if the information is incorrect or incomplete. This is subject to limitations. To request an amendment, you must submit a written request to our privacy officer.

The request must specify each change that you want and provide a reason to support each requested change. We may deny your request in certain circumstances.

F. Paper copy of privacy notice
You have a right to receive, upon request, a paper copy of our Notice of Privacy Practices. To obtain a paper copy, contact our privacy officer.

IV. CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We further reserve the right to make any change effective for all protected health information that we maintain at the time of the change-including information that we created or received prior to the effective date of the change.
We will post a copy of our current notice in the waiting room for the practice. At any time, patients may review the current notice by contacting our privacy officer.

V. Complaints

If you believe that we have violated your privacy rights, you may submit a complaint to the practice or the Secretary of Health and Human Services. To file a complaint with the practice, submit the complaint in writing to our privacy officer. We will not retaliate against you for filing a complaint.

VI. LEGAL EFFECT OF THIS NOTICE

This notice is not intended to create contractual or other rights independent of those created in the federal privacy rule.