Metro Atlanta Urology AND Pelvic Health Center

MALE
New Patient Demographics

Do you need assistance with these forms? ☐Y ☐N

DEMOGRAPHICS

Last Name: First: MI:	DOB: (MM/DD/YYYY) Gender: ☐ Male ☐ Female ☐ Other
Address:	Social Security No.:
City: State: Zip:	Phone:
Primary Care Physician: (Name)	(Phone)
Referring Physician: (Name)	(Phone)
Emergency Contact: (Name) (Phone)	(Relationship)

Additional Information

Email:	
Race: Ethnicity:	Preferred Language: ☐ English ☐ Spanish ☐ Other
Preferred Pharmacy: (Name)	(Phone)
Do you have an Advance Directive (Living Will)? ☐Y ☐N	

NOTICE OF PRIVACY PRACTICE

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I have been provided a copy of Metro Atlanta Urology and Pelvic Health Center's Privacy Practices as required by the Health Insurance Portability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I authorize Metro Atlanta Urology and Pelvic Health Center to release my health information topersons/organizations listed below:

☐ Same as Emergency Contact	Other person/organization Name:________________
	Relationship:________________Phone: ________________

By signing this document, I acknowledge the following:

- I have been provided a copy of Metro Atlanta Urology and Pelvic Health Center's Privacy Practices
- I have reviewed this authorization to release my medical records and confirm it is correct.
- I understand that this authorization will remain in effect for a period of one (1) year, unless revoked.
- I may revoke this authorization at any time by writing to: Metro Atlanta Urology and Pelvic HealthCenter, ATTN: Medical Records
- 1301 Shiloh Rd NW, Suite 660, Kennesaw, GA 30144: The revocation will become effective upon receipt of the notice.

________________________ Signature of Patient (or guardian)

________________________ Date

OFFICE

For Office Use Only

Staff Initials:	☐ Patient Photograph	**Scan ALL patient documents**		
		☐ Pt. ID	☐ Insurance Card	
		☐ Pt. Demographics	☐ Pt. History	☐ Pt. Surveys

Metro Atlanta Urology AND Pelvic Health Center

Annual – Financial Policy & Consents

PAYMENT POLICY

Please *initial and sign* to your acknowledgement and consent for Medical Treatment and Payment Policy.

Thank you for choosing Metro Atlanta Urology and Pelvic Health Center as your provider. We arecommitted to providing you with quality and affordable health care. Please be sure to carefully read our payment policy. A copy will be provided upon request.

- ***Insurance.*** We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you mayhave regarding your coverage.
- ***Booking Fee.*** Surgeries, In-office procedures and in-office diagnostic tests require a scheduling fee of $75 to secure the appointment. At the time of booking, the booking fee amount and payment instructions will be provided to you. Payments can be made either through a payment link sent or in person at the clinic. Appointment is not confirmed until payment of scheduling fee is completed. Scheduling fees are refundable against treatment but non-refundable nor transferable if an appointment is cancelled or re-arranged less than 3 working days before it was scheduled.
- ***Co-payments and deductibles***. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your account is turned over to a collection agency, a $100 collections processing fee will be added to any outstanding balance.
- **"No-show" or late cancellation.** If you do not cancel or reschedule your appointment with at least 24 hours notice, we will assess a $75 "no-show" service charge to your account. This fee will be waived the first time to account for emergencies.
- ***Non-covered services***. Please be aware that some of the services you receive may be non- covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- ***Proof of insurance***. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proofof insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- ***Claims submission***. We will submit your claims and assist you in any way we can to help get yourclaims paid. Please be aware that any unpaid balances are your responsibility.
- ***Coverage changes***. If your insurance changes, please notify us before your next visit so we canmake the appropriate changes to help you receive your maximum benefits.
- ***Nonpayment.*** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account. Please be aware that if a balance remains unpaid, we mayrefer your account to a collection agency.

__________**INITIAL HERE**

CONSENT TO MEDICAL TREATMENT

I have reviewed and consent to the following:

- I voluntarily present for treatment and consent to my provider to provide my care. Such care mayinclude, but is not limited to, diagnostic procedures, blood draws, laboratory tests, medicationadministration, and other procedures considered advisable in my diagnosis, treatment and courseof care.
- I acknowledge that my treatment is intended to address specific illnesses and is not intended as asubstitute for a primary care physician and that no guarantee can be made or has been madeas to the results of treatments or examinations at Metro Atlanta Urology and Pelvic Health Center.
- In the event an employee has a needle stick or otherwise is exposed to my blood or body fluids, Iconsent to testing for HIV or Hepatitis C & B.

__________**INITIAL HERE**

SIGNATURES

By signing below, I acknowledge that I have reviewed Metro Atlanta Urology and Pelvic HealthCenter's payment policy and consent to medical treatment.

Print name of person signing:________________________________ Relationship to patient: ____________________

______________________________________ ______________________________

Signature of patient (or guardian) Date

Metro Atlanta Urology
AND
Pelvic Health Center

Annual – Financial Policy & Consents

NO SHOW/LATE CANCELATION POLICY

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That is why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Metro Atlanta Urology and Pelvic Health Center sends text message and email reminders 1 week, 2 days, and 1 hour in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours notice.

If you do not cancel or reschedule your appointment with at least 24 hours notice, we will assess a $75 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it and will not be allowed to reschedule until the fee is paid. We understand emergencies happen and will waive the fee the first time.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

SIGNATURES

I understand the "no-show" policy of Metro Atlanta Urology and Pelvic Health Center and agree to provide a credit card number, which may be charged $75 for any "no-show" of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge to the credit card provided.

Signature of patient (or guardian)	Date

Metro Atlanta Urology
AND
Pelvic Health Center

Medical Release

Request for Healthcare information
Please forward the healthcare records of the following patient
Fax to 18884942183 or mail to 1301 Shiloh Rd NW, Suite 660, Kennesaw, GA 30144

Authorization to obtain protected healthcare information

Patient Name (LAST) ______________________(FIRST) ____________________(MI) ________(Suffix) _________

Date of Birth:_______/______/_______ Phone: ______________________________

☐ I authorize Metro Atlanta Urology and Pelvic Health Center to obtain and the named facilities to release to Metro Atlanta Urology and Pelvic Health Center my healthcare information.

This release applies to:

☐ All my healthcare information

☐ Healthcare information related to the following treatment, condition or dates

____

☐ Other

____

For Office Use Only

Facility: (Name) ____________________________

Address: ________________________________

Phone: ________________________________

(Fax)____

_______________________________ _______________________

Signature of patient (or guardian) Date

_______________________________ _______________________

Print name of person signing Relationship to patient

Metro Atlanta Urology
AND
Pelvic Health Center

Male
Patient History

Patient Name:________________________________ Date of birth:________________

Height:__________________ Weight: ______________

Reason for today's visit:

CURRENT

List ***ALL*** current medications including over the counter, birth control, vitamins, herbals & prescriptions

Medication Name & Dose	Medication Name & Dose

MED HISTORY

List ***ALL*** current or past medical conditions

ALLERGIES

Are you allergic to the following: ☐ Latex ☐ Band-aids/Adhesives ☐ Iodine ☐ Shellfish ☐ IVP Dye

☐ **No known allergies**

List all medication allergies

Name of medication	Reaction to medication

SURG

List ***ALL*** surgeries including the year

HOSPITALIZATION

List all hospitalizations, including the year **[Not ER visits]**

Metro Atlanta Urology
AND
Pelvic Health Center

Male
Patient History

FAMILY HISTORY

Is there any family history of genitourinary cancer? (kidney, bladder, prostate, testicular) ☐ **Yes** ☐ **No**

Is there any family history of breast cancer? ☐ **Yes** ☐ **No**

Relationship	Type

Please answer the following:

Mother	Father
☐ Alive ☐ Deceased ☐ Unknown Cause of death:	☐ Alive ☐ Deceased ☐ Unknown Cause of death:

SOCIAL HISTORY

Tobacco Use

- Do you use tobacco products? ☐ Yes ☐ No (How long?) _________ (How much?) Packs/day:_________
- Are you a former smoker? ☐ Yes ☐ No (Quit date?) __________

Alcohol Use

- Do you consume alcohol? ☐ Yes ☐ No (Type?) ☐ Beer ☐ Wine ☐ Liquor

How much?_________drinks per ☐ Day ☐ Week ☐ Month (Date of last drink?)____/_____/_____

Drug Use

Do you routinely use any illegal substances? ☐ Yes ☐ No

If yes, please list substance(s):

Patient history completed by:

☐ Patient

☐ Other Name:_____________________________Relationship to patient:____________________

Metro Atlanta Urology AND Pelvic Health Center

MALE - Bladder Survey UDI-6/IIQ-7

Name:	DOB:	Today's date:

The following questions ask about your bladder and urinary function. Please review and answer all questions as best as you can.

Do you usually experience any of the following, and if so, how much are you bothered... (Circle all that apply)	If yes, how much does this bother you?			
	Not at all	**Somewhat**	**Moderately**	**Quite a bit**
1. Frequent urination	0	1	2	3
2. Small amounts of urine leakage (drops)	0	1	2	3
3. Leakage associated with a feeling of urgency, that is, a strong sensation of needing to go to the bathroom	0	1	2	3
4. Urine leakage related to physical activity (coughing, sneezing, or laughing)	0	1	2	3
5. Difficulty emptying your bladder	0	1	2	3
6. Pain or discomfort in the lower abdomen or genital region	0	1	2	3
Has urine leakage affected your... (Circle all that apply)	**Not at all**	**Slightly**	**Moderately**	**Greatly**
1. Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

- If you checked "Yes" to any of the above problems, how long have you been experiencing this?

☐ Less than 1 year ☐ About 1 year ☐ About 2 years ☐ 3 to 5 years ☐ Greater than 5 years

- On average, how many times do you urinate during the daytime (Waking hours)? ____________________
- On average, how many times do you urinate overnight (Sleeping hours)? ____________________
- If you leak urine, how frequently does this occur?

  ☐ Every day ☐ A few times per week ☐ A few times per month ☐ Less than once per month ☐ Never

  - If you leak urine, how much do you lose at a given time? ☐ drops ☐ Small splashes ☐ More
  - Has urine leakage caused you to feel frustrated? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Greatly
  - Do you ever leak urine while asleep? ☐ Yes ☐ No
  - Do you ever leak urine without awareness? ☐ Yes ☐ No

- What events trigger urine leakage? **(Check all that apply)**

  ☐ Cough ☐ Laugh ☐ Sneeze ☐ Exercise ☐ Sex
  ☐ Positional Changes ☐ Urgency ☐ Other:____

Adapted from Uebersax JS, Wyman FF, Shumaker SA, et al. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and urogenital distress inventory. Neurourol Urodyn 1995; 14: 131

- Have you noticed any of the following with regards to your urine stream? **(Check all that apply)**
  - ☐ Slow to start (hesitancy) ☐ Weak stream ☐ Slow stream
  - ☐ Dribbling after stream ends ☐ Double voiding ☐ Intermittent stream
- Do you need to do any of the following to help your bladder empty? **(Check all that apply)**
  - ☐ Bearing down ☐ Pushing on lower abdomen
  - ☐ Position changes ☐ Catheter usage
- Have you had a urinary tract infection (UTI) with a positive urine culture in the past year? ☐ Yes ☐ No
  - If yes, about how many have you had in the past year? _____________
  - When was your most recent one (date)? _____________
  - Do you think you may have one today? ☐ Yes ☐ No
- Have you noticed any blood in your urine? ☐ Yes ☐ No
- Do you have any burning or pain with urination? ☐ Yes ☐ No
- Do you ever have pain associated with a full bladder? ☐ Yes ☐ No
- Have you ever tried any medications for your bladder? (**Check all that apply**
  - ☐ Detrol/Tolterodine ☐ Ditropan/Oxybutynin ☐ Vesicare/Solifenacin ☐ Sanctura/Trospium
  - ☐ Toviaz/Fesoterodine ☐ Enablex/Darifenacin ☐ Myrbetriq/Mirabegron ☐ Cardura/Flomax
  - ☐ Elmiron/PPS ☐ Methenamine/Hipprex ☐ D-Mannose ☐ Antibiotics
- Have you had any side effects from the above medications? (**Check all that apply**)
  - ☐ Dry mouth ☐ Dry eyes ☐ Constipation ☐ Urine retention
  - ☐ Impaired emptying ☐ Other
- Do you have any of the following medical problems?
  - ☐ Glaucoma ☐ Gastroparesis/Slow GI transit ☐ Dementia
  - ☐ Hypertension ☐ Myasthenia gravis ☐ QT prolongation
- Have you had any of the following treatments/procedures for your bladder?
  - ☐ Sling/Sphincter ☐ Urethral bulking ☐ Botox in bladder ☐ PTNS ☐ PNE/Interstim ☐ Hydrodistention
  - ☐ Pelvic floor physical therapy ☐ Other____________

Adapted from Uebersax JS, Wyman FF, Shumaker SA, et al. Short forms to assess life quality and symptom distress for urinary incontinence in women: theincontinence impact questionnaire and urogenital distress inventory. Neurourol Urodyn 1995; 14: 131

Metro Atlanta Urology
AND
Pelvic Health Center

International Prostate Symptom Score for Men Over the Age of 40

Many men over the age of 40 suffer from Benign Prostatic Hyperplasia (BPH). This is a non-cancerous enlargement of the prostate. Your provider will use this form to assess your symptoms and will discuss your score with you.

AUA AND BPH SYMPTOM SCORE	***Name:***					
DIRECTIONS *- Thinking over the past month, check what best describes the following. Then add all the checked numbers to get the total score*	*Not at all*	*Less than 1 - 5 times*	*Less than half the time*	*About half the time*	*More than half the time*	*Almost Always*
1. ***INCOMPLETE EMPTYING*** – Over the past month, how often have you had the feeling of not completely emptying your bladder after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
FREQUENCY *– Over the past month, how often did you have to urinate again less than 2 hours after you had finished urinating?*	**0**	**1**	**2**	**3**	**4**	**5**
INTERMITTENCY *– Over the past month, how often did you stop and start again several times while urinating?*	**0**	**1**	**2**	**3**	**4**	**5**
URGE TO URINATE *– Over the past month, how often did you find it difficult to postpone urination?*	**0**	**1**	**2**	**3**	**4**	**5**
WEAK STREAM *– Over the past month, how often did you have a weak urinary stream?*	**0**	**1**	**2**	**3**	**4**	**5**
STRAINING *– Over the past month, how often did you have to push or strain to begin urination?*	**0**	**1**	**2**	**3**	**4**	**5**
URINATING AT NIGHT *– Over the past month, how many times do you typically get up at night to urinate after going to bed?*	**0**	**1**	**2**	**3**	**4**	**5**
Symptom Score: 1 – 7 Mild, 8 – 19 Moderate, 20 – 35 Severe			***TOTAL SCORE:***			

BOTHER SCORE DUE TO URINARY SYMPTOMS						
Rate the bothersome level of your urinary symptoms by checking what best describes your feelings	***Delighted***	***Pleased***	***Mostly Satisfied***	***Mixed***	***Mostly Dissatisfied***	***Terrible***
How would you feel living the rest of your life with your current urinary condition the way it is now?	**0**	**1**	**2**	**3**	**4**	**5**

Are you interested in minimally invasive surgical intervention?	☐ ***Yes***	☐ ***No***

Metro Atlanta Urology
AND
Pelvic Health Center

IIEF-5 Questionnaire
SHIM

Please encircle the response that best describes you. Your provider will use this form to assess your symptoms and will discuss your score with you.

SHIM	**Name:**				
Over the past 6 months	**Very Low**	**Low**	**Moderate**	**High**	**Very High**
How would you rate your confidence that you could get and keep an erection?	1	2	3	4	5
Over the past 6 months	**Almost never or never**	**A few times**	**Sometimes**	**Most times**	**Almost always or always**
When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	1	2	3	4	5
Over the past 6 months	**Almost never or never**	**A few times**	**Sometimes**	**Most times**	**Almost always or always**
During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	1	2	3	4	5
Over the past 6 months	**Extremely difficult**	**Very difficult**	**Difficult**	**Slightly Difficult**	**Not difficult**
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	1	2	3	4	5
Over the past 6 months	**Almost never or never**	**A few times**	**Sometimes**	**Most times**	**Almost always or always**
When you attempted sexual intercourse, how often was it satisfactory for you?	1	2	3	4	5

Total Score: ______________

1-7 Severe ED 8-11 Moderate ED 12-16: Mild-moderate ED 17-21: Mild ED 22-25: No ED

Adjunct to SHIM					
1. Do you have urinary leakage with sexual activity or orgasm? ☐ Yes ☐ No					
	Never or almost never [0%]	Less than half the time [25%]	About half the time [50%]	Over half the time [75%]	Always or almost always [100%]
2. Do you ejaculate before you want to?	**0**	**1**	**2**	**3**	**4**
3. Do you ejaculate with very little stimulation?	**0**	**1**	**2**	**3**	**4**
4. Have you noticed a bend or abnormal shape to your penis during erections? ☐Yes ☐No					
5. Is this penile deformity negatively affecting sex for you or your partner? ☐Yes ☐No					

Metro Atlanta Urology
AND
Pelvic Health Center

Narcotic and Opioid Patient Prescriber Agreement

Narcotic and Opioid Patient Prescriber Agreement (PPA)

- Pain and pain treatment are different for each person. Narcotic and opioid medicines are a type ofmedicine used to reduce moderate to severe pain. Narcotic and opioid medicines can reduce some(but not all) types of pain. It is not known how much improvement in pain, activity and quality of life I may have by using these medicines.

- My prescriber and I may also try alternative or additional treatment options for my condition, including: Non-opioid medicines, Physical therapy, appropriate exercises, Self-management techniques and coping strategies, or surgical or other medical procedures.

- Using narcotic and opioid medicines may cause:
  - *Physical dependence*: If the medicine is suddenly stopped I may experience withdrawal symptoms.
  - *Tolerance*: Over time, I may need more medicine to get the same pain relief.
  - *Addiction*: I may develop an intense craving for the opioid medicine, even if I take it as prescribed. If someone in my family has been addicted to drugs or alcohol, I may be at greater risk for addiction.

- Narcotic and opioid medicines can impair my judgment and responses. I understand that I must be cautious if I drive or operate machinery or do any activity that requires me to be alert until I am sure I can perform such activities safely.

- Taking even small amounts of alcohol or taking medicines such as sleeping pills, antihistamines, and anti-anxiety medicines while taking an opioid or narcotic medicine will increase the chance of side effect such as drowsiness, dangerously slowed breathing, and decreased alertness. If I start to have more pain or other unusual or severe side effects, I will contact my prescriber right away.

- I agree to discuss with my prescriber my and my family's past and present use of any habit-forming substances before we decide to try to treat my condition with an opioid medicine

- I told my prescriber about all the medicines I am taking, including any prescription, over-the-counter and herbal medicines. I will also discuss with my prescriber any new medicine that I take in the future.

- I will tell my prescriber if I am pregnant or planning to become pregnant

- I will not share this opioid medicine with other people.

- I will keep my opioid medicine in a secure place where other people cannot reach it.

- I will remove expired, unwanted, or unused opioid medicine from my home to avoid accidentally harming children, other adults, or myself.

- I understand that my prescriber may be required to check the Georgia Prescription Drug Monitoring Program before issuing a prescription for certain narcotics or opiates.

____________________________________ ________________________
Patient Signature | Date

Privacy Policy

PRIVACY NOTICE

METRO ATLANTA UROLOGY AND PELVIC HEALTH CENTER, LLC.

NOTICE OF PRIVACY POLICIES

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

Introduction

At Metro Atlanta Urology and Pelvic Health Center we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective May 1, 2022, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit the Metro Atlanta Urology and Pelvic Health Center, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

1. Basis for planning your care and treatment
2. Means of communication among the many health professionals who contribute to your care,
3. Legal document describing the care you received,
4. Means by which you or a third-party payer can verify that services billed were actually provided.
5. A tool in educating health professionals.
6. A source of data for medical research
7. A source of information for public health officials charged with improving the health of this state and the nation,
8. A source of data for our planning and marketing,
9. A tool, which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Metro Atlanta Urology and Pelvic Health Center, the information belongs to you. You have the right to:

1. Obtain a paper copy of this notice of information practices upon request,
2. Inspect and copy your health record as provided for in **45 CFR 164.528,**
3. Request communications of your health information by alternative means or at alternative locations,
4. Request a restriction on certain uses and disclosures of your information as provided by **45 CFR 164.522,** and
5. Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Metro Atlanta Urology and Pelvic Health Center is required to:

1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction, and
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice in our offices. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of Disclosures for Treatment Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Business associates: These are some services provided in our organization through contacts with a business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill your or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representation, or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research proposal has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Metro Atlanta Urology and Pelvic Health Center's Privacy Officer, Bryan Rivera, at (678) 528-0578. If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Humans Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address is:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 500F, HHH Building
Washington, D.C. 20201

Signature: ______________________________________

Print Name: ____________________________________

Date: ____