

# Franklin Urological Associates, P.C.

## NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment and health care operations.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for service, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you we are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by Asking to speak to our Privacy Officer or for Written inquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

# Franklin Urological Associates

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Pharmacy Name

\_\_\_\_\_  
Pharmacy Address

\_\_\_\_\_  
Pharmacy Phone Number

\_\_\_\_\_  
Pharmacy Name

\_\_\_\_\_  
Pharmacy Address

\_\_\_\_\_  
Pharmacy Phone Number

\_\_\_\_\_  
Pharmacy Name

\_\_\_\_\_  
Pharmacy Address

\_\_\_\_\_  
Pharmacy Phone Number

I Have:

\_\_\_\_\_ Taken a HIPAA Notice of Privacy Practices for my records

\_\_\_\_\_ Been offered a Notice of Privacy Practices but decline to take it with me

\_\_\_\_\_ I Grant Permission to my provider to download my Medication History from the pharmacy and or any other providers involved in my healthcare.

\_\_\_\_\_ I Decline permission to my provider to download my Medication History from the pharmacy and or any other providers involved in my healthcare.

\_\_\_\_\_  
Patient(Or legal guardian if under 18)Signature

\_\_\_\_\_  
Date

**FRANKLIN UROLOGICAL ASSOCIATES**  
**PATIENT REGISTRATION FORM**

Physician: Starling Evins,MD\_\_Joel Locke,MD\_\_William Tissot,MD\_\_Alison Skidmore, PA-C\_\_  
Referring Physician: \_\_\_\_\_ **CHART #** \_\_\_\_\_

How did you find out about our practice? \_\_\_\_\_

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

Social Security Number \_\_\_-\_\_\_-\_\_\_ Sex: Male\_\_\_ Female\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Marital Status: Married\_\_\_ Single\_\_\_ Divorced\_\_\_ Widow\_\_\_

Home (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_ Work (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_ Cell (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_

Employment Status: Full-Time\_\_\_ Part-Time\_\_\_ Retired\_\_\_ Unemployed\_\_\_ Student\_\_\_

Name of Employer \_\_\_\_\_

Spouse Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ SSN \_\_\_-\_\_\_-\_\_\_

Spouse Employment: Full-Time\_\_\_ Part-Time\_\_\_ Retired\_\_\_ Unemployed\_\_\_ Student\_\_\_

Spouse Employer \_\_\_\_\_ Work (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_

Do you currently have medical insurance? Yes\_\_\_ No\_\_\_ Plan Name \_\_\_\_\_

Whose insurance plan are you covered under? My Own\_\_\_ Spouse\_\_\_ Other\_\_\_

Please indicate the means by which we may contact you: Phone Yes\_\_\_ No\_\_\_ Mail Yes\_\_\_ No\_\_\_

Email Yes\_\_\_ No\_\_\_ Email Address \_\_\_\_\_

**May we leave a detailed message regarding your personal health information on your answering machine or voice mail? YES \_\_\_\_\_ NO \_\_\_\_\_**

Please list the names of people we can speak to regarding your personal health information

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

According to HIPAA rules we are not allowed to give out any information from your medical record without your written permission

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Who is responsible for this account? SELF SPOUSE MOTHER FATHER OTHER

*If responsible party is someone other than the patient or the patient's spouse, please fill out the following:*

Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ SSN \_\_\_-\_\_\_-\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Home (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_ Work (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_ Cell (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_

Employer \_\_\_\_\_

\_\_\_\_\_  
**PATIENT SIGNATURE/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

**Franklin Urological Associates**  
**Information Regarding Insurance and Billing**

1. It is your responsibility to understand your insurance benefits. If you are not sure if a service or treatment is covered you should contact your insurance carrier. We do not provide information about co-payments, co-insurance, or deductibles. If your insurance card indicates you have a co-payment, that amount is requested at the time you check-in.
2. Your co-payment or co-insurance is required when you check-in. We will accept your payment in cash, check, Visa, MasterCard, Discover or American Express. You are also responsible for payment of your deductible.
3. There is a \$30.00 fee for returned checks plus any additional bank charges.
4. Delinquent accounts may be placed with an outside collection agency or pursued through small claims court. You will be responsible for court cost and attorney fees.
5. We participate with most insurance plans. This means we will file your claim for you. This service is provided as a courtesy to you because we value your patronage. You are responsible for charges not paid by your insurance carrier(s), which includes denied claims due to lack of information from the subscriber.
6. We will be happy to submit charges to any secondary or supplemental plans you may have, however, if payment is not received from the carrier within 60 days we will issue a bill to you for payment in full.
7. If we do not participate with your insurance plan, payment will be expected when services are rendered. You will be given a bill at time of checkout, which you may file with your insurance carrier for reimbursement.
8. If for any reason we do not receive the anticipated payment from your insurance company, please understand you are responsible for treatment fees.
9. All insured patients must present their insurance card at the time of check-in. If you do not have your insurance card, you will be asked to pay for your office visit.
10. It is your responsibility to provide accurate insurance information to this office. If we are unable to bill your insurance carrier because we received incomplete, incorrect or untimely information, you will be responsible for the charges.
11. Surgical removals may be sent for pathology testing. Additional laboratory charges will be incurred for this testing.
12. If your insurance plan requires you to be referred to a surgeon, you must obtain this referral from your primary care physician before coming to our office. You may phone our office the day before your appointment to see if we have received your referral. If you do not have an appropriate referral at the time of your appointment, you will be given the choice of rescheduling your appointment or paying for your visit.
13. We appreciate a 24-hour notice to cancel or reschedule any surgery appointments. A \$25.00 no-show or late cancellation fee may be assessed if advance notice is not provided.
14. Questions regarding your account should be addressed to the Billing Department at (615)790-1660.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand I am responsible for all charges not paid by insurance. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.

\_\_\_\_\_  
Patient (or Guardian) Signature

\_\_\_\_\_  
Date

# Review of Systems

Patient Name \_\_\_\_\_

Chart Number \_\_\_\_\_

**Constitutional Symptoms**

Fever Y N  
 Chills Y N  
 Headache Y N  
 Other \_\_\_\_\_

**Eyes**

Blurred Vision Y N  
 Double Vision Y N  
 Pain Y N  
 Changed Vision Y N

**Allergic/Immun**

Hay Fever Y N  
 Drug Allergies Y N  
 Other \_\_\_\_\_

**Neurological**

Tremors Y N  
 Dizzy Spells Y N  
 Numbness/tingling Y N  
 Other \_\_\_\_\_

**Endocrine**

Excessive Thirst Y N  
 Too Hot/Cold Y N  
 Tired/Sluggish Y N  
 Other \_\_\_\_\_

**Gastrointestinal**

Abdominal Pain Y N  
 Nausea/Vomiting Y N  
 Indigestion/Heartburn Y N  
 Diarrhea/Constipation Y N

**Cardiovascular**

Chest Pain Y N  
 Varicose Veins Y N  
 High Blood Pressure Y N  
 Palpitation Y N

**Integumentary**

Skin Rash Y N  
 Boils Y N  
 Persistent itch Y N  
 Other \_\_\_\_\_

**Musculoskeletal**

Joint Pain Y N  
 Neck Pain Y N  
 Back Pain Y N  
 Other \_\_\_\_\_

**Ears/Nose/Throat**

Ear Infection Y N  
 Sore Throat Y N  
 Sinus Infection Y N  
 Other \_\_\_\_\_

**Genitourinary**

Urine Retention Y N  
 Painful Urination Y N  
 Urinary Frequency Y N  
 Other \_\_\_\_\_

**Respiratory**

Wheezing Y N  
 Frequent Cough Y N  
 Shortness Breath Y N  
 Other \_\_\_\_\_

**Hematologic/Lymph**

Swollen Glands Y N  
 Blood Clotting problem Y N  
 Other \_\_\_\_\_

**Psychological**

Are you satisfied w/Life Y N  
 Do you feel depressed Y N  
 Suicidal Thoughts Y N  
 Other \_\_\_\_\_

Physician Use Only (Comments/Notes)

Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_

Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_

Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_

Physician Signature \_\_\_\_\_

