Cowles Clinic Center for Urology
1000 Cowles Clinic Way
Cedar Cottage, Suite C-100
Greensboro, GA 30642
(706) 454-0100

What to Bring to Your Appointment:

- Your Completed New Patient Forms
- Your Health Insurance Card (s)
- Driver's License or I.D. Card
- Physician Referral Forms (If Required by Insurance)
- List of Prescriptions and/or Over-the-Counter Medication, Including Dose and Frequency
- Information about your Medical and Surgical History
- Recent X-rays, CTs, MRI, Labs or Relevant Records

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Tel: 706-454-0100 I Fax: 706-454-0101
www.cowlesclinic.com

PATIENT INFORMATION FORM

Today's Date:_____Drug Allergies:_____

Patient Information:

First Name:_____Middle Initial:_____Last Name:_____
Preferred Name:_____

Street Address:_____
City:_____State:_____Zip Code:_____

Social Security Number:_____Date of Birth:_____

Race: (check one) □ White □ Black □ Hispanic □ Asian □ Native American □ Other □ Unknown
Sex: (check one) □ Male □ Female

Home Phone:_____ Cell: _____Work:_____
Email Address:_____
Best Means of Communication: □ Home Tele □ Cell Tele □ Email □ Answering Machine Other_____

Occupation:_____Employer:_____
Pharmacy:_____Pharmacy Number:_____

Next of Kin and Emergency Contact Information:
First Name:_____Last Name:_____
Relationship:_____(Check appropriate box) □ Next of Kin □ Conta
Home Phone:_____ Cell: _____Work:_____

Referring Physician Information:
First Name:_____Last Name:_____
Practice:_____Specialty:_____
Physician Street Address:_____
City:_____State:_____Zip Code:_____
Phone:_____Fax:_____
Is this your Primary Care Physician? □ Yes □ No
If No, who is your Primary Care Physician?_____

Insurance Information:
Primary Payor:_____
Subscriber Name:_____Subscriber Number:_____
Group Name:_____Group Number:_____
Copay $:_____Effective Date:_____

Secondary Payor:_____
Secondary Subscriber Name:_____Secondary Subscriber Number:_____
Secondary Group Name:_____Secondary Group Number:_____
Copay $:_____Effective Date:_____

Past Medical History:

List of Medical Illnesses: (Date)

Prior Surgeries and Hospitalizations:

Current Medications – Dose and Schedule:

Allergies and Reactions (Drug, Food or Other):

Family Medical History:

Family History of: (check all that apply)

□ Cancer
□ Hypercholesterolemia (elevated cholesterol)
□ Prostate Cancer
□ Stroke (C.V.A.)
□ Heart Disease (C.A.D.)
□ Hypertension (elevated blood pressure)
□ Kidney Stones

Other Family History:

Social History:

Tobacco Use: □ Non-Smoker □ Former Smoker

Type: □ Cigarettes □ Cigars □ Pipe Tobacco □ Chew

_____Packs per □ Day □ Week □ Month

Years of Use_____ Quit Date_____

Alcohol Use: □ Non Drinker □ Occasional □ Social □ Heavy

Drug Use: □ Non User Type:_____ _____use per □ Day □ Week □ Month

Other Social History:

Date:_____

Patient Name:_____ **Review of Systems: (circle appropriate response)**

Constitutional Symptoms:

Decline in health	No	Yes
Weight gain	No	Yes
Fatigue	No	Yes
Weight loss	No	Yes
Weakness	No	Yes

Head:

Dizziness	No	Yes
Vertigo	No	Yes
Fainting	No	Yes
Headaches	No	Yes

Eyes:

Blurry vision	No	Yes
Eye pain	No	Yes
Infections	No	Yes
Discharge	No	Yes
Glasses	No	Yes
Vision loss	No	Yes
Double vision	No	Yes
Glaucoma	No	Yes

Ears, Nose, Throat:

Headaches	No	Yes
Congestion	No	Yes

Respiratory:

Cough	No	Yes
Short of breath	No	Yes
Coughing blood	No	Yes
Wheezing	No	Yes
Difficulty breathing at rest	No	Yes

Cardiovascular:

Chest pain	No	Yes
High blood pressure	No	Yes
Racing heart beats	No	Yes
Swelling of feet	No	Yes
Difficulty breathing on exertion	No	Yes
History of heart attack	No	Yes
Shortness of breath	No	Yes
Swelling of hands	No	Yes
Heart surgery	No	Yes
Palpitations	No	Yes
Swelling of ankles	No	Yes

Gastrointestinal:

Abdominal pain	No	Yes
Change of freqency of BM	No	Yes
Hemorrhoids	No	Yes
Black tarry stools	No	Yes
Constipation	No	Yes
Rectal bleeding	No	Yes
Blood in stool	No	Yes
Excessive thirst	No	Yes
Rectal pain	No	Yes

Musculoskeletal:

Arthritis	No	Yes
Joint stiffness	No	Yes
Weakness	No	Yes
Back problems	No	Yes
Muscle stiffness	No	Yes
Joint pain	No	Yes
Neck pain	No	Yes

Psychiatric:

Anxiety	No	Yes
Disorientation	No	Yes
Psychiatric disorders	No	Yes
Behavioral change	No	Yes
Mood changes	No	Yes
Depression	No	Yes
Nervousness	No	Yes

Neurological:

Confusion	No	Yes
Headaches	No	Yes
Dizziness	No	Yes
Loss of consciousness	No	Yes
Fainting	No	Yes
Memory loss	No	Yes

Endocrine:

Abnormal hair growth	No	Yes
Increased thirst	No	Yes
Weakness	No	Yes
Breast enlargement	No	Yes
Low level of activity/tired	No	Yes
Weight gain	No	Yes
Fatigue	No	Yes
Sweats	No	Yes

Hematologic/Lymph:

Anemia	No	Yes
Easy bruisability	No	Yes
Bleeding easily	No	Yes
Blood clots	No	Yes

Allergic/Immunologic:

Coughing	No	Yes
Itchy nose	No	Yes
Sneezing	No	Yes
Hives	No	Yes
Recurrent infections	No	Yes
Wheezing	No	Yes
Itchy eyes	No	Yes
Seasonal allergies	No	Yes

Urinary:

Awakening to urinate	No	Yes
Burning	No	Yes
Flank pain	No	Yes
Infections	No	Yes
Pelvic pain	No	Yes
Sexual dysfunction	No	Yes
Urine discoloration	No	Yes
Bed-wetting	No	Yes
Difficulty starting stream	No	Yes
Frequency	No	Yes
Leakage or dribbling	No	Yes
Reduced flow	No	Yes
Stones	No	Yes
Urine odor	No	Yes
Blood in urine	No	Yes
Excessive urination	No	Yes
Incontinence	No	Yes
Pain on urination	No	Yes
Retention	No	Yes
Urgency	No	Yes
Weak stream	No	Yes

Other:_____

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American Urological Association Symptom Score Sheet

Name:_____ **Date:**_____

	Not at All	Less than 1 time In 5	Less than ½ the Time	½ the Time	More than ½ the Time	Almost Always
OVER THE PAST MONTH OR SO . . .						
1. How often have you had a sensation of not emptying your bladder completely after you finished urinating?	[0]	[1]	[2]	[3]	[4]	[5]
2. How often have you had to urinate again less than 2 hours after you finished urinating?	[0]	[1]	[2]	[3]	[4]	[5]
3. How often have you stopped and started again several times during urination?	[0]	[1]	[2]	[3]	[4]	[5]
4. How often have you found it difficult to postpone urination?	[0]	[1]	[2]	[3]	[4]	[5]
5. How often have you had a weak urinary stream?	[0]	[1]	[2]	[3]	[4]	[5]
6. How often have you had to push or strain to begin urination?	[0]	[1]	[2]	[3]	[4]	[5]
7. How many times do you typically get up at night to urinate, from the time you went to bed until getting up?	[0]	[1]	[2]	[3]	[4]	[5]

Bother Score = Sum of Questions 1 – 7 :_____

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about it? (Circle choice):

[1] Delighted
[2] Pleased
[3] Mostly satisfied
[4] Mixed
[5] Mostly dissatisfied
[6] Unhappy
[7] Terrible

Cowles Clinic Center for Urology

Payment Policy

You are responsible for paying your insurance deductible, if not already satisfied, and insurance co-payment upon completion of visit. Please be advised that filing with your insurance plan is a service that is provided by us for your convenience. Therefore, it is your responsibility, as a patient, to determine whether or not Robert S. Cowles III, M.D. is a provider within your plan or is considered a provider "out of network." It is also your responsibility to insure that appropriate referral procedures are executed in accordance with the provisions of your particular plan. If Robert S. Cowles III, M.D. is "out of network", you are responsible for any charges not covered by your insurance plan and must pay those charges within 10 days from the date of invoice.

Please note that after six weeks if your insurance company has not responded to the claim filed, you will be notified that the unpaid balance is payable in full and within 10 days of notification.

If your insurance company requires additional information about you that is unavailable to us, the balance on your bill is your responsibility until the information requested is provided.

Your signature below constitutes your agreement to the above stated policy.

Printed Patient Name_____Signature_____

Medicare Assignment and Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, or its intermediaries or carrier. Any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment and benefits apply.

Signature_____Date_____

Assignment of Benefits to Physician

For value received, I hereby transfer, assign and set over to Robert S. Cowles III, M.D. or Cowles Clinic Center for Urology (CCCFU) and American Professional Associates (APA) all insurance benefits of every kind and description for basic and major medical coverage, which benefits would be payable directly to me but for this assignment, and not to exceed the physicians usual and customary charges for services rendered to me. I understand that I am responsible to the physician for all fess and charges not paid by my insurance.

Signature_____Date_____

Release of Information

I authorize the release of any and all medical information necessary to complete my insurance claims.

Signature_____Date_____

Authorization for Treatment

I am suffering from a condition requiring medical care; do hereby voluntarily consent to medical care encompassing diagnostic procedures and medical treatment, including medical X-rays, drugs, lab work, etc., as may be ordered by physicians responsible for such medical care. I further consent to treatment by authorized employees or agents to the ACFU who are assigned to my care.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments, examinations, medical, or hospital care at the ACFU.

This form has been fully explained to me and I certify that I understand it contents.

Signature_____Date_____

Cowles Clinic Center for Urology

Privacy Practices Acknowledgement

I have either reviewed or received a copy of the Notice of Privacy Practices and I understand that no one can receive a copy of my medical records, including myself, without a signed Medical Records Release. A signed release for records to be obtained for my personal use will be valid for one year from the date the release is signed. A signed release for CCCFU to release to another provider or facility or for CCCFU to obtain my records from another provider or facility will be valid for 90 days from the date the release is signed.

Signature_____Date_____

Personal Representative (PR) Authorization List

I have the right to request that Cowles Clinic Center for Urology authorize my Personal Representative (PR) to obtain medical care/information for me. This includes office visits, diagnostic, lab results, telephone advice/information, etc. Examples of PR might include: spouse, son, daughter, son-in-law, daughter-in-law, grandchild, other family member(s) who may care for me. HIPAA laws require that I provide authorization of such Personal Representative(s) to CCCFU:

PR_____Relationship to you_____
PR_____Relationship to you_____
PR_____Relationship to you_____

Signature_____Date_____

Restriction Release for Desired Means of Communication

I have the right to request that Cowles Clinic Center for Urology send all or some communications to an alternative location or by alternative means (e.g., envelopes without Cowles Clinic Center for Urology return address, information in a closed envelope rather than a post card, e-mail, etc.). CCCFU must accommodate all reasonable requests for confidential communications. However, an agreement by CCCFU to confidential communications does not preclude Cowles Clinic Center for Urology from contacting an individual at any address or means available if necessary for the care and treatment of the individual. A request can be made at any time.

My acceptable means of communication:

- □ Home Telephone
- □ Home Answering Machine
- □ Cell Phone
- □ Mail
- □ Fax Machine
- □ Other _____

Signature_____Date_____

Cowles Clinic Center for Urology
Patient Financial Policy

Thank you for choosing Cowles Clinic Center for Urology. We are honored by your choice and are committed to providing you the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

We are in the business of helping you. Anything that we can do to help you is in your interest and ours. Unfortunately, because of insurance and government regulations, we have had to make these financial policies as described below. As a physician and friend, I want you to know that your health is the most important thing that we deal with in this office.

- **Insurance:** Your health insurance policy is a contract between you and your insurance company. In many instances, the doctor is not involved. We are pleased to bill your insurance on your behalf for those plans for which we have an agreement. Your responsibility of payment depends upon your particular plan.

- **Copayments, Coinsurance, Deductibles:** Some insurance plans may not be fully compatible with reimbursement for services provided by Cowles Clinic Center for Urology. It is recommended that patients contact their insurance carriers to verify benefit and eligibility. **You are responsible for copayments, coinsurance, and deductibles. Payment is due at time of service rendered depending on your insurance contract.**

- **Out of Network:** If you have insurance coverage under a plan in which we do not have a contract, you will be treated as a self-pay (cash pay) patient and you may request documentation to assist you in filing your claim.

- **Uninsured Patients:** Payments are due at time of services rendered.

Not all health plans are the same nor do they all cover the same services and supplies. In the event that your health plan determines a service or supply to be "**not covered**", you will be responsible for the complete charge for that particular service. Payment is due upon receipt of statement. Payment for certain supplies may be required at the time of the visit.

Physician After-Hour Telephone Consultations: We are available by nights and weekends to speak with you, however, **you may be charged $50+ per telephone consultation with the doctor**.

Appointment No-Shows: If you do not show up for your appointment, you will be billed an administrative fee of $25.00.

Prescriptions: You may be charged for communication with your pharmacy for prescription refills &/or precertification or prior-authorization for prescriptions. $25 for refills, $35 for precertification &/or prior-authorization for prescriptions.

Charges for Forms: Requests for processing of forms (e.g., disability forms, life insurance info, etc.) from $15 to $30 (depending on the length of the forms). $50 if forms are required to be completed by the Physician.

Charges for Medical Records and/or Forms: Requests for copying/faxing/mailing medical records $0.97 per page (for pages 1-20), $0.83 per page (for pages 21-100), $0.66 per page (for pages over 100), plus postage.

Insufficient Checks: There will be a $50.00 charge for insufficient fund checks issued.

Outstanding Balances/Collections: Prior to providing additional services to you, payment in full of total outstanding balances will be required. Patients with unpaid delinquent accounts or accounts which have been sent to Collections will be discharged from the practice. Outstanding balances greater than 90 days will be referred to an outside Collection Agency. The patient will be responsible for a Collection Fee of 35% of the balance sent to Collection Agency.

I have read and understand the financial policy of Cowles Clinic Center for Urology and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by the practice.

_____	_____	_____
Signature	Print Name	Date

Cowles Clinic Center for Urology

M E M O R A N D U M O F U N D E R S T A N D I N G

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following Memorandum of Understanding. We are dedicated to providing the best possible healthcare and service to you.

We are in the business of helping you. As a physician and friend, I want you to know that your health is the most important thing that we deal with in this office.

We do everything we can to expedite your office visit, but because I am the sole practitioner in my medical practice, there may be delays. We work hard to stay on schedule in the office, but sometimes this is not possible due to emergencies and surgery; there may be times in which your appointment may be later than your scheduled time.

Our Office Hours are as follows. Please note we close at Noon on Fridays.

Monday 8:30 a.m. to 5:00 p.m.
Tuesday 8:30 a.m. to 5:00 p.m.
Wednesday 8:30 a.m. to 5:00 p.m.
Thursday 8:30 a.m. to 5:00 p.m.
Friday 8:30 a.m. to 12:00 noon

Robert S. Cowles, III, M.D. is on call after hours. If you place a call after hours and decide to speak to Dr. Cowles, you will be charged for the phone call.

We accept and file insurance claims but we are not insurance agents. This is a service, but we are not responsible for insurance non payment.

We also assist with prescriptions, but it is the patients' responsibility to discuss preferred drugs with their pharmacy or insurance company.

Routine medication refills are only done during normal office hours.

We do offer the service of After Hours Phone Consultations with Dr. Cowles. If you are interested in this service, please speak to our Front Office Administration to schedule.

I have read and understand the Memo of Understanding of Cowles Clinic Center for Urology and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by the practice.

_____	_____
Signature	Print Name Date

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Directions to the Cowles Clinic from Greensboro

At the Intersection of Interstate 20 and Highway 44 (Lake Oconee Parkway)

Go 8 miles on Highway 44 West

First Stoplight turn Left on Linger Longer Road (towards The Ritz-Carlton)
Bank South is on the corner to your left

Go 1/2 mile on Linger Longer Road towards the Ritz-Carlton

Cowles Clinic is on the Right (you'll see 3 tall flag poles and 2 large fountains)

See the Reynolds Walk sign - turn Right

See the Cowles Clinic sign

Drive STRAIGHT to Lower Cowles Clinic

Turn Right at the bottom of hill

Cowles Clinic Center for Urology in on your LEFT in CEDAR Cottage

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Directions to the Cowles Clinic from Eatonton

Highway 44 (Lake Oconee Parkway) towards Greensboro

Go approximately 17 miles

Second Stoplight turn Right on Linger Longer Road (towards The Ritz-Carlton) Bank South and Publix Supermarket are on your Right

Go 1/2 mile on Linger Longer Road towards the Ritz-Carlton

Cowles Clinic is on the Right (you'll see 3 tall flag poles and 2 large fountains)

See the Reynolds Walk sign - turn Right

See the Cowles Clinic sign

Drive STRAIGHT to Lower Cowles Clinic

Turn Right at the bottom of hill

Cowles Clinic Center for Urology in on your LEFT in CEDAR Cottage

COWLES CLINIC CENTER FOR UROLOGY
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

Effective Date: _____

If you have any questions about this notice, please contact the office's Privacy Officer.

WHO WILL FOLLOW THIS NOTICE

This notice describes our office practices and those of:

- Any healthcare professional authorized to enter information into your medical record.
- All employees, staff and other personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive here. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by us, whether made by office personnel or by the physician.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical assistants or medical office personnel who are involved in taking care of you here in our office. For example, the doctor may need to schedule you for a colonoscopy. The medical staff will need to review any and all of your indications for this test in order to properly orient you for the procedure. The staffer will then need to schedule you with the facility and may also need to pre-cert the test with your insurance company. In both instances, she would need to have full access to your medical information. We also may disclose medical information about you to people outside our office who may be involved in your medical care, such as referring physicians, your primary care physician or others we use to provide services that are a part of your care.
- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We also may disclose information about you to another health care provider, such as another physician, for their payment activities concerning you.
- **For Healthcare Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend different ways to treat you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to

someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. All research projects, however, are subject to your prior approval.
- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Dept. Of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.
- **Workers' Compensation.** We may release medical information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:

    1. To prevent or control disease, injury, or disability;
    2. To report deaths;
    3. To report reactions to medications or problems with products; to notify people of recalls of products they may be using;
    4. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and

5. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

1. In response to a court order, subpoena, warrant, summons, or similar process;
2. To identify or locate a suspect, fugitive, material witness, or missing person;
3. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
4. About a death we believe may be the result of criminal conduct;
5. About criminal conduct on the office premises; and
6. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

- **Coroners, Medical Examiners, and Funeral Directors.** We May release medical information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release medical information about deceased patients to funeral directors as necessary to carry out their duties upon the request of the patient's family.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and

safety or the health and safety of others; (3) for the safety and security of the correctional institution; or (4) to obtain payment for services provided to you.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you.

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes and other mental health records under certain circumstances.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. If you agree, we may provide you with a summary of the information instead of providing you with access to it, or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay the fees, if any, for preparing the summary or explanation.

  We may deny your request to inspect and copy your medical information in certain very limited circumstances, such as when we, as your physician, would determine that for medical reasons this is not advisable. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by ACFU will review your request and the denial. The person conducting the review will not be the person who denied your request. We will do what this person decides.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for ACFU.
  To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

2. Is not part of the medical information kept by or for ACFU;
3. Is not part of the information which you would be permitted to inspect and copy; or
4. Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of some of the disclosures we made of medical information about you that were not specifically authorized by you in advance.

  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example: on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

  PLEASE SEE ADDITIONAL NOTICE TO PATIENTS REGARDING REQUESTS FOR NONDISCLOSURE TO HEALTH PLAN*

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Confidential Communications.** You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. For example, you can ask that we only contact you at work or by mail, or at another mailing address, besides your home address. We must accommodate your request, if it is reasonable. You are not required to provide us with an explanation as to the reason for your request. Contact our Privacy Officer if you require such confidential communications.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  To obtain a paper copy of this notice, request a copy from the front desk.

CHANGES TO THIS NOTICE

- We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right-hand corner, the effective date. {In addition, each time you visit the office, we will offer you a copy of the current notice in effect.}

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Office, at Atlanta Center for Urology, 1000 Cowles Clinic Way, , Greensboro, GA 30642. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.