

Canyon State Urology

Patient History Form - Male

Name: _____ Date of Birth: _____ Date: _____

Primary Care Physician: _____ Height _____ Weight _____

Past Medical History – Please check any of the following you have been diagnosed with in the past.

<input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Autoimmune Disorder <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Blood Transfusions <input type="checkbox"/> Brain Tumor <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> COPD <input type="checkbox"/> CVA /Stroke/TIA <input type="checkbox"/> Cerebrovascular Disease <input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Colon Cancer <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> DVT/Pulmonary Embolism <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes- Gestational <input type="checkbox"/> Diabetes-Type 1 <input type="checkbox"/> Diabetes-Type 2 <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> GERD or Ulcers <input type="checkbox"/> GI Bleed	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stone <input type="checkbox"/> Liver Disease <input type="checkbox"/> MI/Heart Attack <input type="checkbox"/> Myasthenia gravis <input type="checkbox"/> Neurologic Disorder <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> PVD (Vascular Disease) <input type="checkbox"/> Renal Failure – Acute <input type="checkbox"/> Renal Failure – Chronic <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> STD <input type="checkbox"/> Stones (kidney, ureter, bladder) <input type="checkbox"/> Thyroid Disorder <input type="checkbox"/> Tuberculosis <input type="checkbox"/> UTI – Recurrent <input type="checkbox"/> Uterine Anomaly <input type="checkbox"/> Valvular Heart Disease <input type="checkbox"/> Valley Fever <input type="checkbox"/> Varicose Veins/Phlebitis
--	---	---	---

Past Surgical History – Please check any of the following you have had in the past.

<input type="checkbox"/> Artificial Sphincter <input type="checkbox"/> Circumcision <input type="checkbox"/> ESWL <input type="checkbox"/> Male Sling <input type="checkbox"/> Nephrectomy: <input type="checkbox"/> Penile Prosthesis <input type="checkbox"/> Prostate - Brachytherapy <input type="checkbox"/> Prostate - Laser <input type="checkbox"/> Prostate - Microwave <input type="checkbox"/> Prostate - TUNA <input type="checkbox"/> Prostate - XRT <input type="checkbox"/> Radical Prostatectomy <input type="checkbox"/> Removal Testicle <input type="checkbox"/> Remove Both Testicles <input type="checkbox"/> TURP (Transurethral Prostatectomy) <input type="checkbox"/> UPJ Repair <input type="checkbox"/> Ureteral Stent	<input type="checkbox"/> Ureteroscopy <input type="checkbox"/> Vasectomy <input type="checkbox"/> Abd Surg - _____ <input type="checkbox"/> Appendectomy <input type="checkbox"/> Gallbladder <input type="checkbox"/> Colon Resection <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Dialysis Catheter <input type="checkbox"/> Hernia – Inguinal R L <input type="checkbox"/> Hernia – Abdominal <input type="checkbox"/> Other _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Aorto-Fem Bypass - Left <input type="checkbox"/> Aorto-Fem Bypass - Right <input type="checkbox"/> Angioplasty <input type="checkbox"/> Aortic Valve Replacement <input type="checkbox"/> AV Fistula Creation <input type="checkbox"/> AV Graft <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> CABG <input type="checkbox"/> Carotid Endarterectomy <input type="checkbox"/> Lung Removal <input type="checkbox"/> Mitral Valve Replace <input type="checkbox"/> Pacemaker <input type="checkbox"/> Vascular Bypass (Femoral) <input type="checkbox"/> Do you have any medical condition that requires anti-biotics prior to surgery? <div style="text-align: center;">Yes No</div>	<input type="checkbox"/> Amputation <input type="checkbox"/> Back Surgery <input type="checkbox"/> Breast Surgery <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Cataract Extraction <input type="checkbox"/> Craniotomy <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hip Replacement <input type="checkbox"/> Interventional pain procedure <input type="checkbox"/> Knee Arthroscopy <input type="checkbox"/> Knee Replacement <input type="checkbox"/> Kyphoplasty <input type="checkbox"/> Parathyroidectomy
---	---	--	---

Family History – Please check any that apply

Anemia
 Anesthetic Complication
 Anxiety
 Arthritis
 Asthma
 Blood Clots
 Breast Cancer
 Cervical Cancer
 Colon Cancer
 Diabetes
 Heart Disease
 High Cholesterol
 Hypertension
 Kidney Disease
 Osteoporosis
 Other Diseases
 Prostate Cancer
 Psychiatric Care
 Stroke

Social History/Pharmacy

Marital Status: Married / Single / Divorced

Children: Y or N If yes, how many? _____

Occupation: _____

Pharmacy (please list your pharmacy name, address, phone # and fax # if available (this will allow us to automatically fax your prescriptions to your pharmacy)).

Canyon State Urology

Patient History Form – Page 2

Name: _____ Date: _____

Review of Systems

Please check yes or no and describe

<p>Yes No</p> <p>General</p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Weight loss _____</p> <p>Urologic</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in urine _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Burning with urination _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Incontinence _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Urinary Tract Infections _____</p> <p>Cardiac</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pains _____</p> <p>Pulmonary</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath _____</p> <p>Gastrointestinal</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea _____</p> <p>Neurologic</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty walking _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches _____</p>	<p>Yes No</p> <p>Endocrine</p> <p><input type="checkbox"/> <input type="checkbox"/> Heat /Cold intolerance _____</p> <p>Musculoskeletal</p> <p><input type="checkbox"/> <input type="checkbox"/> Back pain _____</p> <p>Derm</p> <p><input type="checkbox"/> <input type="checkbox"/> Rash _____</p> <p>Psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression _____</p> <p>Hematologic</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding/bruising _____</p> <p>Eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> Blurring _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Double vision _____</p> <p>ENT</p> <p><input type="checkbox"/> <input type="checkbox"/> Nosebleeds _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Ringing of ears _____</p> <p>Allergy/Immune</p> <p><input type="checkbox"/> <input type="checkbox"/> Seasonal Allergies _____</p>
---	--

Medications – List ALL medications you take on a regular or occasional basis
 (To prevent medical errors it is critical you accurately list all medications and allergies)

Allergies (List all allergies)

<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> I have no medical allergies</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
--	--	---

Risk Factors:
 Do you currently smoke? Yes No If Yes, How much? _____ If you quit, how long did you smoke? _____
 When did you quit? _____ Do you drink alcohol? Yes No If yes, how much alcohol per day? _____

I have read this document thoroughly and have answered the questions to the best of my ability.

 Signature

Canyon State Urology, P.C.
Patient Registration Form

Patient Information

Last Name: _____ Gender: F / M Marital Status: _____ Age: _____
First Name: _____ Middle Initial: _____ D.O.B.: ___/___/___
Home Address: _____ E-mail: _____
City/State/Zip: _____ Home Phone: _____
Employer: _____ Social Sec #: _____
Employer Address: _____
City/State/Zip: _____ Work Phone: _____
Primary MD: _____ Referring MD: _____
Please list first and last name Please list first and last name

Please mark all that apply

Preferred Language:

<input type="checkbox"/> English	<input type="checkbox"/> Italian
<input type="checkbox"/> French	<input type="checkbox"/> Mandarin
<input type="checkbox"/> German	<input type="checkbox"/> Spanish
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other _____

Race:

American Indian or Alaska Native
 Asian
 Black or African American
 Caucasian
 Chinese
 Filipino

Japanese
 Multiracial
 Native Hawaiian
 Pacific Islander
 Other
 Undetermined

Ethnicity:

Hispanic or Latino
 Non Hispanic or Latino
 Other or Undetermined

Responsible Party

Last Name: _____ Relationship to patient: _____
First Name: _____ Middle Initial: _____ D.O.B.: ___/___/___
Home Address: _____ E-mail: _____
City/State/Zip: _____ Home Phone: _____
Employer: _____ Social Sec #: _____
Employer Address: _____
City/State/Zip: _____ Work Phone: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

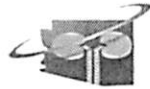
Insurance Information – Please provide Current Card(s)

Primary Ins: _____ Insured ID#: _____
Group#: _____ Policy Owner: _____
Policy Owner DOB: _____ Patient relationship to policy owner: _____
Secondary Ins: _____ Insured D#: _____
Group#: _____ Policy Owner: _____
Policy Owner DOB: _____ Patient relationship to policy owner: _____

The information provided above is accurate

Patient Signature

Date



ARIZONA UROLOGY SPECIALISTS, PLLC

Experienced care one patient at a time

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Canyon State Urology, PC a division of Arizona Urology Specialists, PLLC ("CSU"/"AUS") as your healthcare provider. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is responsible for full payment for his/her treatment and care.
Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your claim. If we do not receive payment within 30 days of submission or your insurance or notifies us that the services are not covered under your insurance plan, you will pay us the outstanding balance for services.
Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan.
Patients may incur, and are responsible for the payment of additional charges at the discretion of AUS. These charges may include but are not limited to (subject to change at any time):
- Charge for returned checks. \$25.00
- Charge for missed appointments without 24 hours advance notice \$25.00
- Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions. \$100.00
- Charge for copying and distribution of patient medical records. \$50.00
- Charge for forms completion, including but not limited to disability and FMLA forms. \$35.00
- Charges for providing non-English speaking interpreters. Price varies depending on language
- Any costs associated with collection of patient balances, including 3rd party collection agency fees.

Patient Authorizations

- By my signature below, I hereby authorize AUS and the physicians, staff, labs and hospitals associated with AUS to release ALL medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
By my signature below, I hereby authorize assignment of financial benefits directly to AUS and any associated healthcare entities for services rendered as allowable under standard third party contracts.
By my signature below, I understand the physicians that treat me may have a financial interest in the facility they refer me to including, but not limited to, surgery centers, lithotripsy centers, pathology labs, oncology treatment facilities, radiation facilities that perform CT and MRI scans and other medical and non medical related entities.
By my signature below, I authorize AUS personnel to communicate by phone, mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Printed Name of Patient

Printed Name of Guardian (if applicable)

Signature of Patient or Guardian

Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Signature of Patient or Guardian

Date

Arizona Urology Specialists, PLLC Confirmation Form

Last Name: _____ **First Name:** _____ **DOB:** _____

Do you have an Advance Directive? Yes No

Payment Authorization

I hereby authorize my benefits to be paid directly to Arizona Urology Specialists, PLLC and I am financially responsible for non-covered services and/or balances not paid by the insurance carrier. I also authorize release of my information required to process these claims. I authorize you to give me my medical care, including diagnosis and/or treatment.

Signature: _____ Date: _____

Acknowledge Receipt of Privacy Practice

I have been offered a copy of the Arizona Urology Specialists, PLLC Notice of Privacy Practices. I understand that Arizona Urology Specialists, PLLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Arizona Urology Specialists, PLLC at any time to obtain a current copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Copy Declined Copy Accepted

Release of Health Information

I authorize the following individual(s) to have access to my personal health information.

Name: _____ Relationship: _____

Signature: _____ Date: _____

Patient Bill of Rights

I have been offered a copy of the Patients Bill of Rights. I understand that I may contact Arizona Urology Specialists, PLLC at any time to obtain a current copy of the Patient Bill of Rights.

Signature: _____ Date: _____

Copy Declined Copy Accepted

Notice of Limited English Proficiency

I have been offered a copy of the Notice of Limited English Proficiency. I understand that if I have Limited English Proficiency, I must provide a reliable, competent and proficient translator. If I cannot provide this translator, I must notify Arizona Urology Specialists, PLLC in writing.

Signature: _____ Date: _____

Copy Declined Copy Accepted

Canyon State Urology, PC

Authorization to use or disclose my health information

Patient Last Name, First Name

Date of Birth

Previous Name / Maiden Name

Patient Signature

Guardian / Parent Signature if patient is 17 years of age or younger

Date

By signing this form, you authorize Canyon State Urology and its staff to release medical information to the following persons and / or answering devices.

Please check and complete the following:

<u>Yes</u>	<u>No</u>		
_____	_____	Name _____	Phone # _____
_____	_____	Name _____	Phone # _____
_____	_____	Answering Machine at home	Phone # _____
_____	_____	Answering Machine at work	Phone # _____
_____	_____	Mobile # _____	
_____	_____	Fax # _____	
_____	_____	Pharmacy # _____	

Medical Testing Notice:

The physicians at Canyon State Urology care about your health. Results for any test ordered by our physicians will be given to you at your follow-up appointment. Please make sure that you schedule and keep that appointment. If you have any questions about a test that one of our physicians has ordered for you please contact us. If you are seeing other physicians for your healthcare we strongly encourage you to make sure that you have obtained all results from them for any tests they have ordered.

Authorization and Acknowledgement:

Patient Signature or legally authorized individual signature

Date

Print name if you signed on behalf of the patient

Relationship to Patient

Arizona Urology Specialists, PLLC

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information; please review carefully.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law (the Health Insurance Portability and Accountability Act of 1996 or HIPAA) to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

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

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

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

At the Arizona Urology Specialists, PLLC we strive to keep your information confidential, and may use and disclose your PHI in the following ways:

- **Treatment:** Our practice may use your PHI to treat you.
- **Payment:** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us.
- **Health Care Operations:** Our practice may use and disclose your PHI to operate our business.
- **Appointment Reminders:** Our practice may use your PHI to contact you and remind you of an appointment.
- **Treatment Options:** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
- **Health-Related Benefits and Services:** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
- **Release of Information to Family/Friends:** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you, with your permission.
- **Disclosures Required By Law:** Our practice will disclose your PHI when we are required to do so by federal, state or local law.

We cannot, and will not, require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving treatment for the office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

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

- **Public Health Risks:** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information.
- **Health Oversight Activities:** e may disclose your PHI to a health oversight agency for activities authorized by law.
- **Lawsuits and Similar Proceedings:** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding.
- **Law Enforcement:** We may release PHI if asked to do so by a law enforcement official.
- **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.
- **Organ and Tissue Donation:** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement, or transplantation.
- **Research:** We may use and disclose your PHI for research purposes in certain limited circumstances with your permission.
- **Serious Threats to Health or Safety:** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
- **Military:** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- **National Security:** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law.
- **Appointment Reminders, Marketing and Treatment Alternatives:** We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not disclose your health information without your written authorization.
- **Sign In Sheet:** We may use and disclose your health information by having you sign in when you arrive at our offices. We may also call you by name when we are ready to see you.
- **Language Translation:** Our practice may disclose your PHI to language translators if you do not speak English and require the services of a translator.
- **Inmates:** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- **Workers Compensation:** Our practice may release your PHI for workers compensation and similar programs.

YOUR RIGHTS REGARDING YOUR PHI:

- **Confidential Communications:** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable requests. You do not need to give a reason for your request
- **Requesting Restrictions:** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
- **Inspection and Copies:** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. All requests must be submitted in writing to the Arizona Prostate Cancer Center and we are permitted to charge for the cost of the copy. Copies will be provided within 30 days for information stored onsite and 60 days for information stored offsite.

We cannot, and will not, require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving treatment for the office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

- **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. You must provide us with a reason that supports your request for amendment. Our practice may deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information. Our practice has 60 days to respond to your request for an amendment.
- **Accounting of Disclosures.** All of our patients have the right to request an accounting of disclosures. An accounting of disclosures is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment, or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. Our practice has 60 days to provide the accounting of disclosures.
- **Right to a Paper Copy of This Notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
- **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please contact the Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint. Our practice has 30 days to investigate the complaint; our practice has 60 days to provide a written response to the individual who submitted the privacy complaint.
- **Right to Provide an Authorization for Other Uses and Disclosures:** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

ADDITIONAL NOTICE REGARDING YOUR PHI:

- Tests and films ordered by a physician outside of Arizona Urology Specialists, PLLC that are admitted into your electronic medical record might not be reviewed or pertain to the services you are receiving from Arizona Urology Specialists, PLLC.
- Arizona Urology Specialists, PLLC operates under the following DBA's in which your PHI will be shared: Arizona Prostate Cancer Center, Arizona Urology Specialists Pathology Lab, Affiliated Urologists, Canyon State Urology, Scottsdale Center for Urology and Urology Associates.

**Arizona Urology Specialists, PLLC
Notice of Privacy Practices**

I have received a copy of the Arizona Urology Specialists, PLLC Notice of Privacy Practices. I understand that the Arizona Urology Specialists, PLLC must change its policies and procedures from time to time as necessary and appropriate to comply with changes in the law. The Arizona Urology Specialists, PLLC reserves the right to change a privacy practice and the related policies and procedures that are contained in the Arizona Urology Specialists, PLLC Notice of Privacy Practices, and all material changes will be reflected in a revised Notice of Privacy Practice that will be effective for all protected health information that Arizona Urology Specialists, PLLC maintains. I understand that I can contact the Arizona Urology Specialists, PLLC at any time to obtain a written copy of the Notice of Privacy Practices that is in effect.

Patient Acknowledgement: _____

If you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer, at Arizona Urology Specialists, PLLC 602-557-0051.

We cannot, and will not, require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving treatment for the office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

**Arizona Urology Specialists, PLLC
Notice of Limited English Proficiency Compliance**

OUR COMMITMENT TO YOUR UNDERSTANDING

Our practice is dedicated to providing assistance for LEP persons when identified. We are required by law (the Title VI of the Civil Rights Act of 1964) to make reasonable effort to provide translation for LEP persons.

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

- Do you have Limited English Proficiency (LEP)? YES _____ NO _____

If you answered YES to this question, what language are you proficient?

- Do you have your own reliable, competent and proficient translator? YES _____ NO _____

If you answered NO to this question, Arizona Urology Specialists, PLLC will provide you with a list of resources to obtain a reliable, proficient translator.

If you answered YES to this question, you fully agree that your translator is competent, reliable and proficient and will accompany you to all visits regarding your care with Arizona Urology Specialist, PLLC. You further have been notified of your rights under the Notice of Privacy Practices and have given permission to Arizona Urology Specialists to disclose your Protected Health Information with your translator(s) to properly communicate with you.

**Arizona Urology Specialists, PLLC
Notice of Privacy Practices**

I have received a copy of the Arizona Urology Specialists, PLLC Notice of Limited English Proficiency Compliance. I understand that Arizona Urology Specialists, PLLC must change its policies and procedures from time to time as necessary and appropriate to comply with changes in the law. Arizona Urology Specialists, PLLC reserves the right to change a practice and the related policies and procedures that are contained in the Arizona Urology Specialists, PLLC Notice of Limited English Proficiency Compliance, and all material changes will be reflected in a revised Notice of Limited English Proficiency Compliance that will be effective for all LEP persons that Arizona Urology Specialists, PLLC maintains. I understand that I can contact Arizona Urology Specialists, PLLC at any time to obtain a written copy of the Notice of Limited English Proficiency Compliance that is in effect.

Patient Acknowledgement: _____

If you have any questions regarding this notice or our health information policies, please contact the Compliance Officer, at Arizona Urology Specialists, PLLC 602-557-0051.