Arizona Prostate Cancer Center

You have a consultation appointment with Dr. Thomas Canty at the Arizona Prostate Cancer Center located at 20601 N 19th Ave., Suite 115, Phoenix, Az 85027.

For your initial consultation, please be sure to bring your driver's license (or any legal form of photo identification) and your insurance cards. Also, if you have an Advance Directive (Living Will), please bring a copy for our records.

Please find attached the necessary registration forms needed for your consultation.

****IT IS VERY IMPORTANT that you complete all the forms PRIOR to your Consultation Appointment as this helps us stay on schedule.**

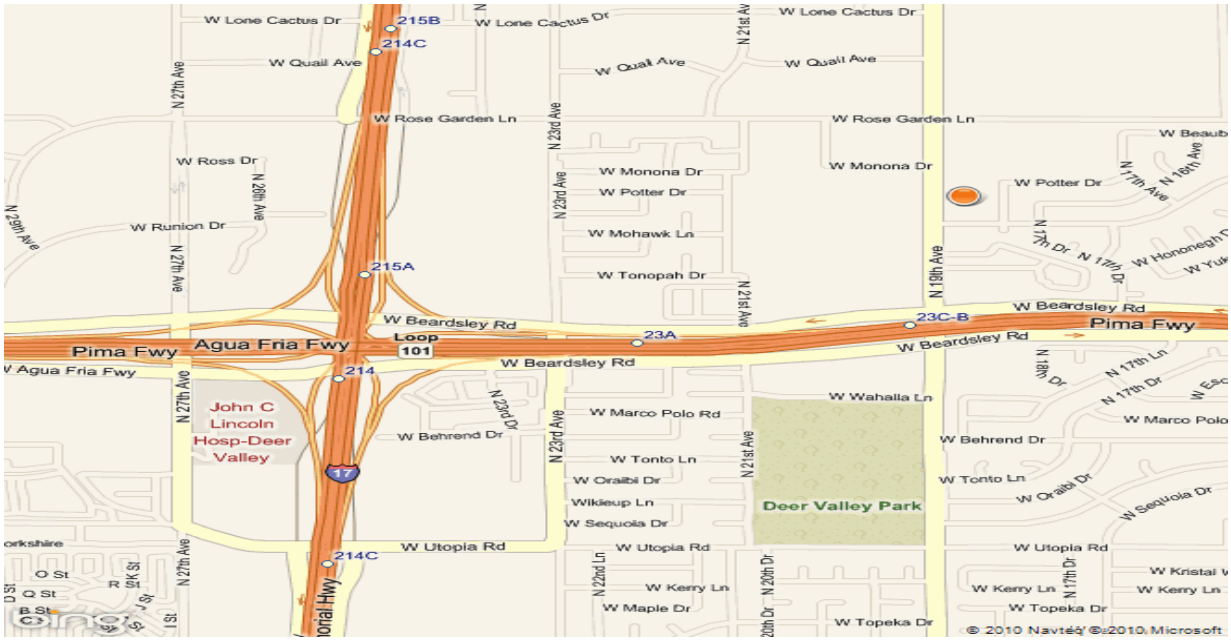
Please do not hesitate to call us (602) 557-0055 if you have any questions or need further information.

Respectfully yours,

Arizona Prostate Cancer Center

Az Prostate Cancer Center
20601 N 19th Ave. Suite 115
Phoenix, Az 85027
602-557-0055
Thomas P. Canty, MD

Appointment date:_____ Time:_____



From the East: From the 101 Loop West
Take Exit 24 (19th Ave.)
Turn Right onto N 19th Ave.
Turn Right into 20601 Business Center Suite 115

From the West: From the 101 Loop East
Follow the I-17 exit toward Flagstaff/Phoenix
Take Exit 23 toward 27th Ave.
Stay **Straight** to go onto W Agua Fria Fwy/W Beardsley Rd
Turn Left onto N 19th Ave.
Turn Right into 20601 Business Center Suite 115

From the North: From I-17 South
Take Exit 215B Deer Valley Rd/Rose Garden Ln
Turn Left onto Rose Garden Ln
Turn Right onto N 19th Ave.
Turn Left into 20601 Business Center Suite 115

From the South: From I-17 North
Take Exit 215A Rose Garden Ln
Turn Right onto Rose Garden Ln
Turn Right onto 19th Ave.
Turn Left into 20601 Business Center Suite 115

Az Prostate Cancer Center

20601 N 19th Ave., Suite 105, Phoenix, AZ 85027

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address:_____

City:_____State:_____ ZIP Code:_____

Home Phone: (_____)_____ ☐Work or ☐ Cell Phone: (_____)_____

Records From:	Records To:
☐ Az Prostate Cancer Center, 20601 N 19th Ave, Suite 115, Phoenix, AZ 85027	☐ Az Prostate Cancer Center, 20601 N 19th Ave, Suite 115, Phoenix, AZ 85027
☐ Other (List Facility/Individual, Address, and Phone/Fax)	☐ Other (List Facility/Individual, Address, and Phone/Fax)

Information To Be Released:

(Check all that apply)

☐Clinic Notes ☐History and Physical ☐Radiology Reports ☐Radiology Images
☐Pathology/Lab Reports ☐Operative Reports ☐Radiation Treatment Records
☐Hospital Notes ☐Billing Information ☐EKG's ☐Hospital Discharge Summary
☐Other (specify information to be released in the space below)

_____

This protected health information is disclosed for the following purposes:

☐ Treatment/Continued Care ☐ Personal ☐ Legal Purposes
☐ Application for Insurance ☐ Disability Determination ☐ Payment of Insurance Claim

☐Other: _____

I understand the following:

1. I have a right to revoke this authorization at any time in writing to the address above. My revocation will not apply to information already retained, used or disclosed in response to this Authorization. Unless sooner revoked, this authorization will expire two years from the date of signature.
2. Once disclosed, health care information may be subject to re-disclosure by the recipient and may no longer be protected under health information privacy laws.
3. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
4. I understand the information to be released may include information related to chemical dependency, behavior and/or mental illness, HIV/AIDS, genetics, communicable, and non-communicable diseases.
5. I understand that I am entitled to receive a copy of this Authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

Az Prostate Cancer Center

20601 N 19th Ave., Suite 105, Phoenix, AZ 85027

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form.

Please indicate your legal authority and include documentation of your relationship:

☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

Arizona Prostate Cancer Center

Patient Intake Information

Patient Name: _____ Date: _____

Address: _____

Sex: M F Age:_____ Birthdate: _____ Soc. Sec. #: _____

Home Phone: _____ May we leave a message? ☐ Yes ☐ No

Work Phone: _____ May we leave a message? ☐ Yes ☐ No

Cell Phone: _____ May we leave a message? ☐ Yes ☐ No

May we send you patient reminders ☐ Yes ☐ No - If **Yes** By Text ☐ OR By Email ☐

If **OK** to send **Text** message - please list your Cell Phone Provider: _____

Communications over the internet and/or using an email system or a text messaging system may not be encrypted and may not be secure. If I selected "yes" to reminders via email or text, I acknowledge that there is no assurance of confidentiality when communicating via email or text, but I still prefer to communicate via the option(s) I selected above.

Email Address: _____

Emergency Contact (Name, Address, Phone # & Relationship)_____

_____

I authorize my Personal Health information to be disclosed to the following family member(s) or other person(s):

Name: _____ Relationship:_____ Phone # _____

Name: _____ Relationship:_____ Phone # _____

Name: _____ Relationship:_____ Phone # _____

PHARMACY INFORMATION:

Name of Pharmacy:	Tel#:
Crossroads:	Fax#:

Race_____ Ethnicity_____ Preferred Language_____

Country of Birth _____

Do you have a Living Will? Yes ☐ No ☐ If **Yes** please bring copy to consult appointment.

Do you have a Medical Power of Attorney? Yes ☐ No ☐ If **Yes** who? _____

Are you an Organ Donor? Yes ☐ No ☐ Do you have a Do Not Resuscitate order? Yes ☐ No ☐

Please List:

Primary Insurance Company: _____ Policy Holder Name: _____
(If other than self)

Secondary Ins. Company:_____ Policy Holder Name: _____
(If you have one) (If other than self)

Patient Signature: _____ Date: _____

AZPCC Patient History and Medication Information

Patient Name: _____ **DOB:** _____

Medical History: (Check all that apply and provide below that you feel are important for us to know)

___Heart Attack? ___Kidney Failure? ___Diabetes? – If yes, do you take insulin? _____

___High Blood Pressure ___Chronic Lung Disease? ___Cancer? – If yes, what type?_____

___Angina? ___Asthma? ___Peptic Ulcer? ___Colitis? ___Bleeding Problems?

___Heart Disease? ___Joint Replacement? ___Blood Disorders? ___Blood Clots? ___Thyroid Problems?

___Heart Valve Problem? ___Liver Problems? ___Osteoarthritis? ___Kidney Stones?

___Pacemaker/defibrillator? ___Emphysema? ___Glaucoma? ___Gastroesphageal Reflux?

___Stroke? ___Hypercholesterolemia? ___Pneumonia? ___Incontinence/Bladder Control?

___Seizures? ___ Rheumatoid Arthritis/Connective Tissue Disorders? ___Infectious Diseases? – _____

Other? _____

Previous Radiation Therapy ☐ YES ☐ NO **Previous Chemotherapy** ☐ YES ☐ NO

REVIEW OF SYSTEMS:
Do you currently have any problems related to the areas outlined below? Please check all boxes that apply or check ***No problems*** if none apply to you.

GENERAL
☐ Weight loss ☐ Loss of appetite ☐ Night Sweats ☐ Fatigue ☐ Nausea ☐ Fever ☐ Chills ☐ ***No Problems***

HEAD/ EYES/ EARS/ NOSE/ THROAT
☐ Headaches/Migraines ☐ Hearing problems ☐ ringing in ears ☐ Nasal congestion ☐ Eye pain

☐ Dental problems ☐ Dry Mouth ☐ Difficulty swallowing ☐ Vision problems ☐ Sore throat ☐ ***No Problems***

RESPIRATORY
☐ Cough ☐ Phlegm ☐ Bloody Phlegm ☐ Shortness of Breath ☐ ***No Problems***

CARDIOVASCULAR
☐ Chest pain ☐ Irregular heart beat ☐ Difficulty breathing ☐ Leg cramps ☐ ***No Problems***

GASTROINTESTINAL
☐ Stomach pain ☐ Vomiting ☐ Bloody stools ☐ Black stools ☐ Constipation ☐ ***No Problems***

NEUROLOGICAL
☐ Numbness ☐ Developmental problems ☐ Tremor ☐ Balance problems ☐ Poor Memory ☐ ***No Problems***

MUSCOLOSKELTAL
☐ Weakness ☐ Difficulty walking ☐ Bone or joint pain ☐ Loss of muscle mass ☐ ***No Problems***

ENDOCRINE
☐ Excessive thirst ☐ Temperature intolerance ☐ Poor growth ☐ ***No Problems***

SKIN
☐ Change in skin or nail texture ☐ Itchy Skin ☐ Hives ☐ Dry skin ☐ Hair Loss ☐ ***No Problems***

LYMPHATIC
☐ Groin node tenderness ☐ ***No Problems***

GU
☐ Blood in the Urine ☐ ***No Problems***

AZPCC Patient History and Medication Information

Patient Name: _____ **DOB:** _____

MEDICATIONS (Please write full dosages):

Please list all prescriptions and over-the-counter medications, including vitamins and herbs that you are taking.

Medication:	Dosage	How Often Taken	Medication:	Dosage	How Often Taken
			Aspirin ☐Yes ☐No		
Allergies to any medications ☐Yes ☐No If yes, which medications are you allergic?: *Please list in boxes below*					

Do you use any **Nitroglycerin medications** (medicine for chest pain?) ☐ Yes ☐ No

Do you use medication (Cialis/Viagra/Levitra) or a device to achieve or maintain an erection? ☐ Yes ☐ No

Are you on HORMONE Therapy (tablet/injection): ☐ **NO** ☐ **YES**: ☐ Less than 1 year ☐ Less than 2 years ☐ More than 2 years

If Taking Hormones Which One: ☐ Eligard ☐ Firmagon (Degarelix) ☐ Zoladex ☐ Lupron ☐ Vantus

SOCIAL HISTORY: Single ____ Married ____ Divorced ____ Widower ____

Retired: ☐Yes ☐No Occupation: _____

Hobbies: _____

Tobacco: ☐ Never smoked ☐ Currently Smoke (# Packs/day) _____ for how long: _____
☐ Quit - Year quit _____ Are you planning on quitting? ☐ Yes ☐ No
Do you presently: ☐ Chew ☐ use Snuff ☐ smoke cigars

Alcohol: ☐Never ☐Occasionally ☐Daily ☐ Yes-but quit Type: _____

Caffeine: Number of cups of coffee per day _____ week _____ month _____
Number of cups of tea per day _____ week _____ month _____
Number of cups of soda per day _____ week _____ month _____

Do you exercise? ☐ Yes ☐ No How Often**:** _____

Have you had a Flu Vaccine recently? ☐ Yes ☐ No Date: _____

Have you ever received the Pneumonia Vaccine? ☐ Yes ☐ No

Date of last colonoscopy or sigmoidoscopy: _____

AZPCC Patient History and Medication Information

Patient Name: _____ **DOB:** _____

Previous Surgeries (Please List):

Year	Type	Year	Type

Family Medical History:

Family Member	Age (If Living)	Current Health (Circle One)	Age at Death	If Deceased - Cause
Grandfather (Father)		Poor Good Excellent		
Grandmother (Father)		Poor Good Excellent		
Grandfather (Mother)		Poor Good Excellent		
Grandmother (Mother)		Poor Good Excellent		
Father		Poor Good Excellent		
Mother		Poor Good Excellent		
Sibling ☐ M ☐ F		Poor Good Excellent		
Sibling ☐ M ☐ F		Poor Good Excellent		
Sibling ☐ M ☐ F		Poor Good Excellent		
Sibling ☐ M ☐ F		Poor Good Excellent		

Indicate below which relatives above (parents, grandparents, siblings) have had the following diseases:

Diabetes_____ **High Blood Pressure** _____

Heart Disease_____ **COPD** _____ **Stroke** _____

Any Relative Diagnosed with Prostate Cancer? ☐ NO ☐ YES Relationship:_____

Any Relative Diagnosed with Bladder Cancer? ☐ NO ☐ YES Relationship:_____

Please inform us of all physicians you are currently seeing:

Physician Name:	Specialty:
Tel#:	Fax #:
Physician Name:	Specialty:
Tel#:	Fax #:
Physician Name:	Specialty:
Tel#:	Fax #:
Physician Name:	Specialty:
Tel#:	Fax #:

Arizona Prostate Cancer Center - AUA Symptom Score (AUASS)

Patient Name: _____ DOB: _____ Today's Date:_____

Please mark the box that best describes your symptoms <u>over the past month</u>

1. **Nocturia: On the average per evening,** how many times have you had to get up to urinate from after the time you went to bed until the time you wake up in the morning. Do not include the time that you finally arose for the day and urinated.

None	1 Time	2 Times	3 Times	4 Times	5 or More Times	**Your Score**
0	1	2	3	4	5	

2. **Incomplete emptying:** Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always	**Your Score**
0	1	2	3	4	5	

3. **Frequency:** During the past month or so, how often have you had to urinate again less than two hours after urination?

Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always	**Your Score**
0	1	2	3	4	5	

4. **Intermittency:** During the past month or so, how often have you found that you stopped and started again several times when urinating?

Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always	**Your Score**
0	1	2	3	4	5	

5. **Urgency:** During the past month or so, how often have you found it difficult to postpone urination?

Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always	**Your Score**
0	1	2	3	4	5	

6. **Weak-stream:** During the past month or so, how often have you had a weak urinary stream?

Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always	**Your Score**
0	1	2	3	4	5	

7. **Straining:** During the past month or so, how often have you had to strain or push to begin urination?

Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always	**Your Score**
0	1	2	3	4	5	

<u>FOR STAFF</u>: SYMPTOM SCORE 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe) **Total Score:** _____

QUALITY OF LIFE (QOL) due to urinary symptoms: How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?

Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
0	1	2	3	4	5	6

Rectal Symptoms:

Frequency of stools	0-1 per day	2 per day	3 per day	4 or more per day
Consistency of stools	All formed	Formed and loose	Loose	Watery
Urgency of stool	None	Somewhat	Urgent	Very urgent
Hemorrhoidal discomfort	None	Requires mild treatment (tucks, sitz baths)	Requires topical medication (Prep H, Anusol)	Requires oral analgesics or narcotics for pain relief

Arizona Prostate Cancer Center - Sexual Health Inventory for Men (SHIM)

Patient Name: _____ DOB: _____ Today's Date: _____

Patient Instructions: Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

******(Completing the SHIM form: This questionnaire should be completed based on your confidence to get and maintain an erection and is not related to your current level of sexual activity)**

*****OVER THE PAST 6 MONTHS:**

1. How do you rate your confidence that you could get and keep an erection?

	Very Low	Low	Moderate	High	Very High	**Your Score**
	1	2	3	4	5	

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

No Sexual Activity	Almost Never Or Never	A Few Times (Much Less Than Half The Time)	Sometimes (About Half The Time)	Most Times (Much More Than Half Time)	Almost Always Or Always	**Your Score**
0	1	2	3	4	5	

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Did Not Attempt Intercourse	Almost Never Or Never	A Few Times (Much Less Than Half The Time)	Sometimes (About Half The Time)	Most Times (Much More Than Half Time)	Almost Always Or Always	**Your Score**
0	1	2	3	4	5	

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult	**Your Score**
0	1	2	3	4	5	

5. When you attempted sexual intercourse, how often was it satisfactory for you?

Did Not Attempt Intercourse	Almost Never Or Never	A Few Times (Much Less Than Half The Time)	Sometimes (About Half The Time)	Most Times (Much More Than Half Time)	Almost Always Or Always	**Your Score**
0	1	2	3	4	5	

For Staff: Add the numbers corresponding to question 1-5. **Total Score:** _____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED 8-11 Moderate ED 12-16 Mild to Moderate ED 17-21 Mild ED

Arizona Urology Specialists, PLLC
Notice of Limited English Proficiency Compliance

Patient Name: _____ DOB:_____Date: _____

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.

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:_____Date: _____

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.

Arizona Urology Specialists, PLLC

Experienced care one patient at a time

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Arizona Prostate Cancer Center a division of Arizona Urology Specialists, PLLC ("AzPCC"/"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. The patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for obtaining any necessary referrals from your primary care physician and prior approval before the start of treatment.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients are responsible for contacting their insurance carrier for explanation of any service not covered. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
- 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
    - Any costs associated with collection of patient balances, including 3rd party collection agency fees.
    - Charges for providing non-English speaking interpreters. Price varies depending on Language.

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. I understand that I am financially responsible for charges not covered by this assignment.
- 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 Prostate Cancer Center

Patient Rights and Responsibilities

It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. **The patient** has the right to considerate care that is respectful of your privacy, personal beliefs, and cultural and spiritual values.
2. **The patient** has the right to obtain from their physician complete current information concerning their diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. Such communication will be in a timely manner.
3. **The patient has the right to have their questions, concerns, or complaints addressed in good faith.**
4. **The patient** has the right to participate in decisions involved in their care and to receive from their physician information necessary to give informed consent prior to the start of any procedure and/or treatment.
5. **The patient** has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of their action.
6. **The patient** has the right to every consideration of their privacy concerning their medical care program. Those not directly involved in their care must have permission of the patient to be present.
7. **The patient** has the right to expect that all communications and records pertaining to their care, including financial records, should be treated as confidential and not released without written authorization by the patient.
8. **The patient** has the right to expect reasonable continuity of care. The patient has the right to expect that AZPCC will provide continuing health care requirements following discharge.
9. **The patient** has the right to examine and receive an explanation of their bill regardless of the source of payment and to be informed regarding the fees for procedures performed in the center.
10. **The patient** has the right to know what facility rules and regulations apply to their conduct as a patient.
11. **The patient has the right to have an advance directive concerning treatment or designation of a surrogate decision maker.**
12. **The patient** has the right to choose where to receive services, including a facility where his/her physician does or does not have an ownership interest.

PATIENT RESPONSIBILITIES:

1. To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and allergies and sensitivities.
2. To follow the treatment plan prescribed by the physician, take medication when prescribed, and ask questions concerning their own health care that they feel are necessary.
3. To make it known whether they clearly comprehend the course of their medical treatment and what is expected of them.
4. To inform their provider about any living will, medical power of attorney, or other directive that could affect their care.
5. To accept financial responsibility for any charges not covered by their insurance.
6. To be respectful of all healthcare professionals and staff, as well as other patients and others' property while in AZPCC facility.
7. To keep appointments and promptly notify AZPCC when unable to do so.

Please contact the Practice Manager if you have any concerns or comments regarding services provided at AZPCC.
Phone: (602) 557-0055
Written correspondence: 20601 N 19th Ave., Suite 115, Phoenix, Az 85027

NOTICE OF PRIVACY PRACTICES
ARIZONA UROLOGY SPECIALISTS

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.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

Arizona Urology Specialists is committed to protecting the privacy of medical information we create or obtain about you. This Notice tells you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information. We are required by law to: (i0) make sure your medical information is protected; (ii) give you this Notice describing our legal duties and privacy practices with respect to your medical information; and (iii) follow the terms of the Notice that is currently in effect.

WHO WILL FOLLOW THIS NOTICE

The privacy practice s described in this Notice will be followed by all physicians, healthcare professionals and employees of Arizona Urology Specialists.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

The following sections describe different ways we may use and disclose your medical information. We abide by all applicable laws related to the protection of this information. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information , however, will fall within one of the following categories:

- **Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research and related activities**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as 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 disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

· **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work related injuries or illness.

· **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

· **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

· **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

· **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

· **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

· **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

· **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

· **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

· **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is 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; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

· **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

· **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

· **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Office and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

· **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

· **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

· **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

· **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

· **Right to Request Amendments.** If you feel that the Protected Health Information we have 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 us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the end of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

· **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

· **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health 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. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

· **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

· **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

· **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the end of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Questions or Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the end of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

AUS Privacy Office
5750 W. Thunderbird Road, Suite B200
Glendale, AZ 85308
(602) 842-6227

Patient Authorization Form

Patient Name: _____ Date of Birth: _____

Acknowledge Receipt of Privacy Practice

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. 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.

Signature: _____ Date: _____

Patient Bill of Rights

I have been offered a copy of the Patient Bill of Rights. I understand that I may contact the Arizona Prostate Cancer Center at any time to obtain a current copy of the Patient Bill of Rights.

Signature: _____ Date: _____

Payment Authorization

I hereby authorize my benefits to be paid directly to Arizona Urology Services 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.

Signature: _____ Date: _____