

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years

_____ Single _____Married _____Separated _____Divorced _____Widowed _____Life Partner _____Common Law Spouse

Dependants: Please indicate # of each, if you have:

_____Sons _____Daughters _____Stepchildren _____Adopted _____Foster _____Parents _____Grandparents

Occupation: Please circle one that applies:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, Other

Hobbies: Please circle any that apply to you:

None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball

Alcohol Consumption:

_____None _____Yes Occasional/Social # of drinks per day _____

Tobacco per day:

_____None _____Yes #_____Packs/day _____Cigarettes/day _____Smokeless Tobacco

If you previously stopped, When? _____

Recreational Drugs: _____None If yes, please list: _____

Caffeinated beverages: None Low Moderate Excessive

Recent Foreign Travel: None Americas _____ Worldwide _____

REVIEW OF SYSTEMS:

Constitutional

Appetite Changes

Anorexia

Aches and Pains

Chills

Easy Bruising

Fever

Fatigue

Generalized Weakness

Insomnia

Night Sweats

Sleep Apnea

Swollen Glands

Weight Gain

Weight Loss

Eyes

Blind

Blurred Vision

Double Vision

Glaucoma

Pain

Worsening Eyesight

Allergic/Immunologic

Animal Allergies

Drug Allergies

Environmental Allergies

Food Allergies

Seasonal Allergies

Neurological

Balance Problems

Disoriented

Dizzy Spells

Headache

Lack of Alertness

Leg or Arm Weakness

Memory Loss

Numbness/Tingling

Stroke

Speech Problems

Other: _____

Tremors

Endocrine

Diabetes

Excessive thirst

Pituitary Disease

Thyroid Disease

Tired/Sluggish

Too Hot/Cold

Gastrointestinal

Abdominal Cramps

Abdominal Pain

Acid Reflux

Bloody Stools

Change in Bowel Habits

Constipation

Diarrhea

Flatulence

Gas

Hemorrhoids

Indigestion/heartburn

Irregular Bowel

Movements

Nausea/vomiting

Rectal Bleeding

Tarry Stool

Cardiovascular

Chest Pain/Angina

Dyspnea on Exertion

Edema

Heart Attack

Heart Failure

Heart Murmur

High Blood Pressure

Irregular Heart Beat

Mitral Valve Prolapse

Orthopnea

Pain/Cramps Hips/Legs

w/exercise

Palpitation

Skipped Heart Beats

Swelling

Skin

Acne

Boils

Changing Moles

Persistent Itch

Pigment Change

Skin rash

Musculoskeletal

Arthritis

Back Pain

Gout

Joint Pain

Muscle Cramps

Muscle Weakness

Neck Pain/Stiffness

Ear/Nose/Throat

Ear Infection

Sinus Problem

Sore Throat

Genitourinary

Back Pain

Bedwetting

Blood in Urine

Dribbling

Burning on Urination

Erection Problems

Flank Pain

Hematuria

Hesitancy

Kidney Failure

Kidney Infections

Kidney Stones

Leak after voiding

Nocturia

Nocturnal Enuresis

Not Emptying

Painful Ejaculation

Stranguria

Stones

Suprapubic Pain

Urgency

Urinary Frequency

Urinary Hesitancy

Urinary Incontinence

Urinary Tract Infections

Urine retention

Urologic Cancer

Urologic Surgery

Vaginal Bleeding

Vaginal

Discharge/Problems

Weak Stream

Respiratory

Asthma

Emphysema-Bronchitis

Environmental Allergies

Frequent Cough

Pneumonia

Shortness of breath

Tuberculosis

Wheezing

Hematological/Lymphatic

Swollen Glands

Blood clotting problem

Bleeding Problem

Hepatitis

HIV (AIDS)

Sickle Cell

Psychologic

Anxiety

Depressed

Generally satisfied with life

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following diseases or conditions:

Cardiovascular

Anemia
Angina
Anorexia
Aortic Aneurysm
Aortic Regurgitation
Aortic Stenosis
Arrhythmia
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Claudication
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Enlarged Heart
Heart Attack
Heart Block
Heart Disease
Heart Murmur
Heart Valve Problem
Hemophilia
Hypertension, well controlled
Hypertension, progressive
Hypertension, severe
Leukemia
Mitral Insufficiency
Mitral Stenosis
Mitral Valve Prolapse
Rheumatic Fever
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins
Ventricular Arrhythmia

Endocrine/Metabolic

Diabetes Mellitus, non-insulin dependent
Diabetes Mellitus, insulin dependent
Diabetes Mellitus, uncontrolled
Goiter
Gout
Hyperthyroidism
Hypothyroidism
Impaired Glucose Tolerance

General

Allergies
Electrical Injury
Exposure to Chemicals

Hepatitis A
Hepatitis B
Hepatitis C
Hypercholesterolemia
Hyperlipidemia
Infectious Disease
Lipid Disorder
Malaise
Obesity
Paget's Disease
PCKD
PCO
Raynaud's Syndrome
Sleep Apnea

GI

Cholecystitis
Cholelithiasis
Chronic Liver Disease
Colitis
Constipation
Colon Condition
Crohn's Disease
Diarrhea
Diverticulitis
Diverticulosis
GERD
Hemorrhoids
Hepatic Failure
Hepatitis
Hiatal Hernia
Inflammatory Bowel Disease
Liver Disease
Pancreatitis
Peptic Ulcer (Duodenal)
Rectal Fissure
Stomach Ulcer
Ulcerative Colitis

GU

AIDS
Bladder Outlet Obstruction
Bladder Stone
Bladder Infection
Chronic Renal Disease
Chronic Renal Insufficiency
Chronic Renal Failure
Crossed Fused Ectopia
Hematuria
Impotence of Organic Origin
Interstitial Cystitis
Irradiation Therapy
Kidney Cancer
Kidney Disease
Kidney Infection
Kidney Stones
Libido Decreased
Nephrolithiasis

Nephrotic Syndrome
Neurogenic Bladder
Orchitis
Penile Discharge
Polycystic Disease
Polycystic Kidney Disease
Prostate Cancer
Radiation or Nuclear Exposure
Recurrent UTI
Renal Cell Cancer
Renal Failure
Renal Insufficiency
Testicular Cancer
Transplant Recipient
Transitional Cell CA Bladder
Transitional Cell CA Ureter
Undescended Testicle (Birth)
Urinary Tract Infection
Venereal Disease

GYN/OB

Breast Cancer
Breast Disease
Endometriosis
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Fibroids

HEENT

Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Meniere's
Mumps
Sinusitis
Tinnitus
Vertigo

Musculoskeletal

Arthritis
Back Pain
Carpal Tunnel Syndrome
Claudication
Fibromyalgia
Mortons Neuroma

Neurological/Psychological

ADD
ADHD
Alcoholism
Alzheimer's Disease
Anxiety
Bi-polar Disorder
Chronic Fatigue Syndrome
Depression
Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Organic Brain Syndrome
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt

Respiratory

Asthma
Bronchitis
Chronic Lung Disease
COPD
Emphysema
Lung Disease
Pneumonia
Pulmonary Embolism
Tuberculosis

Tumors

Brain Cell Carcinoma
Brain Tumor
Breast Cancer
Cervical Cancer
Colon Cancer
Fibrocystic Breast Disease
Gastric Cancer
Laryngeal Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Rectal Cell Cancer
Sarcoidosis
Testicular Cancer
Transitional Cell CA Bladder
Transitional Cell CA Ureter
Uterine CA

Other:

SURGICAL HISTORY

Please **CIRCLE** if you have had any of the following surgeries and date of surgery:

Cadiovascular

Angioplasty
Aortic Aneurysm Repair
CABG
Carotid Artery Surgery
Heart Surgery
Heart Surgery (Stents)
Heart Transplant
Pacemaker Insertion
Vein Stripping

General

Brain Surgery
Laminectomy
Lymphatic Node
Dissection
Parathyroidectomy
Pilonidal Cyst Incision
Skin Grafting

GI

Appendectomy
Bariatric Surgery
Bowel Resection
Cholecystectomy
Colon Resection
EGD
EGD/Dilation
Esophagus
Fissurectomy
Gastric Surgery
Hemorrhoidectomy
Ileostomy
Laparoscopy
Liver Surgery
Liver Transplant
Lumpectomy of Breast
Lysis Adhesions
Nissen Fundoplication
Splenectomy
Stomach Surgery
Umbilical Hernia
Ventral Hernia Repair

GU

Bladder Surgery
Biopsy Prostate
Brachytherapy
Circumcision
Contigen
Cystoscopy
Cystoscopy-Dilation
Cystoscopy-Retrograde
Cystoscopy-Stent
Cysto-TUR Fulguration
Durasphere
Epididymectomy
ESWL
Herniorrhaphy
Hydrocelectomy
Ileal conduit
Indigo Laser Surgery
Inguinal Herniorrhaphy
Interstim
Kidney Stone
Laser Lithotripsy
Meatotomy
Needle Biopsy Prostate
Nephrectomy
Nephrolithotomy
Orchiectomy
Orchiopexy
Penile Implant
Penectomy
Penile Surgery
Pyeloplasty
Radical Prostatectomy
Renal Transplant
Spermatoclectomy
TUMT Prostate
TUNA Prostate
TURBT
TUR Prostate
Ureteroscopy
Variocelectomy
Vasectomy
VLAP

HEENT

Cataract Surgery
Corneal Surgery
Ear Surgery
Eye Surgery
Facial Surgery
Mastoid Surgery
Nasal Surgery
PEG
PE Tubes
Septoplasty
Sinus Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery

Musculoskeletal

Amputation
Arthroscopic Knee
Surgery
Back Surgery
Carpal Tunnel Surgery
Cervical Spine Surgery
Disc Surgery
Foot Surgery
Hand Surgery
Hip Surgery
Knee Surgery
Leg Surgery
Rotator Cuff Surgery
Shoulder Surgery

Respiratory

Lung Surgery

Skin

Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

OTHER:

FAMILY HISTORY

Please CIRCLE and indicate which family member has/had any of the following:

(Mother, Father, Siblings, Grandmother, Grandfather, Uncle , Aunt)

Arthritis	-----	Leukemia	-----
Bedwetting	-----	Malignant Melanoma	-----
Bladder Cancer	-----	Multiple Sclerosis	-----
Cancer (site unknown)	-----	Laryngeal Cancer	-----
Crohn's Disease	-----	Pancreatic Cancer	-----
Depression	-----	Prostate Cancer	-----
Diabetes	-----	Stroke	-----
Gout	-----	Thyroid Disease	-----
Heart Attack	-----	Tuberculosis	-----
Hypertension	-----		
Kidney Cancer	-----		
Kidney Disease	-----		

Other:

AUA SYMPTOM SCORE

MEN OVER 40 PLEASE COMPLETE THE FOLLOWING QUESTIONS

QUESTIONS TO BE ANSWERED	NOT AT ALL	LESS THAN 1 TIME IN 5	LESS THAN ½ TIME	ABOUT ½ THE TIME	MORE THAN ½ THE TIME	ALMOST ALWAYS
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0 (none)	1 (1 TIME)	2 (2 TIMES)	3 (3 TIMES)	4 (4 TIMES)	5 (5 TIMES)
Sum of the seven circled numbers (AUA Symptom Score): _____ Scoring: Mild: 0-7 Moderate: 8-19 Severe: 20-35						

THANK YOU FOR COMPLETING THIS PACKET

SCOTTSDALE UROLOGIC SURGEONS
A Division of Arizona Center for Hematology and Oncology, PLC
Mitchell C. Kaye, M.D. * Edward R. Katz, M.D.

PROTECTED HEALTH INFORMATION DISTRIBUTION

Patient Name: _____
Print First Name Middle Name Last Name

Date of Birth: ____/____/____

1) May our office leave a message regarding test results and appointments on your voicemail?

_____ YES _____ NO

2) Who may receive information regarding your PROTECTED HEALTH INFORMATION
(Office Visit Notes, Diagnosis, Appointment Information, etc)

- SPOUSE Name: _____ Date of Birth: _____
CHILDREN Name: _____ Date of Birth: _____
 Name: _____ Date of Birth: _____
 Name: _____ Date of Birth: _____
 Name: _____ Date of Birth: _____
 Name: _____ Date of Birth: _____
 Name: _____ Date of Birth: _____
- PARENT/
GUARDIAN Name: _____ Date of Birth: _____
 Name: _____ Date of Birth: _____
- OTHER Name: _____ Date of Birth: _____
 Name: _____ Date of Birth: _____
 Name: _____ Date of Birth: _____
 Name: _____ Date of Birth: _____

3) I AUTHORIZE THE ABOVE LIST OF PEOPLE ACCESS TO MY PROTECTED HEALTH INFORMATION SHOULD THEY INQUIRE. I MAY REVOKE THIS AT ANY TIME BY UPDATING THIS FORM.

PATIENT SIGNATURE

DATE OF SIGNATURE

SCOTTSDALE UROLOGIC SURGEONS - OFFICE FINANCIAL POLICY

A Division of AZCCC

Welcome and thank you for choosing our office for your medical care. We hope that by providing you with our policies in advance we can prevent misunderstanding and frustration. Please read this carefully.

Initial ____ SOCIAL SECURITY NUMBERS are a necessary part of your financial information with our office. This information, as with any of your medical record, is protected with strict confidentiality. You are asking us to extend your credit by filing insurance for your charges and not collecting in full at the time of service, therefore we must have this information or all charges must be paid at the time of service. Not providing your social security number at your first appointment will result in you being rescheduled until your social security number is received.

Initial ____ CHECK-IN: Please arrive 10 minutes prior to your appointment time, so that all paperwork may be completed before the time you are scheduled. We also ask that our patients bring their current insurance card to **each** appointment. If you do not have your insurance card you will be asked to reschedule or pay for your services. On follow-up visits, you will be asked to verify demographic and insurance information so that our records remain up-to-date. Even if you have not had any changes to your demographic/insurance information, our office does require each patient update on an annual basis.

Initial ____ INSURANCE: Our office will file claims for primary insurance only, unless you have Medicare or AHCCCS. We do not bill secondary insurance plans. When making an appointment with our office it is your responsibility to confirm whether our office is currently under contract with your plan. If payment is not received from your insurance carrier within 60 days of filing the claim, the balance due will become your responsibility. Our office cannot become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, coinsurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges", etc., other than to supply factual information when necessary. Each patient is ultimately responsible for the timely payment of their account.

Initial ____ REFERRALS AND AUTHORIZATIONS: It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists. If you do not have a referral or authorization for your appointment you can reschedule or accept charges in full as your responsibility.

Initial ____ CO-PAYMENTS: Co-payments are due at the time of service. We do not bill for co-payments. We reserve the right to reschedule an appointment if a co-payment is not paid at the time of the appointment. For your convenience we accept cash, check, MasterCard, Visa, Discover and American Express.

Initial ____ PRIVATE PAY: If you have no insurance or an insurance we do not participate with, payment in full is expected prior to your service.

Initial ____ SURGERY/PROCEDURES: Our office reserves the right to collect, prior to surgery/procedure, deductibles and/or co-insurance up to an amount equal to your expected liability. If we do not receive your expected liability prior to the surgery/procedure your appointment/surgery will be cancelled. **Surgeries not cancelled 72 hours in advance are subject to a minimum fee equal to 50% of the surgery fee but may be up to 100% of anticipated surgical charges.**

Initial ____ BALANCES/CO-INSURANCE/DEDUCTIBLES: Please be prepared to pay for the current visit as well as any past due balance on your account. Payment of deductibles and co-insurance will be required at the time of service.

Initial ____ PAST DUE BALANCES/COLLECTIONS: Should there be any balance remaining after insurance has been collected, it will be due 10 days after receipt of statement. If previous arrangements have not been made with our billing department, any account over 60 days will be turned over to a collection agency and 30-40% fee will be assessed to your account to offset the recovery fee.

Initial ____ FEES: There is a minimum \$500.00 per hour charge, per doctor, to respond to all claims, disputes, complaints, legal proceedings, hearings and similar, on your behalf or as a result of your care.

Initial ____ NO SHOW/CANCELLATION: A \$50.00 fee will be charged to your account should you not cancel your appointment 48 hours prior to your scheduled appointment time. **Surgeries not cancelled 72 hours in advance are subject to a minimum fee equal to 50% of the surgery fee but may be up to 100% of anticipated surgical charges.**

Initial ____ RETURNED CHECKS: A \$25.00 fee will be assessed for any returned checks, plus any bank fees.

Initial ____ FORMS: If you have forms for disability, insurance, work forms, etc. to be completed, there is a minimum \$25.00 to \$50.00 charge per form. Payment is due when the request is submitted to our office. We require a one week turn around (7 business days).

I have read, understand and agree to the above office and financial policies. I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing, if applicable. By signing this statement, I also authorize my insurance company to reimburse Scottsdale Urologic Surgeons, Ltd. directly for any benefits for which I may be eligible.

Signed: _____ Print Name: _____ Date: _____

Scottsdale Urologic Surgeons

A Division of AZCCC

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Adult Male and Female Urology
Pediatric Urology
*Diplomate American Board of Urology

FINANCIAL DISCLOSURE

Dear Patient,

Thank you for choosing one of our physicians to be your surgeon. Our office will contact your insurance company to satisfy any precertification or authorization regarding our physician's services only.

Please be advised that there may be charges related to:

Lab Work	Diagnostic Studies	Medications	X-ray
Pathology	Surgery Facilities	General Hospital Charges	
Anesthesiology	Surgical Assistants		

Some of these services may not be contracted with your insurance company and therefore you will be responsible for the charges. It is typical a surgical assistant may be needed for your surgery.

Please note the following:

- 1 Mr. Sam McReynolds and Arizona Physicians Assistant Surgical Services, as with most surgical assistants, are ***non contracted providers***. These entities will bill you separate from Scottsdale Urologic Surgeons for their services.
- 2 Your physician might have a preference for or a specific interest in certain facilities, as follows:
 - Dr. Kaye has a small ownership interest in North Valley Surgery Center
 - The physicians of Scottsdale Urologic Surgeons have an ownership interest in Southwest Lithotripsy.
- 3 Surgeries not cancelled 72 hours in advance are subject to a fee equal to 50% of the surgery fee.

Patient _____
(print)

Patient _____
(signature)

Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This Acknowledgment of Receipt of Notice of Privacy Practices applies to, but may not be limited to the following ACHO entities & services:

*Academic Urology & Urogynecology of AZ
Arizona Cancer Specialists
Arizona Center for Cancer Care
Desert Springs Cancer Care*

*Diagnostic Radiology
Jamie Kapner, MD
Northwest Urology
Pinnacle Oncology Hematology*

*Scottsdale Cancer Center
Scottsdale Urologic Surgeons
Sun Valley Urology
Valley Urologic Associates*

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice of Privacy Practices. You may refuse to sign this acknowledgement, if you wish. Thank you.

**I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF
ARIZONA CENTER FOR HEMATOLOGY AND ONCOLOGY'S
NOTICE OF PRIVACY PRACTICES.**

Please Print Your Name Here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (Please provide specific details) _____

Employee Name (please print your name here)

Employee Signature

Date

**Your Information.
Your Rights.
Our Responsibilities.**

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.**

**Your
Rights**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ **See page 2** for more information on these rights and how to exercise them

**Your
Choices**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ **See page 3** for more information on these choices and how to exercise them

**Our
Uses and
Disclosures**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ **See pages 3 and 4** for more information on these uses and disclosures

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone’s health or safety
-

Do research

- We can use or share your information for health research.
-

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
-

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.
-

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
-

Address workers’ compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers’ compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
-

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
-

Please note the following:

ACHO does not create or manage a hospital directory.

ACHO does not create or maintain psychotherapy notes at its practices.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice: December 15, 2013

This Notice of Privacy Practices applies to the following organizations.

This notice applies to the following ACHO entities & services:

Academic Urology and Urogynecology of Arizona

Arizona Cancer Specialists

Arizona Center for Cancer Care

Desert Springs Cancer Care

Diagnostic Radiology

Jamie Kapner, MD

Northwest Urology

Pinnacle Oncology Hematology

Scottsdale Cancer Center

Scottsdale Urologic Surgeons

Sun Valley Urology

Valley Urologic Associates



*Compliance/Privacy Officer
(623)773-2873
kcarleton@arizonacc.com*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This Acknowledgment of Receipt of Notice of Privacy Practices applies to, but may not be limited to the following ACHO entities & services:

*Academic Urology & Urogynecology of AZ
Arizona Cancer Specialists
Arizona Center for Cancer Care
Desert Springs Cancer Care*

*Diagnostic Radiology
Jamie Kapner, MD
Northwest Urology
Pinnacle Oncology Hematology*

*Scottsdale Cancer Center
Scottsdale Urologic Surgeons
Sun Valley Urology
Valley Urologic Associates*

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice of Privacy Practices. You may refuse to sign this acknowledgement, if you wish. Thank you.

**I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF
ARIZONA CENTER FOR HEMATOLOGY AND ONCOLOGY'S
NOTICE OF PRIVACY PRACTICES.**

Please Print Your Name Here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (Please provide specific details) _____

Employee Name (please print your name here)

Employee Signature

Date