



Welcome to Urology Health Specialists, LLC.

In order to serve you better, please carefully read and complete the attached forms.

Please arrive 15 minutes prior to your appointment time so we may process all necessary paperwork. Please bring the following:

- All of the attached patient information and history forms – completed.
- Your insurance card
- Co-payment amounts are due at the time of service.
- If your insurance requires one, a REFERRAL from your primary physician
- The name and phone number of your primary care physician.
- List of all medications/allergies.
- Copies of all recent lab test results, x-rays and medical records.
- Money for parking at our Abington, Chestnut Hill, Lankenau and Nazareth locations.

If you need to cancel your appointment, please notify us 24 hours in advance. A fee will be assessed for all no-shows or cancellations without 24 hours notice.

Directions to all Urology Health Specialists locations can be found on our website at www.uhsurology.com.

If you have any questions prior to your appointment, please call our office.

Thank you.

UROLOGY HEALTH SPECIALISTS

www.uhsurology.com

UROLOGY HEALTH SPECIALISTS, LLC
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: _____ First: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home # _____ Work # _____ Cell # _____

E-mail address: _____ Social Security # _____

DOB: _____ AGE: _____ SEX: ___ M ___ F

Spouse/Partner name: _____

If minor, name of Parent/Guardian: _____

Married _____ Single _____ Partnered _____ Widowed _____ Separated _____ Divorced _____

Employment Status: Currently not employed _____ Employed _____ Retired _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone # _____

Relationship of Emergency Contact: _____

Referring Physician: _____ Phone # _____

Primary Care Physician: _____ Phone # _____

Local Pharmacy: _____ Phone # _____

Mail Order Pharmacy Plan Name: _____

Explain any special requirements for pharmacy plan – Quantity/Time interval

PLEASE SHOW INSURANCE CARD AT EACH VISIT.

**INSURANCE
PRIMARY**

Primary Subscriber Name: _____

Subscriber's Social Security Number: _____

DOB: _____ Employer: _____

I.D.# _____ Group # _____

**INSURANCE
SECONDARY**

Subscriber Name: _____

DOB: _____ Employer: _____

I.D.# _____ Group # _____

I hereby authorize Urology Health Specialists, LL to furnish my medical or other information to insurance carriers, their intermediaries, my attorney, or another physician's office. I understand that sensitive material from my medical history could be included.

I hereby assign to Urology Health Specialists, LLC all payments for medical services rendered to myself or my dependents. I understand I have financial responsibility for any amount whether or not paid by insurance.

A copy of this authorization is as valid as the original. This assignment will remain in effect until revoked by me in writing.

Signed: _____ Date: _____

UROLOGY HEALTH SPECIALISTS, LLC

PATIENT INFORMATION AND HISTORY

HISTORY OF PRESENT ILLNESS

PATIENT NAME: _____ **DATE OF BIRTH:** _____

REASON FOR VISIT: _____

When did you first notice the problem? 2 days ago 2 weeks ago Other _____

Are your symptoms getting worse? _____

Is the problem constant or variable dull then sharp very sharp then leaves always

Does the problem interfere with your normal activities? Yes No (If yes, explain) _____

Is there anything else occurring at the same time? Yes No (If yes, explain) _____

Nausea Rash Headache Fever Other _____

Have you had this problem before? Yes No I don't know

Have you had prior urological evaluation or surgery? Yes No I don't know

What is your level of pain right now (with 1 being the least bothersome and 10 being severe)? _____

Any recent tests related to this problem? (Blood work, urine test, radiology examination) _____

PAST SURGICAL HISTORY (FOR ANY MEDICAL PROBLEM) List any past surgeries and dates.

PAST MEDICAL HISTORY-ILLNESSES OR HOSPITALIZATION (List with date first diagnosed)

DO YOU HAVE ANY FOOD OR DRUG ALLERGIES? Yes No
 (Please refer to page 5 to list any allergies and allergic reactions)

DO YOU SMOKE? Yes No **If Yes, how much?/years?** _____
 I quit **Date stopped** _____

DO YOU DRINK ALCOHOL? Yes No

If yes, how much? Occasionally 3-4X per week Every day Other _____

ARE YOU ON A SPECIAL DIET? Yes No

If yes, describe _____ Weight loss Diabetic Low sodium Low carbohydrates

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL OR OTHER PROCEDURES? Yes No

If yes, what do you take? _____ **If so, why?** _____

FAMILY HISTORY

<u>ILLNESS</u>	<u>FATHER</u>	<u>MOTHER</u>	<u>BROTHER(S)</u>	<u>SISTER(S)</u>	<u>GRANDFATHER</u>	<u>GRANDMOTHER</u>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	_____	_____	_____	_____	_____
Family Members that are deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other family history information: _____

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Check Yes or No.

Please explain any Yes answers in space provided.

Constitutional Symptoms

Fever Yes No
Chills Yes No
Headache Yes No
Other _____

Integumentary

Skin rash Yes No
Boils Yes No
Persistent itch Yes No
Other _____

Eyes

Blurred vision Yes No
Double vision Yes No
Pain Yes No
Other _____

Musculoskeletal

Joint pain Yes No
Neck pain Yes No
Back pain Yes No
Other _____

Allergic/Immunologic

Hay Fever Yes No
Drug allergies Yes No
Other _____

Ear/Nose/Throat/Mouth

Ear infection Yes No
Sore throat Yes No
Sinus problems Yes No
Other _____

Neurological

Tremors Yes No
Dizzy spells Yes No
Numbness/tingling Yes No
Other _____

Genitourinary

Urine retention Yes No
Painful urination Yes No
Urinary frequency Yes No
Other _____

Endocrine

Excessive thirst Yes No
Too hot/cold Yes No
Tired/sluggish Yes No
Other _____

Respiratory

Wheezing Yes No
Frequent cough Yes No
Shortness of breath Yes No
Other _____

Gastrointestinal

Abdominal pain Yes No
Nausea/vomiting Yes No
Indigestion/heartburn Yes No
Other _____

Hematologic/Lymphatic

Swollen glands Yes No
Blood clotting problem Yes No
Other _____

Cardiovascular

Chest pain Yes No
Varicose veins Yes No
High blood pressure Yes No
Other _____

Psychologic

Are you generally satisfied with your life?

Yes No

Do you feel severely depressed? Yes No

Have you considered suicide? Yes No

Other _____

Reviewed by: _____

Date: _____

WOMEN ONLY – GYNECOLOGIC/OBSTETRIC HISTORY

Age at onset of periods _____ Frequency _____ Length _____

Pregnancies _____ Births _____ Miscarriages _____

Prolonged abnormal bleeding No Yes (Describe) _____

Leakage of urine No Yes (Describe) _____

Pelvic pain No Yes (Describe) _____

Abnormal discharge No Yes (Describe) _____

History of abnormal Pap test No Yes (Describe) _____

UROLOGY HEALTH SPECIALISTS, LLC
BILLING AND PAYMENT POLICY

Medicare and Managed Medicare Plans

Urology Health Specialists, LLC participates in most Medicare and most “managed” Medicare plans. We will bill Medicare or the other Medicare contract carrier directly. They will pay us directly. We will bill our standard fee and will write off the portion of the bill considered to be our “contractual” adjustment. The balance, which is usually 20% is paid by the patient or a supplemental insurance. For “managed Medicare plans” there is a co-pay due at each visit. For all Medicare plans there is an annual deductible each year that members are responsible for.

Urology Health Specialists, LLC will bill your secondary or supplemental insurance for you if we are given all the necessary billing information at the time of service. Your secondary or supplemental insurance is billed once we have received payment from your primary insurance. Medicare does have arrangements with many secondary payers to automatically forward Medicare payment information. The secondary or supplemental insurance pays Urology Health Specialists, LLC directly. You will receive a bill from Urology Health Specialists, LLC after Medicare, the Managed Medicare contractor and your supplemental insurance has paid. Medicare will send you an “explanation of benefits”. If you have questions about the payment from Medicare, please call Highmark Medicare Services at 1-800-663-4227.

Private Insurance

Urology Health Specialists, LLC will bill your insurance directly for you if supplied with the complete billing information. This includes: name and complete address of insurance company, policy holder name, date of birth, ID and group numbers. It is not necessary to supply an insurance form as most insurance companies comply with the federally mandated standard form programmed for our billing system. We bill daily.

If your insurance company does not pay the bill within sixty (60) days we will hold you responsible for payment. We recommend that you contact your insurance carrier if the bill has not been paid within 30 days to determine what is delaying the claim. Regardless, this office will look directly to you for payment of your services beginning on the 61st day from date of service. Co-payments, deductibles and/or co-insurances are due at the time of service. We accept cash, private checks (with proper ID), VISA and MasterCard.

Self-Pay and Health Savings Account

Patients with no insurance coverage or have an HSA (Health Savings Account) are asked to pay in full at every visit. To establish a Payment Plan, please contact our Billing Office at 484-530-0203.

I will be responsible for any and all charges incurred with Urology Health Specialists, LLC. I have read and understand UHS Billing and Payment Policy.

Signature: _____

Printed Name: _____

Date: _____

Urology Health Specialists LLC
Policies and Procedures
Identity Theft Prevention and Detection and Red Flags Rules Compliance

Policy

It is the policy of Urology Health Specialists, LLC to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how Urology Health Specialists, LLC will (1) identify, (2) detect and (3) respond to “red flags.” A “red flag” as defined by this policy includes a pattern, practice or specific account or record activity that indicates possible identity theft.

Procedure:

1. When a patient calls to request an appointment, the patient will be asked to verify their current address or date of birth and their current insurance provider. They will be asked to bring the following at the time of the appointment:
 - Driver’s license or other photo ID;
 - Current health insurance card; and
 - Utility bills or other correspondence showing current residence if the photo ID does not show the patient’s current address. If the patient is a minor, the patient’s parent or guardian should bring the information listed above.

2. When the patient arrives for the appointment, the patient will be asked to produce the information listed above. After verifying the patient’s identity, the staff will take a photo ID to be entered into the patients EMR. **The photo ID requirement may be waived for patients who have visited the practice and already have a photo ID in the Electronic Medical Record (EMR). If the patient does not have a photo ID in the EMR, photo ID will be required at each visit. Insurance and address will be verified at each visit.**

3. **Insurance and address will be verified at each visit. Phone call with patients will require the person to verify name, address, and/or date of birth before discussing medical or financial information.**

If you have any questions about this policy please ask the administrative assistant at the time of your visit.

UROLOGY HEALTH SPECIALISTS, LLC

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provided to you. We are required by law 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 IIHI. 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 IIHI
- Our obligations concerning the use of and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI 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.

B. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIIHI in order to write a prescription for you, or we might disclose your IIIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIIHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIIHI to bill you directly for services and items. We may disclose your IIIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIIHI to operate our business. As examples of ways in which we may use and disclose your information for our operations, our practice may use your IIIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIIHI to other health care providers and entities to assist in their health care operations.

OPTIONAL:

4. **Appointment Reminders.** Our practice may use and disclose your IIIHI to contact you and remind you of an appointment.

OPTIONAL:

5. **Treatment Options.** Our practice may use and disclose your IIIHI to inform you of potential treatment options or alternatives.

OPTIONAL:

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:

7. **Release of Information to Family/Friends.** Our practice may release your IIIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

C. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

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

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- * maintaining vital records, such as births and deaths
- * reporting child abuse or neglect
- * preventing or controlling disease, injury or disability
- * notifying a person regarding potential exposure to a communicable disease
- * notifying a person regarding a potential risk for spreading or contracting a disease or condition
- * reporting reactions to drugs or problems with products or devices
- * notifying individuals if a product or device they may be using has been recalled
- * notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- * notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- * Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement

- * Concerning a death we believe has resulted from a criminal conduct
- * Regarding criminal conduct at our offices
- * In response to a warrant, summons, court order, subpoena or similar legal process
- * To identify/locate a suspect, material witness, fugitive or missing person
- * In any emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL:

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL:

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye, or tissue procurement or transplantation; including organ donation banks, as necessary, to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL:

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers, or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI 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. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. 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. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Urology Health Specialists, LLC, 140 W. Germantown Pike, Suite 250, Plymouth Meeting, PA 19462, Attention: **Brenda Esopi, CEO** specifying the requested method of contact, or the location where you wish to be contacted and the name of the doctor who is caring for you. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

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2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment of your care, such as family members and friends. **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. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing. Your request must describe in a clear and concise fashion:

- a) the information you wish restricted;
- b) whether you are requesting to limit our practice's use, disclosure or both; and
- c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. 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 will 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 IIHI kept by or for the practice; (c) not part of the IIHI 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.

5. 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 IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Urology Health Specialists, LLC, 140 W. Germantown Pike, Suite 250, Plymouth Meeting, PA 19462, Attention: **Robert Lev, Controller** . All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. 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.

7. 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. . . All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. 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. Any authorization you provide us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

To file a written complaint, request information, or for information on our health information privacy policies please submit your request in writing to **Ms. Brenda Esopi, CEO, Urology Health Specialists, LLC, 140 W. Germantown Pike, Suite 250,**

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| **Plymouth Meeting, PA 19462** Please include the name of the physician who is providing your care, your full name, address and phone number.

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