PLEASE PRINT ALL PAGES OF THIS DOCUMENT AND FOLLOW YOUR DOCTOR'S OFFICE INSTRUCTIONS.

Please complete these forms.
Reading information and instructions at home
before your visit can benefit you during your office appointment.

If you have questions, please call your doctor's office.

Forms and information provided here are the property of, and
are supplied by, this practice for your convenience
as a service of vasectomy.com.

***ProMedical Alliance LLC** does not review these forms and makes no claims as to the accuracy of the information within the forms. The information found in these forms is not a substitute for direct consultation with your health care professional. Consult your own physician regarding your medical questions, symptoms or condition or the applicability of any information within the forms.*

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Urology Associates, Ltd.

If you are interested in being contacted by our practice to set up an appointment you may print out the following 2 forms to expedite your registration. Once they are filled out please fax them to our office and a representative will call you to set up your appointment(s). Our fax number is (602) 266-3870. Please send to the attention of Jill Capodilupo. If you are not able to fax the forms, a representative will still contact you and this information will be obtained at the time the appointment is scheduled.

1. PATIENT REGISTRATION FORM
   This demographic information is necessary for us to place you in our computer and must be completed fully with accurate information. We need to have this information and a copy of your insurance card if you are new to the practice, if you have not been seen within the last 6 months or if your information is incorrect. At your appointment, please review all the information on the form and make any changes necessary to update our records. All new patients will also need their valid driver's license copied in addition to the insurance card. If you have a HMO coverage that requires an authorization/referral, please give the referral to the receptionist at check in.

2. HIPAA CONSENT FORM
   The HIPAA Privacy regulation applies to every physician, every hospital, every health plan (both insured and self funded), and every health care clearinghouse. Basically, it applies to every person or organization that creates or maintains Protected Health Information. It also applies, though indirectly, to vendors and business associates. The Privacy regulation is meant to protect individuals, not burden organizations or physicians. It is intended to balance the right of individuals to control access to their **PHI** with the needs of the community (i.e. reporting communicable diseases) and the need for accessible, accountable, and accurate health care. As individuals, we all have gone to the doctor and shared information that we want only the doctor to know. Our doctors need to have our entire medical history in order to provide the proper care. We won't share everything with our doctors unless we trust the doctor to keep the information safe. Until now, it has been up to each state to implement its own privacy protections. Even then, these protections only address specific issues (i.e. mental health, substance abuse, etc.). That is why it is important to have guidelines for privacy that are set by the federal government and apply to anyone who has Personal Health Information (**PHI**). Our commitment to your privacy is outlined in our Notice of Privacy Practices. Please read this thoroughly to understand how your health information is handled in this office. After reading the **NPP**, read the HIPAA consent form. **There are three (3) areas that you must complete.** You must acknowledge receiving this information and may keep a copy of the NPP, if so desired. The **NPP** is posted in every waiting room and copies are available for you to take home. Please take a copy from the waiting room magazine rack. If you wish for our office to discuss or release information with another person (spouse, etc.) please complete the bottom section of the HIPAA consent form.

Patient Registration Form

UROLOGY ASSOCIATES LTD., 202 E EARLL DRIVE #360, PHOENIX AZ 85012 (602) 264-4431 FAX (602) 266-3870	
NAME	HOME PHONE
ADDRESS	WORK PHONE (OR CELL PHONE)
CITY	DATE OF BIRTH
STATE/ZIP	SOCIAL SECURITY #
EMPLOYED (CIRCLE ONE) YES NO	MARITAL STATUS
EMPLOYER	SPOUSE NAME
NAME OF PRIMARY CARE PHYSICIAN	
PRIMARY INSURANCE	SECONDARY INSURANCE (IF ANY)
MAILING ADDRESS FOR CLAIMS (ON INSURANCE CARD)	MAILING ADDRESS FOR CLAIMS (ON INSURANCE CARD)
GROUP/ ACCOUNT #	GROUP/ ACCOUNT #
IDENTIFICATION #	IDENTIFICATION #
POLICYHOLDER'S NAME (IF OTHER THAN PATIENT)	POLICYHOLDER'S NAME (IF OTHER THAN PATIENT)
POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S DATE OF BIRTH
POLICYHOLDER'S SOCIAL SECURITY	POLICYHOLDER'S SOCIAL SECURITY
POLICYHOLDER'S EMPLOYER	POLICYHOLDER'S EMPLOYER

Urology Associates, Ltd.
HIPAA Consent to Use Protected Health Information
For Treatment, Payment and Health Care Operations

I consent to allow Urology Associates, Ltd. to use or disclose my protected health information for treatment, payment and health care operations.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.

Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.

Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Urology Associates, Ltd.

I consent to allow Urology Associates, Ltd. to disclose my protected health information for treatment activities of another health care provider.

I consent to allow Urology Associates, Ltd. to disclose my protected health information to any Urology Associates, Ltd. Facility or Provider or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Urology Associates, Ltd. to disclose protected health information to another Urology Associates, Ltd. Facility or Provider for health care operations activities, provided that Urology Associates, Ltd. and the other Urology Associates, Ltd. has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations or for the purpose of health care fraud and abuse detection or compliance.

____________________________ ____________________________

(Please Print Patient Name) (Signature of Person Authorizing Consent)

____________________ __________________________

Relationship to patient Date

I hereby acknowledge that I have been presented with a copy of Urology Associates, Ltd. Notice of Privacy Practices.

____________________________ ____________________

Signature of Person Authorizing Consent Date

At times patients may wish to have information regarding their medical condition(s), lab reports, medications, appointment times, etc., discussed verbally with other individuals such as a spouse, other family member, friend, or caregiver in the office or by telephone. If this applies to you, please indicate below any person whom you authorize us to verbally release information regarding your care at Urology Associates, Ltd.
If this does not apply, initial here________

Name________________________ Relationship____________ Phone________________

Name________________________ Relationship____________ Phone________________