ATLANTIC UROLOGY ASSOCIATES, PC — CENTER FOR NO-SCALPEL VASECTOMY ™

Patient Information

Name (Last, First, MI)		Today's Date
Street Address *(if PO Box also give physical home address)* APT #		Marital Status: Single Married Divorced Widowed Separated

City	State	Zip	Gender: Male Female	Date of Birth
Social Security #	Daytime Phone ( )	Evening Phone ( )	Cell Phone ( )	
Occupation:	Employer Name and Address:		If Student: Full time Part Time	

Insurance Information

* Please give your insurance card ***and*** drivers license or picture ID to the receptionist to be copied *

Name of Primary Insurance Company	Policy #	Group #
Please indicate the policyholder for the primary insurance: Self Spouse Parent Other ________		
Name of Secondary Insurance Company	Policy #	Group #
Please indicate the policyholder for the secondary insurance: Self Spouse Parent Other ________		

Spouse's information or Parent's information *(if Patient is covered by parent's Insurance)*	**Emergency Contact**	**Referral Info How did you hear about us?**
Spouse's or Parents Name ____________ In case of an emergency, we may contact this person: Yes No	*Please list the nearest living relative or friend not living in your household* In case of an emergency, we may contact: Name ____________ Daytime Phone ( ) ____________ Evening Phone ( ) ____________ Relationship to Patient	From a Current/Prior Patient Name ____________ Internet Practice web site- www.vasectomynj.com www.Vasectomy.Com Goggle search Other Web avenue ____________ Newspaper Which one? ____________ From a physician Name ____________ Town ______ Yellow pages Referred by health plan/insurance directory
Spouse's or Parent's Date of Birth *(Required if covered by their insurance)*		
Spouse's or Parents Employer *(Required if covered by their insurance)*	*Your Primary Care Physician is: NAME* ____________ *Town* ____________	

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION and ACKNOWLEDGMENT of RECEIPT OF NOTICE OF PRIVACY PRACTICES and FINANCIAL/ CANCELLATION POLICY

Please read the following and sign below:

Assignment of Benefits and Release of Information: By signing below, I hereby assign all insurance benefits to which I am entitled including Medicare and/or any other insurance or health plans to Jeffrey I. Silverstein, M.D. and/or AUA, PC. I authorize Dr. Silverstein and/or AUA, PC to release to the Health Care Financing Administration, its agents or to other insurance company any information that is in the record and is necessary to secure payment.

Notice of Privacy Practices Acknowledgment By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Financial and Cancellation Policy Acknowledgment I understand that by signing below, I agree to abide to the financial and cancellation policy described herein. I am financially responsible for all charges including any copay, deductible, non-covered service, or any charges not paid by the insurance company. I understand that if my insurance requires a referral or precertification and I do not have same, I will be responsible for the charges.

Co-payments, deductibles, non-covered services, and past due balances are due at the time of service. I understand that it is my responsibility to inform this office if there is a change in my health insurance. Payment in full will be due at the time of service if I do not have insurance, if this office does not participate in my plan, or if the services are not covered under my plan. **Cancellation policy**: Office Visit: The office requires at least 24 hours notice when canceling an office visit appointment. Failure to provide this notice will result in a $ 75.00 charge. In- office Procedure: A $150.00 fee will be charged if I cancel a procedure with less than 48 hours notice. Returned Check Fee $40.00. **Overdue accounts**: Outstanding balances are due upon receipt of statement. An interest charge of 1.5% per month will be added to unpaid patient balances. I understand that if account goes to collections for non-payment I will be responsible for all court and legal fees. Additionally, if I had an in-network discount applied to fees and I breech my responsibility to pay balances due under the terms of my insurance agreement, then as a result of that breech I will forfeit any and all such discounts and I will be responsible for the full fee of services rendered.

X____________________________ Date:____________

Signature of Patient or responsible Party

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ATLANTIC UROLOGY ASSOCIATES, P.C.

Center for No-Scalpel Vasectomy

JEFFREY I. SILVERSTEIN, M.D.

Diplomate American Board of Urology

PRINT YOUR NAME: ______________________________ **Today's date:** ________

1. Describe current medical problem/reason for today's visit:

____

____

____

2. Describe all **MEDICAL PROBLEMS** you have had or are under treatment for:

Diabetes Mellitus NO YES

Specify: ________

High Blood Pressure NO YES

Stroke NO YES

Lung disease NO YES Specify: __________

Congestive Heart (CHF) NO YES

Angina/ Chest pain NO YES Specify: __________

Heart valve disease NO YES Specify: __________

Heart Attack (MI) NO YES WHEN? __________

Kidney disease NO YES Specify: __________

(male) Prostate disease NO YES Specify: __________

Cancer NO YES

Arthritis NO YES

Seizures NO YES

Hepatitis NO YES Specify: ________

HIV/ AIDS NO YES

other (please list)

3. List other physicians currently treating you: ______________ ______________ ______________

4. List any **SURGERY** you have had and date performed:

Operation	Date	Operation	Date
____________	________	____________	________

5. List all **MEDICATIONS** you take: (If you have list we would like to make copy. Copy on chart ☐) ____________________

____

____

Do you take Aspirin regularly? ☐YES ☐NO

6. List all your known **ALLERGIES:** ______________________________

Check If Applies: Are You Allergic To: Latex ☐ Shellfish ☐ X-Ray Dye☐

7. **SOCIAL HISTORY:**

Do You Smoke? NO YES How Much? ______________ QUIT When? ______

Do You Drink Alcohol? NO YES How Much? ______________

Have you ever used recreational (non-prescribed) drugs? NO YES What Type?_____________

Are You: Married Single Widowed Divorced

Females: When was your last menstrual period?_______________________

Are you pregnant? YES NO
Are you planning a pregnancy? YES NO
Have you had a hysterectomy? YES NO or tubal ligation YES NO?

8. **FAMILY HISTORY**:
   Check If Applies: Prostate Cancer☐ High Blood Pressure☐ Heart Disease☐ Diabetes☐
9. Please provide us with your **Pharmacy**
   Name:__________Town__________Phone:____________
10. Please give details explaining **any additional information** that you feel may be important:____________

____

____

____

REVIEWED BY DR.________

Atlantic Urology Associates, PC
Review of Systems Questionnaire

PATIENT NAME: ____________________________
DATE: ____________________________

Constitutional	Yes	No
Feeling tired		
Fever		
Chills		
Recent weight loss (lbs _______)		
Recent weight gain (lbs _______)		

Ear, Nose, Throat	Yes	No
Nasal congestion		
Post-nasal drip		
Sore throat		
Earache (right)		

Urinary	Yes	No
Pain during urination		
Increased frequency of urination		
Blood in urine		
Urinating more than 1 time at night		

GI	Yes	No
Decreased appetite		
Abdominal pain		
Nausea		
Vomiting		
Diarrhea		
Constipation		
Heartburn		
Blood in stool		

Male History (men only)	Yes	No
Difficulty with erections		
Discharge from penis		
Hx of STD		
Hx of prostate infection		

Skin / Musculoskeletal	Yes	No
Skin rash		
Neck pain		
Back pain		
Joint pain		

Chest	Yes	No
Difficulty swallowing		
Cough		
Shortness of breath		
Palpitations		
Chest pain or discomfort		

Hemo / Endocrine	Yes	No
easy bruising tendency		
Excessive sweating		
Sweating heavily at night		
Excessive thirst		
Temperature intolerance		

Neuro / Eyes	Yes	No
Headache		
Dizziness		
Ringing in the ears		
Numbness		
Decrease in strength		
Red eyes		
Sleep disturbances		
Depression		
Anxiety		

Gynecological (women only)	Yes	No
Unexplained vaginal bleeding		
Vaginal discharge		
Vaginal pain		
Vaginal itching or burning		

REVIEWED BY DR. ______________

ATLANTIC UROLOGY ASSOCIATES, PC

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 provide 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
- Your privacy rights in your IIHI
- Our obligations concerning the use 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. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Jeffrey I. Silverstein, M.D.
495 Iron Bridge Road, Suite 11
Freehold, NJ 07728
732 683-1617

C. 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 IIHI 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 IIHI in order to write a prescription for you, or we might disclose your IIHI 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 IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI 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 IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI 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 IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI 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 IIHI to other health care providers and entities to assist in their health care operations. The practice may call you by name in the waiting room when your physician is ready to see you.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment. This includes the leaving of appointment reminder information on your telephone answering machine.

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

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

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you.

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.

D. 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 the 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 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 an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

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.

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.

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 <u>except when</u> 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 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.

E. 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 **Jeffrey I. Silverstein, M.D.** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

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 for 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 to **Jeffrey I. Silverstein, M.D.** 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 writing to **Jeffrey I. Silverstein, M.D.** in order to inspect and/or obtain a copy of your IIHI. Our practice will need to 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. To request an amendment, your request must be made in writing and submitted to **Jeffrey I. Silverstein, M.D** 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 **Jeffrey I. Silverstein, M.D.** 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 will need to 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 at any time. To obtain a paper copy of this notice, contact **Jeffrey I. Silverstein, M.D. 732 683-1617**.

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. To file a complaint with our practice, contact **Jeffrey I. Silverstein, M.D.** 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 to 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.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Jeffrey I. Silverstein, M.D. 732 683-1617.**

This notice was published and becomes effective on April 14, 2003.