Acknowledgement of Receipt of Notice of Privacy Practices

Urology Associates Of Silicon Valley
555 Knowles Drive Los Gatos, CA 95032
(408) 871-1200

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

Notice of Privacy Practices

Urology Associates Of Silicon Valley
555 Knowles Drive Los Gatos, CA 95032
(408) 871-1200

Effective Date: April 14, 2003

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.

The AIG American General Health Plan* (referred to as "we" or "the Plan") is required by federal law to provide you with this notice about your rights and our legal duties and privacy practices with respect to your personal medical information. We must follow the terms of this notice while it is in effect. Some of the uses and disclosures described in this notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

HOW WE USE AND DISCLOSE YOUR MEDICAL INFORMATION

We have the right to use or disclose your personal medical information to facilitate the payment of your covered health expenses and to operate the plan. The following examples illustrate some of the ways we may use your information:

- To process claims or be reimbursed by another insurer that may be responsible for payment.
- To conduct quality assessment activities or administrative activities, including data management or customer service.

We must use or disclose your personal medical information:

- When required to do so by law.
- Do you or your designated representative upon request.

We may use or disclose your personal medical information:

- If you are enrolled through a group health plan, to provide summaries of claims and expenses for enrollees in group health plan to the plan sponsor, who may be an employer or an association.
- To mail materials regarding plan benefits and other materials containing your personal medical information to the address we have on record for the subscriber of the health plan.
- To public health agencies to prevent or control disease, injury or disability.
- To government oversight agencies for activities authorized by law.
- In response to a court or administrative order, a subpoena, a discovery request or other lawful process.
- To a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- For research purposes, provided certain measures have been taken to protect your privacy.
- When necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- To the extent necessary to comply with state law for workers' compensation programs.

Other uses or disclosures of your personal medical information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the plan.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding your personal medical information:

- To review or obtain copies of your personal medical records, with some limited exceptions. Your request to review and/or obtain a copy of your personal medical records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- To request an amendment of your personal medical information, if you feel that information maintained by the plan is incorrect or incomplete. Your request must be made in writing and must include the reason you are seeking a change. If we deny your request, you may have a statement of your disagreement with our decision added to your medical information.
- To request a listing of the plan's disclosures of your personal medical information. The list will not include our disclosures related to our payment or health care operations, disclosures made to you or with your authorization, or certain other disclosures, such as for national security purposes. Your request for a listing of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. The first listing of disclosures that you request within a 12-month period will be free.
- To request that we restrict or limit how we use or disclose your personal medical information for payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing and must clearly state (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- To request that we use a certain method to communicate with you about the plan in a different manner or send plan information to a different place. Your request to receive confidential communications must be made in writing and must clearly state (1) that all or part of the communication from us could endanger you and (2) how or where you wish to be contacted. We will accommodate all reasonable requests.
- To receive a paper copy of this notice.

You may exercise any of the rights described above by contacting our privacy office. See the end of this notice for the contact information.

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the United States Department of Health and Human Services. All complaints to the plan must be made in writing and sent to the privacy office listed at the end of this notice. *We will not retaliate against you or penalize you for filing a complaint.*

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice at any time, effective for personal medical information that we already have about you as well as any information that we receive in the future. If you have any complaints or questions about this notice or you want to submit a written request to the plan as required in any of the previous sections of this notice, please contact our office.

PATIENT INFORMATION: (Mr. Mrs. Ms.) DATE:_____

Last Name:_____First Name_____MI___AGE_____

Address:_____City_____Zip_____

e-mail (optional)_____

Birthdate_____Phone _____Sex_____Soc Sec_____

Name of Employer_____Phone_____Ext_____

Spouse_____Birthdate_____

Name of Employer_____Phone_____

If Minor-Name of Mother and Father_____

Mother's Place of Employment_____Phone_____

Father's Place of Employment_____Phone_____

Name of your Primary Care Doctor_____

INSURANCE INFORMATION

Does your insurance require authorization for office visits?_____

Primary Insurance:_____Effective:_____

Address:_____City_____State _____Zip_____

ID#_____Group_____Co Pay_____

Name of Policy Holder_____Relationship_____Birthdate_____

2ND Insurance:_____Effective_____

Address:_____City_____State_____Zip_____

ID#_____Group_____Co Pay_____

Name of Policy Holder_____Relationship_____Birthdate_____ ____

OVER

To All Our Patients:

Due to the fact insurance contracts change frequently it is **Your responsibility** to check with your insurance company before each visit to see if we are members.

_____ _____

Signature Date

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize release of patient information.

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment shall be considered as a valid an original. I understand that I am responsible for all charges for services rendered. Any amount unpaid by my insurance, such as deductible, co-payment or balance not covered, is my responsibility.

If this account is assigned to an attorney or collection agency, the prevailing party shall be entitled to attorney's fee, collection fee's and related costs. All accounts 90 days past due may be subject to service charge of 1.5% per month (18%APR).

_____

SIGNED (responsible party) Date

MEDICARE EXTENDED AUTHORIZATION
"SIGNATURE ON FILE"

_____

NAME (please print) MEDICARE #

I request that payment of Medicare benefits be made either to me or to my doctor at Urology Associates of Silicon Valley for services rendered to me for one year from the date of this form. I authorize the release of information, as necessary to satisfy submitted claims, by the above named medical office to Medicare.

_____

PATIENTS SIGNATURE DATE