P.A.R.C. Urology

PATIENT INFORMATION

Name: _____

Address: _____

_____

City, State, Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Date Of Birth: ___/___/_____ [ ] Male [ ] Female

Best email to contact: _____

Ethnicity: [ ]Hispanic or Latino [ ] Not Hispanic or Latino

Race: [ ]American Indian or Alaska Native [ ]Asian [ ]Black or African American

[ ]Native Hawaiian or Other Pacific Islander [ ]White

Preferred Language Spoken: [ ]English [ ]Spanish [ ]Other

GUARANTOR (person responsible for bill)

[ ] Same as Patient

Name: _____

Address: _____

_____

City, State, Zip: _____

Employer: _____

Phone: _____

Date of Birth: _____

PRIMARY INSURANCE

[ ] SELF PAY/ NO INSURANCE

[ ] Same as Patient [ ] Spouse [ ] Parent [ ] Not Applicable

Insured's Name: _____

Insured's Date of Birth: _____

Insurance Name: _____

Insured's ID: _____

Policy Group: _____

SECONDARY INSURANCE

[ ] Same as Patient [ ] Spouse [ ] Parent [ ] Not Applicable

Insured's Name: _____

Insured's Date of Birth: _____

Insurance Name: _____

Insured's ID: _____

Policy Group: _____

AUTHORIZATION

I hereby authorize any and all insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I also authorize the physician to release any information required by above insurance company. I authorize treatment by PARC Urology and staff.

Patient or Responsible Party Authorization

_____

By writing your name you signify your authorization.

PARC UROLOGY

Welcome to PARC Urology. We strive to provide excellent, compassionate service to you and your loved ones. In order to provide this high level of service and better your healthcare experience, we have some policies that we would like to share with you. By signing, you agree to our policies.

➡We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance. If you have a change of address, telephone numbers, employer, or insurance please notify our office as soon as possible.

➡If we do not participate with your insurance company and you have out-of-network benefits we will verify those benefits with your insurance. You will be expected to make payment in full at the time service is rendered. If your insurance denies our charges or refuses payment for services rendered the insurance portion will be transferred to the patient portion and billed to the responsible party on the patient's account. If we do not participate with your insurance and you do not have out of network benefits please be sure to make private pay arrangements with our office prior to your first visit.

➡We will collect your co-payment, patient responsibility, and/or charge for non-covered services at the time of your visit or before a scheduled procedure. If you have a balance after an insurance payment from a previous service we will also ask for that payment. We accept cash, cashiers checks, check payments for balances under $100.00, Visa, MasterCard, and Discover. Patient care is our top priority, however payment is due for services rendered. If your account becomes delinquent we reserve the right to refer your account to a collection agency.

➡Insurance Billing: If we participate with your plan, we will bill your insurance for you. Your plan provider can verify if we are in-network with your insurance plan. If your plan requires you to have an authorization to see a specialist, you need to obtain that prior to visiting our office.

➡Self-Pay Patients: Patients with no insurance will be expected to pay in full before services are rendered. There are no exceptions to this rule.

➡Your insurance is a contract between you (in some cases, your employer) and your insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection of a code or claim which the American Medical Association considers payable does not relieve you of your financial obligation. Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact us at 214-618-4405.

➡Our office uses secure electronic auto-reminders, electronic patient messaging, and secure attachments. Should you wish to opt out of these services please notify us in writing here.

➡Your health information may be entered into a quality database to assist the physicians in understanding of the patients condition and/or help with medical research. Medical documentation and medical images may be used in publications for educational purposes. This will allow providers to improve in quality care.

➡No show or missed appointments: When an appointment is scheduled with the Physician and/or Nurse Practitioner, time is specifically allocated for you. If the appointment is not canceled in advance, we cannot offered that time to another patient. We appreciate a minimum of 48 hours advance notice if you believe you need to cancel or change your appointment. Failure to do so may result in a $10.00 fee applied to your account.

➡Rescheduling Surgery: Due to the large block of time reserved for your procedure, last minute cancellations can create access-to-care problems as well as significant expenses to our office, the hospital, and the anesthesiologist. If you need to cancel or change your surgery date, please contact our office at least 2 weeks in advance. If you fail to show up for a surgery, or if you call to reschedule or cancel a surgery with less than 14 days prior notice you will be charged a $250.00 change fee. This fee is not covered by insurance and must be paid in full prior to rescheduling the surgery. We understand that extenuating circumstances may occur and fees in these instances may be waived subject to management approval.

➡Choice of Law and Forum required provision (HB270): The patient, including patient's representative and heirs or beneficiaries, and PARC Urology, including the employees and agents of PARC Urology, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to the patient; and in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall be brought only in a Texas court in the county/district where all or substantially all of the health care was provided or rendered, and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

I have read and have full understanding of the policies of PARC UROLOGY.

_____	_____	_____
Patient Signature	Patient Name (Printed)	Date
_____	_____	_____
Patient Representative Signature	Name and Relation To Patient	Date

P.A.R.C. *Urology*

PF-1000 Notice of Privacy Practices

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to- day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail and/or the US mail.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

☐ By checking this box and writing your name below you signify your acknowledgement of the receipt of our notice of privacy practices.

Signature (Responsible party please also include the patient name) _____ Today's Date _____

Individual Rights
You have certain rights under the federal privacy standards. These include:
- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Practice Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address shown below. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address shown below. You will not be penalized or otherwise retaliated against for filing a complaint.
You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:
Whitney Wells
PARC Urology
5680 Frisco Square Blvd, Suite 2300
Frisco, TX 75034
214-618-4405

Effective Date
This Notice is effective on or after 09/02/14.

PARC UROLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As our patient, under HIPAA, you have specific privacy rights. We are required by law to attempt to obtain acknowledgement of receipt of "Patient Notice of Privacy Rights".

We are required to have a notice available for our patients detailing how medical information about you may be used and disclosed and how you can get access to this information. You have a right to review our notice before signing this acknowledgement. A copy of our "Patient Notice of Privacy Rights" is posted in our waiting room and is made available from the receptionist to each patient. The terms of our notice may change. Any change in our notice will be posted in our waiting room.

A summary of your rights includes your right to:

Restrict the use and disclosure of health care information (but your doctor is not required to grant this type of request)
Receive confidential communications in an alternate form or location
Inspect, copy, and amend protected health information (you may be billed for the cost of copying)
Know about any unauthorized disclosure of protected health information
Have a copy of our patient privacy notice

I acknowledge the receipt of a copy of the "Notice of Privacy Practices" from PARC Urology.

_____

Printed Name Signature Date

_____

Patent Representative Signature (If patient is minor) Name and Relation to Patient Date

LOC STAFF ONLY

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

This notice and acknowledgement was mailed to the patient's home on _____/_____/_____ or presented to the patient in person on _____/_____/_____.

The acknowledgement was not obtained because:

- The patient refused to sign the acknowledgement
- The patient was undergoing emergency treatment
- Other:_____

_____

Printed Name of Staff Member Signature Date