



To streamline the process of completing forms, ASUI has placed the required patient acknowledgments at the top of the new patient packet for your signature. Detailed agreements for each section are included within the packet and can be accessed anytime through your patient portal.

Acknowledgement of Receipt of Notice of Privacy Practices

[CL_NAME] is commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our Practice and outlines your rights with regard to your health information. Please sign this form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Arizona State Urological Institute, LLC.

Patient Name:

Signature of Patient or Personal Representative:

Date:

Notice of Health Information Practices and Acknowledgement

(Participant) participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information.

I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

Patient Name:

Signature of Patient or Personal Representative:

Date:

Acknowledgment of Receipt of Patient Financial Responsibility Agreement

Patient Authorizations: By my signature below:

- I hereby authorize ASUI and the physicians, staff, labs and facilities associated with ASUI to release necessary medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- I hereby assign my financial benefits directly to ASUI for all items and services rendered by or on behalf of ASUI, to the maximum extent permitted by law. I understand that I am financially responsible for charges not covered by this assignment.
- I understand the physicians that treat me may have a financial interest in the facility they refer me to including, but not limited to, surgery centers, lithotripsy centers, pathology labs, and other medical and non-medical related entities.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Agreement:

Patient Name:

Signature of Patient or Personal Representative:

Date:

For Male Patients Only! Acknowledgment of Receipt of Insurance Payment Guidelines for Erectile Dysfunction, Low Testosterone, Peyronie's Disease and Sterilization Patient Agreement

Patient Agreement:

As the patient and/or responsible party, I acknowledge that my health plan(s) may not cover services related to Erectile Dysfunction, Testosterone Deficiency, Infertility, Sterilization, Peyronie's Disease or associated diagnoses. I confirm that I have been informed of this policy and agree to its terms by signing this agreement prior to reviewing the treatments described. I understand that my insurance will be billed; however, if coverage or payment is denied, I accept full financial responsibility for all charges incurred for services provided by ASUI.

To avoid any misunderstanding, please review and sign the following statement:

"I understand that if I receive treatment for Erectile Dysfunction, Impotence, Infertility, Sterilization, Peyronie's Disease or related diagnoses, and my insurance denies payment, I will be fully responsible for all related charges. I also understand that ED samples (such as Viagra, Cialis, or Levitra) are limited and may not be covered by my insurance."

Patient Name:

Signature of Patient or Personal Representative:

Date:

Intake Forms

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Gender: _____

Social Security Number: _____

Address: _____ New Address: _____

Telephone: _____ Unchanged New Telephone: _____

Cell Phone: _____ Unchanged New Cell Phone: _____

Email Address: _____ Unchanged New Email Address: _____

Marital Status: _____ Unchanged Married Single Divorced Widowed

Employer Name: _____ Unchanged New Employer: _____

Employer Phone: _____ Unchanged New Work Number: _____

APPOINTMENT REMINDERS: *(Please select the option you wish to receive appointment reminders.)*

I request to receive appointment reminders via Text Message I request to receive appointment reminders via email

I Decline currently to receive appointment reminders

PROVIDER INFORMATION:

Unchanged-Current Primary Care Physician: _____ Phone: _____

New-Primary Doctor: _____ New Primary Care Phone : _____

POLICY HOLDER INFORMATION: *If you have new insurance, please provide the insurance information and cards to the representative at the desk.*

Primary Insurance:	ID Number:	Group Number:	PO Box Address:
Phone Number:	Policy Holder Name:	Relationship to patient:	Date of Birth:
Secondary Insurance:	ID Number:	Group Number:	PO Box Address:
Phone Number:	Policy Holder Name:	Relationship to patient:	Date of Birth:

PATIENT CONTACT LIST: Emergency Contact: Indicate any person who should be notified in case you experience a medical emergency while at our office.

Unchanged-Current Emergency Contact: _____ Phone: _____ Relation to Patient: _____

New -Emergency Contact: _____ Phone: _____ Relation to Patient: _____

SPOUSE/ PARENT/ LEGAL GUARDIAN DETAILS:

Unchanged-Current Contact Name: _____ Phone Number: _____ Relation to patient: _____

New- Contact Name: _____ Phone Number: _____ Relation to patient: _____

SOCIAL HISTORY:

Do you have children? No Yes, how many? _____

Do you currently smoke? No Yes, how much? _____

Are you a former smoker? No Yes, how many years did you smoke? _____

Do you chew tobacco? No Yes, how much do you chew? _____

Do you drink alcohol? None Socially 1-2 per day 3-4 per day Over 4 per day

Do or have you used illegal drugs? No Yes, what kinds and when? _____

Are you sexually active? No Yes

Have you ever had a sexually transmitted disease (STD)? No Yes, list types and dates below.

Types: _____ Date(s): _____

AUTHORIZATION TO DISCLOSE PROTECT HEALTH INFORMATION:

Arizona State Urological Institute (ASUI) is committed to protecting your privacy and ensuring that your health information is used and disclosed properly. **List people with whom you authorize ASUI to discuss your healthcare and protected health information.**

First and Last Name:

Relation to patient:

Phone number:

First and Last Name:

Relation to patient:

Phone number:

Please select a security question. ASUI will verify with the individuals who are authorized to access and discuss your medical records/ results with our office. <input type="checkbox"/> Security Question: _____ <input type="checkbox"/> Security Pin Code: _____ <input type="checkbox"/> Security Phrase: _____ Answer: _____	May we leave Protected Health Information & results on your voicemail? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list what phone number we may leave information on: _____
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PAST MEDICAL HISTORY:

No past medical history

Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Panic Attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	TB	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	IBS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: (please specify)					

Have you received a Pneumococcal Vaccine in the past? No Yes, when was the last injection date: _____

Have you received the Influenza Vaccine? No Yes, when was the last injection date: _____

FAMILY MEDICAL HISTORY: NONE Unknown

	Mother	Father	Siblings	Paternal grandmother	Paternal grandfather	Maternal grandmother	Maternal grandfather
Cancer							
Diabetes							
Heart Disease							
High Blood Pressure							
Lung Disease							
Stroke							
Other:							

SURGICAL HISTORY: NONE

Surgeries / Hospitalizations:	Dates:

MEDICATION HISTORY: No, I do not take medications yes, I do take medications and are listed below:

Medication Name:	Dosage & how often taken:	Reason for taking medication:

ALLERGIES: No known drug allergies yes, I do have drug allergies and are listed below:

Medication Name:	Reaction to medication:

PHARMACY INFORMATION:

Pharmacy-Local

Phone Number:

Cross Streets:

Pharmacy-mail order

Phone Number:

Fax Number:

REVIEW OF SYSTEMS:

Constitutional Symptoms

- Appetite Change No Yes
- Weight Gain No Yes
- Weight Loss No Yes
- Fatigue No Yes
- Fever No Yes
- Chills No Yes

Skin

- Hives No Yes
- Itching No Yes
- Rash No Yes

Allergy/ Immune

- Cancer No Yes
- Seasonal Allergies No Yes

Ears/Nose/Mouth/Throat

- Hearing Changes No Yes
- Nose Bleeds No Yes
- Tinnitus No Yes

Comments: _____

Eyes/Head

- Dizziness No Yes
- Headaches No Yes
- Vision Changes No Yes

Comments: _____

Respiratory

- Shortness of Breath No Yes
- Cough No Yes
- Bronchitis/Emphysema No Yes
- Wheezing No Yes

Comments: _____

Cardiovascular

- Edema No Yes
- Chest Pain/Discomfort No Yes
- Syncope/Loss of consciousness No Yes

Comments: _____

Gastrointestinal

- Bloody Stool No Yes
- Bowel Changes No Yes
- Abdominal Pain No Yes
- Nausea No Yes
- Heartburn No Yes
- Diarrhea No Yes

Genitourinary

- See HPI No Yes
- Decreased flow/force No Yes
- Vaginal Discharge No Yes
- Dysuria No Yes
- Pain with urination No Yes
- Weak urinary stream No Yes
- Constipation No Yes

- Diabetes No Yes

Comments: _____

Endocrine

Musculoskeletal

- Bursitis No Yes
- Gout No Yes
- Osteoporosis No Yes
- Muscle/Joints Stiffness No Yes
- Back Pain/Injuries No Yes
- Arthralgias/arthritis No Yes

Comments: _____

Neurological

- Epilepsy No Yes
- Palsy No Yes
- Speech No Yes
- Stroke No Yes
- Tingling No Yes

Hematologic/Lymphatic

- Anemia No Yes
- Easy Bruising No Yes

Comments: _____

All Other Symptoms: _____

**ARIZONA STATE UROLOGICAL INSTITUTE
NOTICE OF PRIVACY PRACTICES:**

About Us

In this notice, we use terms like "we", "us". or "our" to refer to Arizona State Urological Institute and its physicians, employees, staff, and other personnel. All of the sites and locations of Arizona State Urological Institute follow the terms of this notice and may share health information with each other for treatment, payment, or health care operations purposes as described in this notice.

Purpose

This notice describes how we may use and disclose your health information to conduct treatment, payment, or healthcare operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibility

We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We will abide by the terms of this notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use your health information to provide you with medical treatment or services. For example, your health information will be disclosed to those who participate in your care. We may also disclose your health information to your physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company, or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment of supplies used in the course of treatment.

We may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

For HealthCare Operations: We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and other essential activities.

We may ask you to sign your name on a sign-in sheet at the registration desk and we may call your name in the waiting room when we call you for your appointment. We may disclose your health information to a third party that performs services, such as billing and collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

Appointment Reminder: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail, or email you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. If you would like us to refrain from releasing your health information to a family member or friend, please notify the Practice Administrator; 2730 S Val Vista Dr. Building 13 Suite 177 Gilbert, Arizona 85295.

We are also allowed by law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state, or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful processes by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes: comply with a court order, warrant, subpoena, summons, or other similar processes.

- To identify or locate a suspect, fugitive, material witness, or missing person; About the victim of a crime, if unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and

-To report a crime, the location of a crime, and the identity, description, and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- To report adverse events, product defects or problems;
- To track FDA-regulated products;
- To notify people and enable product recalls; and
- To notify a person who may have been at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws.

Serious Threat to Health or Safety: If there is a serious threat to your health or safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

Workers' Compensation: We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety, or the health and safety of others, or for the safety of the correctional institute.

Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

Your rights Regarding Your Health Information

You have the following rights regarding health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment, or health care operations. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to the Practice Administrator; 2730 S Val Vista Dr. Building 13 Suite 177 Gilbert, Arizona 85295.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to the Practice Administrator; 2730 S Val Vista Dr. Building 13 Suite 177 Gilbert, Arizona 85295. We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or in use in, a civil, criminal, or administrative action or proceeding. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the Practice Administrator at 2730 S Val Vista Dr. Building 13 Suite 177 Gilbert, Arizona 85295. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing, or preparing the requested documents.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the Practice Administrator 2730 S Val Vista Dr. Building 13 Suite 177 Gilbert, Arizona 85295.

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us.

Right to any Accounting of Disclosures: You have the right to request an accounting of certain disclosures we make of your health information. Please note that certain disclosures, such as those made for treatment, payment or health care operations, need not be included in the accounting we provide to you. To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the Practice Administrator 2730 S Val Vista Dr. Building 13 Suite 177 Gilbert, Arizona 85295. Your request must state a time period that may not be longer than six years, and which may not include dates before 5/1/2020. The first accounting you request within a 12-month period will be free. For additional accounting, we may charge you for the costs of providing the accounting, we will notify you of the costs involved and give you an opportunity to withdraw or modify your request because any costs have been incurred.

ARIZONA STATE UROLOGICAL INSTITUTE

Notice of Health Information Practices:

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?

The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.
2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may “opt out” of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider. **Caution:** If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.
2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.
3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

ARIZONA STATE UROLOGICAL INSTITUTE

Patient Financial Responsibility Agreement:

Thank you for choosing Arizona State Urological Institute (ASUI) as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, phone number, name, insurance information, etc.)

Because insurance coverage varies, it is important that you understand your individual health plan and what it covers, including deductibles, coinsurance, and copays. We recommend that you call the customer service number on the back of your insurance card for any questions regarding your health insurance plan.

Patient Financial Responsibilities: We will bill your primary insurance company and any secondary insurance as a courtesy to you. In order to properly bill your insurance company, you must timely and accurately disclose all insurance information, including primary and secondary insurance plans, as well as any change of insurance information. Failure to provide timely, accurate and/or complete insurance information may result in you being responsible for the entire bill. We do our best to estimate your financial responsibility up front, but please understand this is

only an estimate. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits.

Copayments, Coinsurance, and Outstanding Balances: Copayments, coinsurance, deductibles and balances not covered by insurance are due prior or at the time services are rendered. Inability to pay at the time of service may result in having to reschedule your appointment. Payment can be made by check, cash, MasterCard, VISA, and Discover.

We cannot waive co-payment, deductibles, co-insurance or any service amounts defined as patient responsibility under the terms of our contractual agreement with your insurance plan. We are required to bill for services rendered. You will be asked to pay on any estimated out of pocket costs and past due balances at the time of check-in.

Account Balances: Our billing office will provide you with a monthly statement of all account activity including our charges, payments and contractual adjustments from your insurance carrier along with payments made by you. Please be aware that you will be charged a returned check fee for all payments, made by a personal check, that have been returned by your banking institution for any reason. Please note that failure to pay outstanding balances that are your responsibility may result in having to reschedule future appointments until the balances are paid in full. In addition, any unpaid delinquent balance may: (a) delay scheduling of future appointments; (b) result in your account being forwarded to a collection agency or collection attorney of our choice; (c) and/or termination from ASUI.

Referrals: Certain insurance plans require referrals to see a Specialist. It is your responsibility to obtain a referral from your primary care physician. Referrals must be presented at the time services are rendered, if applicable. As a courtesy, we will make efforts to obtain referrals and prior authorizations on your behalf. If you need to have a referral faxed to us, our office will provide you with our fax number. If your insurance plan requires you to have a referral or other authorization, and you fail to provide that to us, your appointment will be rescheduled or your claim for that date of service will be processed via opt-out benefits, if applicable.

Surgical procedures: You will be required to pay estimated out-of-pocket costs associated with your surgical procedure prior to the procedure. The amount you will be required to pay will be determined based upon your individual insurance plan and will include any deductibles, co-payments and co-insurance which your insurance carrier indicates that you will owe. We do our best to estimate your financial responsibility up front, but please understand this is only an estimate. In addition, you will be required to make arrangements to pay any other outstanding balances that you may owe to us at that time. Failure to do so may result in rescheduling your procedure. You may receive separate bills for services related to your surgical procedure provided by third-parties, which may include hospital fees, anesthesiology fees, surgical assist fees, laboratory fees, and/or radiology fees.

For self-pay patients, payment is due at check-in. The account balance is expected to be paid in full. We do our best to estimate your financial responsibility up front, but please understand this is only an estimate.

Diagnostic Testing: During the course of your medical treatment with ASUI, your urologist may request a tissue, blood or urine specimen be obtained for diagnostic testing. This testing is being performed in order to assist your urologist in the diagnosis and management of your urologic condition. Depending upon the requirements of your insurance coverage, these specimens may be processed at ASUI's in-house pathology laboratory or at a third-party laboratory, for example Quest or LabCorp. The costs of these laboratory tests vary depending upon the nature and complexity of each test. The cost for a diagnostic test, including the cost that you will be required to pay, if any, depends on your insurance carrier and the type of insurance coverage you have. Please note: 1) All charges for specimens processed at ASUI's laboratory will be included in the statement you receive 2) Charges for specimens processed at a third-party laboratory will be billed to you directly by that laboratory.

FMLA/Disability Form Completion: \$25.00 charge per form

Arizona Compliant Patient Appointment Cancellation & No-show Policy

To ensure prompt access to care for all patients and to minimize unused appointment times, Arizona State Urological Institute supports a cancellation and no-show policy in accordance with Arizona regulatory guidelines.

No-show/ Cancellation charges can vary depending on the type of visit/surgery.

Office Visit: \$100.00

Office procedures: \$150.00-\$250.00

Surgery (Hospital/Surgery Center) \$500.00

Imaging visits: \$500.00

Patient Authorizations: By my signature below:

• I hereby authorize ASUI and the physicians, staff, labs and facilities associated with ASUI to release necessary medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

- I hereby assign my financial benefits directly to ASUI for all items and services rendered by or on behalf of ASUI, to the maximum extent permitted by law. I understand that I am financially responsible for charges not covered by this assignment.
- I understand the physicians that treat me may have a financial interest in the facility they refer me to including, but not limited to, surgery centers, lithotripsy centers, pathology labs, and other medical and non-medical related entities.

ARIZONA STATE UROLOGICAL INSTITUTE

Male Patients Only!

Erectile Dysfunction, Infertility, Sterilization, and Peyronie’s Disease Acknowledgement

As you prepare for your visit with our Physicians, we must make you aware of a potential situation regarding insurance coverage for certain diagnoses and conditions which are commonly treated by Urologists.

It is possible that treatment for erectile dysfunction, impotence, infertility, sterilization, Peyronie’s Disease and related conditions may not be reimbursed by your insurance carrier. Typically, insurance carriers do not cover these types of services.

BCBS of Arizona typically does not cover certain Testosterone replacement therapies. For example, TESTOPEL pellets, or Testosterone Injections are or can be considered as experimental. **United Health Care Community Plan** (formerly APIPA) does not cover TESTOPEL pellets. We recommend and ask patients to contact your insurance to find out your coverage and individual plan(s) benefits.

In this case, you will be responsible for payment for any treatment you receive related to these conditions.

While some insurance plans do cover such treatment, there is no way for us to know in advance whether your carrier will, in fact, cover your treatments and or visits. ASUI advises all patients to contact their insurance plan(s) and discuss what coverage or guidelines that may be listed under your current plan.

If you are a Medicare patient, you should know that these services are generally a non-covered benefit.

Also, many plans do not cover medications that treat or are used for Erectile Dysfunction, Testosterone Therapy, Infertility and Sterilization.

While some insurance plan(s) do cover medications, others may have specific limitations or restrictions. ASUI advised all patients to contact their insurance carrier(s) and discuss your coverage regarding medications, limitations and / or restrictions. Others may also require specific step therapy or formulary guidelines which indicate patient(s) must try prior to approving a non-covered medication or medication that requires prior authorization.

Samples are extremely limited and may only be distributed up to one time as deemed necessary by the Physician or availability.

Patient Agreement:

I am the patient and or responsible party. I understand my health plan(s) may no pay for the services pertaining to Erectile Dysfunction, Testosterone Deficiency, Infertility, Peyronie’s Disease and Sterilization or diagnoses related to. I have been informed and have agreed with the policy by signing this agreement before reviewing the described treatments. I am aware that my insurance(s) will be billed. If my insurance denies coverage or payment for the services provided by ASUI, I am fully responsible for paying all charges / services provided by ASUI.

We ask you to sign the following statement so that there is no confusion regarding this issue:

“I understand that if I am ever treated for erectile dysfunction, impotence, infertility, sterilization or a related diagnosis, and that any of my insurance carriers refuse payment for this treatment, I am fully responsible for paying all charges incurred during my treatment. I also understand ED samples (**Viagra, Cialis, Levitra**) are very limited and my insurance may not cover such medications.”

Patient Printed Name or Personal Representative:

Today’s Date:

Signature of Patient or Personal Representative Signature:

Today’s Date: