Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS LLC

Appointment Policy

Thomas Cerasaro, MD | James Fogarty, DO | Walter Frank, MD | Timothy Gajewski, MD | Glenn Gangi, MD
Andrew Grudzinski, MD | Robert Jansen, MD | Kenneth Krzyzaniak, MD | Timothy Quillen, MD
Brian Roberts, MD | Neal Shore, MD | Joseph Wood, MD | Richard Young, MD
Kailen Gonzalez, PA -C | Debra Joyner, PA-C | Will Putnam, PA-C | Michelle Wirt, PA | Rebecca Crawford, AGACNP-BC
Jackie Flanegan, NP | Melanie Lawrence, NP | Leslie Oleskowicz, NP | Ashley Sarvis, NP

Atlantic Urology Physicians and staff are dedicated to providing the highest quality healthcare in a professional and timely manner. In order to provide this level of care it is important that our patients are informed of our office policies regarding appointments and assignment of benefits.

APPOINTMENT POLICY

- Patients should make financial arrangements prior to the appointment to pay co-pays, deductibles and any out of pocket expenses.
- Payment is due prior to services being rendered for deductible, co-pay and out of pocket expenses.
- Patients should arrive at least 15 minutes prior to their scheduled appointment.
- Our physicians are on call at the local emergency rooms. Your Physician may be delayed for a medical emergency. The office staff will give the patient the option to reschedule their appointment or wait for the Physician to return to the office.
- Minors must be accompanied by a parent or legal guardian.

Compliance with these policies will help assure that all patients are seen in a timely fashion.

ASSIGNMENT OF BENEFITS

- I hereby authorize payment of benefits be made directly to Atlantic Urology Clinics. I understand that some services may not be covered by my insurance. Therefore, I will be responsible for payment of any non-covered services as well as any balance not covered by my insurance. _____**Initials**
- I further understand that if my account is turned over to a collection agency a 30% fee will be charged to my account. _____**Initials**

I have read and agree to the above policies. I authorize the release of any medical or other information necessary to process insurance claims.

Patient/Guardian Signature: _____ Date: _____

AUC Representative Signature: _____

Staff Initials: _____

Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS LLC

Patient Registration Form

Patient Information

Last Name:_____ First Name:_____ MI:____ Suffix:_____

SS#_____ Sex: ☐ Male ☐ Female Date of Birth: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated Language:_____

Race: ☐ Caucasian/ White ☐ Black/African American ☐ Asian Native American ☐ Other:_____

Ethnicity: Hispanic, Latino, Spaniard, Mexican, Central American, South American, Latin American, Puerto Rican, Cuban, Dominican, Not Hispanic / Latino

Patient Mailing Address:_____ City:_____ St:_____ Zip:_____

Physical/Alternate Address:_____ City:_____ _____St:_____ Zip:_____

Email: _____ Phone #: _____ Work #: _____ Cell #:_____

Referring Physician:_____ Phone #:_____

Family Physician:_____ Phone #: _____

Pharmacy: _____ Location:_____ Phone #: _____

Emergency Contact:_____ Relationship: _____ Emergency Phone:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student (Full Time) ☐ Student (Part Time)

Employer/School: _____ May we contact you at work: ☐ YES ☐ NO

Spouse/Guarantor/Parent Information

Last Name:_____First Name:_____ MI:_____ Relationship:_____

Date of Birth:_____ Employer:_____ Work Phone #: _____

Insurance Information

Primary Insurance:_____ Policy Holder Name:_____

Policy Holder is: ☐Self ☐Spouse ☐Parent ☐Other: _____ Policy Holder Date of Birth_____

Policy #:_____ Group #:_____

Secondary Insurance:_____ Policy Holder Name:_____

Policy Holder is: ☐Self ☐Spouse ☐Parent ☐Other: _____ Date of Birth _____

Policy #:_____ Group #:_____

Authorization for release of information and to pay insurance benefits: Atlantic Urology Clinics, LLC is hereby authorized to lease information to healthcare providers that have referred me to this physician or who may benefit from this information in the future. I authorize release of medical information to my insurnace carrier, their utilization management agency, my employer, or any toher agency that may be assisting in payment for my care. In the event of hopitalization, I herby assign payment to Atlantic Urology Clinics, LLC for surgical and/or medical benefits otherwise payable to me.

_____ _____

Signature/Patient/Parent/Guardian Date AUC Staff Signature Date

Staff Initials: _____

Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS LLC

Medical Information Form

Name: _____Date: _____

Referring Doctor: _____Family Doctor: _____

Why are you seeing the doctor today?

_____

CURRENT MEDICATIONS - Please list ALL medications you are currently taking including over the counter meds

Drug Name:	**Strength:**	**Directions/How you take it:**

Attach list if necessary

Pharmacy Name: _____Phone #: _____

ALLERGIES - Please list ALL types (Drug, seasonal, pets, environmental foods)

_____

_____

PAST MEDICAL HISTORY- Please CIRCLE if you have or have had any of the following diseases or conditions:

Cardiovascular
Atrial Fibrillation
Congestive Heart Failure
Coronary Artery Disease
Stroke
Other: _____
_____

Endocrine/Metabolic
Diabetes Mellitus
Other: _____
_____

General
Hepatitis
Sleep Apnea
Other: _____
_____

Genitourinary
Kidney Cancer
Prostate Cancer
Other: _____
_____

GYN/OB
Breast Cancer
Other: _____
_____

HEENT
Glaucoma
Other: _____
_____

Neurological/Psychological
Multiple Sclerosis

Parkinson's
Stroke
Other: _____
_____

Respiratory
Pulmonary Embolism
Tuberculosis
Other: _____
_____

Tumors
Breast Cancer
Ovarian Cancer
Rectal Cancer
Other: _____
_____

Other: _____

Staff Initials: _____

Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS

Medical Information Form

SURGICAL HISTORY- Please CIRCLE if you have had any of the following surgeries and date of surgery:

Cardiovascular
CABG
Heart Surgery (Stents)
Other: _____
_____

Gastrointestinal
Appendectomy

Colon Resection
Other: _____
_____

Genitourinary
Biopsy Prostate
Brachytherapy
ESWL

Nephrectomy
Other: _____
_____

Musculoskeletal
Back Surgery
Other: _____
_____

Other: _____

_____

FEMALE PATIENTS ONLY

Date of last period:_____ # of Pregnancies:_____ # of Deliveries: _____

FAMILY HISTORY Please CIRCLE and indicate which family member has/had any of the following:
(Mother, Father, Siblings, Grandmother, Grandfather, Uncle, Aunt)

Arthritis_____ Leukemia_____

Bladder Cancer _____ Multiple Sclerosis_____

Cancer (site unknown) _____ Laryngeal Cancer_____

Depression_____ Prostate Cancer_____

Diabetes_____ Stroke_____

Heart Attack_____ Tuberculosis_____

Hypertension_____ Other_____

Kidney Cancer_____

Kidney Disease_____

SOCIAL HISTORY- Please provide the following information:

Marital Status: Please indicate years
_____ Single _____Married _____Separated _____Divorced _____Widowed _____Life Partner ____Common Law

Spouse Dependants: Please indicate # of each, if you have:

_____Sons _____Daughters _____Stepchildren _____Adopted _____Foster _____Parents _____Grandparents

Occupation:_____

Alcohol Consumption:_____None _____Yes Occasional/Social # of drinks per day _____

Tobacco per day:_____None _____Yes #_____Packs/day _____Cigarettes/day _____Smokeless Tobacco

If you previously stopped, When? _____

Recreational Drugs: _____None If yes, please list: _____

Staff Initials: _____

Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS LLC

Medical Information Form

REVIEW OF SYSTEMS:

Constitutional
Appetite Changes
Anorexia
Aches and Pains
Chills
Easy Bruising
Fever
Fatigue
Generalized Weakness
Insomnia
Night Sweats
Sleep Apnea
Swollen Glands
Weight Gain
Weight Loss

Eyes
Blind
Blurred Vision
Double Vision
Glaucoma
Pain
Worsening Eyesight

Allergic/Immunologic
Animal Allergies
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies

Neurological
Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems
Tremors

Endocrine
Diabetes
Excessive thirst
Pituitary Disease
Thyroid Disease
Tired/Sluggish
Too Hot/Cold

Gastrointestinal
Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Flatulence
Gas
Hemorrhoids
Indigestion/heartburn
Irregular Bowel Movements
Nausea/vomiting
Rectal Bleeding
Tarry Stool

Cardiovascular
Chest Pain/Angina
Dyspnea on Exertion
Edema
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Mitral Valve Prolapse
Orthopnea
Pain/Cramps Hips/Legs w/exercise
Palpitation
Skipped Heart Beats
Swelling

Skin
Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin rash

Musculoskeletal
Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain/Stiffness

Ear/Nose/Throat
Ear Infection
Sinus Problem
Sore Throat

Genitourinary
Back Pain
Bedwetting
Blood in Urine
Dribbling
Burning on Urination
Erection Problems
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Leak after voiding
Nocturia
Nocturnal Enuresis
Not Emptying
Painful Ejaculation
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge/Problems
Weak Stream

Respiratory
Asthma
Emphysema-Bronchitis
Environmental Allergies
Frequent Cough
Pneumonia
Shortness of breath
Tuberculosis
Wheezing

Hematological/Lymphatic
Swollen Glands
Blood clotting problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickle Cell

Psychologic
Anxiety
Depressed
Generally satisfied with life
Other:

_____
_____
_____
_____
_____
_____
_____

Staff Initials: _____

Patient name:_____Account#:_____

Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Medical Record Number
Address (Street, City, State, ZIP Code)		Telephone Number

I request that my health information or medical billing record be disclosed or restricted, as follows:

I authorize the names listed below to have access to my medical Information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

Authorized Name	Relationship to Patient

*DO NOT discuss or provide information to the following individuals or entities:

Restricted Name/Entity	Relationship to Patient

*I request the use of ONLY the following address and/or phone number(s) to contact me regarding my health or billing information:

_____

_____

_____

Patient Rights: Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such personÕs involvement with the patientÕs care; and disclosures of protected health information to notify or assist inthotification of a family member, a personal representative, or another person responsible for the care of the patient of the patientÕs locationgeneral condition, or death. All requests for restrictions must be submitted in writing.

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient

_____

DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:

*Granted _____ Denied _____

*If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s).

Reason(s) for Denial, if Applicable _____

_____

_____

Physician Office Representative: Date:

Staff Initials:_____

Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS LLC

AUC Insurance and Collection Policy

Atlantic Urology Clinics participates with the following insurances:

Absolute Total Care	Humana Choice Care (No HMO)	Railroad Medicare
Aetna (No HMO)	Medcost	Select Health AKA First Choice
BCBS	NC Medicaid	Tricare
Blue Choice	SC Medicaid	United Healthcare (No HMO)
Cigna	NC Medicare	United Healthcare Comm Plan
Coventry Health Care	SC Medicare	
Department of Energy	Multiplan	

Atlantic Urology Clinics will submit claims to your primary carrier on your behalf. We will file a single claim to your secondary insurance as a courtesy. The insurance contract is between the patient and their insurance carrier. After 70 days of non-payment from the secondary carrier the balance will become the patient's responsibility. _____**Initials**

Eligibility is verified prior to your visit. Deductibles, co-pay and coinsurance are due at the time services are rendered. _____**Initials**

Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS LLC

Frequently Asked Questions

What is the difference between deductibles, copayments and co-insurance?

A deductible is the amount of covered medical expenses you will pay out of your own pocket each calendar year before benefits begin to be paid by your plan. The deductible amount is set by the insurance carrier. A copayment is the fee charged to you for a covered medical expense. The coinsurance is a percentage due by the patient set forth by your carrier.

How does my out-of-pocket expense work?

An out-of-pocket maximum is the total amount you will need to pay on your own before your plan benefits are paid in full.

If I receive a denial from my insurance as a non-covered service who should I contact?

Contact your insurance carrier. The contact information should be on the back of your insurance card.

Who should I contact if I have a billing question?

You may contact our billing office at 843-347-8600. Please listen carefully to the menu so that you reach the representative that is assigned to your account.

Staff Initials: _____

Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS LLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge:

I hereby acknowledge: A copy of the Notice of Privacy Practices was given to me. If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____

SIgnature of Patient or Represenative Date

_____

Print Name

****

FOR OFFICIAL USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgment was not obtained:

- ☐ Patient/family member received notice but refused to sign acknowledgment
- ☐ Emergency treatment situation
- ☐ Patient was incapacitated and no family member was present
- ☐ Unable to communicate due to language barriers
- ☐ Other (please describe below) _____

_____

_____ _____

SIgnature of Employee Date

Staff Initials: _____

Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS LLC

Assignment of Benefits/Right to Payment, Patient Responsibility and Release of Information Form

Atlantic Urology Clinics, LLC | PO Box 602460 Charlotte, NC 28260-2460

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____

SIgnature of Patient/Person Legally Responsible Date

_____

Print Name of Patient/Person Legally Responsible

_____

Relationship to Patient

(If signed by Person Legally Responsible)

Staff Initials: _____

Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS LLC

Notice of Privacy Practices Atlantic Urology Clinics, LLC

Thomas Cerasaro, MD | James Fogarty, DO | Walter Frank, MD | Timothy Gajewski, MD | Glenn Gangi, MD
Andrew Grudzinski, MD | Robert Jansen, MD | Kenneth Krzyzaniak, MD | Timothy Quillen, MD
Brian Roberts, MD | Neal Shore, MD | Joseph Wood, MD | Richard Young, MD
Kailen Gonzalez, PA -C | Debra Joyner, PA-C | Will Putnam, PA-C | Michelle Wirt, PA | Rebecca Crawford, AGACNP-BC
Jackie Flanegan, NP | Melanie Lawrence, NP | Leslie Oleskowicz, NP | Ashley Sarvis, NP

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.

Each time you visit our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by your physician.

Our Responsibilities
We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to that protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

Uses and Disclosures - How we may use and disclose protected health information about you.

For Treatment: We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to doctors, nurses, or other personnel who are involved in taking care of you. For example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

For Payment: We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

For Healthcare Operations: We may use or disclose, as needed, your protected health information in order to run our practice. For example, members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.

We may also use and disclose protected health information:
- To business associates we have contracted with to perform an agreed-upon service
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To inform you about possible treatment alternatives
- To inform you about health-related benefits or services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

Individuals Involved in Your Care or Payment for Your Care: We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

Research: We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

Individuals Involved in Your Care or Payment for Your Care: We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

Research: We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

Future Communications: We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS LLC

Notice of Privacy Practices Atlantic Urology Clinics, LLC

As Required by Law, we may also disclose health information to the following types of entities, including but not limited to:

- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

Law Enforcement / Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Other Uses of Your Protected Health Information That Require Your Authorization
Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses and disclosures not described in this notice or required by law will be made only with your separate written permission. If you give us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and copy protected health information. You may request access to your records by contacting us. You may also ask that we send your health information directly to another person based on your signed written instructions. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records.
- Request an amendment. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information by making a request in writing that explains the reason for the requested amendment. You have the right to request an amendment for as long as the information is kept for or by us. We may deny your request for an amendment; if this occurs, you will be notified of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes.
- Request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you ask us not to disclose your health information to your health plan, we will agree as long as (i) the disclosure would be for the purpose of payment or health care operations and is not otherwise required by law and (ii) the information only relates to items or services that someone other than your health plan has paid for in full.
- Request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will grant requests for vconfidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where you will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.
- A paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Web site at www.21stcenturyoncology.com.

Changes to This Notice We reserve the right to change this notice; the revised notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be available on our website and will be provided to you upon your next visit to our facility after the effective date.

Complaints If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Privacy Officer toll-free at 1-866-679-8944, or by contacting the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

For further information, contact:
Privacy Officer, 2270 Colonial Boulevard, Fort Myers, FL 33907, 1-866-679-8944

Staff Initials: _____

Patient name:_____Account#:_____

ATLANTIC UROLOGY CLINICS LLC

Financial Policy

Adult & Pediatric Urology • Coastal Urology • Grand Strand Urology • Waccamaw Urology

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PATIENT RESPONSIBILITY:
Patients are responsible for payment in full of their account regardless of insurance coverage. Patients are responsible for presenting current insurance information at the time of service, and for understanding the provisions and limitations of their insurance plan. If you have any questions regarding your insurance plan, please contact your insurance company or our billing office. Please do not ask your physician, as our doctors do not usually know what is covered or not covered. *Please note: Many insurance companies DO NOT cover preventative or elective services. Patients are responsible for payment of all non-covered services.*

If Atlantic Urology Clinics (AUC) is a participating provider with the patient's insurance, the patient will be responsible for payment of any deductible and/or co-payment at the time of service. AUC will accept assignment and bill the insurance company for the contracted fee. However, ifthe insurance company denies the charges or fails to pay any portion of the bill, the patient agrees to pay that portion immediately.

If AUC is not a participating provider with the patient's insurance company, the patient will be responsible for payment of all charges in full at the time of service. As a courtesy, AUC will bill the insurance company on the patient's behalf if we have accurate and complete insurance information.

DISCOUNTS:
If you are a member of an insurance plan that Atlantic Urology Clinics participate with, your charges will be adjusted according to your contract with your insurance company. Other discounts may be available on the basis of proof of financial hardship.

FOR PAYMENT:
We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

NOTE: The waiver of deductibles and co-pays is unlawful and may be construed by the Federal Government as Insurance Fraud.

MEDICARE:
Atlantic Urology Clinics accepts assignment of Medicare benefits. Medicare patients are responsible for their yearly deductible and 20% co-pay, as well as any non-covered services provided. Patients will be responsible for payment in full at time of service.

MEDICAID:
Medicaid is a federal and state funded program designed to provide coverage of medically necessary services for individuals that meet a minimum income criteria. This practice accepts Medicaid as payment in full upon receipt of a valid Medicaid card and proper authorization.

WORKER'S COMPENSATION:
Atlantic Urology Clinics will bill your employer or the Worker's Compensation carrier for services rendered. If you are covered, we will accept the payment made by Worker's Compensation as payment in full. If Worker's Compensation denies payment or goes into litigation, the entire balance will become your responsibility and will be due within 10 days from the date of the denial. It is your responsibility to provide us with the name and address of your employer and the insurance company at the time of the appointment is made and to provide the office with a copy of your Notice Compensation Payable Letter from Worker's Compensation. All insurance is verified prior to the patient's initial visit, but does not guarantee payment.

RETURNED CHECKS:
Any check that is returned to Atlantic Urology Clinics with insufficient funds will result in a $29.00 charge to the patient.

I have read and agree to the above policy. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits directly to Atlantic Urology Clinics for services rendered:

Patient Signature: _____ Date: _____

This form was explained to you by (AUC Repesentative): _____

ATLANTIC UROLOGY CLINICS LLC

TCPA Consent Form

Adult & Pediatric Urology • Coastal Urology • Grand Strand Urology • Waccamaw Urology

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Patient Full Name_____

Patient Acct# _____

DOB_____ **Age:**_____ **Sex:** _____

AUC Physician:_____

Referring Physician:_____

Telephone Consumer Protection Act [TCPA] Consent Form

I, authorize Atlantic Urology Clinics and all of its independent contractors, business associates, agents and/or affiliates to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any claim I may have against the practice, its independent contractors, business associates, agents and affiliates for making such calls, including any claim under the Telephone Consumer Protection Act.

_____

Patient Signature

_____

Patient Name

_____

Date