Name: _____ **Date:** _____

GENDER: MALE / FEMALE (CIRCLE ONE) **DOB:** _____ **AGE:** _____

Height: _____ **Weight:** _____

Referring Doctor: _____**Family Doctor:** _____

EMAIL ADDRESS (REQ FOR PATIENT PORTAL): _____**Preferred Language:** _____

ETHNICITY(circle one): Hispanic/Latino Spaniard Mexican Central American South American Latin American Puerto Rican Cuban Dominican Not Hispanic or Latino DECLINE TO ANSWER

RACE: _____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

What improves or worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous or does it come and go? _____

Describe the pain (sharp/dull, etc.) _____

Have you tried any medicine/treatment for this problem/pain? _____

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

Drug Name:	**Strength:**	**Directons/How you take it:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Attach list if necessary

Pharmacy Name: _____**Phone #:** _____

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

_____

_____

By what method did you choose our practice:

_____Referring Physician _____Friend _____Yellow Pages _____Insurance Company _____Other

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: Please circle one that applies:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, Other

Hobbies: Please circle any that apply to you:

None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball

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: _____

Caffeinated beverages: None Low Moderate Excessive

Recent Foreign Travel: None Americas _____ Worldwide _____

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
Stranguria
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: _____

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following diseases or conditions:

Cardiovascular
Anemia
Angina
Anorexia
Aortic Aneurysm
Aortic Regurgitation
Aortic Stenosis
Arrhythmia
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Claudication
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Enlarged Heart
Heart Attack
Heart Block
Heart Disease
Heart Murmur
Heart Valve Problem
Hemophilia
Hypertension, well controlled
Hypertension, progressive
Hypertension, severe
Leukemia
Mitral Insufficiency
Mitral Stenosis
Mitral Valve Prolapse
Rheumatic Fever
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins
Ventricular Arrhythmia

Endocrine/Metabolic
Diabetes Mellitus, non-insulin dependent
Diabetes Mellitus, insulin dependent
Diabetes Mellitus, uncontrolled
Goiter
Gout
Hyperthyrodism
Hypothyrodism
Impaired Glucose Tolerance

General
Allergies
Electrical Injury
Exposure to Chemicals
Hepatitis A
Hepatitis B
Hepatitis C
Hypercholestolemia
Hyperlipidemia
Infectious Disease
Lipid Disorder
Malaise
Obesity
Paget's Disease
PCKD
PCO
Raynaud's Syndrome
Sleep Apnea

GI
Cholecystitis
Cholelethiasis
Chronic Liver Disease
Colitis
Constipation
Colon Condition
Crohn's Disease
Diarrhea
Diverticulitis
Diverticulosis
GERD
Hemorrhoids
Hepatic Failure
Hepatitis
Hiatal Hernia
Inflammatory Bowel Disease
Liver Disease
Pancreatitis
Peptic Ulcer (Duodenal)
Rectal Fissure
Stomach Ulcer
Ulcerative Colitis

GU
AIDS
Bladder Outlet Obstruction
Bladder Stone
Bladder Infection
Chronic Renal Disease
Chronic Renal Insufficiency
Chronic Renal Failure
Crossed Fused Ectopia
Hematuria
Impotence of Organic Origin
Interstitial Cystitis
Irradiation Therapy
Kidney Cancer
Kidney Disease
Kidney Infection
Kidney Stones
Libido Decreased
Nephrolithiasis
Nephrotic Syndrome
Neurogenic Bladder
Orchitis
Penile Discharge
Polycystic Disease
Polycystic Kidney Disease
Prostate Cancer
Radiation or Nuclear Exposure
Recurrent UTI
Renal Cell Cancer
Renal Failure
Renal Insufficiency
Testicular Cancer
Transplant Recipient
Transitional Cell CA Bladder
Transitional Cell CA Ureter
Undescended Testicle (Birth)
Urinary Tract Infection
Venereal Disease

GYN/OB
Breast Cancer
Breast Disease
Endometriosis
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Fibroids

HEENT
Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Menniere's
Mumps
Sinusitis
Tinnitis
Vertigo

Musculoskeletal
Arthritis
Back Pain
Carpal Tunnel Syndrome
Claudication
Fibromyalgia
Mortons Neuroma

Neurological/Psychological
ADD
ADHD
Alcoholism
Alzheimer's Disease
Anxiety
Bi-polar Disorder
Chronic Fatigue Syndrome
Depression
Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Organic Brain Syndrome
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt

Respiratory
Asthma
Bronchitis
Chronic Lung Disease
COPD
Emphysema
Lung Disease
Pneumonia
Pulmonary Embolism
Tuberculosis

Tumors
Brain Cell Carcinoma
Brain Tumor
Breast Cancer
Cervical Cancer
Colon Cancer
Fibrocystic Breast Disease
Gastric Cancer
Laryngeal Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Rectal Cancer
Rectal Cell Cancer
Sarcoidosis
Testicular Cancer
Transitional Cell CA Bladder
Transitional Cell CA Ureter
Uterine CA

Other:

SURGICAL HISTORY

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

Cadiovascular
Angioplasty
Aortic Aneurysm Repair
CABG
Carotid Artery Surgery
Heart Surgery
Heart Surgery (Stents)
Heart Transplant
Pacemaker Insertion
Vein Stripping

General
Brain Surgery
Laminectomy
Lymphatic Node Dissection
Parathyroidectomy
Pilondial Cyst Incision
Skin Grafting

GI
Appendectomy
Bariatric Surgery
Bowel Resection
Cholecystectomy
Colon Resection
EGD
EGD/Dilation
Esophagus
Fissurectomy
Gastric Surgery
Hemorrhoidectomy
Ileostomy
Laparoscopy
Liver Surgery
Liver Transplant
Lumpectomy of Breast
Lysis Adhesions
Nissen Fundoplication
Splenectomy
Stomach Surgery
Umbilical Hernia
Ventral Hernia Repair

GU
Bladder Surgery
Biopsy Prostate
Brachytherapy
Circumcision
Contigen
Cystoscopy
Cystoscopy-Dilation
Cystoscopy-Retrograde
Cystoscopy-Stent
Cysto-TUR Fulguration
Durasphere
Epididymectomy
ESWL
Herniorrhaphy
Hydrocelectomy
Ileal conduit
Indigo Laser Surgery
Inguinal Herniorraphy
Interstim
Kidney Stone
Laser Lithotripsy
Meatotomy
Needle Biopsy Prostate
Nephrectomy
Nephrolithotomy
Orchiectomy
Orchiopexy
Penile Implant
Penectomy
Penile Surgery
Pyeloplasty
Radical Prostatectomy
Renal Transplant
Spermatocelectomy
TUMT Prostate
TUNA Prostate
TURBT
TUR Prostate
Ureteroscopy
Variocelectomy
Vasectomy
VLAP

HEENT
Cataract Surgery
Corneal Surgery
Ear Surgery
Eye Surgery
Facial Surgery
Mastoid Surgery
Nasal Surgery
PEG
PE Tubes
Septoplasty
Sinus Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery

Musculoskeletal
Amputation
Arthroscopic Knee Surgery
Back Surgery
Carpal Tunnel Surgery
Cervical Spine Surgery
Disc Surgery
Foot Surgery
Hand Surgery
Hip Surgery
Knee Surgery
Leg Surgery
Rotator Cuff Surgery
Shoulder Surgery

Respiratory
Lung Surgery

Skin
Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

OTHER:
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Please CIRLCE and indicate which family member has/had any of the following:

(Mother, Father, Siblings, Grandmother, Grandfather, Uncle , Aunt)

Arthritis _____

Bedwetting _____

Bladder Cancer _____

Cancer (site unknown) _____

Crohn's Disease _____

Depression _____

Diabetes _____

Gout _____

Heart Attack _____

Hypertension _____

Kidney Cancer _____

Kidney Disease _____

Leukemia _____

Malignant Melanoma _____

Multiple Sclerosis_____

Laryngeal Cancer_____

Pancreatic Cancer_____

Prostate Cancer _____

Stroke _____

Thyroid Disease _____

Tuberculosis _____

Other:

_____

AUA SYMPTOM SCORE

MEN OVER 40 PLEASE COMPLETE THE FOLLOWING QUESTIONS

QUESTIONS TO BE ANSWERED	NOT AT ALL	LESS THAN 1 TIME IN 5	LESS THAN ½ TIME	ABOUT ½ THE TIME	MORE THAN ½ THE TIME	ALMOST ALWAYS
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0 (none)	1 (1 TIME)	2 (2 TIMES)	3 (3 TIMES)	4 (4 TIMES)	5 (5 TIMES)
Sum of the seven circled numbers (AUA Symptom Score): _____ Scoring: Mild: 0-7 Moderate: 8-19 Severe: 20-35						

THANK YOU FOR COMPLETING THIS PACKET

SCOTTSDALE UROLOGIC SURGEONS
A Division of Arizona Center for Hematology and Oncology, PLC
Mitchell C. Kaye, M.D. * Edward R. Katz, M.D.

PROTECTED HEALTH INFORMATION DISTRIBUTION

Patient Name: _____
Print First Name Middle Name Last Name

Date of Birth: _____/_____/_____

1) May our office leave a message regarding test results and appointments on your voicemail?

_____YES _____NO

2) Who may receive information regarding your PROTECTED HEALTH INFORMATION (Office Visit Notes, Diagnosis, Appointment Information, etc)

- SPOUSE / CHILDREN
  Name: _____ Date of Birth: _____
  Name: _____ Date of Birth: _____
  Name: _____ Date of Birth: _____
  Name: _____ Date of Birth: _____
  Name: _____ Date of Birth: _____
  Name: _____ Date of Birth: _____
  Name: _____ Date of Birth: _____
- PARENT/ GUARDIAN
  Name: _____ Date of Birth: _____
  Name: _____ Date of Birth: _____
- OTHER
  Name: _____ Date of Birth: _____
  Name: _____ Date of Birth: _____
  Name: _____ Date of Birth: _____
  Name: _____ Date of Birth: _____

3) I AUTHORIZE THE ABOVE LIST OF PEOPLE ACCESS TO MY PROTECTED HEALTH INFORMATION SHOULD THEY INQUIRE. I MAY REVOKE THIS AT ANY TIME BY UPDATING THIS FORM.

_____ _____
PATIENT SIGNATURE DATE OF SIGNATURE

SCOTTSDALE UROLOGIC SURGEONS - *OFFICE FINANCIAL POLICY*

A Division of AZCCC

Welcome and thank you for choosing our office for your medical care. We hope that by providing you with our policies in advance we can prevent misunderstanding and frustration. Please read this carefully.

Initial _____ SOCIAL SECURITY NUMBERS are a necessary part of your financial information with our office. This information, as with any of your medical record, is protected with strict confidentiality. You are asking us to extend your credit by filing insurance for your charges and not collecting in full at the time of service, therefore we must have this information or all charges must be paid at the time of service. Not providing your social security number at your first appointment will result in you being rescheduled until your social security number is received.

Initial _____ CHECK-IN: Please arrive 10 minutes prior to your appointment time, so that all paperwork may be completed before the time you are scheduled. We also ask that our patients bring their current insurance card to ***each*** appointment. If you do not have your insurance card you will be asked to reschedule or pay for your services. On follow-up visits, you will be asked to verify demographic and insurance information so that our records remain up-to-date. Even if you have not had any changes to your demographic/insurance information, our office does require each patient update on an annual basis.

Initial _____ INSURANCE: Our office will file claims for primary insurance only, unless you have Medicare or AHCCCS. We do not bill secondary insurance plans. When making an appointment with our office it is your responsibility to confirm whether our office is currently under contract with your plan. If payment is not received from your insurance carrier within 60 days of filing the claim, the balance due will become your responsibility. Our office cannot become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, coinsurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges", etc., other than to supply factual information when necessary. Each patient is ultimately responsible for the timely payment of their account.

Initial _____ REFERRALS AND AUTHORIZATIONS: It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists. If you do not have a referral or authorization for your appointment you can reschedule or accept charges in full as your responsibility.

Initial _____ CO-PAYMENTS: Co-payments are due at the time of service. We do not bill for co-payments. We reserve the right to reschedule an appointment if a co-payment is not paid at the time of the appointment. For your convenience we accept cash, check, MasterCard, Visa, Discover and American Express.

Initial _____ PRIVATE PAY: If you have no insurance or an insurance we do not participate with, payment in full is expected prior to your service.

Initial _____ SURGERY/PROCEDURES: Our office reserves the right to collect, prior to surgery/procedure, deductibles and/or co-insurance up to an amount equal to your expected liability. If we do not receive your expected liability prior to the surgery/procedure your appointment/surgery will be cancelled. **Surgeries not cancelled 72 hours in advance are subject to a minimum fee equal to 50% of the surgery fee but may be up to 100% of anticipated surgical charges.**

Initial _____ BALANCES/CO-INSURANCE/DEDUCTIBLES: Please be prepared to pay for the current visit as well as any past due balance on your account. Payment of deductibles and co-insurance will be required at the time of service.

Initial _____ PAST DUE BALANCES/COLLECTIONS: Should there be any balance remaining after insurance has been collected, it will be due 10 days after receipt of statement. If previous arrangements have not been made with our billing department, any account over 60 days will be turned over to a collection agency and 30-40% fee will be assessed to your account to offset the recovery fee.

Initial _____ FEES: There is a minimum $500.00 per hour charge, per doctor, to respond to all claims, disputes, complaints, legal proceedings, hearings and similar, on your behalf or as a result of your care.

Initial _____ NO SHOW/CANCELLATION: A $50.00 fee will be charged to your account should you not cancel your appointment 48 hours prior to your scheduled appointment time. **Surgeries not cancelled 72 hours in advance are subject to a minimum fee equal to 50% of the surgery fee but may be up to 100% of anticipated surgical charges.**

Initial _____ RETURNED CHECKS: A $25.00 fee will be assessed for any returned checks, plus any bank fees.

Initial _____ FORMS: If you have forms for disability, insurance, work forms, etc. to be completed, there is a minimum $25.00 to $50.00 charge per form. Payment is due when the request is submitted to our office. We require a one week turn around (7 business days).

I have read, understand and agree to the above office and financial policies. I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing, if applicable. By signing this statement, I also authorize my insurance company to reimburse Scottsdale Urologic Surgeons, Ltd. directly for any benefits for which I may be eligible.

Signed: _____Print Name: _____ _____ Date: _____

Scottsdale Urologic Surgeons
A Division of AZCCC

7301 East 2nd Street • Suite 308 • Scottsdale, Arizona 85251
10210 North 92nd Street • Suite 100 • Scottsdale, Arizona 85258
Tel (480) 949-1212 • Fax (480) 994-5633
www.scottsdaleurology.com

Mitchell C. Kaye, M.D., F.A.C.S.*
Edward R. Katz, M.D.*

Adult Male and Female Urology
Pediatric Urology
*Diplomate American Board of Urology

FINANCIAL DISCLOSURE

Dear Patient,

Thank you for choosing one of our physicians to be your surgeon. Our office will contact your insurance company to satisfy any precertification or authorization regarding our physician's services only.

Please be advised that there may be charges related to:

Lab Work	Diagnostic Studies	Medications	X-ray
Pathology	Surgery Facilities	General Hospital Charges	
Anesthesiology	Surgical Assistants		

Some of these services may not be contracted with your insurance company and therefore you will be responsible for the charges. It is typical a surgical assistant may be needed for your surgery.

Please note the following:

1. Mr. Sam McReynolds and Arizona Physicians Assistant Surgical Services, as with most surgical assistants, are ***non contracted providers***. These entities will bill you separate from Scottsdale Urologic Surgeons for their services.
2. Your physician might have a preference for or a specific interest in certain facilities, as follows:
   - Dr. Kaye has a small ownership interest in North Valley Surgery Center
   - The physicians of Scottsdale Urologic Surgeons have an ownership interest in Southwest Lithotripsy.
3. Surgeries not cancelled 72 hours in advance are subject to a fee equal to 50% of the surgery fee.

Patient _____
(print)

Patient _____
(signature)

Date _____

Arizona Center for Hematology and Oncology, PLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This Acknowledgment of Receipt of Notice of Privacy Practices applies to, but may not be limited to the following ACHO entities & services:

Academic Urology & Urogynecology of AZ
Arizona Cancer Specialists
Arizona Center for Cancer Care
Desert Springs Cancer Care
Diagnostic Radiology
Jamie Kapner, MD
Northwest Urology
Pinnacle Oncology Hematology
Scottsdale Cancer Center
Scottsdale Urologic Surgeons
Sun Valley Urology
Valley Urologic Associates

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice of Privacy Practices. You may refuse to sign this acknowledgement, if you wish. Thank you.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF
ARIZONA CENTER FOR HEMATOLOGY AND ONCOLOGY'S
NOTICE OF PRIVACY PRACTICES.

_____

Please Print Your Name Here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)* _____

_____
Employee Name (please print your name here)

_____
Employee Signature

_____
Date

ARIZONA CENTER FOR HEMATOLOGY AND ONCOLOGY, PLC

5750 West Thunderbird Road, Suite C300
Glendale, Arizona 85306
Compliance/Privacy Officer: 623-773-2873
kcarleton@arizonaccc.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Please note the following:
ACHO does not create or manage a hospital directory.
ACHO does not create or maintain psychotherapy notes at its practices.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice: December 15, 2013

This Notice of Privacy Practices applies to the following organizations.

This notice applies to the following ACHO entities & services:
Academic Urology and Urogynecology of Arizona
Arizona Cancer Specialists
Arizona Center for Cancer Care
Desert Springs Cancer Care
Diagnostic Radiology
Jamie Kapner, MD
Northwest Urology
Pinnacle Oncology Hematology
Scottsdale Cancer Center
Scottsdale Urologic Surgeons
Sun Valley Urology
Valley Urologic Associates

Compliance/Privacy Officer
(623)773-2873
kcarleton@arizonaccc.com

Arizona Center for Hematology and Oncology, PLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This Acknowledgment of Receipt of Notice of Privacy Practices applies to, but may not be limited to the following ACHO entities & services:

Academic Urology & Urogynecology of AZ
Arizona Cancer Specialists
Arizona Center for Cancer Care
Desert Springs Cancer Care
Diagnostic Radiology
Jamie Kapner, MD
Northwest Urology
Pinnacle Oncology Hematology
Scottsdale Cancer Center
Scottsdale Urologic Surgeons
Sun Valley Urology
Valley Urologic Associates

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice of Privacy Practices. You may refuse to sign this acknowledgement, if you wish. Thank you.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF
ARIZONA CENTER FOR HEMATOLOGY AND ONCOLOGY'S
NOTICE OF PRIVACY PRACTICES.

_____

Please Print Your Name Here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)* _____

_____
Employee Name (please print your name here)

_____
Employee Signature

_____
Date