

PREMIER UROLOGY GROUP, LLC

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PATIENT INFORMATION				
NAME (Last, First Middle)	SSN#	SEX	BIRTHDATE	AGE
ADDRESS	CITY, STATE, ZIP			
HOME PHONE	DAY PHONE	CELL PHONE		
EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	EMERGENCY CONTACT HOME PHONE	EMERGENCY CONTACT DAY PHONE	
PRIMARY PHYSICIAN NAME	PRIMARY PHYSICIAN ADDRESS		PRIMARY PHYSICIAN PHONE NUMBER	
WHO REFERRED YOU TO OUR PRACTICE?				
WHY ARE YOU SEEING THE DOCTOR TODAY?				
EMPLOYER	PHONE NUMBER	EMPLOYER ADDRESS		
RESPONSIBLE PARTY INFORMATION (if Different than above)				
NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX
ADDRESS	CITY, STATE ZIP	MARITAL STATUS	EMAIL ADDRESS	
HOME PHONE	DAY PHONE	RELATIONSHIP TO PATIENT		
PRIMARY INSURANCE				
NAME OF INSURANCE COMPANY		POLICY #		
ADDRESS OF INSURANCE COMPANY		GROUP #		
CITY, STATE ZIP OF INSURANCE COMPANY		EFFECTIVE DATE OF INSURANCE	COPAY FOR SPECIALIST \$	
PHONE NUMBER OF INSURANCE COMPANY		NAME OF PERSON INSURED	RELATIONSHIP TO PATIENT	
SECONDARY INSURANCE (If Applicable)				
NAME OF INSURANCE COMPANY		POLICY #		
ADDRESS OF INSURANCE COMPANY		GROUP #		
CITY, STATE ZIP OF INSURANCE COMPANY		EFFECTIVE DATE OF INSURANCE	COPAY FOR SPECIALIST \$	
PHONE NUMBER OF INSURANCE COMPANY		NAME OF PERSON INSURED	RELATIONSHIP TO PATIENT	

ASSIGNMENT OF BENEFITS: I irrevocably assign by right to payment from any insurance company/other payor of health benefits to Premier Urology Group, LLC for services furnished to me.

RELEASE OF INFORMATION: I understand that Premier Urology Group, LLC is entitled to release my medical and insurance information to any entity for the purpose of treatment, payment or operational purposes.

RECEIPT OF INFORMATION: I acknowledge that I have received Premier Urology Group, LLC's Notice of Privacy Practices.

I have read and understand each of the 3 foregoing paragraphs and my questions have been answered.....

SIGNATURE OF PATIENT/GUARDIAN

DATE

Have you ever seen a urologist before? _____ If so, why? _____

Please list any surgical procedures you have had _____

Have you ever received a blood transfusion? Yes _____ No _____

Do you have any allergies or bad reaction to any foods or drugs? Yes _____ No _____

(Particularly lobster, shellfish or drugs like penicillin)

IF YES, PLEASE SPECIFY: _____

Please circle any of the following conditions you currently have or have been treated for in the past:

High blood pressure	Diabetes	Tuberculosis	Heart Attack	Cancer	HIV
Thyroid Imbalance	Syphilis	Gonorrhea	Asthma	Gout	AIDS
Nervous Breakdown	Hepatitis	Glaucoma	Ulcers	Stroke	

Please list any medications you are presently taking:

Name	Dosage
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Pharmacy Information: Name _____ Phone _____

Pharmacy Address: _____

Do you take aspirin or other anti-inflammatory medication daily? Yes _____ No _____

Do you have any pain of difficulty with urination? Yes _____ No _____

Have you ever had a kidney infection? Yes _____ No _____

Do you have any back pain? Yes _____ No _____

Have you had any chills or fever recently? Yes _____ No _____

Have you ever seen or been told there is blood in your urine? Yes _____ No _____

Have you ever had kidney stones? Yes _____ No _____

Have you ever been unable to urinate? Yes _____ No _____

How many times do you awaken at night to urinate? _____

How many times do you urinate during the day? _____

MEN: Do you have difficulty obtaining or maintaining an erection? Yes _____ No _____

WOMEN: When was your last menstrual period? _____

IMPORTANT NOTICE REGARDING REFERRALS

You may be referred to a laboratory or other facility by our physicians. Please note that you have the option to have your procedure done at any facility of your choice and are not obligated to utilize the facility to which you were referred.

IMPORTANT NOTICE

Please be advised that Medicare and/or your private health insurance carrier may not cover certain procedures or services that your doctor deems necessary for the complete evaluation and management of your care. This may include various ultrasound procedures, injections, diagnostic tests, etc. Please note that you may be responsible of any balance not paid by your insurance company.

Also, please be advised that if your insurance company requires a referral or authorization for any services or procedures performed it is YOUR responsibility to present a valid referral or authorization to this office PRIOR to services being rendered.

Current insurance regulations require that we notify you, the patient, of this situation prior to your treatment.

Patient Signature _____

Patient Name _____ Date _____

REVIEW OF SYSTEMS

Do you now have or had any problems related to the following systems?
Please explain any Yes Answers in the space provided.

Circle Yes or No

Constitutional Symptoms

Fever Yes No
Chills Yes No
Headache Yes No
Other _____

Eyes

Blurred Vision Yes No
Double Vision Yes No
Pain Yes No
Other _____

Allergic/Immunologic

Hay Fever Yes No
Drug Allergies Yes No
Other _____

Neurological

Tremors Yes No
Dizzy Spells Yes No
Numbness/Tingling Yes No
Other _____

Endocrine

Excessive Thirst Yes No
Too Hot/Cold Yes No
Tired/Sluggish Yes No
Other _____

Gastrointestinal

Abdominal Pain Yes No
Nausea/Vomiting Yes No
Indigestion/Heartburn Yes No
Other _____

Cardiovascular

Chest Pain Yes No
Varicose Veins Yes No
High Blood Pressure Yes No

Integumentary

Skin Rash Yes No
Boils Yes No
Persistent Itch Yes No
Other _____

Musculoskeletal

Joint Pain Yes No
Neck Pain Yes No
Back Pain Yes No
Other _____

Ear/Nose/Throat/Mouth

Ear Infection Yes No
Sore Throat Yes No
Sinus Problems Yes No
Other _____

Genitourinary

Urine Retention Yes No
Painful Urination Yes No
Urinary Frequency Yes No
Other _____

Respiratory

Wheezing Yes No
Frequent Cough Yes No
Shortness of Breath Yes No
Other _____

Hematologic/Lymphatic

Swollen Glands Yes No
Blood Clotting Problem Yes No
Other _____

Psychologic

Are you generally satisfied with your life? Yes No
Do you feel severely depressed? Yes No
Have you ever considered suicide? Yes No
Other _____

Family History:

Mother _____ Diabetes

Father _____ Diabetes

List significant sibling diseases (brothers/sisters)

Heart Disease Cancer

Heart Disease Cancer

(Age at death, if deceased)

Prostate Cancer

(Age at death, if deceased)

**Premier Urology Group, LLC
DISCLOSURE FORM**

Dear Patient:

Public Law of the State of New Jersey mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners must inform patients of any significant financial interest in a health care service to which they refer their patients. The purpose of this notice is to advise you that Premier Urology Group, LLC, which is the medical practice of which your treating urologist is a member, operates its own anatomic pathology laboratory. In addition, your physician may have a financial interest in one or more of the following facilities to which our patients may be referred:

**THE AMBULATORY CENTER FOR SURGERY
Mountainside, NJ**

**THE STONE CENTER OF NEW JERSEY
Newark, NJ**

**THE SHORT HILLS SURGERY CENTER
Millburn, NJ**

**PREMIER UROLOGY GROUP, LLC
RADIATION ONCOLOGY
Cranford, NJ**

As our patient you may require, at some time, a urological procedure to be performed at one of our facilities which may result in the need to have certain tissue samples tested at an anatomic pathology laboratory. To the extent your physician determines that anatomic pathology laboratory tests are necessary, Premier Urology Group, LLC will provide such tests through its own anatomic laboratory and will bill you separately from any bill issued by the facility where the urological procedure is performed.

By signing this disclosure you or your legal representative, acknowledge that: (1) you have been informed of the financial interests of the practitioners in this office.

Understood and agreed:

Patient Signature:

Witness:

Printed Name

Printed Name

_____, 20____
Date

_____, 20____
Date

Complaints may be lodged with the following:
N.J. Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
PO Box 367
Trenton, NJ 08625-0367
Complaint Hotline: 1-800-792-9770
<http://www.state.nj.us/health/healthfacilities>
and/or

Office of the Medicare Beneficiary Ombudsman
<http://www.medicare.gov/Ombudsman/activities.asp>

Premier Urology Group, LLC
Effective Date: **April 14, 2003**

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the practice's Notice of Privacy Practices detailing how my medical information, also known as "Protected Health Information" or PHI, may be used and disclosed as permitted under federal and state law. I understand that I have the right to review the Notice and ask questions about this practice's privacy practices.

By signing this form you acknowledge that you have received our Notice of Privacy Practices.

Name of Patient

Signature of Patient

Date

IF PATIENT REFUSES TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

[] Patient refused to sign this Acknowledgement.

Date: _____

Employee Name: _____

Premier Urology Group, LLC
Notice of Privacy Practices

Effective date of this notice: **April 14, 2003**

This notice is required as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

If you have questions about this notice please ask to speak to our Privacy Officer or call our Privacy Officer at 908-654-5100 X 303.

We are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of Privacy Practices with respect to your Protected Health Information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. As required by federal law we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

Our Privacy Officer may be contacted at: Privacy Officer c/o Consultants in Urology, P.A., 275 Orchard Street, Westfield, NJ 07090 or by phone at 908-654-5100 X 303.

We may use and disclose your PHI in the following ways:

Treatment: We may use and disclose your PHI in order to treat and diagnose you. For example, we may request laboratory tests (such as blood or urine tests) to help us reach a diagnosis. We may disclose your PHI when we order or write a prescription for you. The physicians in this practice in addition to other employees of the practice may use or disclose your PHI in order to assist other providers involved in your treatment. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Employees of our practice, in using their best judgment, may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

Payment: Our practice may use and disclose your PHI in order to bill and collect payment for services provided. We may also use and disclose your PHI in order to determine if your insurer will cover future treatment and to obtain prior authorization and/or approval for future treatment.

Health Care Operations: We may use and disclose your PHI for office operations. Our practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities.

We may use and disclose your PHI in certain special circumstances:

Law Enforcement: Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

2. **Military:** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
3. **Deceased Patients:** Our practice may release your PHI to a coroner or medical examiner. This may be necessary to identify a deceased individual or to identify the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.
4. **Inmates:** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
5. **Workers' Compensation:** Our practice may release your PHI for workers' compensation claims and similar programs.
6. **Organ and Tissue Donation:** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. **Public Health Risks:** Our practice may use and disclose your PHI for public health activities authorized by law to collect information for the purpose of:
 - *Maintaining vital records, such as births and deaths
 - *Reporting child abuse or neglect
 - *Preventing or controlling disease, injury or disability
 - *Notifying a person regarding a potential exposure to a communicable disease
 - *Notifying a person regarding a potential risk for spreading or contracting a disease or condition
 - *Reporting reactions to drugs or problems with products or devices
 - *Notifying individuals if a product or device they may be using has been recalled
 - *Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are authorized by law to disclose this information
 - *Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

8. **Serious Threats to Health or Safety:** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **National Security:** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Your Rights Regarding Your PHI

You have the following rights regarding the PHI that we maintain about you:

Confidential Communications. You have the right to request that our office communicate with you regarding matters related to your health care in a particular manner or certain location. In order to request a specific type of communication you must make a written request to our Privacy Officer (see section B). The request must specify particular method of contact, or location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. You have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction of our use or disclosure of your PHI, you must make your request in writing to our Privacy Officer (see section B). You must describe in a clear and concise fashion:

The information you wish restricted

Whether you wish to limit our practice's use, disclosure or both

To whom you want the limits to apply

Inspection and Copies of your PHI. You have the right to inspect and obtain a copy of your PHI including medical records and billing records. You must submit your request in writing to our Privacy Officer (see section B) in order to inspect or obtain a copy of your PHI. Our practice has the right to charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice has the right to charge a fee associated with your request to inspect your PHI. Our practice may deny your request to inspect and/or copy in certain circumstances; however, you may request a review of our denial.

Amendment. You may ask us to amend your PHI if you believe it is incorrect or incomplete. To request an amendment, your request must be made in writing and submitted to our Privacy Officer (see section B). You must provide us with a reason that supports your request for amendment. We may deny your request if you ask us to amend information that is in our opinion accurate and complete.

Accounting Of Disclosures. You have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of non-routine disclosures our practice has made of your PHI. Use of your PHI as part of routine patient care is not required to be documented. In order to obtain an accounting of disclosures, you must submit your request in writing to our Privacy Officer (see section B). All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates prior to April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. To obtain a copy of this notice, contact our Privacy Officer (see section B).

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer (see section B) or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Right to Provide an Authorization for Other Used and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.

9. **Changes to this Notice.** We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. You may request a copy of the current notice from our staff.

