TEXAS UROLOGY SPECIALISTS

Dear Patient:

We would like to take this opportunity to welcome you to our practice. We are pleased that you have chosen us to provide you with the highest urologic care. Our providers and staff look forward to meeting you.

Please be prepared for your appointment by printing and completing the new patient registration forms attached. Please bring the completed forms with you to your appointment, along with your insurance card(s) and your insurance co-pay. If you are unable to complete your paperwork prior to your appointment, please arrive 30 minutes early to complete the paperwork in our office.

If your insurance carrier requires a referral when seeing a specialist, please contact your primary care physician and confirm that this has been completed prior to your appointment.

We make every effort to see our patients as close to their appointment times as possible. However, please understand that we are a surgical practice and therefore are subject to emergency room and operating room circumstances that are unplanned. We ask for your patient in the event a delay should occur.

If you have any questions or need assistance, please do not hesitate to call our office. We will be happy to assist.

Once again, we appreciate your confidence in us and look forward to meeting with you.

Texas Urology Specialists
Austin Midtown:
Dr. C. Alexander Wilson
901 W. 38th St., Suite 200
Austin, TX 78705
512-421-4235

TEXAS UROLOGY SPECIALISTS

Patient Name: _____

Why are we asking these questions? In 2009, Congress passed the HITECH Act to create uniformity among electronic health records. Asking for your language ensures you and your healthcare providers will be able to communicate clearly. We will be asking about race and ethnicity because some groups are at a higher risk of developing certain diseases. This information will be updated in your medical record and will remain confidential.

Preferred Language: _____

Circle Ethnicity: Hispanic or Latino Not Hispanic or Latino

Circle Preferred Method of Contact: Home phone Cell phone Work phone email Mail (home address)
Phone number not previously provided: _____ Circle type **H C W**

Email address: _____
Circle Race:

African American	Hmong	Pacific Islander Nos
Asian Indian, Pakistani SRI Lankan	Japanese	Polynesian Nos
Caucasian	Kampuchean Cambodian	Samoan
Chamorran	Korean	Tahitian
Chinese	Laotian	Thai
Fiji Islander	Melanesian Nos	Tongan
Filipino	Micronesian Nos	Vietnamese
Guamanian Nos	Native American	Unknown
Hawaiian	New Guinean	Other
Hispanic	Other Asian	

TEXAS UROLOGY SPECIALISTS

NO SHOW POLICY

Keeping your appointment is very important and crucial to good medical care; however, if you are unable to make your appointment for any reason, please call to cancel at least 24 hours prior to your scheduled appointment. Cancellations can be taken by calling the office at any time, including after business hours.

Please be aware that you may be dismissed from the practice in the event that you NO SHOW after three (3) scheduled appointments without calling to cancel or reschedule your appointment.

Dismissal from the practice will be given in writing with 30 days for you to find another physician and transfer medical care.

I agree to the terms of this notice.

Signature: _____

Thank you,

Texas Urology Specialists

TEXAS UROLOGY SPECIALISTS

PATIENT MEDICAL HISTORY

NAME: _____ AGE: _____ DATE OF BIRTH _____

Who referred you for this condition (Doctor & Clinic)? _____

What is the reason for your visit? _____

Do you have any associated problems?_____

PAST MEDICAL & SOCIAL HISTORY

Have you ever had or been treated for any of the following? No Yes If yes, please check or write down any conditions you have had.

( )High cholesterol
( )High blood pressure
( )Tuberculosis
( )Glaucoma
( )Gastroesophageal reflux
( )Heart Attack
( )Herpes
( )Heart Disease
( )Mitral Valve Prolapse
( )Diabetes
( )Gout
( )Prostatitis
( )Kidney Infection
( )HIV
( )Mumps
( )Asthma
( )Cancer:_____
( )Depression
( )Blood clot
( )Sexually transmitted disease
( )COPD
Other:_____

Have you ever had any surgery? No Yes -If yes, then please check or write down any surgeries you have had.

( )Colon
( )Bladder
( )Lung
( )Knee replacement
( )Prostate
( )Vasectomy/Tubal ligation
( )Breast
( )Heart Valve
( )Inguinal Hernia
( )Hip replacement
( )Incontinence
( )Urinary Stone
( )Thyroid
( )Angioplasty
( )Umbilical hernia
( )Gallbladder
( )Spleen
( )Kidney
( )Hysterectomy
( )Heart Bypass
( )Appendectomy
( )Back
( )Gastric Bypass
( )Testicular/Scrotal
Other:_____

Please identify any family history of medical problems. Adopted? YES NO

( )Heart disease
( )Kidney Tumors
( )Liver disease
( )Kidney cysts
( )Sickle Cell
( )Kidney Stones
( )Diabetes
( )Cystic Fibrosis
( )Prostate Cancer
( )Bladder Cancer
( )Tuberculosis
( )Other Cancer _____
( )Kidney Failure
( )Anemia
( )High blood pressure
( )Other:_____

TEXAS UROLOGY SPECIALISTS

PAST MEDICAL & SOCIAL HISTORY

Do you have any drug allergies? YES NO
If yes, please list below:

DRUG:	**TYPE OF REACTION: (rash,nausea, etc)**

Do you take Ibuprofen, Aspirin, Coumadin, Plavix or other blood thinners? YES NO

Are you on any medication (prescription or over the counter)? YES NO

If yes, please list below:

DRUG:	**DOSE:**	**HOW MANY TIMES A DAY:**

Do you or did you ever smoke? YES NO
IF yes, how many packs per day? _____ How many years? _____

Did you quit? YES NO If yes, when: _____

Do you drink alcohol? YES NO
If yes, how much and how often: _____

Have you or do you use now: Marijuana, cocaine, anabolic steroids or heroin?

Are you married? YES NO DIVORCED WIDOWED
Any children? YES #_____ NO

What is your occupation? _____

Did you or do you ever work around chemicals? YES NO
If yes, please list: _____

FOR FEMALES: Are you or could you be pregnant? YES NO

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Urology Specialists is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. 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 the 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 Texas Oncology.

Name: (Please Print): _____

Signature: _____

Name of Personal Representative (if appropriate):

_____

Signature of Personal Representative (if appropriate): _____

Date: _____

Texas Urology Specialists Use Only

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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.

About Us

In this Notice, we use terms like “we,” “us,” “our,” or "Practice" to refer to Texas Oncology, its physicians, employees, staff and other personnel. All of the sites and locations of Texas Oncology follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

Purpose of This Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care 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 Responsibilities
We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured 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 without your written authorization:

For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another health care provider to be sure they 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 or supplies used in the course of treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third-party “business associates” that perform various services on our behalf, such as transcription, billing, and collection services.

In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

We may ask you to sign your name to 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.

Appointment Reminders: 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.

Individuals Involved in Your Care or Payment for Your Care and Notification: If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

If you would like us to refrain from releasing your health information to a family member or friend who is involved in your care, you must make your request in writing and submit it to the Medical Records Manager of your local Texas Oncology office.

We may use or disclose your information to notify or assist in notifying a family member, personal representative, or any other person responsible for your care regarding your physical location within the Practice, general condition, or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status, and location.

We are also allowed to the extent permitted by applicable 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 process 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.

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, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if the victim agrees or we are 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 not occurring on our premises, the nature of 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;
- Activities related to the quality, safety, or effectiveness of FDA-regulated products;
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

Serious Threat to Health or Safety: If there is a serious threat to your health and 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 or as necessary for law enforcement authorities to identify or apprehend an individual.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation, or banking of organs, eyes, or tissues.

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.

Workers' Compensation: We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

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 your health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.

- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.
- Sale of Your Health Information: We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, 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 the 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. **In most circumstances, we are not required to agree to 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 your local Texas Oncology office. We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

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 your local Texas Oncology office. 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. 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 your local Texas Oncology office. You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

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 your local Texas Oncology office. 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 that will become part of your medical record.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures 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 your local Texas Oncology office. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within

a 12-month period will be free. For additional accountings, 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 before any costs have been incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact your local Texas Oncology office. You may also obtain a paper copy of this Notice at our website, **www.TexasOncology.com**.

Changes to This Notice
We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the waiting area of your local Texas Oncology office. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, **www.TexasOncology.com**.

Complaints If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: Texas Oncology at 1-888-864-ICAN (4226)and ask for the Privacy Officer. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing a complaint.

Questions If you have questions about this Notice, please contact Texas Oncology at 1-888-864-ICAN (4226) and ask for the Privacy Officer.

CONSENT/AUTHORIZATION FOR RELEASE OF INFORMATION

1. I hereby authorize Texas Urology Specialists to release the following information from the health record(s) of:

Patient's Name: _____ Phone: _____

Birth date: _____

Covering the periods of treatment: From: _____ To: _____

**********Note to Patient: We are unable to release records or discuss your care with your spouse or family without a written release. **********

2. Information to be released:

- Progress Note — Mail Copies: _____
- Radiology — Patient Pick-up: _____
- Lab Billing Records — Fax: _____
- X-ray film
- Complete Medical Record (includes information regarding insurance, demographic, referral documents, and records)

3. Information is to be released to: Spouse: _____ Children: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: _____ Fax: _____

4. Purpose of disclosure (circle one): Treatment Payment Other_____

5. I understand that I may revoke this consent/authorization at any time by notifying Texas Oncology in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.

6. This authorization will remain in effect until revoked by me in writing.

7. The facility, its employees and officers, and attending providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.

Signature: _____ Date: _____

Witness: _____ Relationship: _____