G. U. INC. UROLOGY

Whitney R. Snowman, M.D., M.P.H.
Geoffrey J. Bisignani, M.D.
Norman P. Gebrosky, M.D.
Stephanie M. Rubino, M.D.

Clare A. Boast, PA-C
Erin A. Shaffer, PA-C
Lindsay B. Leggett, PA-C

600 LIGONIER STREET
LATROBE, PENNSYLVANIA 15650
PHONE 724-539-9736
FAX 724-539-2836

522 WEST NEWTON STREET, SUITE 300
GREENSBURG, PENNSYLVANIA 15601
PHONE 724-838-7500
FAX 724-837-6670

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and *will* be used by G. U., Inc. to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received G. U., Inc.'s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that G. U., Inc. has the right to change its *Notice of Privacy Practices* from time to time and that I may contact G. U., Inc.'s privacy officer in writing at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing to the privacy officer that G. U., Inc. restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that G. U., Inc. is not required to agree to my requested restrictions, but if it is agreed then G. U., Inc. is bound to abide by such restrictions.

____

Patient Name

____

Signature of Patient Date
(or patient's personal representative)

____

Name of personal representative (If applicable)

____

Relationship of personal representative to patient (If applicable)

++
++

OFFICE USE ONLY

I provided the above named patient (or their personal representative) with our *Notice of Privacy Practices.* I attempted to obtain their signature in acknowledgement but was unable to do so as documented below:

________________ ________________

Date Initials

Reason: ____

____

____

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PERSONS WITH WHOM WE MAY DISCUSS YOUR PROTECTED HEALTH INFORMATION

Patient Name _____ Birthdate _____

I hereby give permission to release/disclose my protected health information, including my medical condition, test results and appointments with the following individuals/offices.

(If not permissible to disclose all information, please list ALL limitations.)

PLEASE LIST BELOW WHO WE ARE PERMITTED TO DISCUSS YOUR CONDITION WITH AND WHAT INFORMATION MAY BE RELEASED.

Physicians/Facility _____

Information _____

Spouse/Significant Other

Name _____

Information _____

Other Persons

Name _____ Relationship _____

Phone _____ Information _____

Name _____ Relationship _____

Phone _____ Information _____

Name _____ Relationship _____

Phone _____ Information _____

Name _____ Relationship _____

Phone _____ Information _____

This authorization expires on _____
(must be a DATE in future, ie: 5-11-2010)("never" "indefinite" or "upon death" is not acceptable)
***If no date is written in, expiration will be 1 (one) year from date signed (below).

_____ _____
Signature Date

WHITNEY R. SNOWMAN, M.D., M.P.H.
GEOFFREY J. BISIGNANI, M.D.
NORMAN P. GEBROSKY, M.D.
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PATIENT INFORMATION SHEET

Patient Name _____ Date of Birth _____ Age _____

Street Address _____ Social Security # _____

City,State _____ Zip _____ Home Phone # _____

Daytime Phone # _____ Work Phone # _____
*(****MUST HAVE****)*

Family Doctor Name _____ Patient Cell/Alternate Phone # _____
*(****MUST HAVE****)*

Marital Status: ____Married ____Single ____Divorced ____Widow(er) ____Separated

Patient Occupation: _____ If Student, Full or Part-time? _____

Place of Employment & Address _____

Status: ____Full-Time ____Part-Time ____Self-Employed ____Unemployed ____Retired

Referring Doctor _____ Next of Kin _____

If male referred by Gynecologist, entire name of spouse/girlfriend: _____

BILLING/FINANCIAL INFORMATION

Please list **ALL** Insurances:
1. Primary (1st) _____
2. Secondary (2nd) _____
3. Third (3rd) _____

If insurance is under someone's name other than the patient, please complete the following:

Insured's Full Name _____ Relationship to patient _____
Insured's Date of Birth _____ Insured's Soc Sec # _____
Insured's Sex ___Male ___Female Which Insurance is in this Name? _____
Insured's Place of Employment & Address _____
Insured's Employ Status: ____Fulltime ____Parttime ____Self-Employed ____Unemp'd ____Ret'd
If retired, give retirement date: _____

****PLEASE BRING THIS COMPLETED FORM AND INSURANCE CARDS/FORMS TO RECEPTIONIST**

ALL INSURANCES & MEDICARE AUTHORIZATION

G. U., Inc.

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Clare A. Boast, PA-C Erin A. Shaffer, PA-C Lindsay B. Leggett, PA-C

600 Ligonier Street
Latrobe, PA 15650

522 West Newton Street, Suite 300
Greensburg, PA 15601

SIGNATURE ON FILE

I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS
I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE CARRIERS
I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR MY BILLS/CHARGES FOR SERVICES
I AUTHORIZE MY DOCTOR(S) AND THEIR STAFF TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE CARRIERS
I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR
I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL

NAME _____ DATE _____
(Please print clearly)

SIGNATURE _____ DATE _____

****ALL copays and/or amounts not paid/covered by insurance are due at time service is rendered. THANK YOU!****

NAME _____ AGE _____ DOB _____ DATE _____

ADDRESS _____ PHONE _____

INSURANCE _____ SS# _____

(This is a confidential record to be kept in your doctor's office. Information contained here will not be released to anyone without your authorization.)

CHIEF COMPLAINT - Circle where your problem is and give details of symptoms:

Kidney Prostate Bladder Other _____

_____

_____

_____

_____

HISTORY OF PRESENT ILLNESS

When did you first notice the problem?

N/A 2 days ago 2 weeks ago 1 month ago Other: _____

Does anything help or make the problem worse?

N/A Moving around Standing up Lying on my side Other: _____

How long does the problem last?

N/A 30 minutes 1 hour It is always there Other: _____

Do you have any difficulties urinating?

None Burning Blood in Urine Frequency Other: _____

Does the problem interfere with any other normal functions?

No Yes If yes, please explain: _____

PAST MEDICAL & SOCIAL HISTORY

Please list any medications you are now taking. Include dosages.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any medicines? Please list.

_____ _____

_____ _____

Please list any personal illnesses (diabetes, emphysema, heart murmer, heart attack, cancer, asthma, hypertension, etc.)

_____ _____

_____ _____

Please list and date any previous operations.

_____ _____

_____ _____

Have you ever smoked? Yes No **If yes, when? (dates)** _____

Do you currently smoke? Yes No **If yes, how much?** _____

How often do you drink alcohol? _____

How often do you drink caffeine products? _____

PLEASE COMPLETE BACKSIDE ---------->

REVIEW OF SYSTEMS

Do you now or have you ever had any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other _____

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Glaucoma	Y	N

Other _____

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Latex Allergy	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/Tingling	Y	N

Other _____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other _____

Gastrointestinal

Abdominal pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/heartburn	Y	N

Other _____

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other _____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Arthritis	Y	N

Other _____

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus problems	Y	N

Other _____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other _____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other _____

Cardiologic

Chest pain	Y	N
Varicose veins	Y	N
High Blood Pressure	Y	N

Other _____

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel depressed?	Y	N
Have you considered suicide?	Y	N

Other _____

FAMILY HISTORY			FOR OFFICE USE ONLY
F			PROST.CA
M			HEART DISEASE
B			LUNG DISEASE
B			HIGH B.P.
S			STROKE
S			DIABETES
H/W			KIDNEY DISEASE
S			OTHER CANCERS
S			BLEEDING DISORDER
D			MENTAL ILLNESS
D			

PHYSICIAN _____ DATE _____

NOTICE OF PRIVACY PRACTICES FOR G. U., INC.

Effective date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

If you have any questions regarding this Notice, you may contact our privacy officer at:

G. U., Inc. Attention: Privacy Officer 600 Ligonier Street Latrobe, PA 15650
Telephone: 724-539-9736 Fax: 724-539-2836

I. YOUR PROTECTED HEALTH INFORMATION

This Notice is provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (HIPAA). It is designed to tell you how we, G. U., Inc., may use or disclose your health information.

Generally speaking, your protected health information (PHI) is any information that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for health care provided to you, and individually identifies you or reasonably can be used to identify you. Your medical and billing records at our practice are examples of information that usually will be regarded as your protected health information.

II. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. Treatment, payment and health care operations

This section describes how we may use and disclose your PHI for treatment, payment and health care operations purposes without obtaining your prior authorization. We have included examples; however, not every possible use or disclosure for treatment, payment and health care operations purposes is listed.

1. Treatment

We may use and disclose your PHI for our treatment purposes as well as the treatment purposes of other health care providers. Treatment includes the provision, coordination, or management of health care services to you by one or more health care providers. Examples include:

1. Physicians and other office staff may review/share/discuss your medical information with each other
2. We may share/discuss your medical information with:
   - outside referral or consulting physicians and their staff members
   - outside laboratories, radiology centers or other facilities where we have referred you for testing
   - outside home health agency, durable medical equipment agency, pharmacies or other health care providers where we have referred you for health care services or products
   - hospitals or other health care facilities where we are admitting or treating you
   - another health care provider who seeks information for the purpose of treating you
3. We may use patient sign-in sheets in the waiting area which is accessible to all patients
4. We may call patients by name from the waiting room
5. We may contact you to provide appointment reminders/changes and test results at the phone numbers you provide and/or the person you designate to discuss this information

2. Payment

We may use and disclose your PHI for our payment purposes as well as the payment purposes of other health care providers and health plans. Payment uses and disclosures include activities conducted to obtain payment for the care provided to you or so that you can obtain reimbursement for that care, for example, from your health insurer. Some examples of payment uses and disclosures include:

1. Sharing information with your health insurer to determine whether you are eligible for coverage or whether a proposed treatment is a covered service
2. Submission of claim forms and supporting documentation to your health insurer and supplemental insurers to facilitate the processing of your claim for reimbursement and coordination of benefits if applicable
3. Sharing demographic information (ie: address, etc) with other health care providers
4. Mailing you, or the person responsible for payment of your services, billing information in envelopes with our practice name and return address
5. Provide medical records and other documentation to your health insurer to support medical necessity of a health service or quality review audit
6. Provide information to a collection agency or our attorney, or disclose information in a legal action, for purposes of securing payment of a delinquent account
7. We may confirm/request insurance information at check-in window

3. Health Care Operations

We may use and disclose your PHI for our health care operation purposes as well as certain health care operation purposes of other health care providers and health plans. Some examples include:

1. Quality assessment and improvement activities
2. Reviewing the competence, qualifications or performance of health care professionals
3. Conducting training programs for medical and other students
4. Accreditation, certification, licensing and credentialing activities
5. Health care fraud and abuse detection and compliance programs
6. Conducting other medical review, legal services and auditing functions

7. sharing information regarding patients with [illegible]
patient records to entities that have purchased our practice
8. Other business management and general administrative activities such as compliance with federal privacy rule and resolution of patient grievances

B. Uses and disclosures for other purposes

We may use and disclose your PHI for other purposes. This section generally describes those purposes by category; however, not every use or disclosure is listed.

1. Individuals involved in care or payment for care, such as spouse, family member, significant other, or close friend.
2. Notification or assistance in notification of spouse, family member, significant other or another person responsible for your care, regarding your location, hospitalization, general condition or death.
3. Requirements by laws of federal, state or local government and their mandatory reporting requirements involving births, deaths, child abuse, disease prevention and control, medical device-related deaths and serious injuries, gunshot and other injuries by a deadly weapon or criminal act, driving impairments and blood alcohol testing.
4. Other public health activities including communicable disease reports, child abuse and neglect reports, FDA-related reports and disclosures, such as adverse event reports, OSHA requirements for workplace surveillance and injury reports.
5. Victims of abuse, neglect and domestic violence including reports to Department of Aging or Department of Public Welfare.
6. Health oversight activities authorized by law, such as DEA inspection of patient records, or other legal proceedings.
7. Judicial and administrative proceedings such as response to a court order or subpoena regarding your medical condition.
8. Law enforcement purposes which include complying with legal processes such as search warrants or mandatory reporting of gun shot wounds, information for identification purposes, information about a crime victim or regarding crime on premises.
9. Coroners and medical examiners for such purposes as identifying a deceased patient or determining cause of death.
10. Funeral directors as necessary to carry out their duties.
11. Organ and tissue donation and transplantation to necessary entities.
12. Threat to public safety.
13. Specialized government functions including military and veterans activities, national security and intelligence, correctional institutions and other law enforcement custodial situations, protective services for the President and others, and medical suitability determinations for the Department of State.
14. Workers' compensation and similar programs as necessary to comply with related laws.
15. Business associates such as a transcriptionist, law firm or accounting firm.
16. Creation of de-identified information such as research purposes using your PHI with all identifying information removed.
17. Incidental disclosures such as other people in waiting room overhearing your name when you are called from the waiting room.

C. Uses and disclosures with authorization

For all other purposes which do not fall under a category listed under sections III.A and III.B, we will obtain your written authorization to use or disclose your PHI. Your authorization can be revoked at any time except to the extent that we have relied on the authorization.

III. PATIENT PRIVACY RIGHTS

A. You may request further restrictions on the use and disclosure of your PHI by submitting a written request to our privacy officer including a) what information you want restricted; b) how you want the information restricted; c) to whom you want the restriction to apply. We are not required to agree to a request for a further restriction.

B. You have a right to request that we communicate your PHI to you by a certain means or at a certain location such as by mail or at work. The request must to be specific, complete and in writing and submitted to our privacy officer. We are not required to agree to requests for confidential communications that are unreasonable.

C. You have a right to obtain, upon written request to our privacy officer, an "accounting" of certain disclosures of your PHI by us limited to disclosures within 6 years of the request, but not before April 14, 2003, and other limitations. We may charge for this accounting. The request should designate the applicable time period.

D. You have the right to inspect and obtain a copy of your PHI that we maintain in a designated records set by submitting a written request to our privacy officer including a) describe the health information to which access is requested; b) state how you want to access the information, such as inspect copy, pick up a copy, fax copy or mail copy; c) include mailing address or fax phone number if applicable. This right is subject to limitations and we may impose a charge for the labor and supplies involved in providing copies.

E. You have a right to request that we amend protected health information that we maintain in a designated records set if the information is incorrect or incomplete by submitting a written request to our privacy officer specifying each change that you want and supporting reasons. We are not required to make the requested amendment and will provide you information about our denial and how you can disagree with the denial.

F. You have a right to receive, upon request, a paper copy of our Notice of Privacy Practices by contacting our privacy officer.

IV. CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We further reserve the right to make any change effective for all PHI that we maintain at the time of the change – including information that we created or received prior to the effective date of the change. We will post a copy of our current notice in the waiting room for the practice. We will also provide you with a copy of the Notice, at any time, upon request.

V. COMPLAINTS

If you believe that we have violated your privacy rights, you may submit a complaint in writing to the practice's privacy officer at the address written above or you may contact the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

VI. LEGAL EFFECT OF THIS NOTICE

This notice is not intended to create contractual or other rights independent of those created in the federal privacy rule.