BLUE RIDGE UROLOGICAL ASSOCIATES, P.C.

70 Medical Center Circle, Suite 208,212 Fishersville, VA 22939 (P) 540-332-5926 (F) 540-332-5930
130 Walker Street, Suite C Lexington, VA 24450 (P) 540-462-6171 (F) 540-332-5930
2006 Health Campus Drive, Suite 201 Harrisonburg, VA 22801 (P) 540-689-5900 (F) 540-689-5603

PATIENT INFORMATION:

Last Name: _____ First: _____ Middle: _____

DOB: _____ Age: _____ Gender: _____ SSN: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status: _____ Spouse/Partner Name: _____

Emergency Contact: _____ Phone: _____

Family / Referring Doctor: _____ Phone: _____

Were You Referred Today? YES _____ NO _____ BY _____

What Pharmacy Do You Use? _____ Phone: _____ Zip: _____

Patient's Employer: _____

Employer's Address: _____ City: _____

State: _____ Zip: _____ Work Phone: _____

GUARANTOR INFORMATION: (Complete Only If Other Than Patient)

Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

REASON FOR YOUR VISIT:_____ **WEIGHT**_____ **HEIGHT**_____

HAVE YOU HAD A HEART ATTACK IN THE LAST YEAR? YES NO

If YES, date of heart attack _____ **Are you taking aspirin or blood thinner as a result? YES NO**

HAVE YOU HAD A COLONOSCOPY? YES NO DATE:_____

ARE YOU DIABETIC? YES NO If Yes, date you were diagnosed:_____

HAVE YOU BEEN DIAGNOSED WITH DIABETIC NEUROPATHY? YES NO

DO YOU HAVE HIGH BLOOD PRESSURE? YES NO If Yes, date diagnosed:_____

HAVE YOU RECEIVED THE PNEUMOCOCCAL VACCINATION? YES NO

If YES, who administered it and when? _____

SURGICAL HISTORY: (PLEASE LIST ALL SURGERIES AND DATES)

_____

_____

_____

_____

_____

PERSONAL MEDICAL HISTORY: (CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING)

Anemia

Anxiety

Arthritis

Asthma

Blood Clots

Bronchitis

Cerebrovascular Accident

Constipation

COPD

Depression

Diabetes

Diverticulitis

Gallstones

GERD

Glaucoma

Heart Attack

Heart Disorder/Disease

Hepatitis/Liver Problems

High Blood Pressure

High Cholesterol

Kidney Stones

Migraines

Pacemaker

Pneumonia

Seizures

Shortness of Breath

Thyroid Disorder/Disease

Frequent Urination

Cancer (If so, what type)

_____

List Any Other Medical Condition(s) _____

_____

_____

Have You Ever Had Any Problems With Anesthesia? _____

SOCIAL HISTORY: (Please Circle Correct Response)

Marital Status: Married Single Divorced Widowed Separated Annulled Life Partner

Smoking Status: Every Day Smoker Some Day Smoker Former Smoker Non-Smoker

If Former smoker, when did you quit?_____

If Current Smoker, how many cigarette per day?_____

Smokeless Tobacco: Yes No

Do You Drink Alcohol? Yes Which type? Beer Wine Liquor How much? _____

Not Anymore When did you quit? _____ Never drank _____

Do You Use Recreational Drugs? No Yes If Yes explain:_____

How Many Caffeinated Drinks Do You Have Each Day?: _____

Race: White Black/African American Hispanic/Latino Other: _____

Ethnicity: Hispanic/Latino Yes No

Have You Ever Had A Blood Transfusion? Yes No

FAMILY HISTORY: (INCLUDE PARENTS, SIBLINGS, AND GRANDPARENTS ONLY)

CONDITION:	WHO?
Anemia	_____
Anxiety	_____
Arthritis	_____
Asthma	_____
Blood Clots	_____
Bronchitis	_____
Cerebrovascular Accident	_____
Constipation	_____
COPD	_____
Depression	_____
Diabetes	_____
Diverticulitis	_____
Gallstones	_____
GERD	_____

FAMILY HISTORY: (INCLUDE PARENTS, SIBLINGS, AND GRANDPARENTS ONLY)-CONTINUED

CONDITION:	WHO?
Glaucoma	
Heart Attack	
Heart Disorder/Disease	
Hepatitis/Liver Problems	
High Blood Pressure	
High Cholesterol	
Kidney Stones	
Migraines	
Pacemaker	
Pneumonia	
Seizures	
Shortness of Breath	
Thyroid Disorder/Disease	
Frequent Urination	

Cancer (If so, what type)

ALLERGIES

CURRENT MEDICATIONS:

NAME OF MEDICATION	STRENGTH OF MEDICATION	WHEN, HOW, AND HOW MUCH IS TAKEN

ARE YOU TAKING BLOOD THINNERS SUCH AS ASPIRIN, COUMADIN/WARFARIN, NSAIDS, PLAVIX, PRADAXA, ETC? **YES NO LIST**

PATIENT NAME_____

RESPIRATORY

Shortness of Breath	Y	N
Asthma	Y	N
Bronchitis	Y	N
Emphysema	Y	N
Frequent Cough	Y	N
Wheezing	Y	N
Pneumonia	Y	N
Blood Clot in Lung	Y	N
Asbestos Exposure	Y	N
Cough Up Blood	Y	N

GASTROINTESTINAL

Swallowing Problems	Y	N
Hiatal Hernia	Y	N
Heartburn	Y	N
Stomach Ulcer	Y	N
Abdominal Swelling	Y	N
Constipation	Y	N
Hemorrhoids	Y	N
Hepatitis	Y	N
Liver Problems	Y	N
Cirrhosis of Liver	Y	N
Gallbladder Problems	Y	N
Colitis/diverticulitis	Y	N

HEMATOLOGIC

Anemia	Y	N
Blood Clot in Leg	Y	N
Bruise Easily	Y	N
Swollen Glands	Y	N

ANESTHESIA

Ever had Anesthesia	Y	N
Any problems placing breathing tube?	Y	N
Difficulty waking up after anesthesia?	Y	N
Vomiting after surgery	Y	N

SKIN

Skin Cancer	Y	N
Psoriasis	Y	N
Changing Mole	Y	N
Other Skin Conditions	Y	N

GYNECOLOGIC (FOR WOMEN)

Are You Pregnant?	Y	N
Number of Pregnancies	_____	
Age of Menstruation	_____	
Age of Menopause	_____	
Date of Last Period	_____	
Hysterectomy? Date	_____	
Bloody Vaginal Discharge	Y	N
Prolonged Menses	Y	N
Gynecologic Problems	Y	N
Breast Lumps	Y	N
Breast Cancer	Y	N
GYN Cancer	Y	N
Date of Last Pap Smear	_____	

MUSCULOSKELETAL

Arthritis	Y	N
Gout	Y	N
Osteoporosis	Y	N

ENT

Ear Infection	Y	N
Hearing Loss	Y	N
Hearing Aids	Y	N
Hoarseness	Y	N
Sore Throat	Y	N

ENDOCRINE

Excessive Thirst	Y	N
Diabetes	Y	N
Easy Fatigue	Y	N
Hyper/Hypo Thyroid	Y	N

GENERAL

Fever in last week	Y	N
Night Sweats	Y	N
Recent Weight Loss	Y	N

NEUROLOGY

Seizures	Y	N
Concussions	Y	N
Weakness	Y	N
Strokes	Y	N
Other	_____	
	_____	

EYES

Change/Loss of Vision	Y	N
Cataracts	Y	N
Glaucoma	Y	N

If Yes, what type?

_____

CARDIOVASCULAR

Heart Attack	Y	N
Chest Pain	Y	N
Irregular Heart Rhythm	Y	N
Congestive Heart Failure	Y	N
Rheumatic Fever	Y	N
Mitral Valve Prolapse	Y	N
Heart Surgery/Stent	Y	N
Date _____		
Abnormal EKG	Y	N
Leg or Ankle swelling	Y	N
Leg Cramps	Y	N
High Blood Pressure	Y	N
If yes, how many years _____		

PSYCHIATRIC

Depression	Y	N
Other _____		
_____		

BLUE RIDGE UROLOGICAL, P.C.

Patient's Consent for Provider to Disclose PHI to Authorized Persons

1. Authorization to Disclose PHI (Protected Health Info). I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the persons indicated below.
2. Persons to Whom Disclosure May be Made. Provider may disclose my PHI to the following persons:

NAME	RELATIONSHIP, IF ANY	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Purpose of Disclosure. The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.
4. Expiration of Authorization. This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Office to any office where I am treated by Provider.
5. Conditioning of Treatment. Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.
6. Redisclosure by Recipient. I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer be protected by federal or state law.
7. Acknowledgement of Reading and Agreement. I have read and understand this authorization.

_____ _____

Patient Name or Representative Date

If a Representative Signs, state the Representative's Authority:

_____

Acknowledgement of Recipient of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

_____ _____

Patient Signature
Or Personal Representative

Date

BLUE RIDGE UROLOGICAL, PC

70 MEDICAL CENTER CIRCLE, SUITE 208 & 212
FISHERSVILLE, VA 22939
(P) 540-332-5926 (F) 540-332-5930

130 WALKER STREET, SUITE C
LEXINGTON, VA 24450
(P) 540-462-6171 (F) 332-5930

2006 HEALTH CAMPUS DR, SUITE 201
HARRISONBURG, VA 22801
(P) 540-689-5900 (F) 540-689-5603

JORDAN BURNS, DO
WILLIAM R. JONES MD
MARCUS N. MORRA, MD
EMILY M. GREENE, PA-C
JENNIFER WRITSEL, PA-C

THEODORE CISU, MD
STEPHEN G. LEGG, MD
MATTHEW RISENDAL, DO
ANNE S. WONG, NP-C

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, (PATIENT'S NAME) _____ authorize the release of medical information FROM doctors, Jordan Burns, Theodore Cisu, William R. Jones III, Stephen Legg, Marcus N. Morra, Matthew Risendal, Anne S. Wong, FNP-C, Jennifer Writsel, PA-C and Emily M. Greene, PA-C.

TO THE FOLLOWING PHYSICIAN OR HOSPITAL:

_____

_____

_____

_____

_____

Signature of Patient: _____

Date: _____

Patient's date of birth: _____

BLUE RIDGE UROLOGICAL, PC

Effective 11/14/2018

Contingency Fee Agreement For Delinquent Accounts

A *Debt placed for collection with Agency and referred to an Attorney* to satisfy payment of this account or to obtain judgment on this account, shall be subject to a collection fee of 33.3% of the amount paid if collected by Attorney. Should an account be referred for legal action, this amount shall be in addition to any other costs incurred directly or indirectly by Agency's attorney to collect amounts owed under Agreement such as court costs, sheriff's fees, interest, late fees, investigatory fees, credit reporting fees, etc. (only accounts requested by Creditor will be referred for legal action).

Once an account has been assigned for collection, any payments received by the creditor, agency, and/or attorney including, but not limited to consumer payments, insurance payments, attorney payments, shall be subject to the agreed-upon contingency fee.

My signature below acknowledges that I am aware of the above Contingency Fee Agreement

_____ _____

Signature Date

Contact By Phone

You agree, in order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable. I/we have read this disclosure and agree that Blue Ridge Urological may contact me/us as described above.

_____ _____

Signature Date

I do not agree to be contacted by any telephone numbers associated with my billing account.

_____ _____

Signature Date

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.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. § 164.520

Our Duties

We are required by law to maintain the privacy of your Protected Health Information ("PHI"). PHI consists of individually identifiable health information, which may include demographic information we collect from you or create or receive by another health care provider, a health plan, your employer, or a health care clearinghouse, and that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

We must provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to PHI and make new privacy policies effective for all PHI that we maintain. We will post a copy of our current Notice of Privacy Practices in the waiting room, and keep a copy of the revised Notice at the registration desk, and provide you with a copy upon your request, and if we maintain a website, we will post our Notice of Privacy Practices on our website.

Examples of Uses and Disclosures of Your PHI relating to Treatment, Payment & Operations

HIPAA privacy regulations give us the right to use and disclose your PHI without your consent to carry out (i) treatment, (ii) payment, and (iii) health care operations. Here are some examples of how we intend to use of your PHI in regard to your treatment, payment, and health care operations.

Treatment. In connection with treatment, we will, for example, use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We will disclose your PHI to other providers who may be treating you. Additionally, we may disclose your PHI to another provider who has been requested to be involved in your care.

Payment. We will use your PHI to obtain payment for our services, including sending claims to your insurer or to a federal program, such as Medicare, that pays for your treatment and sending you a bill for any amounts due which your insurer does not pay. We may also employ Business Associates, such as a billing company or collection agency to help us bill and collect. The PHI will include items such as description of your condition(s), our treatment, your diagnosis, supplies and drugs we used, etc.

Health Care Operations. We will use your PHI to support our business activities, such as allowing our auditors, consultants, or attorneys access to your PHI to audit our claims to determine if we

billed you accurately for the services we provided to you, or to evaluate our staff to see if they properly cared for you, or to send information about you to third party Business Associates so they may perform some of our business operations.

Description of Other Required or Permitted Uses and Disclosures of Your PHI

Appointment Reminders. We will call you to remind you of an appointment. We may call your residence, office, or any other number we have on file. We will leave a message if you are not in, and we will state the name of our clinic, the date and time of the appointment, and the address at which the appointment is to be kept. We may also mail you a notice of your appointment to any address we have on file.

As Required by Law. We will use and disclose your PHI when required to by federal, state, or local law. For example, we may receive a subpoena for which we are required by law to provide copies of your medical file.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your PHI to public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Workers Compensation. We will use and disclose your PHI for workers compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. If you are an inmate, we will use and disclose your PHI to a correctional institution or law enforcement official only if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Other Services and/or Fundraising. We may use your PHI to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your PHI to contact you in an effort to raise funds for our operations, however, you have the right to opt out of receiving any fundraising communications by sending a letter to our Privacy Officer in writing at the address at which you are treated.

Uses and Disclosures to which You have an Opportunity to Object

Others Involved in Your Care. We may provide relevant portions of your PHI to a family member, a relative, a close friend, or any other person you identify as being involved in your medical care or payment for care. If you bring someone with you into a treatment room, you are hereby notified that you will have identified that person to us as being involved in your care or payment for your care, by voluntarily bringing them in the room. If you do not object to us discussing your PHI in front of them, we may discuss your PHI in their presence because you did not object. In an

emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it after the emergency, and give you the opportunity to object to future disclosures to family and friends.

Uses and Disclosures that Require Your Signed Authorization

There are certain uses and disclosures of your PHI that require your written authorization. For example, most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require your signed authorization. Also, any use or disclosure of your PHI not described in this Notice requires your signed authorization.

Your Right to Revoke Your Authorization

If you sign an authorization allowing us to use or disclose your PHI outside of the uses and disclosures made in this Notice, you may revoke that authorization by advising us in writing with a letter addressed to Privacy Officer, at the address where we treat you. Your revocation will become effective as soon as we are reasonably able to enter it into our records, which is typically within 5 business days after we receive the letter. Your revocation will not affect our prior reliance on your authorization prior to the effective date of revocation.

Your Right to Restrict Certain PHI to a Health Plan

You have the right to require us to restrict any disclosure of your PHI to a health plan regarding an item or service for which you (or someone on your behalf - other than a health plan) paid out-of-pocket to us the entire amount due for the health care item or service which we provided and billed to you. You must make such a request in writing to us, with a letter addressed to Privacy Officer at the address where you receive your treatment. If you make such a request, we are required to honor it.

Notification in Case of Breach of Unsecured PHI

In the event of an unauthorized or improper use or disclosure of your PHI (i.e., a "breach"), you have the right to receive, and we will notify you of the circumstances surrounding, the breach, what we have done to investigate and mitigate it, and how to best protect yourself in our opinion.

Patient Rights Related to PHI

In addition to your other rights provided herein, you have the right to:

Request an Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our Privacy Officer, stating what information is incomplete or inaccurate and the reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason

that we believe supports the request. We may also deny your request if the information was not created by us, or the person who created it is no longer available to make the amendment.

Request Restrictions. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to the Privacy Officer addressed to the address at which you receive care. We are not required to agree to your request. If we do agree, we will comply with your request except for emergency treatment.

Inspect and Copy. You have the right to inspect and copy the PHI we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer at address at which you receive treatment. We will have 30 days to respond to your request for information that we maintain at our facility. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay. HITECH expands this right, giving individuals the right to access their own e-health record in an electronic format if we maintain your records in an electronic format, and to direct us to send the e-health records directly to a third party. We may only charge for labor costs under electronic transfers of e-health records.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made that were not for treatment, payment, or health care operations. Your request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests; however, we will not accommodate a request that we perceive is an attempt to avoid receiving notice of a bill for the payment of our services.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us or directly to the Secretary of the United States Department of Health and Human Services: U.S. Department of Health & Human Services, 200 Independence

Avenue, S.W. Washington, D.C. 20201, Phone: (202) 619-0257, Toll Free: (877) 696-6775. To file a complaint with us, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer at the address at which you were treated. No patient will be retaliated against for making a complaint.

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking for it.

Contact Person

You may contact our Privacy Officer at our office phone number with any questions.

Effective Date

The effective date of this revised Notice of Privacy Practices is September 23, 2013.