Privacy Notice Acknowledgement (HIPAA)

I hereby authorize NorCal Urology Medical Group, Inc. to use and disclose my protected health information ("Health Information") as defined by federal and state law, in the manner describe below:

- A basis for planning my care and treatment.
    - A means of communicating among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
    - A means by which a third-party payor may verify the services billed were actually provided.
- A tool for routine healthcare operations including assessing quality of care and reviewing the competence of healthcare professionals.

Any and all of the following Health Information may be disclosed by NorCal Urology Medical Group, Inc. with my permission, to the individual listed below in person, by letter and/or by phone:

Name of individual: _____

Please check all that apply.

- □ Attorney
- □ Personal Representative (Circle One) Guardian / Conservator / Beneficiary / Other _____
- □ Relative (other than spouse)
- □ Spouse

- □ Permission to leave messages on my answering machine

Please check all Health Information that apply.

- □ Medical Records
- □ Claims/Billing Information

□ I understand that my health care will not be affected if I do not sign this form.

□ I understand that this authorization will expire one year from the date of my signature.

□ I understand that I may revoke this authorization, in writing, at any time by notifying NorCal Urology Medical Group, Inc. I understand that my revocation of this authorization will not affect any actions taken by NorCal Urology Medical Group, Inc. prior to the time NorCal Urology Medical Group, Inc. received the revocation.

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

Important Information About NorCal Urology Medical Group and YOU

1. On your behalf, we will bill your primary insurance carrier. If you have a secondary insurance, please present both insurance cards at the time of your appointment. We will, also, bill your secondary insurance carrier.

2. You are responsible for notifying us of any changes in your insurance coverage. Failure to notify us makes you responsible for payments for that date of service.

3. If we cannot collect on our claims from your insurance carrier within 90 days, you are responsible for paying your bill. After paying us, you may collect your money directly from your insurance carrier.

4. You are required to pay all deductibles and co-insurance determined by your insurance carrier. Payment plans are arranged with our business department.

5. The following fees are for "Missed Appointments" without 24 hour cancellation notice:
   - $25.00 - Follow up appointment
   - $40.00 - Penile Ultrasound Testing
   - $40.00 - Urodynamics Study
   - $50.00 - Vasectomy
   - $75.00 - Trans Urethral Microwave Therapy (TUMT)

6. You are responsible for having all laboratory testing completed at a laboratory contracted with your insurance carrier, all X-Rays completed at a facility contracted with your insurance carrier, and confirming all specialists referred to by NorCal Urology Medical Group are contracted with your insurance carrier.

7. You are responsible for obtaining and/or confirming NorCal Urology Medical Group has an updated referral authorization to treat you.

Signature: _____ Date:

We Gratefully Appreciate Your Cooperation