To: Patient Advocates at Nursing Homes/Care Centers

We ask you take a few moments to complete the enclosed forms. Doing so prior to the office visit will make the appointment more efficient and productive.

We require the following information be sent to our office **before** the appointment is made.
Please Fax To: 513.841.7553.

- Please fill out the forms included in this packet
  - Registration form
  - HIPPA
  - Patient current health questionnaire

- Please send back with this packet the following additional information
  - Photo ID
  - Insurance card(s)
  - Medication list
  - Problem list
  - Past surgery list
  - Patient allergies
  - Family history

Upon receiving this information, we will contact you to schedule an appointment for the patient.

If the patient's insurance requires a referral or pre-authorization when seeing a specialist, please have him/her contact a primary care physician and confirm this has been completed.

We appreciate you taking the time to work with your patients and residents to help us streamline their office visits so we can serve them as efficiently as possible.

If you have any questions regarding the information needed or need any assistance, please call 513.841-7400. We will be happy to help you in any way we can.

Calling after hours

If you need to reach your physician after-hours, please call the office where you were seen. A live agent will answer your call, take a message and then get in touch with the physician on-call.

Office phone numbers:

Ohio

Anderson -Five Mile Rd.
513-841-7840

Anderson – State Road
513-841-7795

Blue Ash
513-841-7800

Eastgate
513-841-7750

Fairfield/Hamilton
513-841-7900

Middletown
513-423-2244

Mt. Auburn
513-841-7795

Norwood
513-841-7500

Oxford
513-841-7900

West Chester
513-841-7800

West Side
513-841-7700

Kentucky

Crestview Hills
859-363-2200

Indiana

Lawrenceburg
859-363-2200

We are looking forward to meeting your patient.

Patient Registration Form

THE UROLOGY GROUP
Advanced Care. Improving Lives.

Today's date: _____

Patient name: _____ Age: ____ Date of birth: _____
LAST FIRST MI

Please circle: Sex: Male / Female
Marital status: Single / Married / Divorced / Widowed

Address: _____

City / State / ZIP: _____

Phone: (check primary number)
☐ Home: ( ) _____ SS#: _____
☐ Mobile: ( ) _____
☐ Work: ( ) _____ Email: _____ @ _____

Emergency contact: Name: _____ Relationship: _____
Home: ( ) _____ Mobile: ( ) _____

Spouse: Name: _____ Date of birth: _____
☐ Check if same as emergency contact Phone: ( ) _____

Nursing home/hospice: (Check if applicable)
☐ I live in a nursing home Facility name: _____
Address: _____
☐ I am in hospice care Facility name: _____

Family physician: _____ Phone: ( ) _____

Referring physician: (if other than above): _____ Phone: ( ) _____

Pharmacy name: _____ Phone: ( ) _____

Person responsible for charges: _____ Home: ( ) _____
LAST FIRST
☐ Check if same as patient Work: ( ) _____

Primary insurance: _____ Policy #: _____ Group #: _____
Subscriber's name: _____ Subscriber DOB: _____

Secondary insurance: _____ Policy #: _____ Group #: _____
Subscriber's name: Subscriber DOB:

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at each time of service exactly what those guidelines are. Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work, x-rays, or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. As the policy holder, YOU ARE RESPONSIBLE for knowing the benefits and restrictions of your insurance coverage.

WAIVER: I understand that should my insurance company require a REFERRAL/AUTHORIZATION prior to my receiving Medical Service, and I have not obtained this and/or this office has not received this, I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

I understand that should it become necessary to place my account with an outside collection agency there will be an **additional 30% late fee** added to my delinquent balance.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Signature: _____ Date: _____

*A $35.00 charge will be collected for all RETURNED CHECKS.
**A $35.00 charge will be collected for all DECLINED CREDIT CARDS.

Medicare Lifetime Signature on File

_____
Name of Beneficiary

_____
HIC Number

I request that payment of authorized Medicare benefits be made either to me or on my behalf to TRI STATE UROLOGIC SERVICES, P.S.C., INC. for any services furnished me by TRI STATE UROLOGIC SERVICES, P.S.C., INC. or their contracted agents PeriOp Anesthesia, P.S.C. or Professional Radiology Inc. or Southern Ohio Pathology. I authorize any holder of medical information about me to release the Center for Medicare/Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medical assigned cases, the physician agrees to accept the charge determination of the Medical carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. In Medicare non-assigned cases, the patient is responsible for the entire charge.

Patient Signature: _____ Date: _____

_____
Witness if signed with an “X”

THE UROLOGY GROUP
Advanced Care. Improving Lives.

Patient Current Health Questionnaire (PLEASE PRINT)

Patient name: _____ Today's date: _____

Date of birth: _____ Family or referring doctor: _____

The Urology Group physician / office patient typically visits: _____

Pharmacy: _____ Pharmacy #_____

Nursing home contact:_____ Phone #_____

Family contact: _____ Phone#_____

HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT (What is the main reason for your visit to the urologist?)_____

_____

Date of onset of problem above: _____ List location (left or right):_____

Type of test done: _____

Have you had this problem before? Y / N When? _____

Blood in urine? Y/N
Visible___ Microscopic___

Frequent urination? Y/N
How Often? Every___hours

Leaking of urine? Y/N
With exercise___ With cough___
Nearly constant ___

Nocturia? (Urinating at night) Y/N
How often? ____times a night

Slow or weak stream? Y/N
Burning with urination? Y/N
Clots in urine? Y/N

Retention? Y/N
Does the patient have a Foley catheter in? Y/N
Date Foley placed_____

Does the patient smoke? Y/N

Does the patient drink coffee? Y/N

DOES THE PATIENT CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?

Y/N Fever
Y/N Headaches
Y/N Cataracts
Y/N Glasses
Y/N Seasonal Allergies
Y/N Tremors
Y/N Dizziness Spells
Y/N Chest Pain
Y/N Ankle Swelling
Y/N Abdominal Pain
Y/N Skin Rash
Y/N Joint Pain
Y/N Back Pain
Y/N Neck Pain
Y/N Excessive Thirst
Y/N Sinus Problems
Y/N Shortness of Breath
Y/N Easy Bruising
Y/N Bleeding Problems
Y/N Depression
Y/N Anxiety

Acknowledgement of Receipt of Notice of Privacy Practices

THE UROLOGY GROUP
Advanced Care. Improving Lives.

I_____acknowledge that either ***[please check appropriate box].***

☐ I have received a copy of Tri State Urologic Services P.S.C., Inc dba The Urology Group/The Urology Center's Notice of Privacy Practices.

or

☐ I declined the offered copy of Tri State Urologic Services P.S.C., Inc dba The Urology Group/The Urology Center's Notice of Privacy Practices.

This notice describes how Tri State Urologic Services P.S.C., Inc dba The Urology Group/The Urology Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

BY CHECKING THE BOXES BELOW, YOU CAN AUTHORIZE US TO DISCLOSE INFORMATION (OR RESTRICT ANY SUCH DISCLOSURES).

Messages with APPOINTMENT or MEDICAL information

You may send information or leave messages of this type via (check all that apply):

- ☐ Home phone
- ☐ Work phone
- ☐ Mobile phone
- ☐ In-person
- ☐ Mail
- ☐ Email
- ☐ Voicemail

My health Information can be left/discussed with:

☐ Anyone who answers the phones indicated above.

☐ Only with the following individuals:

First Name	Last Name	Relationship to patient	Phone number

☐ Do not give/leave appointment or medical information with anyone other than myself **(This will exclude your information from spouses, significant others, parents, children, or any other family member.)**

_____ _____

(Signature of patient or Personal Representative) (Date)

_____

Relationship to patient (if other than patient)

TRI STATE UROLOGIC SERVICES P.S.C., INC. dba THE UROLOGY GROUP
NONDISCRIMINATION NOTICE

Tri State Urologic Services P.S.C., Inc. doing business as The Urology Group ("The Urology Group") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Urology Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Urology Group:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Tom Moehringer, Civil Rights Coordinator.

If you believe that The Urology Group has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tom Moehringer, Civil Rights Coordinator
2000 Joseph E. Sanker Boulevard
Cincinnati, Ohio 45212
Phone: 513-841-7503
Fax: 513-841-7402
Email: civilrightscoordinator@urologygroup.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Tom Moehringer, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TRI STATE UROLOGIC SERVICES P.S.C., INC. dba THE UROLOGY GROUP
NONDISCRIMINATION STATEMENT

Tri State Urologic Services P.S.C., Inc. doing business as The Urology Group ("The Urology Group") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

TAGLINES:

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-513-841-7471.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-513-841-7471.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-513-841-7471。

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-513-841-7471.

لعربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-513-841-7471 (رقم

Deitsch (Pennsylvania Dutch)
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-513-841-7471.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-513-841-7471.

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-513-841-7471.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-513-841-7471.

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-513-841-7471 번으로 전화해 주십시오.

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-513-841-7471.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-513-841-7471まで、お電話にてご連絡ください。

Nederlands (Dutch)
AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-513-841-7471.

Українська (Ukrainian)
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-513-841-7471.

Română (Romanian)
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-513-841-7471.

Srpsko-hrvatski (Serbo-Croatian)
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-513-841-7471.

नेपाली (Nepali)
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-513-841-7471 ।

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-513-841-7471.

Ikirundi (Bantu – Kirundi)
ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-513-841-7471.

(Burmese)
သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-513-841-7471 သုိ႔ ေခၚဆိုပါ။

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-513-841-7471 'ਤੇ ਕਾਲ ਕਰੋ।

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-513-841-7471 पर कॉल करें।

NOTICE OF PRIVACY PRACTICES

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.

I. Who We Are

Practice, Facility and Health Professionals in this notice are members of the Solaris Health Affiliated Covered Entity (ACE). An Affiliated Covered Entity is a group of organizations under common ownership or control who designate themselves as a single Affiliated Covered Entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The Practice, Facility, its employees, workforce members and members of the ACE who are involved in providing and coordinating health care are all bound to follow the terms of this Notice of Privacy Practices ("Notice"). The members of the ACE will share PHI with each other for the treatment, payment and health care operations of the ACE and as permitted by HIPAA and this Notice. For a complete list of the members of the ACE, please contact the Privacy Office.

II. Our Privacy Obligations

We understand that your health information is personal and we are committed to protecting your privacy. In addition, we are required by law to maintain the privacy of your Protected Health Information, to provide you with this Notice of our legal duties and privacy practices with respect to your Protected Health Information, and to notify you in the event of a breach of your unsecured Protected Health Information. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your Protected Health Information. However, unless the Protected Health Information is Highly Confidential Information (as defined in Section IV.B below) and the applicable law regulating such information imposes special restrictions on us, we may use and disclose your Protected Health Information without your written authorization for the following purposes:

A. Treatment. We use and disclose your Protected Health Information to provide treatment and other services to you--for example, to provide medical care or to consult with your physician about your treatment. We may use your information to contact you to provide you appointment reminders or to recommend alternative treatments, therapies, health care providers, or settings of care to you or to describe a health-related product or service. We may also disclose Protected Health Information to other providers involved in your treatment.

B. Payment. We may use and disclose your Protected Health Information to obtain payment for health care services that we provide to you--for example, disclosures to claim

and obtain payment from Medicare, Medicaid, your health insurer, HMO, or other company or program that arranges or pays the cost of your health care ("**Your Payor**") to verify that Your Payor will pay for the health care. We may also disclose Protected Health Information to your other health care providers when such Protected Health Information is required for them to receive payment for services they render to you.

C. Health Care Operations. We may use and disclose your Protected Health Information for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use Protected Health Information to evaluate the quality and competence of our staff and/or other health care professionals. We may disclose Protected Health Information to our Office Manager and/or Privacy Officer in order to resolve any complaints you may have and ensure that you our satisfied with our services. Your PHI may be provided to various governmental or accreditation entities to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Practice, Facility and Health Professionals. Additionally, your PHI may be used or disclosed for the purpose of allowing students, residents, nurses, physicians and others who are interested in healthcare, pursuing careers in the medical field or desire an opportunity for an educational experience to tour, shadow employees and/or physician faculty members or engage in a clinical Practicum.

D. Health Information Organizations. We may disclose your Protected Health Information to other health care providers or other health care entities for treatment, payment, and health care operations purposes, as permitted by law, through a Health Information Organization. For example, information about your past medical care and current medical conditions and medications can be available to other physicians if they participate in the Health Information Organization. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed treatment decisions. You may opt out of the Health Information Organization and prevent providers from being able to search for your information through the exchange. You may opt out and prevent your medical information from being searched through the Health Information Organization by completing and submitting an Opt-Out Form to privacyoffice@solarishp.com. A list of Health Information Organizations in which this facility participates may be obtained upon request or found on our website at www.solaris.com or the Affiliated Covered Entity website.

E. Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your Protected Health Information to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if: (1) we obtain your agreement or provide you with the opportunity to object to the disclosure and you do not object; or (2) we reasonably infer that you do not object to the disclosure.

If you are not present for or unavailable prior to a disclosure (e.g., when we receive a telephone call from a family member or other caregiver), we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose

information under such circumstances, we would disclose only information that is directly relevant to the person's involvement with your care.

F. As Required by Law. We may use and disclose your Protected Health Information when required to do so by any applicable federal, state or local law.

G. Public Health Activities. We may disclose your Protected Health Information: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to a government authority authorized by law to receive such reports; (3) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

H. Victims of Abuse, Neglect or Domestic Violence. We may disclose your Protected Health Information if we reasonably believe you are a victim of abuse, neglect or domestic violence to a government authority authorized by law to receive reports of such abuse, neglect, or domestic violence.

I. Health Oversight Activities. We may disclose your Protected Health Information to an agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

J. Judicial and Administrative Proceedings. We may disclose your Protected Health Information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

K. Law Enforcement Officials. We may disclose your Protected Health Information to the police or other law enforcement officials as required by law or in compliance with a court order. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the Practice or Facility.

L. Correctional Institution. We may disclose your Protected Health Information to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

M. Decedents. We may disclose your Protected Health Information to a coroner or medical examiner as authorized by law.

N. Organ and Tissue Procurement. We may disclose your Protected Health Information to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

O. Clinical Trials and Other Research Activities. If applicable, we may use and disclose your Protected Health Information for research purposes pursuant to a valid authorization from you or when an institutional review board or privacy board has waived the authorization requirement. Under certain circumstances, your Protected Health Information may be disclosed without your authorization to researchers preparing to conduct a research project, for research or decedents or as part of a data set that omits your name and other information that can directly identify you.

P. Health or Safety. We may use or disclose your Protected Health Information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Q. Specialized Government Functions. We may use and disclose your Protected Health Information to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

R. Workers' Compensation. We may disclose your Protected Health Information as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

S. Appointment Reminders. Your Protected Health Information may be used to tell or remind you about appointments.

IV. Uses and Disclosures Requiring Your Written Authorization

For any purpose other than the ones described above in Section III, we only use or disclose your Protected Health Information when you give us your written authorization.

A. Marketing. We must obtain your written authorization prior to using your Protected Health Information for purposes that are marketing under the HIPAA privacy rules. For example, we will not accept any payments from other organizations or individuals in exchange for making communications to you about treatments, therapies, health care providers, settings of care, case management, care coordination, products or services unless you have given us your authorization to do so or the communication is permitted by law.

We may provide refill reminders or communicate with you about a drug or biologic that is currently prescribed to you so long as any payment we receive for making the communication is reasonably related to our cost of making the communication. In addition, we may market to you in a face-to-face encounter and give you promotional gifts of nominal value without obtaining your written authorization.

B. Sale of Protected Health Information. We will not make any disclosure of Protected Health Information that is a sale of Protected Health Information without your written authorization.

C. Uses and Disclosures of Your Highly Confidential Information. Federal and state law requires special privacy protections for certain health information about you ("**Highly Confidential Information or information under 41 CFR Part 2**"), including Alcohol and Drug Abuse Treatment Program records, HIV/AIDS, Communicable Disease(s),

Genetic Testing, Sexual Assault, Domestic Abuse of an Adult, Child Abuse and Neglect, and other health information that is given special privacy protection under state or federal laws other than HIPAA. **We generally do not maintain any Highly Confidential Information.** However, in order for us to disclose any Highly Confidential Information for a purpose other than those permitted by law, we must obtain your authorization.

D. Revocation of Your Authorization. You may revoke your authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below.

V. Your Individual Rights

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your Protected Health Information, you may contact our Privacy Office. You may also file written complaints with the Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your Protected Health Information (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction unless the request is to restrict our disclosure to a health plan for purposes of carrying out payment or health care operations, the disclosure is not required by law and the information pertains solely to a health care item or service for which you (or someone on your behalf other than the health plan) have paid us out of pocket in full. If you wish to request additional restrictions, please obtain a request form from our Privacy Office and submit the completed form to the Privacy Office. We will send you a written response.

C. Right to Receive Communications by Alternative Means or at Alternative Locations. You may request, and we will accommodate, any reasonable written request for you to receive your Protected Health Information by alternative means of communication or at alternative locations.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from the Privacy Office and submit the completed form to the Privacy Office. If you request copies, we may charge you a reasonable copy fee.

E. Right to Amend Your Records. You have the right to request that we amend your Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Office and submit the completed form to the Privacy Office. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

F. Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us during any period of time prior to the date of your request provided such period does not exceed six years. If you request an accounting more than once during a twelve (12) month period, we may charge you a reasonable fee for the accounting statement.

T. Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your Protected Health Information, except to the extent that the Practice, Facility and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office.

G. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on 01/01/2024.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all your Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in our waiting room and on our Internet site. You also may obtain any new notice by contacting the Privacy Office.

VII. Privacy Office

You may contact the Privacy Officer at our entity:

Privacy Office
The Urology Group
2000 Joseph E. Sanker Blvd, Cincinnati, Ohio 45212
Telephone Number: 513-841-7400
Privacy Office Email: privacyofficer@urologygroup.com
Solaris Privacy Office Email: privacyoffice@solarishp.com

Health Information Exchange (HIE) Information:

Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical

information electronically—improving the speed, quality, safety and cost of patient care. The Urology Group participates in the Ohio Health Information Partnership (CliniSync) https://clinisync.org. Patients have the right to Opt-Out from participating in the electronic sharing of his/her Protected Health Information. However, please understand that individuals cannot opt-out of disclosures of information that are required by law (i.e., public health reporting). If you would like to Opt-Out, please contact our Privacy Officer by emailing: privacyofficer@urologygroup.com.

Version 1.0 January 2024