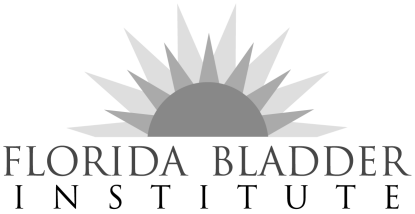

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Amanda Schultz, PA-C ❑

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PATIENT INFORMATION

Name:_____
First Last Maiden Nickname

Address:_____

City, State, Zip:_____

Permanent Address (if different from above): _____

City, State, Zip:_____

Social Security Number:_____ Marital Status: S M W D SEP

Birth Date: _____Age: _____ Race: _____

Home #_____ Work # _____ Cell # _____

Email: _____

Patient's Employer: _____

Spouse/Parent Name: _____ Spouse's DOB: _____

Spouse's Employer: _____

Work # _____ Cell # _____

Spouse's S.S.# _____Person Responsible for Bill: _____

All payments are due at the time of service. Charges will be billed to your insurance carrier.
Forms of payment accepted: Cash, Check, Money Order, Visa, MasterCard, American Express, Discover.
How do you intend to pay for today's visit?

Who may we contact in case of emergency? _____ Phone # _____

DO YOU HAVE HEALTH INSURANCE COVERAGE?

Insurance Company: _____ Medicare: _____ Medicaid: _____

Policy Holder: _____ Policy Holder's SS# _____ DOB:_____

Policy Holder's Employer: _____

Relationship to Patient: _____ Policy/ID # _____Group/Account #_____

SECONDARY INSURANCE COVERAGE?

Insurance Company: _____ Policy Holder: _____

Policy/ID #_____ Group/Account # _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Florida Bladder Institute/Joseph Gauta, MD, Amanda Schultz, PA-C to furnish information to all insurance carriers concerning my illness and treatments and hereby assign all payments for medical services rendered to myself or my dependents to Florida Bladder Institute/Joseph Gauta, MD, Amanda Schultz, PA-C. I understand that I am responsible for any amount not covered by my insurance in the event that an outside collections agency is necessary to enforce payment of the account, I agree to pay for all collection fees deemed reasonable.

_____ _____
Patient Signature Date

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PATIENT HEALTH HISTORY QUESTIONNAIRE

Please complete both pages

Name: _____ Date: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widow Date of Birth: _____ Age: _____

Primary Care Doctor _____ Doctor's Office Phone #: _____

Pharmacy Used/Location_____

Referred by: _____

Reason for Visit: _____

ALLERGIES: ❑ None ❑ If Yes, please list below:

	Medication(s) or Substance	Reaction
1.		
2.		
3.		
4.		

CURRENT MEDICATIONS: ❑ None

	Medication	Dosage	Frequency	Reason
1.				
2.				
3.				
4.				
5.				
6.				

FAMILY HISTORY: ❑ None:

	Age	Heath Problem or cause of death
Father:	_____	_____
Mother:	_____	_____
Siblings:	_____	_____
	_____	_____
	_____	_____
Grandparents:	_____	_____
	_____	_____
	_____	_____
	_____	_____
Uncles / Aunts:	_____	_____

PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

REPRODUCTIVE & MENSTRUAL HISTORY:

Total # of Pregnancies _____
Living children _____
of Vaginal Deliveries _____
Cesarean Sections _____
Weight of Largest Baby _____
Episiotomy Performed? _____

Forceps or Vacuum Used? _____
Date Last menstrual period: ___
Frequency: _____
Flow Amount: _____
Method of birth control: _____
_____

Date of last Pap smear: _____
Are you in Menopause? _____
On hormone replacement? ____
Date of last Mammogram: _____

PAST GYNECOLOGIC MEDICAL / SURGICAL HISTORY: (Do you have or have you ever had):

- ❑ Abnormal PAP Smear
- ❑ Irregular Periods
- ❑ Abnormal Bleeding
- ❑ Menstrual Cramps
- ❑ Ovarian cysts
- ❑ Pelvic adhesions/infections
- ❑ Painful sex
- ❑ Endometriosis
- ❑ Endometrial ablation
- ❑ Fibroids
- ❑ Pelvic inflammatory disease
- ❑ Recurrent vaginitis
- ❑ Hysterectomy – year: ____
- ❑ Ovary Removal – year: ___
- ❑ Tubal Ligation – year: ____
- ❑ D&C - how many? _____
- ❑ Dropped Uterus
- ❑ Dropped Bladder
- ❑ Dropped Rectum
- ❑ Urinary Tract Infections
- ❑ Blood in Urine
- ❑ Interstitial Cystitis
- ❑ Kidney Infection/stone
- ❑ Overactive Bladder
- ❑ Bladder lift/Sling
- ❑ Urinary Incontinence
- ❑ Cystometrogram
- ❑ Cystoscopy
- ❑ Irritable bowel syndrome
- ❑ Fecal Incontinence
- ❑ Pelvic Floor Rehabilitation
- ❑ Appendectomy
- ❑ Lower Back surgery
- ❑ Breast surgery
- ❑ Heart Surgery
- ❑ Pacemaker implant
- ❑ Gallbladder Surgery
- ❑ Colonoscopy
- ❑ Gastric Bypass
- ❑ Hemorrhoid
- ❑ Hernia
- ❑ Hip replacement
- ❑ Hysteroscopy
- ❑ Knee surgery
- ❑ Laparoscopy
- ❑ Splenectomy
- ❑ Tonsillectomy & Adenoids

Please note any other areas of concerns, problems or related health issues:

_____

_____

	Yes	No	If so, how much?
Do you exercise regularly?	❑	❑	_____
Do you smoke?	❑	❑	_____
Have you ever smoked?	❑	❑	_____
Do you drink?	❑	❑	_____
Do you use recreational drugs?	❑	❑	_____
Do you perform Kegel exercises?	❑	❑	_____
Do you wear Pads?	❑	❑	_____
Do you wake up to urinate?	❑	❑	_____
Do you leak when you cough, laugh, sneeze, run, etc.?	❑	❑	_____
How often do you urinate in the daytime?	❑	❑	_____
Do you leak while running to the bathroom?	❑	❑	_____
Do you leak with sexual intercourse?	❑	❑	_____
Do you ever wet the bed?	❑	❑	_____

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Amanda Schultz, PA-C ❑

BLADDER PATIENT SATISFACTION SURVEY

Patient Name_____ Date: _____

Which symptoms best describe you? (Check all answers that apply)

❑ Frequent Urination – Day, Night, or Both
❑ Leaking with Sneezing, Coughing, Exercising
❑ Sudden or Strong Urge to urinate
❑ Leaking with Urge or With No Warning – Unable to make it to the bathroom in time
❑ Unable to Empty the Bladder
❑ Bladder or Pelvic Pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? ❑ Yes ❑ No

If so, which ones have you tried? (Check all that apply)

❑ Detrol LA	❑ Ditropan XL	❑ Cardura	❑ DDAVP
❑ Oxytrol Patch	❑ Enablex	❑ Vesicare	❑ Other
❑ Sanctura	❑ Elavil	❑ Elmiron	_____
❑ Oxybutinin	❑ Flomax	❑ Oxybutinin	

Did these medications help your symptoms?

No Relief – 1 2 3 4 5 6 7 8 9 10 - Completely Cured

If you stopped taking your medications, why? (Check all that apply)

❑ Did not Help ❑ Side Effects ❑ Too Expensive

Explain side effects _____

On a scale from 1 to 10 (1 is worst and 10 is best) how would you describe your satisfaction with your current OAB/Incontinence therapy? Circle One

1 2 3 4 5 6 7 8 9 10

I would like to have even more relief from my bladder symptoms and am interested in hearing about a reversible TEST that is covered by insurance.

❑ Yes ❑ No

Have you ever or are you currently experiencing any problems with bowel or gas incontinence or leakage of stool?

❑ Yes ❑ No

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INSURANCE ADVISORY NOTICE

Please be advised that many insurance companies do not cover annual exams, certain procedures, weight control counseling and screening tests, etc.

Florida Bladder Institute participates with many insurance plans, and it is impossible for us to know what type of plan you or your company has purchased. It is your responsibility to know what type of coverage, benefits, deductibles and co-payments you have with your insurance plan.

If your visit is for an exam or screening test that is not covered under your plan, you will be billed directly. We cannot change our coding of visits to accommodate your coverage. Incorrect coding is considered fraud and can result in large fines for our office and yourself.

In the event that an outside collections agency is necessary to enforce payment of the account, the patient agrees to pay for all collection fees deemed reasonable.

By signing this document, I am aware that it is my responsibility to know what type of coverage, benefits, deductibles and co-payments my insurance requires and allows. I am aware that I will be billed directly for uncovered services.

Please sign and date below:

_____ _____

Patient signature Date

_____ _____

Witness (For office use) Date

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MEDICARE QUESTIONNAIRE

MEDICARE SCREENING SERVICES

Medicare does not cover preventative examination services. However, it does cover some of the screening services that are often provided during a preventative visit. The screening services are discussed below.

COLLECTION OF SCREENING PAP SMEAR SPECIMEN

Medicare reimburses for collection of a screening Pap Smear every two years in most cases. A screening Pap Smear is performed in the absence of an illness, disease, or symptoms. This service is reported using HCPCS code Q0091.

HIGH RISK FACTORS FOR CERVICAL CANCER

- ❑ Yes ❑ No My onset of sexual activity was under 16 years of age.
- ❑ Yes ❑ No I have had five or more sexual partners in my lifetime.
- ❑ Yes ❑ No I have a history of sexually transmitted disease. (PID, Gonorrhea, Chlamydia, Syphilis, Herpes, Warts HPV, or HIV)

HIGH RISK FACTOR FOR VAGINAL CANCER

- ❑ Yes ❑ No I had prenatal exposure to DES (Diethylstilbestrol) DES is a drug that was given to many women during pregnancy for nausea or threatened pregnancy loss.

_____ _____

Patient Signature Date:

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MEDICARE WAIVER OF LIABILITY

Patient Name_____ **Medicare #**_____

Medicare will only pay for services that it determines to be "Reasonable and Necessary" under Section 1862 (A) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. As your provider, I feel that the service listed below is in your medical interest. I believe that, in your case, Medicare is likely to deny payment for this service for the reason(s) stated below:

1) Medicare does not usually pay for this many visits or treatments.
2) **Medicare usually does not pay for this service.**
3) Medicare usually pays for only one rest home visit per month.
4) Medicare usually does not pay for this injection.
5) Medicare usually does not pay for this many injections.
6) Medicare does not pay for this because it is a treatment that has yet to be proven effective.
7) Medicare does not pay for this office visit unless it was needed because of an emergency.
8) Medicare usually does not pay for like services by more than one doctor during the same time period.
9) Medicare usually does not pay for this many services within this period of time.
10) Medicare usually does not pay for more than one visit per day.
11) Medicare usually does not pay for such an extensive procedure.
12) Medicare usually does not pay for like services by more than one doctor of the same or similar specialty.
13) Medicare usually does not pay for this equipment.
14) **Medicare usually does not pay for this lab test.**

……

I have been notified by the provider that, in my case, Medicare is likely to deny payment for the service identified below for the reason(s) stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

There **might** be two portions of your exam that will be covered. Your Pap Smear and Screening exam. Medicare only covers these exams every other year.

Date	Service	Reason	Charge	Signature
_____	**New** Pt. Exam	**Routine**	**$250.00**	**Collect**_____
_____	**Est.** Pt. Exam	**Routine**	**$190.00**	**Collect**_____
_____	**Screening Exam Only**	**Routine**	**$ 42.00**	_____
_____	**Medicare Initial Exam**	_____	**$250.00**_____	_____
_____	**Pap Smear**	**Routine**	**$ 70.00**	_____
_____	**Hemoglobin ****	**Routine**	**$ 14.00**	_____
_____	**Stool Test for Blood****	**Routine**	**$ 11.00**	_____
_____	**Urine ****	**Routine**	**$ 12.00**	_____
_____	**Blood Sugar****	**Routine**	**$ 12.00**	_____

****Medicare will be billed for these items, if they do not cover these items we will bill you.**
Hgb-$14.00, Hmct-$11.00, Urine-$12.00, Blood Sugar-$12.00 = Lab Total $49.00

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Patient Name: _____ **Identification Number:** _____

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need.
We expect Medicare may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:	**1)**Pelvic Screening Exam (includes breast exam)	**2)**Screening Pap Test	**3)**Routine Lab ie: urine screen, hemoglobin, blood sugar	**4)**Misc Lab ie: cultures, biopsies, tests,supplies ** Welcome to Medicare visit**
Reason Medicare May Not Pay:	Covered service every 24 months. Your last billed pelvic screening will be determined by Medicare	Covered service every 24 months. Your last billed screening pap test will be determined by Medicare.	Routine labs are never a covered benefit for Medicare.	Not all charges are deemed medically necessary by Medicare guidelines *visit done by other provider
Estimated Cost:	$42.00	$70.00	$12 urine screen $14 hemoglobin $12 glucose	*$250.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

- ❑ **OPTION 1.** I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ❑ **OPTION 2.** I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
- ❑ **OPTION 3.** I don't want the _____ listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

Form CMS-R-131 (03/08)

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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. If you have any questions about this notice, please contact our office Privacy Officer at
1890 SW Health Parkway, Suite 201, Naples, FL 34109 or call (239) 449-7979.

WHO WILL FOLLOW THIS NOTICE:

This notice describes information about privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION:

This notice applies to the information and records we have about your health, health status, and the health care services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclosed health information about you and describes your rights and our obligations regarding the disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pays us or reimburse you for the service. We may also tell your plan about treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest of benefit to you.

Health-Related Products or Services: We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (see office address at end of notice) that you do not wish to receive such communications, we will use every effort to not use or disclose your information for these purposes.

You may revoke your ***Consent***, at any time by giving us a written notice. Your revocation will be effective when we receive it, but it will not apply to any uses or disclosures which occurred prior to that time.

If you do revoke your ***Consent***, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operation, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS:

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent serious threat to your health and safety or the health and safety of the public or another person.

Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Military, Veterans, National Security, and Intelligence: If you were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you.

Worker's Compensation: We may release health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information about you to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may release health information about you if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring our spouse with you into the exam room during treatment or while your treatment is being discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies or x-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

We will not use or disclose your health information for any other purpose other than those identified in the previous sections without your specific, written ***Authorization.*** We must obtain your ***Authorization*** separate from and ***Consent*** we may have obtained from you. If you give us ***Authorization*** to use or disclose health information about you, you may revoke that ***Authorization*** in writing at any time. If you revoke your ***Authorization,*** but, we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different from the ***Authorization*** and ***Consent*** mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed ***Consent*** and a special written ***Authorization*** that complies with the law governing HIV or substance abuse.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights regarding health information we maintain about you:

Right To Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the practice Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing and other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health care information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right To Amend: If you believe that health information that we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the practice Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect or copy
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request "an accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the practice Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14,2003. Your request should indicate in what form you want the list. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also, have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

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.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will make all reasonable efforts to accommodate this request. For example, you may not wish us to contact you at work.

Right to a Paper Copy of This Notice: You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To receive a copy of this notice, contact the practice Privacy Officer.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date. You are entitled to a copy of the notice currently in effect.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Security of the Department of Health and Human Services. To file a complaint with our office, contact the practice Privacy Officer. You will not be penalized for filing a complaint.

Thank you for taking the time to read this information.

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Amanda Schultz, PA-C

Consent for Purpose of Treatment, Payment or Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Bladder Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Florida Bladder Institute. I understand that diagnosis or treatment of me by Florida Bladder Institute may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Florida Bladder Institute is not required to agree to the restrictions that I may request. However, if Florida Bladder Institute agrees to a restriction that I request, the restriction is binding on Florida Bladder Institute practice. I have the right to revoke this Consent, in writing, at any time, except to the extent that Florida Bladder Institute practice has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information is information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Notice of Privacy Practices for Florida Bladder Institute prior to signing this document.

Notice of Privacy Practices for Florida Bladder Institute has been provided to me.

The Notice of Privacy Practices for Florida Bladder Institute practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of Florida Bladder Institute health care operations.

A summary of the Notice of Privacy Practices for Florida Bladder Institute is also posted in the waiting room.

This Notice of Privacy Practices for Florida Bladder Institute also describes my rights and the duties of Florida Bladder Institute practice with respect to my protected health information.

Florida Bladder Institute reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices for Florida Bladder Institute.

I may obtain a revised Notice of Privacy Practices for Florida Bladder Institute by contacting the office of Florida Bladder Institute at 1890 SW Health Parkway, Suite 201, Naples, FL 34109 or by calling (239) 449-7979.

Name of Patient (Please Print) Signature of Patient or Representative Date

Name of Representative (Please Print) Employee Initials