GULFSTREAM
UROLOGY
ASSOCIATES, P.A.

Adam J. Ball, MD, FACS, Diplomate of the American Board of Urology

DEMOGRAPHICS

Patient name:	Female Male	DOB:_ _/_ _/_ _ Age:
Residential Address:	City/State/Zip	Marital Status: Married Divorced Widowed Single
Reason for visit:	Referred by:	
Emergency Contact Name:	Emergency Phone Number:	

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Gulfstream Urology Associates, P.A. for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning heath care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating & administering claims of benefits.

______________________________ ________________

Patient Signature Date

Private Insurance Authorized for Assignment of Benefits:

I, the undersigned authorize payment of medical benefits to Gulfstream Urology associates, P.A. for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company/agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

______________________________ ________________

Patient signature Date

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Patient Name:______________________ Date:____________________

1. Please list all Allergies:_______________________________________
____

2. Please place a check in the appropriate boxes below indicating if you have the following, or if it has occurred in self or family:

	SELF	FAMILY		SELF	FAMILY
Asthma	____	____	Kidney Stones	____	____
Bedwetting	____	____	Mental/Nervous	____	____
Blood disorders	____	____	Disorders	____	____
Cancer:	____	____	Sickle Cell Disease	____	____
Prostate			Thyroid Dysfunction	____	____
Other_______	____	____	Tuberculosis	____	____
Change in Weight	____	____	Urinary Tract Infection	____	____
Constipation	____	____			
Diarrhea	____	____	Other: ____________________		
Diabetes	____	____	____________________		
Hypertension	____	____			

3. **Females** - Last menstrual period date?: ____________
4. Have you ever had a reaction to: X-ray dye? ____________
   Seafood ? ____________ What kind?____________
   Iodine ? ____________

5. ADULTS ONLY: Do you consume alcohol?____Never______Occasionally___Frequently

6. ADULTS ONLY: Do you smoke cigarettes?____________________
   If "NO", have you smoked cigarettes in the past?____________________
   Please indicate the approximate date that you stopped:____________________
7. List any serious illnesses, injuries, or disabilities you have or have had in the past:____
   ____
   ____

8. Please indicate if you have had any of the following Urologic procedures:
   Kidney X-ray (IVP, CT, U/S) YES/NO Date___/___/_____ Location:__________
   Cystoscopic Exam : YES/NO Date____/___/__________ Location:__________
9. Please list any surgical procedures that you have had in the past:

Procedure	Date Performed	Hospital

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Patient's Name: ______________________________ Date____________

Urological History: (Please answer Yes or No)

1. Do you urinate frequently? Yes No
2. How many times a day? ________
3. Do you awaken at night to urinate? Yes No
4. How many times a night? _______
5. Do you experience pain or burning with urination? Yes No
6. Do you have blood in your urine? Yes No
7. Do you have a weak urinary stream? Yes No
8. Do you strain to urinate? Yes No
9. Have you had bladder or kidney infection? Yes No
10. Do you get sudden urges to urinate? Yes No
11. Do you leak urine at any time? Yes No
12. What causes you to leak?

Women

1. How many children have you had? _________
2. How many times have you been pregnant? _________
3. Do you have pain with intercourse? Yes No
4. Do you still menstruate? Yes No
5. If no, are you on Estrogen replacement? Yes No

Men

1. How many children have you had? ________
2. Have you had a vasectomy? Yes No
3. Do you have difficulty with erections? Yes No

Physician notes

____

____

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Medication list

Medication	Dosage	Frequency

Patient name & DOB: ______________________________

Pharmacy name and location: ______________________________

____

____

International Prostate Symptom Score (IPSS)

Patient Name: ______________________ Today's Date: ______________________

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often do you find it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:		+	+	+	+	+

Total International Prostate Symptom Score = __________

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms
Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

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Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No. Please explain any Yes answers in space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other		

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	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		

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	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

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

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other		

Hematological/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problems	Y	N
Other		

Patient Name: ______________________

Physician use only: Comments/Notes: ______________________

____

____

Physician: ______________________ Date : ______________________

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I acknowledge receipt of this summary of Gulfstream Urology Associates, P.A. Notice of Privacy.

Print Name: ________________ Signature:________________ Date:________

At times patients may wish to have information regarding their medical condition(s), lab reports, medications, appointment times, etc. Discussed verbally with other individuals such as spouse, other family members, friend and caregiver in the office or by the telephone. If this applies to you please indicate below any person authorized to receive verbal information regarding your care.

Name:______________________ Relationship:______________ Date:________

Name:______________________ Relationship:______________ Date:________

Authorization for Treatment

I hereby authorize Dr. Adam J. Ball, or a physician designated by him, or whomever he may designate as assistant to render medical care to me. I consent to care and treatment that may encompass laboratory, diagnostic, or medical treatment that my physician or his assistant may deem necessary for my health and well being.

Signature of Patient

____________________________ Date ____________

Signature of Parent/Guardian

____________________________ Date ____________

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Patient Bill of Rights

1. The patient has the right to high quality care delivered in a safe, timely, efficient, and cost-effective manner without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment.
2. The patient has the right to dignity, respect, and consideration of legitimate concerns.
3. The patient has the right to privacy and confidentiality of all information and records regarding their care.
4. The patient has the right to know the names and qualifications of the physicians, nurses, and other staff members involved in their care.
5. The patient has the right to considerate and respectful care in a clean and safe environment, free of unnecessary restraints.
6. The patient has the right to be involved in all aspects of care. An informed consent following a discussion of risks, benefits, and alternatives should be obtained. The patient has the right to information about current diagnosis, treatment, and prognosis. If it is not advisable to give such information to the patient for health reasons, it should be available to a person designated by that patient or a legally authorized person.
7. The patient has the right to be advised of all reasonable options and alternative care and treatment and the potential advantages and disadvantages of each.
8. The patient has the right to refuse any diagnostic procedure or treatment, and to be advised of the likely medical consequences of such refusal.
9. The patient has the right to education to address his or her needs. The education process will consider the patient's values, abilities, and readiness to learn, and patient and family responsibilities in the care process.
10. The patient has the right to change the practitioner if other qualified are available.
11. The patient has the right to request and receive information about alternate sources of appropriate care.
12. The patient has the right to inspect and obtain a copy of his or her medical records. In addition, the patient has the right to expect a reasonable and timely transfer of information from one practitioner to another when required. Charges for copies of medical records shall not exceed the charges provided for by Section 17 of the Public Health Law.
13. The patient has the right to request and receive information concerning the bill for services regardless of the source of payment.
14. The patient has the right to know about the expectations of the office based practice with regards to his or her behavior and the consequence of failure to comply with these expectations.
15. The patient has the right to help with understanding these rights if they need help.

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Patient Payment Policy

It is your responsibility to provide GUA with your updated insurance and demographic information at the time of your visit. (i.e. current address, telephone, etc.) The following is the payment policy of Gulfstream Urology Associates, PA. We have put this policy in writing so that all patients clearly understand our billing and collections procedures.

If applicable, a co-payment is required on each visit. There are no waivers for co-payments or deductibles.

From time to time your physician must request tests that are medically necessary, but may not be covered by your insurance company. If an Advanced Beneficiary Notice (ABN) form must signed in order to allow you to receive services not covered by your insurance carrier, the form and its financial responsibility will be reviewed with you at the time of service. No services will be provided until the form is signed. After signing an ABN, you are responsible for the total charges due for services provided to you which are not covered by your insurance.

For any procedures performed in the office, verification of insurance benefits will be done prior to your visit. A deposit may be required to pay at the time of service, regardless of benefits. Any monies exceeding your responsibility will be refunded.

The following are allowable forms of payment: cash, check, money order, and ATM/credit card (Mastercard and Visa only).

If you need to cancel your appointment, you must give this office notice at least 24 hours notice in advance of the scheduled appointment. Failure to give proper notice may result in a charge of $25.00 to your account.

Extended payment plans should be discussed with our billing office. In the event that full payment is not received within six (6) months of our initial billing statement to you, your remaining balance and account may be turned over to collections. If your account is turned over to collections, you may be dismissed from the practice for financial non-compliance and you will not be entitled to any medical services except in the event of an emergency, and only for thirty (30) days after you are reported to collections unless your accounts paid in full or are being paid pursuant to a payment plan. A list of other physicians in the area is available upon request.

In the event your check is returned because of insufficient funds in your account, there will be a $35.00 charge added to your account for each returned check. Refund consideration upon patient request.

Billing questions will be handled only during office hours, Monday-Friday, 9:00am-4:00pm. We welcome the opportunity to discuss any aspect of our financial policy with you.

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Receipt of Notice of Gulfstream Urology Associates, P.A. Payment Policy

I,____, hereby acknowledge receipt of Gulfstream Urology Associates, P.A.'s Payment Policy. The "Notice" provides detailed information about how the practice processes your account.

I understand that the practice has reserved the right to change its policies and procedures that are described in the "Notice". I also understand that a copy of any future revisions will be provided to me or made available.

I understand that if I cannot keep my appointment, I need to call Gulfstream Urology Associates, P.A. twenty-four (24) hours in advance to cancel. I agree to pay $25.00 dollars if I do not comply.

I have read and I understand the aforementioned policy. I hereby agree to each and every provision.

Patient:____

Signature:_____________________________ Date:___________

If you are not the patient, please specify your relationship to the patient: ____

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FINANCIAL DISCLOSURE

Dear Valued Patient,

Government regulations require that all patients having services provided must be notified prior to the service the financial relationship between the referring provider and the treatment facility or modality.

Adam J. Ball, MD, FACS is a physician investor and/or has financial interests in several companies and products. They are listed below for your convenience.

- **Theralogix, LLC**
- **University Lithotripter, Ltd.**
- **Tradition Surgery Center, LLC**

Your signature below will also confirm that you have been made aware of your physician's ownership in the companies listed above.

Patient Signature:________________________________ Date:__________

Witness Signature:________________________________ Date:__________

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BY SIGNING THIS AGREEMENT YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL AND YOU ARE AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT

Arbitration Program for Medical Malpractice Claims (3 pages)

Medical malpractice lawsuits are on the rise, and often very lengthy and expensive for all parties. The high cost of malpractice lawsuits contributes to the rising cost of healthcare. As a result, many physicians have been forced to raise their fees, reduce their practices or leave Florida altogether, threatening patients' access to medical care. In order to help combat this cycle, GulfStream Urology Associates, P.A. has adopted an arbitration program. Arbitration is a relatively informal process of resolving disputes outside of the court room. Through arbitration, patients and physicians benefit because they are able to more promptly resolve malpractice claims for less cost to each party. It is also believed that arbitration panels will help to avoid unreasonable jury awards thereby further lowering costs. These cost savings would positively impact medical professional liability rates and the cost and availability of health care services in Florida.

Please thoroughly read this Arbitration Agreement provided to you at check in. If you have any questions, please address these with the front desk or ask to speak with the Practice Manager. Once you have signed the Arbitration Agreement, you will receive two copies of the signed agreement. A third copy will be placed in your medical file. Unless you are seeing the Physician due to an emergent or urgent condition, signing the agreement is a prerequisite to future treatment.

Thank you for your assistance with this program, with your help, we can work together to reduce the rising cost of healthcare.

ARBITRATION AGREEMENT FOR CLAIMS ARISING OUT OF OR RELATED TO MEDICAL CARE AND TREATMENT

1. **AGREEMENT TO ARBITRATE CLAIMS REGARDING FUTURE CARE & TREATMENT.** The patient agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by the undersigned provider of medical services, including any partners, agents, or employees of the provider of medical services, shall be submitted to binding arbitration.

2. **AGREEMENT TO ARBITRATE CLAIMS REGARDING PAST CARE & TREATMENT.** The patient further agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the past diagnosis, treatment, or care of the patient by a provider of medical services, or the provider's agents or employees, shall be submitted to the binding arbitration.

3. **WAIVER OF RIGHT TO JURY TRIAL.** Both parties to this Agreement, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

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4. **ALL CLAIMS MUST BE ARBITRATED BY ALL CLAIMANTS.** All claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or related to treatment or services provided by the provider of medical services, including the patient, the patient's estate, any spouse or heirs of the patient, and any children of the patient, whether born or unborn, at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or, children. By signing this Agreement, the parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

5. **ARBITRATION PROCEDURES.** The parties agree and recognize that the provisions of Florida Statutes, Chapter 766, governing medical malpractice claims shall apply to the parties and/or claimant(s) in all respects except that at the conclusion of the pre-suit screening period and provided there is no mutual agreement to arbitrate under Florida Statutes, 766.106 or 766.207, the parties and/or claimant(s) shall resolve any claim through arbitration pursuant to this Agreement. Within (15) days after a party to this Agreement has given written notice to the other of a demand for arbitration of said dispute or controversy, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other, Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. The parties agree that the arbitration proceedings are private, not public, and the privacy of the parties and of the arbitration proceedings shall be preserved.

6. **ARBITRATION EXPENSES.** Expenses of the arbitration shall be shared equally by the parties to this agreement.

7. **APPLICABLE LAW.** Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes, Section 682.01 et seq. In conducting the arbitration under Florida Statutes, Section 682.01 et seq., all substantive provisions of Florida law governing medical malpractice claims, including but not limited to, Florida's Wrongful Death Act, the standard of care for medical providers, and the applicable statute of limitations shall apply.

8. **EFFECT OF REFUSAL TO PROCEED WITH ARBITRATION.** In the event that any party to this Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of this arbitration Agreement or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this Agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite that party's absence at the arbitration hearing.

9. **SEVERABILITY.** If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

10. **ACKNOWLEDGEMENTS BY PATIENT.** The patient, by signing this agreement, also acknowledges that he or she has been informed that:
    a. **NO DURESS.** The Agreement may not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;

    b. **AGREEMENT BASED UPON OWN FREE WILL.** The decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence by the physician or hospital;

    c. **RECEIPT OF COPY OF AGREEMENT.** I have received two copies of this Agreement;

    d. **BINDING ARBITRATION AND EFFECT ON RIGHT OF APPEAL.** Binding arbitration means that the parties give up their right to go to court to assert or defend a claim covered by this Agreement. The resolution of claims covered by the Agreement will be determined by a neutral panel of arbitrators and not a judge or jury. Each party is entitled to a fair hearing, but the arbitration procedures are simpler and more limited than rules applicable in court. Arbitration decisions are as enforceable as any court order. The decision of an arbitration panel is final and there will generally be no right to appeal an adverse decision.

    e. **READ AGREEMENT & UNDERSTOOD.** I understand that I have the right to have my questions about arbitration or this Agreement answered and I do not have any unanswered questions. I execute this Agreement of my own free will and not under any duress.

Patient/Responsible Party Signature: ______________________ **Date:** __________

Name Printed: ______________________________ **DOB:** __________

By______________________________ **Date:** __________
Parent or Guardian if patient is a Minor (Sign &Print name)

Dr.______________________ **Date:** __________
On behalf of GulfStream Urology Associates, P.A.

Dr. ______________________ **Date:** __________
Adam J. Ball., F.A.C.S

Please DO NOT use Patient Portal to communicate with your Practice for urgent or emergency medical issues. If you are experiencing an urgent medical need, please contact us by phone. For emergencies call 911.

Patient Portal User Agreement and Consent Effective: October 9, 2015

The Patient Portal (defined below) is owned and operated by the practice to which you are seeking to online access (the "Practice"). The Practice has adopted this user agreement ("User Agreement" or "Agreement") to make you aware of the terms and conditions of your use of the Patient Portal and any derivative websites of the Patient Portal (collectively, the "Patient Portal"). In the event that you purport to be the agent of, represent, or otherwise act on behalf of any other person, references to "you," "your" or "User" shall include such entity or person in addition to such representative, and your acceptance of this Agreement shall constitute acceptance on behalf of such person.

The Practice uses reasonable efforts to maintain the Patient Portal, but the Practice is not responsible for any defects or failures associated with the Patient Portal, any part thereof or any damages (such as lost profits or other consequential damages) that may result from any such defects or failures. The Patient Portal may be inaccessible or inoperable for any reason, including, without limitation: (a) equipment malfunctions, (b) periodic maintenance procedures or repairs which the Practice may undertake from time to time or (c) causes beyond the control of the Practice or which are not foreseeable by the Practice. In addition, the Practice makes no guarantees as to the web sites and information located worldwide throughout the Internet that you may access as a result of your use of the Patient Portal, including as to the accuracy, content, or quality of any such sites and information or the privacy practices of any such site. The Practice is not a backup service for storing data you submit to the Patient Portal, and the Practice shall have no liability regarding any loss of such data. You are solely responsible for creating backups of any data you submit using the Patient Portal

The Patient Portal is a secure website that allows you to use a computer to interact with medical information via the internet. The Patient Portal also allows you to communicate with the Practice via secure messaging. Please note that all communication via the Patient Portal will be included in your permanent patient record.

Responsibilities, Risks and Benefits:

The Patient Portal is provided as a convenience to you at no cost and is only available in English at this time. We do not sell or give away any private information, including email addresses. We reserve the right to suspend or terminate the Patient Portal access at any time and for any reason. All messages sent to you will be electronically secure. Messages and emails from you to any staff member must be sent through the Patient Portal for security and confidentiality reasons. The Patient Portal messages will be handled by our staff in a manner similar to how phone communication is handled. Although we strive to reply to Patient Portal messages within one business day, we cannot guarantee that we will be able to address your messages in that timeframe. We encourage you to use the Patient Portal at any time but understand that we can only reply to messages during our office hours, excluding holidays recognized by the Practice. If

you do not receive a response within two business days, please feel free to call our office. You are responsible to provide us with your correct email address and inform us immediately of any change. You are also responsible for the protection of your login information and password. Please understand that all electronic communications carry some degree of risk, even in a secured environment. Even with all due precautions, online communications may be intercepted, forwarded or changed without a patient's or the healthcare provider's knowledge. By using or accessing the Patient Portal, you expressly accept these risks. Note that it is easier for a patient's identity to be stolen or for someone to try to impersonate a patient via online communication. Online communications are admissible as evidence in court just as medical records are in the event the physician-patient privilege is waived or if a court orders disclosure. Online communications may disrupt or damage a computer if a computer virus is transmitted via an attached file, hyperlink or other method. You assume liability for such disruptions or damages caused by such transmissions. Responses to online communications are limited by the information provided and your question may necessitate a follow-up phone call or a request to meet with you in person to gain further information. Electronic communications will be viewed by not only the physician, but the staff members assigned to handle such communications and any other provider covering for the patient's physician if the patient's physician is unavailable to respond. Applicable law may allow a health care professional to determine that a minor patient is "mature" to keep a portion of the minor's medical information confidential. If the minor patient is determined "mature" by his or her physician, all Patient Portal communication will be with the minor directly and a new consent form with the minor's email address will be required. Applicable law may also permit confidential communication with a minor patient in regards to treatment and reporting of sexually transmitted diseases to the minor and communications with pregnant minors in regards to questions about the health of her fetus. In these situations, all Patient Portal communications will be directly with the minor and a new consent form with the minor's email address will be required. The Practice will keep a copy of all medically important online communications in your medical record secure pursuant to applicable federal and state laws and regulations. Print or store in a secure place (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you. The Practice will not forward online communications with you to third parties except as authorized or required by law. Please note that online communications should never be used for emergency communications or urgent requests. These should occur via telephone or using existing emergency communications tools as noted above. Follow-up is solely your responsibility. You are responsible for scheduling any necessary appointments and for determining if an online communication did not receive a response. You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. The Practice is not responsible for breaches of confidentiality caused by you or an independent third-party.

Guidelines for Safe Online Communications:

Take steps to keep your online communications to and from the Practice confidential, including:

Do not store messages on your employer-provided devices (e.g. computer, cell phone, tablet, etc.); otherwise personal information could be accessible or owned by your employer. Use a screen saver or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private. Do not allow other individuals or third parties

access to the devices(s) upon which you store medical communications. Keep your login and password information secure and confidential. Do not use email for medical communications. Standard email lacks the necessary security and privacy features and may expose medical communications to employers or other unintended third-parties.

Access to Online Communications:

The following pertains to access to and use of online communications:

Online communications do not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement. The Practice may stop providing online communications with you or change the services provided online at any time without prior notification to you.

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All of my questions have been answered and I understand and concur with the information

Print Patient Name: ____

Date of Birth _________________________________

Email address: ____

Signature: ____

Date: _______________________________________

I am over the age of 18 and have sole responsibility of my medical care

□ Yes
□ No

(We do not offer the Patient Portal to minors or those patients which do not make their own medical decisions at this time. We apologize for the inconvenience.)

I choose not to participate in Patient Portal at this time because:

□ I do not have an E-mail address
□ I do not wish to share my E-mail address
□ English is not my preferred language
□ Other