PATIENT SIGN-IN SHEET

Date ____________________ Referred By ____________________

Patient's Name (first, middle, last) ____________________

Permanent address ____________________ City ________ State ________ Zip ________

Phone home ( ) - - Cell ( ) - -

Patient's e-mail address ____________________

Patient's Date of Birth ________ Age ________ Sex ________

Primary Ins Subscriber's Name & Date of Birth ____________________

Secondary Ins Subscriber's Name & Date of Birth ____________________

Drivers License No. ____________________ Social Security Number ____________________

Occupation ____________________

Employer Name and Address ____________________

____________________ Work Phone ____________________

Marital Status (circle one): Single, Married, Widowed, Divorced, Separated

Spouse's Name : ____________________ Employed by ____________________

____________________ Work Phone ____________________

If someone other than the patient is responsible for payment, please list their name and address:

(This does not pertain to insurance payments

____________________ ________

____________________ ________

Medicine Allergies: ____________________ ________

MEDICAL INSURANCE: F For copying purposes, please give your insurance I.D. Card to the secretary

Patients or Authorized Person's Signature. I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignments below.

Signed ____________________ Date ____________________

I authorize payment of medical benefits to undersigned physician for service described below

Signed (insured or authorized person) ____________________ Date ____________________

ANY AMOUNT NOT COVERED BY YOUR INSURANCE SHOULD BE PAID AT THE TIME SERVICES ARE PROVIDED.

$10.00 CHARGE FOR ALL RETURNED CHECKS

PAYMENT IS EXPECTED AT EACH APPOINTMENT

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED BY ME.

Patients signature ____________________ Date ____________________

Carlos G. Arcangeli, MD
Mark A. Rosen, MD
Urology
A Professional Corporation
Diplomate of the American Board of Urology

A Message To Our Patients About Arbitration

Our goal is to provide medical care to our patients in a way that will avoid disputes. We know that most problems occur as a result of miscommunication. So, if you have concerns about your medical care, please discuss them with us.

Please read the attached contract entitled Physician-Patient Arbitration Agreement. By signing the contract, we are agreeing that any dispute arising out of the medical services you receive will be resolved in binding arbitration before an arbitration panel instead of by a lawsuit in a court of law.

Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

We believe that the method of resolving disputes in arbitration spares the parties some of the rigors of a court trial and the publicity which may accompany judicial proceedings.

Thank you.

1595 Soquel Drive Suite 110   Santa Cruz California 95065
Phone 831-475-6500   Fax 831-475-4533

Effective Date April 14, 2003

Carlos G. Arcangeli, MD
Mark A. Rosen, M.D.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMTATION. PLEASE REVIEW IT CAREFULLY

Why am I receiving this Notice? We are required by law to maintain the privacy of your health information we are required to inform yo of our legal duties and privacy practices where your protected health information is concerned.

This notice contains a summary of our health information privacy practices and of your rights relating to your health information. In the absence of an express statement to the contrary, this notice is not intended to preclude or restrict uses or disclosures of health informatio that are otherwise permitted by law, or to give you rights that we are not required by law to give to you.

We are required to follow the terms of this Notice of Privacy Practices. We also have the right to change the terms of this notice, and to make the new notice effective for all health information we maintain. If we make material changes to this notice, you will be provided a updated copy at your next office visit.

How do you use and disclose my health information? We maintain health –related records about you, including medical records and billing and payment information. We use this information and disclose it to others for the following purposes.

Treatment. We use your health information to provide health care to you and to coordinate your health care with other providers, and we disclose it to other health care providers to enable them to provide health care services to you. For example, it we refer you to a specialis physician we send all or a part of your health record to the specialist to assist him or her in evaluating and treating you.

Payment. We use and disclose your health information to obtain payment for health care services we provide to you, including determining your eligibility for benefits. For example, we may send a claim to your insurer that contains information about the services we provided to you, or we may send a bill to a family member who is responsible for paying for your care.

Health care operations. We use and disclose your health information as necessary to enable us to operate our medical practice. For example, we use our patients' claims information for our internal financial accounting activities, and we review health records to ensure quality.

We also disclose health information to our contractors and agents who assist us in these functions, but we obtain a confidentiality agreement from them before we make such disclosures s for payment or operational purposes. For example, companies that provide or maintain our computerized health information in the course of providing services to us.

Contacting you. We may contact you to provide appointment reminders or information about treatment options available to you. We may also contact you about other health-related services that may interest you.

Others involved in your care. Unless you object, we may disclose medical information to a friend or family member who is involved in your care, to the extent we judge necessary for their participation.

Other disclosures. We may disclose health information without your authorization to government agencies and private individuals and organizations in a variety of circumstances in which we are required or authorized by law to do so. Hear are the general kinds of disclosures we may be required or allowed to make without your authorization:

- Disclosures that are required by state or federal law
- Disclosures to public health authorities or to other persons in connection with public heath activities.
- Disclosures to government agencies authorized to receive reports of abuse or neglect of children or dependent adults or domestic violence
- Disclosures to agencies responsible for overseeing the health care system, for audits, inspections or investigations
- Disclosures for judicial and administrative proceedings, such as lawsuits.
- Disclosures to law enforcement agencies
- Disclosures to coroners and medical examiners
- Disclosures to organ procurement agencies, if you are an organ donor or possible donor
- Disclosures to researcher conducting research under the auspices of an Institutional Review Board or privacy board\

- Disclosures to avert a serious threat to health or safety.
- If you are a member of the armed forces or a veteran, we may release health information to your military command authori or to the veterans administration to assist in determining your eligibility for veterans ' benefits, Disclosures to assist authorized federal officials in national security activities, or for the provision of protective services to officials.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the institution or official.
- Disclosure to other agencies administering government health benefit programs, as authorized by law.
- Disclosure to comply with worker' compensation laws

Limitations. In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described above. For example, government health benefit programs may limit the disclosure of health information for purposes unrelated to the program. In addition, there are special restrictions on the disclosure of health information relating to HIV/AIDS status, mental health treatment, developmental disabilities, and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.

Authorization. Except as described above, we will not permit other uses and disclosures of your health information without your written authorization, which you may revoke at any time in the manner described in our authorization form

Your Rights

What rights do I have as a patient of this practice? As a patient of this practice, you have the following rights:

- You have the right to ask us to restrict certain uses and disclosures of you health information. However, we are not require to agree to any restrictions requested by our patients.

- You have the right to receive confidential communications from us, for example by asking us to contact you at a particular telephone number, post office box or other address.

- You have the right to see and copy any certain records that we maintain. These include our medical records and billing records concerning you. Under certain circumstances, we may deny your request. If your request is denied we will tell you the reason why in writing. You have the right to appeal the denial.

- If you feel the information in our records is wrong, you have the right to request us to amend the records. We may deny your request in certain circumstances. . If your request is denied, you have the right to submit a statement for inclusion in the record.

- You have the right to receive a report of non-routine disclosures that we made of your health information, up to six years prior from the date of your request (but not earlier than April 14, 2003). There are some exceptions: for example, we do no maintain records of disclosures made with your authorization; disclosures made for the purposes of treatment, obtaining payment for health services, or operating a medical practice; disclosures made to you; and certain other disclosures.

- If you received this notice electronically, you have the right to request a paper copy form us at any time.

The foregoing is a general statement of your rights. They are subject to all limitations permitted or required by law.

How do I exercise these rights? You can exercise any of your rights by sending a written request to our Privacy Official at the address below.

How do I file a complaint if my privacy rights are violated? You have the right to file a complaint with our Privacy Official if you believe your privacy rights have been violated. You must provide us with specific, written information to support your complaint. You may also file a complaint with the Secretary of Health and Human Services. We will not retaliate against you in any way for filing a complaint.

Contact us at: Carlos G. Arcangeli, MD, 1595 Soquel Drive, Ste 110 Santa Cruz CA 95065 Phone 831-475-6500

Contact the Secretary of Health and Human Services at: Secretary of Health and Human Services, Office for Civil Rights, 50 United Nations Plaza, Room 322, San Francisco CA 94102

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
FOR
CARLOS G. ARCANGELI, M.D
MARK A. ROSEN, M.D.

SIGNATURE

Date:________________________ Time_________________a.m/p.m.

Printed Name:____

Signature:____
(*Patient/Representative/Spouse/Financially responsible party)*

If signed by someone other than the patient state your legal relationship to the patient:

____