

WELCOME!

UROLOGY FOR CHILDREN – MAIN OFFICE
200 Bowman Dr., Ste. E-360
Voorhees, NJ 08043
Telephone: (856) 751-7880

Fax: (856) 751-9133
NPI: 1780736686

When you choose Urology for Children, LLC (UFC), your child's urological concerns become our responsibility and we work as hard for your child's health as you do. We all share that commitment, setting high standards for ourselves and the quality of our care and we deliver on that promise through caring, convenience, and qualifications.

We will attempt to have you see your child's personal provider at each of your appointments. However, if he or she is not available, our providers work as a team and use our electronic medical records system to provide coordinated care.

In order to facilitate your appointment, we ask that you please take a few moments and complete the enclosed forms. By doing this prior to your office visit, we hope to make your visit as efficient as possible. We will need you to bring the following to your appointment:

- | | |
|------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Completed New Patient Paperwork | <input type="checkbox"/> CD disk and reports, if performed, relating to your current problem |
| <input type="checkbox"/> Insurance cards | <input type="checkbox"/> Any Lab Test Results |
| <input type="checkbox"/> Driver's license or picture ID | <input type="checkbox"/> Legal documentation certifying guardianship status (if applicable) |
| <input type="checkbox"/> Insurance copay | |
| <input type="checkbox"/> List of medications and allergies | |

If your insurance requires a referral or pre-authorization when seeing a specialist, please contact your primary care physician and confirm this has been completed.

We appreciate you taking the time to help us streamline your visit and serve you as efficiently as possible. If you have any questions or need any assistance, please call our office. We will be happy to help you in any way we can. We look forward to meeting you and your child soon.

GENERAL INFORMATION

Scheduling Appointments

Please make sure you keep our office up-to-date with your current insurance information so we can properly receive the necessary referral and/or authorizations before your scheduled appointment. Be sure to tell the receptionist the reason for the appointment so we can schedule with the best-suited provider and on a date and time that allows for all imaging studies, records, referrals, and authorizations to be received **prior to** or the day of the visit. If all information is not available by the appointment time, most likely your appointment will have to be rescheduled. Patients arriving more than fifteen minutes after their scheduled time, without a referral and/or without films, test results or studies, may also need to be rescheduled. Our office will work with you to procure this information but, ultimately, it is left up to you to ensure our office receives this important information.

Regular Office Hours

Monday through Thursday 8:30 a.m. to 5:00 p.m. Friday 8:30 a.m. to 4:00 p.m.



Office Locations

New Jersey

200 Bowman Dr., Ste. E360
Voorhees, NJ 08043

239 Hurffville-Crosskeys Rd., Ste. 240
Sewell, NJ 08080

1000 Atlantic Avenue
Camden, NJ 08104

Pennsylvania

160 East Erie Ave., Ste. 2205
Philadelphia, PA 19134

2701 Blair Mill Rd., Ste. 6 1521 8th Avenue, Suite 201
Willow Grove, PA 19090

Bethlehem, PA 18018

After Hours Emergencies

Health care emergencies can happen anytime. If you have an urgent problem and the office is closed, call us anyway at (856) 751-7880. We're on call 24 hours a day. If you feel that you have a life-threatening emergency, call 911 or go straight to the nearest hospital emergency department. Please remember, it is your responsibility to inform the practice regarding care with any other health care facilities and providers.

First Visit and Follow-up Visits

On your first visit, check-in at the reception desk so your information can be reviewed for accuracy. You can help us serve you better by notifying the receptionist of any changes in name, address, telephone number, or insurance coverage since the time of your last visit. Verifying this information at each visit will help ensure the accuracy of submitting your services to your insurance company in a timely manner.

We try to follow our scheduled appointments as closely as possible. However, due to unavoidable circumstances, a provider may be called away to perform emergency surgery or may have to spend additional time with a patient who may have an appointment prior to yours. This may result in a delay in seeing your provider. We appreciate your patience and understanding in such circumstances.

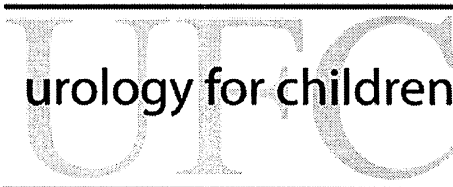
Prescriptions and Refills

Please evaluate your medication supply prior to your office visits and try to correlate all refills with your scheduled appointments. Should refills be requested after a visit, they will only be authorized if the provider determines there is an extenuating circumstance warranting a refill outside of the timeframe of a scheduled office visit. In those situations, the refill will only be performed during normal office hours and will require a 24-hour turnaround time.

When you call, please have the following information ready: patient name and date of birth; prescription name and number; pharmacy name and telephone number. Please check at the pharmacy after 24 hours - please do not first recall our office. We will only call you back if there is a problem with refilling your request. If you utilize mail in a pharmacy, we will attempt to electronically prescribe the medication. If we cannot electronically complete the prescription and have to write the prescription, it becomes your responsibility to pick up the script and mail it in.

Surgical Deposits

The decision to proceed with a surgical procedure is often a difficult one. At UFC, we respect your need for certainty regarding your decision to schedule a surgical procedure for your child. The administrative work involved in booking a procedure is extensive. Just as you would like to be certain of your choice, we also need to know that your decision is well thought out and secure. We require a \$250 surgical deposit to be paid at the time of scheduling the procedure. If the amount of your deposit exceeds the actual amount that is owed (after all charges and payments have been applied to your account) you will be issued a refund.



PATIENT REGISTRATION

PLEASE PRINT CLEARLY TO ENSURE CORRECT SPELLING/ PUNCTUATION IN OUR SYSTEM
(EVERYTHING MUST BE FILLED OUT)

Patient Information

Name: _____ Nickname: _____ Date of Birth ____/____/____
SSN: _____ Phone: (____) _____ Cell: (____) _____
Home Address: _____ APT#: _____
City: _____ State: _____ Zip Code: _____

(PLEASE PROVIDE TWO PHONE NUMBERS IN CASE WE ARE UNABLE TO REACH THE FIRST ONE)

Guarantor/Parent/Caretaker Information (Responsible party other than patient)

Name: _____ Date of Birth ____/____/____ SSN: _____
Phone: (____) _____ Cell: (____) _____
Home Address: _____ APT#: _____
City: _____ State: _____ Zip Code: _____
Relationship to patient: _____ Parent's email: _____
Employer Name: _____ Address: _____ Phone: (____) _____

Insurance Information (Company name only)

Primary: _____ Subscriber Name: _____ Subscriber DOB: _____
Secondary: _____ Subscriber Name: _____ Subscriber DOB: _____
Other: _____ Subscriber Name: _____ Subscriber DOB: _____

Emergency Contact Information (Preferably someone with an alternate phone number from home phone number)

Name: _____ Relationship to Patient: _____ Phone: (____) _____

Communication Preferences

How do you wish to receive appointment reminders:

☐ Text # _____ (If different from above) ☐ Phone Call # _____ (If different from above)

Pediatrician/Primary Care Provider (PCP)

Physician/Practice Name: _____
Phone: (____) _____ Address: _____

Referring Physician/Practice/Institution

☐ Check box if same as Pediatrician/Primary Care Provider (PCP)

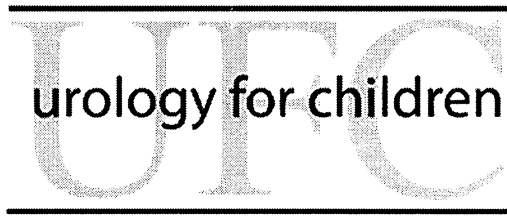
Referring Physician/Practice/Institution Name: _____
Phone: (____) _____ Address: _____

Desired Pharmacies

Pharmacy Name: _____ Phone: (____) _____ Location: _____
Pharmacy Name: _____ Phone: (____) _____ Location: _____

By signing below, I certify that the information provided in this document, and any other documents completed for Urology for Children, to be true and correct to the best of my knowledge.

Patient/Parent/Guardian Signature: _____ Date: _____



200 Bowman Dr Suite E-360 Voorhees, NJ 08043
NJ 856-751-7880 PA 888-876-7880 Fax 856-751-9133

Gregory E. Dean, MD, FACS, FAAP
Michael G. Packer, MD, FACS, FAAP
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Diana London, MSN, FNP-BC
Michelle Sheel, MSN, CPNP

Cultural Competency:

State of New Jersey mandates that every physician document and barrier to care including cultural and linguistic needs in the medical record. Factors affecting care are visual and auditory factors which may impede the member's ability to comprehend medical discussion. Language, cultural and/or religious customs, which may impact the provider's ability to provide medical care. Addressing these needs will improve patient satisfaction and also decreasing health care disparities. When documenting cultural competency in the member's medical record, it's imperative to document if no barrier exists.

Please answer the following question:

Do you have any impairment? (i.e. Visual, hearing, speech, learning, physical and language/cultural barrier)

Yes _____ No _____

What languages do you speak, read and write? _____

Do you have any religious or cultural customs that the doctor should know about? Yes _____ No _____

If yes, please describe:

Advanced Directives: Advance directives are federal and state mandated Self-Determination Act enacted in 1990. This allows the patient to provide specific instruction and direction regarding his/her own medical care wishes if they become incapacitated. The patient-physician relationship provides a direct opportunity for you to discuss these types of decisions with your patient. Physicians need to ask and document in the medical record for all patients who are 18 years of age and older.

Please answer the following questions:

Is the patient 18 years or older? Yes _____ No _____

If "yes", Do they have a "Living Will" or Advanced Directive? Yes _____ No _____

If the patient is over the age of 12, the following questions must be answered:

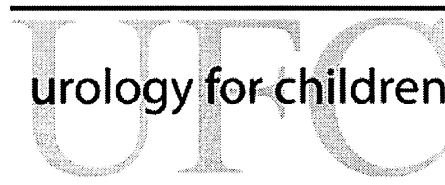
Does the patient smoke cigarettes? Yes _____ No _____ If "yes" how many packs per day _____

Is there any alcohol or substance abuse? Yes _____ No _____

Patients Name: _____ Date of Birth: _____

Signature(Parent/Guardian IF patient is under 18 years old): _____

Relationship to patient: _____ Date: _____



GUARDIANSHIP DOCUMENTATION

(Must be completed prior to appointment)

Patient Information

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Date of Birth: _____

Guardianship Questions

1) What is your relationship to the patient? _____

****Please complete the following questions below.**

2) Do you have the legal custody to make medical decisions on behalf of the patient? _____

****If NO**, please provide the name, relation, and legal documentation of the individual who has custody to the patient with medical rights

Name : _____

Relationship to Patient: _____

Forms of documentation accepted: Proof of judicial decree, court ordered by a judge, proof of guardianship through legal will, or copies of court-ordered documentation.

3) If a case worker has been assigned to the patient, please provide that information below

Caseworker Name: _____

Caseworker Phone Number: _____

Caseworker Email: _____

UFC Guardianship Policies

- All parents or legal guardians must provide a photo ID at the time of the appointment.
- If you are not in legal custody of the patient, and cannot provide legal documentation of guardianship, as well as a detailed medical history of the patient, then the patient's appointment will be canceled.

Parent/Legal Guardian Name (Print)

Parent/Legal Guardian Name (Signature)



FINANCIAL AND PRIVACY POLICIES AND PROCEDURES

At Urology For Children, we believe that all patients who are rendered care at this office deserve the best medical care that can be provided. In order for us to provide you with the highest quality medical care and current technology, we must ensure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met, we provide you with this Agreement regarding our financial policy and your agreement to pay for services provided. Please sign and date this Agreement on the last page to indicate you accept these terms.

PAYMENT AT TIME OF SERVICE, FEES AND COLLECTIONS

Your insurance policy is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance carrier. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, non-covered charges and "usual and customary" charges. If your insurance carrier does not provide payment within 60 days after treatment, you will be responsible for payment. You are responsible for timely payment on your account. Urology For Children, is required in accordance with its contract with your insurer to collect from you deductibles and copayments at the time of service. We will try to determine your copay and how much of your yearly deductible under your policy has been met for the year.

We will require that you pay any amount not covered by your insurance, such as un-met deductibles and copayments under your policy, on the day of service. Our policy is to collect it prior to seeing the doctor. If your plan requires you to pay co-insurance, you will be required to pay that amount. If you are unable to pay your copayment at check-in, another appointment will be made for you, unless you have a credit card on file with us. Any additional payment owed will be collected in full at the time of service. If needed, we are happy to work with you to arrange a payment plan.

It is your responsibility to provide us with your current insurance card and photo identification at every visit so that we may bill the correct insurance company in a timely fashion. It will be reviewed or copied every time you are here for a visit, no matter how frequently you are seen. If a claim is rejected because your insurance does not cover the type of service rendered, you will be held responsible for the outstanding balance. **Please call the telephone number on your insurance card before your appointment and they will assist you in determining whether the service to be provided at the appointment is covered, the amount of your copay and the amount of your deductible.** It is your responsibility to understand your insurance coverage. If your insurance does not cover the cost of your visit or procedure, you will be responsible for the charges for all services rendered. Please educate yourself as to your coverage so that office visits, procedures, testing, and specialist referrals may be arranged to best suit your needs.

Once we determine your personal financial obligation or after your insurance company reimburses Urology For Children, for a portion of your care, we may mail you one (1) statement. Payment is expected upon receipt of the statement. Any account past due by 30 days or more may be subject to submission to our collection agency. If your account becomes delinquent and is placed into our collection process, **collection fees will be your responsibility and added to your balance.** Urology For Children, reserves the right to discharge any patient at this point. By signing our financial policy, you agree to pay these added fees, along with any and all costs associated with the collection of your account, including interest charges and attorney fees. We may contact you by mail, email or automated call system if we need to speak to you regarding your insurance or billing issues. This form authorizes these contacts.

If a new problem is encountered, or if changes in treatment of a pre-existing condition are discussed in the process of performing a visit or exam, an additional copay and deductible payment may be incurred.

If you are seen in our office by a nurse or a medical assistant for minor medical services you may be charged a limited office visit, and applicable co-pays will be collected.

If you carry a balance on your account during the time you present at our office, a payment on your account will be required at the time unless a Credit Card is kept on file or a payment plan is in place. Urology For Children, reserves the right to terminate any patient who misses a payment. Under unusual circumstances, we are willing to work out personalized payment schedules if you so require and can demonstrate need. We accept cash, check or credit card.

CREDIT CARD ON FILE

In an effort to reduce costs and unnecessary use of paper, we will be reducing the amount of statements we send out from our office in the mail. We may require a credit or debit card on file with our office. Statements are wasteful of paper, stamps, and envelopes and are not efficient. We need to ensure that we have a guarantee of payment on file in our office. Times are changing in healthcare, and we need to be sure that patient responsible balances are paid in a timely manner. We have to be fair and apply the policy to all patients. We have wonderful patients and we know that most of you pay your balances. Unfortunately, this is not the case every time.

You will receive a letter in the mail from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits, or EOB. This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay. We receive the same letter that you do. It arrives about 20 – 30 days after your appointment. We look at each Explanation of Benefits (EOB) carefully, and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a bill for in the mail.

We do not store your sensitive credit card information in our office. We store it in a secure fashion with a reputable financial firm called a

Urology for Children

gateway. We access your information only on this site to process a payment. You will be required to sign a credit card on file authorization statement that will allow us to charge an amount agreeable to each of us until your balance is paid in full.

We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the letter they send to us and the amount that you have agreed to, in the same way that we normally determine how much to send you a bill for in the mail.

ELECTIVE PROCEDURES/NON-COVERED PROCEDURES

Patients are required to pay the estimated self-pay portion of elective/non-covered procedures prior to services being rendered based on insurance verification and eligibility of benefits.

SUBMISSION OF CLAIMS

We will submit your insurance claims. However, it is important to remember that your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

PAYMENT OPTIONS

Our office accepts most credit and debit cards. Our office also accepts valid check or cash. There will be a \$50 fee for all returned checks. Once we have a returned check for you, we may require that all future payments be with cash, money order, cashier's check or credit card. Anytime a co-pay, deductible or balance is due, we will charge the fee to your credit card which will help to keep you at a zero balance and paid up in full with your credit card on file.

CASH PAYMENT

If you wish to pay cash, you will always be provided with a receipt so that you will have a record of your payment. Please make us aware if you are not provided a receipt.

NON-CONTRACTED INSURANCE (Out of Network)

If you have an insurance plan that we do not participate with, you may have out-of-network benefits. These benefits typically have a higher copay, coinsurance, and/or deductible out of pocket cost. You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits.

UNINSURED/SELF-PAY

We offer a discount to all self-pay patients who pay in full at time of service. Payment is expected at each visit. All other ancillary, treatment and future care will be reviewed with you in order to make arrangements for payment.

MISSED APPOINTMENTS/NO SHOWS/LATE FOR APPOINTMENT

We understand that you may not be able to keep all of your scheduled appointments or might occasionally be late. Please understand that missed appointments have a detrimental impact on our practice and other patients. They also affect our ability to serve other patients in need of medical care. We understand there may be inclement weather or other circumstances that may require you to cancel your appointment. If you must cancel or re-schedule your appointment, please do so at least 24 hours in advance. Failure to cancel or reschedule an appointment at least 24 hours in advance will be considered a no-show. We reserve the right to charge you \$50.00 for any no-show if permitted by law and your insurance contract. Payment of the missed appointment will be required prior to scheduling another appointment. Urology For Children, reserves the right to impose a hold charge on your credit or debit card in order to ensure you keep your appointment. If you fail to show for the appointment the charge will be levied against your credit or debit card. Urology For Children reserves the right to discharge any patient with more than two no-show appointments upon 30 days written notice to the patient to seek medical help from another practice.

If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointment. If you are more than 15 minutes late for an appointment, Urology For Children, may reschedule your appointment and refuse to see you at the originally scheduled time due to the scheduling impact on other patients.

REFERRALS

If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that our office receives current valid authorization. If you do not have a valid referral or authorization at the time of service, we will be unable to treat you until a valid authorization/referral is obtained, and you may be sent back to your primary care physician to obtain authorization prior to being treated or full payment will be expected at the time of service. Please remember that it is your responsibility to make sure we are on your plan's provider listing. We appreciate your understanding of the ever-changing requirements of managed care plans and our position to adhere to their policies or requirements.

FORMS AND MEDICAL RECORDS FEES

Due to the increasing costs of providing our patients with the highest standards of care, we must impose a charge for certain records and forms. It takes time for our providers and staff to retrieve and copy files, complete forms and write letters. Additional charges may apply for the following type of forms or documents:

FMLA, Disability, Corps, School forms not completed during an appointment, and Supplemental insurance forms, dictated letters, extensive forms with review of medical records

Copies of records for personal use will be charged an amount allowed by the States of New Jersey and Pennsylvania which is currently \$.75 per page and postage.

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid and commercial insurance benefits be made on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents, or any other insurer and its agents, any information needed to determine these benefits or the benefits payable for related service.

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Urology For Children, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or this assignment.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to review Urology for Children's HIPAA Privacy Practices Notice and understand that the information is also available online at urologyforchildren.com.

AUTHORIZATION TO RELEASE OR REQUEST INFORMATION

I hereby authorize Urology For Children: (1) to release or request any medical records or other information necessary to any healthcare providers or insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for all services provided to me by Urology For Children. This order will remain in effect until revoked by me in writing.

Patient Name (PRINT)

Patient's Date of Birth

Name of Person Financially
Responsible for Patient's
Treatment (PRINT)

Name of Person Financially
Responsible for Patient's
Treatment (SIGNATURE)

Today's Date

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your medical services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement HIPAA/@Notice of Privacy Practices.doc officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or

NOTICE OF PRIVACY PRACTICES

the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Urology for Children
200 Bowman Dr., Ste. E-360
Voorhees, NJ 08043
Ph #: 856-751-7880

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
8776966775 (tollfree)