William L. Mulchin, M.D.

DIPLOMATE OF THE AMERICAN BOARD OF UROLOGY
FELLOW OF AMERICAN COLLEGE OF SURGEONS
ADULT & PEDIATRIC UROLOGY

NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION FOR MEDICAL TREATMENT

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services render by us, or to assist with, aid in, or facilitate the collection of data for purposes or utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for you medical care of the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective as of 4/14/03 .

PATIENT / PARENT SIGNATURE_____

Despite the risk that information transmitted through facsimile (fax) communication devices or electronic transmission may be intercepted or inadvertently transmitted to people not authorized to receive the information, I hereby authorize the transmission of my medical records, or any part thereof, through facsimile (fax) communication devices or electronic transmission.

PATIENT / PARENT SIGNATURE _____

I authorize medical treatment by Dr. William L. Mulchin, MD. I have read or have been given a copy of the Patient Bill of Rights and the Notice of Privacy Practices and understand its contents. I also understand that any balance due after 90 days,
which is not covered by the insurance company, will be my responsibility and may incur interest at the rate of 10% per month. There will also be a $20.00 charge for returned checks. Due to contract language between physician and insurance company, I understand that I am financially responsible for all charges deemed to be "non-covered benfits" by my insurance company even if the insurance's Explanation of Benefits state the procedure is a "non-covered benefit" and "patient is not responsible."

PATIENT / PARENT SIGNATURE_____

DATE: _____

As our patient, we would like you to be aware that Dr. Mulchin has interest in Frisco Medical Center, Plano Surgery Center, and USA Lithotripsy.