NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (PHI)
Donald P Snyder MD LLC (DBA Donald P Snyder MD/ No Stork)

Healthcare/Business Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of Dr Snyder's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when Dr Snyder is ready to see you. We may use or disclose your protected health information (PHI), as necessary, to contact you to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing or transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI. We will use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact Dr. Snyder to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment at this office, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact Dr. Snyder and request that these fundraising materials not be sent to you.
Email, Voicemail and Text Messages: You agree and allow Dr Snyder and/ or his staff to communicate with you or your designee through electronic means for the purpose of timely and efficient communication in regards to all aspect of care including but not limited to scheduling, billing and health related issues. You acknowledge that electronic communication is vulnerable to being seen by unauthorized personnel either purposefully or accidentally despite Dr Snyder and yourself taking reasonable precautions to avoid such unwanted disclosure of PHI or other personal information. **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:** Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the practice has already taken an action in reliance on the use or disclosure indicated in the authorization.
Other Permitted and Required Uses and Disclosures that may be made without your Authorization or Opportunity to Object: We may use and disclose your protected health information whether or not you have had the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed. **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your appointment time, general condition and or reason for your visit. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. **Emergencies**: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your acknowledgment of our Privacy Practices as soon as reasonably practicable after the delivery of treatment. If your physician or another physician covering for him is required by law to treat you and the physician has attempted to obtain your acknowledgment, but is unable, he or she may still use or disclose your protected health information for treatment, payment, and health care operations. **Communication Barriers:** We may use and disclose your protected health information if your physician or a covering physician attempts to obtain an acknowledgment of our Privacy Practices from you, but is unable to do so due to substantial communication barriers. **Other permitted and required uses and disclosures that may be made without your consent, authorization or opportunity to object**: We may use or disclose your PHI in the following situations without your acknowledgment or authorization. These situations include: • As Required by Law • Legal Proceedings • Military Activity • Public Health • Law Enforcement • National Security • Communicable Diseases • Coroners • Funeral workers • Health Oversight Directors • Organ Procurement • Abuse or Neglect • Donation • Inmates' Caretakers • Food and Drug Authorities • Research • Required Uses and Administration • Criminal Activity Disclosures
The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights: You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and/or billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however; you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact Dr. Snyder or his Office Manager if you have questions about access to your medical record.

Reviewed/updated 09/2020

HIPAA ACKNOWLEDGEMENT FORM

_____ DOB_____

On April 24th, 2003, the "Privacy Act" of the Health Information Portability and Accountability Act (HIPAA) was placed into effect to protect your Personal Health Information (PHI) from being disclosed to unauthorized persons.

The accompanying information:

"NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (PHI) Donald P Snyder MD LLC (DBA Donald P Snyder MD / No Stork)" Updated September, 2020

Explains how your PHI may be used or disclosed as well as your rights for access and control of your PHI.

Please sign this form to acknowledge that you have received and read a copy of our privacy policy. If you have any questions regarding the privacy policy, please ask Dr. Snyder or one of his staff members. Thank You

_____ _____

Signature Date

Reviewed/updated Sept. 2020

CONSENT FOR DR. SNYDER TO PERFORM NO NEEDLE NO SCALPEL VASECTOMY

Please read and initial each statement:

_____ I understand that vasectomy is a method for permanent birth control, meaning it will forever prevent me from having children. Vasectomy reversal procedures often fail to restore fertility and are very expensive.

_____ I understand that no-needle anesthesia is administered prior to making an opening in the skin, and that local anesthesia may also be given with a needle if needed, to maximize procedural comfort.

_____ I understand that to be sure the vasectomy has been successful in preventing pregnancy, I will need to submit a specimen (semen analysis) to Dr. Snyder via US Mail as instructed by Dr. Snyder with the kit he supplies. This is expected nine weeks after the vasectomy to be sure there are no more sperm in the semen.

_____ I understand that another form of birth control must be used until the semen analysis has confirmed that there are no more sperm in my ejaculation fluid (semen).

_____ I understand that a few men will not have successful clearing of their sperm, even after multiple tests over a six month period. If this happens to me, I will need to have the vasectomy repeated or rely on another method of birth control. Dr. Snyder offers to repeat the vasectomy at no additional charge under this circumstance if I so desire.

_____ I understand that if I do not get the semen analysis done, then I am taking an unnecessary risk of causing pregnancy in my partner.

_____ I understand that there will be less than one man in two thousand (<0.05%) who might cause pregnancy in his partner once his semen analysis is clear of sperm at 9 weeks after a vasectomy, and that it is reasonable to rely on vasectomy alone for birth control for the rest of my life once my semen is clear of sperm.

_____ I understand that risks associated with vasectomy include bleeding, swelling, infection, and significant pain, but occur less than 1% of the time. Treatment of complications is not included in the cost of the vasectomy.

_____ I understand that I should rest for 18 to 24 hours after the procedure, then avoid lifting and/or strenuous activity for at least two more days after that. I should also avoid sexual activity for at least three days.

_____ I understand that other complications rarely occur such as Chronic Scrotal Pain Syndrome which can be caused by sperm granuloma (scar tissue at the end of the cut tube), long term congestion in the epididymis, and other known or unknown causes. Treatment of Chronic Scrotal Pain Syndrome is not included in the cost of the vasectomy.

_____ I understand that sometimes a vasectomy is not able to be completed due to variations in anatomy, scarring from prior surgery, or other reasons. Dr. Snyder may need to abandon the vasectomy attempt if he feels it is in my best interest to do so, and I will need to rely on another form of birth control if that happens.

_____ I understand that rarely it is possible for a man to get light headed or pass out several minutes after a vasectomy. This is especially true in men who have a history of passing out or getting light headed in the past. I have been informed that being driven home is the safest alternative. If I choose to drive myself, I accept all responsibility if an accident occurs.

_____ I authorize Dr. Snyder to send correspondence to my family doctor and/or my spouse's doctor concerning my vasectomy.

_____ I will have the opportunity to ask questions regarding vasectomy for permanent birth control just prior to having it done and can change my mind at any time prior to the procedure. I have watched the consult video and have reviewed the content on the www.nostork.com website. I wish to proceed with No Needle No Scalpel Vasectomy by Dr. Snyder.

Signature_____ Date_____

_ (09-2020)

Payment Policy

Donald P Snyder MD, LLC

If you have insurance, you were quoted an *ESTIMATE* OF WHAT YOU WILL OWE. This estimate is based on information provided by you and/or your insurance company.

THE AMOUNT QUOTED TO YOU MAY NOT BE THE FINAL AMOUNT YOU OWE OUT OF POCKET!!

If the total amount paid as of the day of your vasectomy (based on the estimate we gave you) ends up being an overpayment, Dr. Snyder will refund the balance. This is usually within 1 month of the date your insurance company issues their "explanation of benefits".

If the amount you have paid, along with any payment from your insurance company, is not adequate to cover the amount owed to Dr. Snyder, then you will owe the balance immediately upon receiving a bill from Dr. Snyder. This can happen if deductible is applied, if there is a determination of non-coverage, or other reasons. You will need to pay Dr. Snyder even if you think your insurance company is wrong. If, through appeal, etc. you can get your insurance company to pay more to Dr. Snyder after that, then he will refund the amount to you.

PROMPT PAYMENT IS EXPECTED EVEN IF IT IS SIGNIFICANTLY MORE THAN YOUR PRE-PROCEDURE ESTIMATE.

Failure to pay the balance, once insurance has paid or refused to pay, is likely to result in your account being turned over for collections. This will substantially increase the amount you ultimately will have to pay.

On the day of the vasectomy, you will be asked to sign a statement that you will pay the amount owed to Dr. Snyder based on your insurance company's "explanation of benefits" once it is issued. You will also agree to pay all reasonable attorney fees and any other costs associated with Dr. Snyder's attempts to collect any outstanding balance.