To: Patient Advocates at Nursing Homes/Care Centers

We ask you take a few moments to complete the enclosed forms. Doing so prior to the office visit will make the appointment more efficient and productive.

We require the following information be sent to our office **before** the appointment is made.
Please Fax To: 513.841.7553.

- Please fill out the forms included in this packet
  - Registration form
  - HIPPA
  - Patient current health questionnaire

- Please send back with this packet the following additional information
  - Photo ID
  - Insurance card(s)
  - Medication list
  - Problem list
  - Past surgery list
  - Patient allergies
  - Family history

Upon receiving this information, we will contact you to schedule an appointment for the patient.

If the patient's insurance requires a referral or pre-authorization when seeing a specialist, please have him/her contact a primary care physician and confirm this has been completed.

We appreciate you taking the time to work with your patients and residents to help us streamline their office visits so we can serve them as efficiently as possible.

If you have any questions regarding the information needed or need any assistance, please call 513.841-7400. We will be happy to help you in any way we can.

Calling after hours

If you need to reach your physician after-hours, please call the office where you were seen. A live agent will answer your call, take a message and then get in touch with the physician on-call.

Office phone numbers:

Ohio

Anderson – State Rd.
513-841-7795

Blue Ash
513-841-7800

Eastgate
513-841-7750

Fairfield/Hamilton
513-841-7900

Middletown
513-423-2244

Mt. Auburn
513-841-7795

Norwood
513-841-7500

Oxford
513-841-7900

West Chester
513-841-7400

West Side
513-841-7700

Kentucky

Crestview Hills
859-363-2200

Indiana

Lawrenceburg
859-363-2200

We are looking forward to meeting your patient.

Patient Registration Form

THE UROLOGY GROUP
Advanced Care. Improving Lives.
25TH ANNIVERSARY

Today's date: _____

Patient name: _____ Age: ____ Date of birth: _____
LAST FIRST MI

Please circle: Sex: Male / Female
Marital status: Single / Married / Divorced / Widowed

Address: _____

City / State / ZIP: _____

Phone: (check primary number)
☐ Home: ( ) _____ SS#: _____
☐ Mobile: ( ) _____
☐ Work: ( ) _____ Email: _____ @ _____

Emergency contact: Name: _____ Relationship: _____
Home: ( ) _____ Mobile: ( ) _____

Spouse: Name: _____ Date of birth: _____
☐ Check if same as emergency contact Phone: ( ) _____

Nursing home/hospice: (Check if applicable)
☐ I live in a nursing home Facility name: _____
Address: _____
☐ I am in hospice care Facility name: _____

Family physician: _____ Phone: ( ) _____

Referring physician: (if other than above): _____ Phone: ( ) _____

Pharmacy name: _____ Phone: ( ) _____

Person responsible for charges: _____ Home: ( ) _____
LAST FIRST
☐ Check if same as patient Work: ( ) _____

Primary insurance: _____ Policy #: _____ Group #: _____
Subscriber's name: _____ Subscriber DOB: _____

Secondary insurance: _____ Policy #: _____ Group #: _____
Subscriber's name: Subscriber DOB:

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at each time of service exactly what those guidelines are. Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work, x-rays, or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. As the policy holder, YOU ARE RESPONSIBLE for knowing the benefits and restrictions of your insurance coverage.

WAIVER: I understand that should my insurance company require a REFERRAL/AUTHORIZATION prior to my receiving Medical Service, and I have not obtained this and/or this office has not received this, I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

I understand that should it become necessary to place my account with an outside collection agency there will be an **additional 30% late fee** added to my delinquent balance.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Signature: _____ Date: _____

*A $35.00 charge will be collected for all RETURNED CHECKS.
**A $35.00 charge will be collected for all DECLINED CREDIT CARDS.

Medicare Lifetime Signature on File

_____
Name of Beneficiary

_____
HIC Number

I request that payment of authorized Medicare benefits be made either to me or on my behalf to TRI STATE UROLOGIC SERVICES, P.S.C., INC. for any services furnished me by TRI STATE UROLOGIC SERVICES, P.S.C., INC. or their contracted agents PeriOp Anesthesia, P.S.C. or Professional Radiology Inc. or Southern Ohio Pathology. I authorize any holder of medical information about me to release the Center for Medicare/Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medical assigned cases, the physician agrees to accept the charge determination of the Medical carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. In Medicare non-assigned cases, the patient is responsible for the entire charge.

Patient Signature: _____ Date: _____

_____
Witness if signed with an “X”

THE UROLOGY GROUP
Advanced Care. Improving Lives.
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Patient Current Health Questionnaire
(PLEASE PRINT)

Today's date: _____

Patient name: _____ Age: ____ Date of birth: _____
LAST FIRST MI

Family or referring physician: _____ Phone: (____) _____

The Urology Group physician/office patient typically visits: _____

Pharmacy name: _____ Phone: (____) _____

Nursing home contact: _____ Phone: (____) _____

Family contact: _____ Phone: (____) _____

HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT (What is the main reason for your visit to the urologist?) _____

_____

Date of onset of problem above: _____ List location (left or right): _____

Experienced before? ☐ Yes ☐ No When? _____ Type of testing done, if any: _____

Blood in urine? Y / N

___ visible ___ microscopic

Frequent urination? Y / N

How often? Every _____ hours

Leaking of urine? Y / N

___ with exercise ___ with cough ___ nearly constant

Nocturia? (urinating at night) Y / N

How often? _____ times a night

Slow or weak urine stream? Y / N

Burning with urination? Y / N

Clots in urine? Y / N

Retention? (feeling of urination but can't go) Y / N

Does the patient have a Foley catheter in? Y / N

Date Foley placed _____

Does the patient smoke? Y / N

Does the patient drink coffee? Y / N

Does the patient currently have any of the following symptoms?

Y / N Fever
Y / N Headaches
Y / N Cataracts
Y / N Glasses
Y / N Seasonal Allergies
Y / N Tremors
Y / N Dizziness Spells
Y / N Chest Pain
Y / N Ankle Swelling
Y / N Abdominal Pain
Y / N Skin Rash
Y / N Joint Pain
Y / N Back Pain
Y / N Neck Pain
Y / N Excessive Thirst
Y / N Sinus Problems
Y / N Shortness of Breath
Y / N Easy Bruising
Y / N Bleeding Problems
Y / N Depression
Y / N Anxiety

Notice of Privacy Practices

THE UROLOGY GROUP
Advanced Care. Improving Lives.
25TH ANNIVERSARY

NOTICE OF PRIVACY PRACTICES
OF
TRI STATE UROLOGIC SERVICES, P.S.C., INC.
AND
THE UROLOGY CENTER, LLC

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), part of the American Recovery and Reinvestment Act of 2009 (ARRA).

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.

In this Notice of Privacy Practices (this "Notice"), the words you or your shall refer to you as our patient. The words we, us, or our, shall refer to Tri State Urologic Services, P.S.C., Inc. dba The Urology Group and The Urology Center, LLC. The letters "PHI" shall be an acronym meaning protected health information, which is defined in the applicable Privacy Regulations, and which generally means your individually identifiable health information.

A. OUR COMMITMENT TO YOUR PRIVACY

We are dedicated to maintaining the privacy of your individually identifiable health information or PHI. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this Notice of our legal duties and the privacy practices that we maintain concerning your PHI. By federal and state law, we must follow the terms of this Notice as it may be amended from time to time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this Notice apply to all records containing your PHI that are created or retained by us. We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will be effective for all of your records that we have created or maintained in the past, and for any of your records that we may create or maintain in the future. We will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer
2000 Joseph E. Sanker Blvd
Cincinnati, Ohio 45212
(513) 841-7400

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. We may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for us including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. We may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.

3. Health Care Operations. We may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, we may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business activities for our business.

4. Appointment Reminder. We may use and disclose your PHI to contact you and remind you of an appointment. We may also leave you a message on an answering machine to remind you of an appointment.

5. Treatment Options. We may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. We may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Affiliated Entities. Tri State Urologic Services, P.S.C., Inc. dba The Urology Group and The Urology Center, LLC are legally separate entities that are affiliated with each other because of common ownership. Each such affiliated entity may use and disclose your PHI to the other such affiliated entity.

8. Release of Information to Family/Friends. We may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for treatment. In this example, the babysitter may have access to this child's medical information.

9. Disclosures Required By Law. We will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. We may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices

- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audit, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. We may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in 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.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime, victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- To an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. We may release your PHI 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.

6. Organ and Tissue/Donation. We may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation if you are an organ donor.

7. Research. We may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for research and (iii) the researcher will not remove any of your PHI from our premises; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

8. Serious Threats to Health or Safety. We may use and disclose your PHI 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.

9. Military. We may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. We may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. We may disclose your PHI to correctional institutions or law enforcement 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, or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. We may release your PHI for workers' compensation and similar programs.

13. Sale of PHI. We are not permitted to sell your PHI unless you have authorized the disclosure.

14. Marketing. Except as provided in HIPAA and the HITECH Act, we are not permitted to use your PHI for marketing purposes unless you have authorized the communication.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that we communicate with you about your health and related issues in a particular manner or a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Privacy Officer, 2000 Joseph E. Sanker, Blvd, Cincinnati, Ohio 45212** specifying the requested method of contact, or the location where you wish to be contacted. We will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions.

General Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Health Plan Restrictions. You have the right to request a restriction in our disclosure of your PHI to a health plan for payment or health care operations with respect to specific items and services for which you have paid out of pocket in full. Unless disclosure to such health plan is required by law, we will grant such request.

In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Privacy Officer, 2000 Joseph E. Sanker Blvd, Cincinnati, Ohio 45212**. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our use, disclosure or both;
(c) to whom you want the limits to apply; and
(d) when applicable, that such request relates to a health plan and specific items and services for which you have paid out of pocket in full.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Privacy Officer, 2000 Joseph E. Sanker Blvd, Cincinnati, Ohio 45212** in order to inspect and/or obtain a copy of your PHI. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing and submitted to **Privacy Officer, 2000 Joseph E. Sanker Blvd, Cincinnati**

Ohio 45212. You must provide us with a reason that supports your request for amendment. We will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI we keep; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by us, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an accounting of disclosures. An accounting of disclosures is a list of certain non-routine disclosures we have made of your PHI for purposes other than treatment, payment and health care operations. Use of your PHI as part of the routine patient care and payment is not required to be documented. For example, the doctor sharing information with the nurse, or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Privacy Officer, 2000 Joseph E. Sanker Blvd, Cincinnati, Ohio 45212**. All requests for an accounting of disclosures must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but may charge you for additional lists within the same 12-month period. We will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, contact **Privacy Officer, 2000 Joseph E. Sanker Blvd, Cincinnati, Ohio 45212**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a compliant with us, contact **Privacy Officer, 2000 Joseph E. Sanker Blvd, Cincinnati, Ohio 45212**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. We will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

F. BREACH NOTIFICATION

In the event of a breach of unsecured PHI, we fully comply with the breach notification requirements of HIPAA and the HITECH Act. These requirements include notification of (i) the breach, (ii) the impact of such breach, and (iii) actions we have taken to minimize the impact such breach could have upon you.

G. EFFECTIVE DATE

This Notice of Privacy Practices is effective as of April 14, 2003, with revisions effective September 20, 2013.

Again, if you have any questions regarding this notice of our health information privacy policies, please contact **Privacy Officer, 2000 Joseph E. Sanker Blvd, Cincinnati, Ohio 45212.**

END OF NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt of Notice of Privacy Practices

I_____acknowledge that either ***[please check appropriate box].***

☐ I have received a copy of Tri State Urologic Services P.S.C., Inc dba The Urology Group/The Urology Center's Notice of Privacy Practices.

or

☐ I declined the offered copy of Tri State Urologic Services P.S.C., Inc dba The Urology Group/The Urology Center's Notice of Privacy Practices.

This notice describes how Tri State Urologic Services P.S.C., Inc dba The Urology Group/The Urology Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

BY CHECKING THE BOXES BELOW, YOU CAN AUTHORIZE US TO DISCLOSE INFORMATION (OR RESTRICT ANY SUCH DISCLOSURES).

Messages with APPOINTMENT or MEDICAL information

You may send information or leave messages of this type via (check all that apply):

- ☐ Home phone
- ☐ Work phone
- ☐ Mobile phone
- ☐ In-person
- ☐ Mail
- ☐ Email
- ☐ Voicemail

My health Information can be left/discussed with:

☐ Anyone who answers the phones indicated above.

☐ Only with the following individuals:

First Name	Last Name	Relationship to patient	Phone number

☐ Do not give/leave appointment or medical information with anyone other than myself **(This will exclude your information from spouses, significant others, parents, children, or any other family member.)**

_____ _____

(Signature of patient or Personal Representative) (Date)

_____

Relationship to patient (if other than patient)

TRI STATE UROLOGIC SERVICES P.S.C., INC. dba THE UROLOGY GROUP
NONDISCRIMINATION NOTICE

Tri State Urologic Services P.S.C., Inc. doing business as The Urology Group ("The Urology Group") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Urology Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Urology Group:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

○ Qualified sign language interpreters

○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

○ Qualified interpreters

○ Information written in other languages

If you need these services, contact Robin Brink, Civil Rights Coordinator.

If you believe that The Urology Group has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Robin Brink, Civil Rights Coordinator,
2000 Joseph E. Sanker Boulevard
Cincinnati, Ohio 45212
Phone: 513-841-7471,
Fax: 513-841-7402,
Email: civilrightscoordinator@urologygroup.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Robin Brink, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TRI STATE UROLOGIC SERVICES P.S.C., INC. dba THE UROLOGY GROUP
NONDISCRIMINATION STATEMENT

Tri State Urologic Services P.S.C., Inc. doing business as The Urology Group ("The Urology Group") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

TAGLINES:

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-513-841-7471.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-513-841-7471.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-513-841-7471。

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-513-841-7471.

لعربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-513-841-7471 (رقم

Deitsch (Pennsylvania Dutch)
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-513-841-7471.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-513-841-7471.

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-513-841-7471.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-513-841-7471.

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-513-841-7471 번으로 전화해 주십시오.

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-513-841-7471.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-513-841-7471まで、お電話にてご連絡ください。

Nederlands (Dutch)
AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-513-841-7471.

Українська (Ukrainian)
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-513-841-7471.

Română (Romanian)
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-513-841-7471.

Srpsko-hrvatski (Serbo-Croatian)
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-513-841-7471.

नेपाली (Nepali)
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-513-841-7471 ।

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-513-841-7471.

Ikirundi (Bantu – Kirundi)
ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-513-841-7471.

(Burmese)
သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-513-841-7471 သုိ႔ ေခၚဆိုပါ။

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-513-841-7471 'ਤੇ ਕਾਲ ਕਰੋ।

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-513-841-7471 पर कॉल करें।