# NEW PATIENT REGISTRATION FORM

**PATIENT INFORMATION:** _____ **(I HAVE REVIEWED ALL THE INFORMATION BELOW IS ACCURATE)**
PATIENT INITIALS

**Office:** _____ **Date:** _____

**Last Name:** _____ **First Name:** _____ **M.I.:** _____

**SSN:** _____ **DOB:** _____ **Sex:** _____

**Address:** _____ **Apt/Suite #:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Home Phone:** _____ **Mobile Phone:** _____

**E-Mail Address:** _____

**Primary Care Physician:** _____

**Employer:** _____ **Work Phone:** _____

**Marital Status:** _____ **Is your spouse working or retired?** _____

**Spouse Name:** _____ **Spouse DOB:** _____

**Spouse SSN:** _____ **Spouse Contact Number:** _____

**ALTERNATE ADDRESS:** _____ **(I HAVE REVIEWED ALL THE INFORMATION BELOW IS ACCURATE)**
PATIENT INITIALS

☐ **I do not have an alternate address**

**Alternate Address:** _____ **Apt/Suite#:** _____

**City:** _____ **State:** _____ **Zip:** _____

**INSURANCE INFORMATION:** _____ **(I HAVE REVIEWED ALL THE INFORMATION BELOW IS ACCURATE)**
PATIENT INITIALS

**Primary Insurance:** _____ **Plan ID:** _____

**Group #:** _____ **Phone Number:** _____

**Secondary Insurance:** _____ **Plan ID:** _____

**Group #:** _____ **Phone Number:** _____

**EMERGENCY CONTACT INFORMATION:** _____ **(I HAVE REVIEWED ALL THE INFORMATION BELOW IS ACCURATE)**
PATIENT INITIALS

**Name:** _____ **Phone:** _____

**Relationship to Contact:** _____ **Guardian:** _____

**Address:** _____ **Apt/Suite #:** _____

**City:** _____ **State:** _____ **Zip:** _____

## NEW PATIENT REGISTRATION FORM

Are you currently admitted to a hospital or enrolled in a Hospice or Skilled Nursing Facility?
Yes_____ No_____ If **yes**, please fill out the following:

**Facility Name:** _____ **Phone:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

Are you receiving benefits from the Veterans Administration?
Yes_____ No_____ If **yes**, please fill out the following:

**VA Name:** _____ **Phone:** _____

**City:** _____ **State:** _____ **Zip:** _____

**WHICH OF THE FOLLOWING BEST DESCRIBES YOUR RACE?**

| | | | |
|---|---|---|---|
| ☐ Asian | ☐ Caucasian | ☐ Black / African American | ☐ Hispanic |
| ☐ Subcontinent Asian American | | ☐ Asian Pacific American | ☐ Native American |
| ☐ American Indian/Alaskan Native | | ☐ Hawaiian | ☐ Pacific Islander |
| ☐ More than one race | | ☐ Other | ☐ Decline |

**PLEASE SELECT ONE ETHNIC GROUP THAT BEST DESCRIBES YOUR ANCESTRY:**

| | |
|---|---|
| ☐ Hispanic or Latino | ☐ Non-Hispanic or Latino |
| ☐ Decline | ☐ Don't know |

**WHAT LANGUAGE DO YOU FEEL MOST COMFORTABLE USING WHEN DISCUSSING YOUR HEALTHCARE?**

| | | | |
|---|---|---|---|
| ☐ English | ☐ Spanish | ☐ German | ☐ French |
| ☐ Italian | ☐ Russian | ☐ Portuguese | ☐ Chinese |
| ☐ Other | ☐ Decline | ☐ Don't know | ☐ Haitian Creole |

**WE ARE DEDICATED TO PROVIDING THE BEST CARE POSSIBLE TO OUR PATIENTS. WE CAN BETTER ACCOMPLISH THIS GOAL BY OBTAINING YOUR OPINION ON HOW WE ARE DOING. MAY WE CONTACT YOU BY MAIL, E-MAIL, TEXT, OR TELEPHONE FOR OUR SURVEY?**

| | |
|---|---|
| ☐ Yes | ☐ No |

**HOW DID YOU HEAR ABOUT US?**

| | | |
|---|---|---|
| ☐ Physician Referral | ☐ Family or Friend | ☐ Insurance Referral |
| ☐ Internet (website, search engine, Facebook, etc) | | ☐ Media (newspaper, magazine, billboard, radio, TV) |

**WHEN CONDUCTING YOUR OWN RESEARCH, HOW OFTEN DO YOU USE THE INTERNET FOR GATHERING INFORMATION?**

| | | | |
|---|---|---|---|
| ☐ Always | ☐ Usually | ☐ Sometimes | ☐ Never |
| | | | |

**Assignment of Benefits/Right to Payment Authorization, Patient Responsibility, and Release of Information Form**

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**21st Century Oncology**
**PO Box 862149**
**Orlando, FL 32886-2149**

I, the undersigned, assign to the provider/entity referenced above ("Provider"), my rights and benefits in any medical insurance plan, health benefit plan, or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I authorize my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider are owed to Provider and I agree to remit those funds directly to Provider.

**Patient Responsibility**

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

**Release of Information**

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment/Authorization shall be considered as effective and valid as the original.

_____ _____
Signature of Patient/Person Legally Responsible Date

_____ _____
Print Name of Patient/Person Legally Responsible Date

_____
Relationship to Patient (if signed by Person Legally Responsible)

**Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications**

## NEW PATIENT REGISTRATION FORM

I hereby request the following use or disclosure of my health information as described below.

| **Patient Name**: | **Date of Birth:** | **Medical Record Number:** |
|---|---|---|
| **Address (Street, City, ZIP, Code):** | | **Telephone Number:** |

**I requested that my health information or billing record be disclosed or restricted, as follows:**

I authorize the names listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

| **Authorized Name** | **Relationship to Patient** |
|---|---|
| | |
| | |
| | |

***DO NOT** discuss or provide information to the following individuals or entities:

| **Restricted Name/Entity** | **Relationship to Patient** |
|---|---|
| | |
| | |
| | |

***I request the use of ONLY the following address and/or phone number(s) to contact me regarding my health or billing information:**

_____ _____

_____ _____

**Patient Rights:** Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

**Physician Office Responsibilities:** Your physician office is not required to grant most restrictions and is precluded from granting restrictions that violate the law. If we agree to the restrictions, we will comply with it unless you ask to terminate the restriction, or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

| **Signature of Patient or Legal Representative** | **Date:** |
|---|---|

**If signed by Legal Representative, Relationship to Patient**

**THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY**

**DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:**

☐ ***Granted** _____ | ☐ **Denied** _____

***If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s)**

**Reason(s) for Denial, if Applicable:** _____

_____

| **Physician Office Representative:** | **Date:** |
|---|---|

**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.**

Each time you visit our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by your physician.

**Our Responsibilities**

We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to that protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

**Uses and Disclosures - How we may use and disclose protected health information about you**

**For Treatment:** We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to doctors, nurses, or other personnel who are involved in taking care of you. For example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

**For Payment:** We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

**For Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to run our practice. For example, members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.

We may also use and disclose protected health information:

- To business associates we have contracted with to perform an agreed-upon service
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To inform you about possible treatment alternatives
- To inform you about health-related benefits or services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

**Individuals Involved in Your Care or Payment for Your Care**: We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

**Research:** We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

**Future Communications:** We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

**As Required by Law**, we may also disclose health information to the following types of entities, including but not limited to:

- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

**Law Enforcement/Legal Proceedings:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

# NOTICE OF PRIVACY PRACTICES
# 21st Century Oncology

**Other Uses of Your Protected Health Information That Require Your Authorization**

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses and disclosures not described in this notice or required by law will be made only with your separate written permission. If you give us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any lime. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

**Your Health Information Rights**

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and copy protected health information. You may request access to your records by contacting us. You may also ask that we send your health information directly to another person based on your signed written instructions. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records.
- Request an amendment. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information by making a request in writing that explains the reason for the requested amendment. You have the right to request an amendment for as long as the information is kept for or by us. We may deny your request for an amendment; if this occurs, you will be notified of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes.
- Request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you ask us not to disclose your health information to your health plan, we will agree as long as (i) the disclosure would be for the purpose of payment or health care operations and is not otherwise required by law and (ii) the information only relates to items or services that someone other than your health plan has paid for in full.
- Request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will grant requests for confidential communications at alternative locations and/or via alternate means only if the request is submitted in writing and the written request includes a mailing address where you will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.
- A paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Web site at www.21stcenturyoncology.com.

**Changes to This Notice**

We reserve the right to change this notice; the revised notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be available on our website and will be provided to you upon your next visit to our facility after the effective date.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Privacy Officer toll-free at 1-866-679- 8944, or by contacting the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

For further information, contact:
Privacy Officer
2270 Colonial Boulevard
Fort Myers, FL 33907
1-866-679-8944

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**21st Century Oncology**
**PO Box 862149**
**Orlando, FL 32886-2149**

**I hereby acknowledge:**

A copy of the Notice of Privacy Practices was given to me.
If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name of Patient or Representative

---

**FOR OFFICE USE ONLY**

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgement was not obtained:

- ☐ Patient/family member received notice but refused to sign acknowledgment
- ☐ Emergency treatment situation
- ☐ Patient was incapacitated, and no family member was present
- ☐ Unable to communicate due to language barriers
- ☐ Other (please describe below)

_____
_____
_____
_____

_____ _____
Signature of Employee Date

**Telephone Consumer Protection Act [TCPA] Consent Form**

I, «PatientFullName», authorize «PracticeName» and all of its independent contractors, business associates, agents and/or affiliates to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any claim I may have against the practice, its independent contractors, business associates, agents and affiliates for making such calls, including any claim under the Telephone Consumer Protection Act.

_____

**Patient Signature**

_____

**Patient Name**

_____

**Date**


## Lee/Collier Counties, Florida Market
## Patient Protection and Affordable Care Act of 2010
## Patient Disclosure for Diagnostic MRI, PET or CT Services

Dear Patient,

If your physician determines that a referral for diagnostic MRI, PET or CT services is appropriate as a part or your medical evaluation and treatment; we may have these services available at one of our locations. We will provide you information about those options.

You, however, have the freedom to choose the supplier for this service. To the best of our knowledge, the following providers furnish these services in the area:

**Name:** Radiology Regional Centers
**Address:** 6100 Winkler Rd, Ft. Myers, FL 33919

**Name:** Advanced Radiology Imaging Associates, LLC
**Address:** 13731 Metropolis Ave, Ft. Myers, FL 33912

**Name:** Florida Radiology Consultants
**Address:** 6311 Southpointe Blvd, Ft. Myers, FL 33919

**Name:** NCH Imaging
**Address:** 311 9th St N, Ste 104, Naples, FL 34102

**Name:** NCH Imaging
**Address:** 1715 Medical Blvd, Naples, FL 34110

**Name:** Radiology Regional Centers
**Address:** 700 Goodlette Rd, Naples, FL 34102

**Name:** Pro Scan Imaging
**Address:** 260 Tamiami Trail N, Naples, FL 34102

**Name:** Pro Scan Imaging
**Address:** 7947 Airport Pulling Rd, Naples, FL 34109

## *UROLOGY EXPERTS SYSTEM REVIEW*

**Patient Name:** _____ **Date:** _____

**Do you currently or have you had any problems related to the following systems? Check YES or NO. Please explain any YES answers in the space provided**

**Constitutional Symptoms**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Chills |
| Yes ☐ | No ☐ | Fever |
| Yes ☐ | No ☐ | Headache |

Other _____

**Eyes**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Blurred Vision |
| Yes ☐ | No ☐ | Double Vision |
| Yes ☐ | No ☐ | Cataracts |
| Yes ☐ | No ☐ | Glaucoma |
| Yes ☐ | No ☐ | Pain |

Other _____

**Allergies/Immunologic**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Hay Fever |
| Yes ☐ | No ☐ | Drug Allergies |

Other _____

**Neurological**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Headaches |
| Yes ☐ | No ☐ | Black Outs |
| Yes ☐ | No ☐ | Seizures |
| Yes ☐ | No ☐ | Stroke |
| Yes ☐ | No ☐ | Tremor |
| Yes ☐ | No ☐ | Dizzy Spells |
| Yes ☐ | No ☐ | Numbness/Tingling |
| Yes ☐ | No ☐ | Depression |

Other _____

**Endocrine**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Diabetes |
| Yes ☐ | No ☐ | Thyroid Trouble |
| Yes ☐ | No ☐ | Excessive Thirst |
| Yes ☐ | No ☐ | Too Hot/Cold |
| Yes ☐ | No ☐ | Tired/Sluggish |

Other _____

**Cardiovascular**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Chest Pain |
| Yes ☐ | No ☐ | Varicose Veins |
| Yes ☐ | No ☐ | High Blood Pressure |
| Yes ☐ | No ☐ | Irregular Heart Beat |
| Yes ☐ | No ☐ | Heart Attack |
| Yes ☐ | No ☐ | Heart Operations |
| Yes ☐ | No ☐ | Blood Vessel Problems |

Physician_____

**Abdomen**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Pain |
| Yes ☐ | No ☐ | Ulcers |
| Yes ☐ | No ☐ | Gallbladder Trouble |
| Yes ☐ | No ☐ | Colitis |
| Yes ☐ | No ☐ | Blood in Stools |
| Yes ☐ | No ☐ | Diverticulitis |
| Yes ☐ | No ☐ | Jaundice |
| Yes ☐ | No ☐ | Liver Problems |

Other _____

**Respiratory**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Wheezing or Cough |

**Integumentary**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Skin Rash |
| Yes ☐ | No ☐ | Boils |
| Yes ☐ | No ☐ | Persistent Itch |

**Musculoskeletal**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Joint Pain |
| Yes ☐ | No ☐ | Back Pain |
| Yes ☐ | No ☐ | Arthritis |
| Yes ☐ | No ☐ | Gout |

**Ear/Nose/Throat/Mouth**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Sinus Problems |
| Yes ☐ | No ☐ | Hearing Problems |
| Yes ☐ | No ☐ | Ear Infection |
| Yes ☐ | No ☐ | Throat Problems |

**Genitourinary**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Urinary Frequency |
| Yes ☐ | No ☐ | Prostate Surgery |
| Yes ☐ | No ☐ | Infection |
| Yes ☐ | No ☐ | Stones |
| Yes ☐ | No ☐ | Blood in Urine |
| Yes ☐ | No ☐ | Urine Leakage |
| Yes ☐ | No ☐ | Urine Retention |
| Yes ☐ | No ☐ | Painful Urination |

**Hematologic/Lymphatic**

| | | |
|---|---|---|
| Yes ☐ | No ☐ | Anemia |
| Yes ☐ | No ☐ | Leukemia |
| Yes ☐ | No ☐ | Unusual Bruising |
| Yes ☐ | No ☐ | Swollen Glands |
| Yes ☐ | No ☐ | Blood Clotting |

## Urology Experts

### Note: This is a confidential record and will be kept at your doctor's office

**Name:** _____ **Today's Date:** _____

**Age:** _____ **DOB:** _____ **Referring Physician:** _____

**LIST ALL MEDICAL AND SURGICAL HISTORY (Sate of Onset)**

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____

**CURRENT MEDICATIONS (dosage/strength – including aspirin)**

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____

**ALLERGIES**

A _____
B _____
C _____
D _____
E _____
F _____
G _____
H _____
I _____

**FAMILY HISTORY (List any disease of Immediate Family Members)**

1 _____ 3 _____
2 _____ 4 _____

**FAMILY HISTORY OF PROSTATE CANCER** NO YES/ _____
What relation is that family member to you?

**Mother** Alive Deceased Age _____ From What? _____

**Father** Alive Deceased Age _____ From What? _____

**Social History: Do you Smoke?** Yes No How Much? _____

Did you quit smoking, If yes, when? _____ How many years of smoking? _____

**ALCOHOL** YES NO HOW MUCH # OF YEARS

Primary Phone # _____ Name of pharmacy and Phone # _____

Occupation (what do you or did you do for a living?) _____

Where are you from originally? _____

What is the main Reason for your visit today? _____