Broward Urology Center
New Patient Intake Form

We'd like to welcome you as a new patient! Please take the time to fill out this form as accurately as possible so we can give you the best service. If you are a returning patient, it's likely been 3 years since we last saw you, thus please give us the updated information in the form below. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

Personal Information

First Name: _____ Last Name: _____ Age: ____ DOB: ____/_____/_____

Sex/Gender: _____ Marital Status: _____ Occupation:(current or former)_____

Race: □Black/African American □White □American Indian □Hispanic/Latino □Asian □Unknown/Declined
Ethnicity: □Black/African American □White □American Indian □Hispanic/Latino □Asian □Unknown/Declined
Primary Language: □English □Español □Français □Kreyòl □ Русский □Italiano Other: _____

Contact Information

Address: _____
_____
Email: _____
Mobile Phone: _____
Home Phone: _____
Work Phone: _____

Emergency Contact: _____
Relationship: _____
Emergency Contact Phone: _____
Do you have a living will? □Yes □ No
Who would make medical decisions for you if you were unable to do so yourself?_____

Referring Doctor: _____
Referring Doctor Phone: _____
Referring Doctor Fax: _____

Primary Doctor (PCP): _____
PCP Phone: _____
PCP Fax: _____

Pharmacy: _____ **Pharmacy Phone**: _____
Do you give our office permission to contact your pharmacy for a list of your medications? □Yes □ No

Please list ALL your current doctors besides your PCP (i.e. pulmonologist, oncologist, internist, cardiologist, etc…)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Medical Illnesses that Run in the Family (write relationship)

- ☐ Diabetes
- ☐ Enlarged Prostate
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Cancer
- ☐ Stroke
- ☐ Urinary Tract Infections
- ☐ Cancer, type: _____
- ☐ Other

Broward Urology Center
New Patient Intake Form

Reason I am here:

- ☐ Urinary Infection
- ☐ Urinary Leakage
- ☐ Difficulty with Urination
- ☐ Frequency of Urination
- ☐ Blood in the Urine
- ☐ Bladder Cancer
- ☐ Overactive Bladder
- ☐ Kidney Stones
- ☐ Kidney Tumor
- ☐ Kidney Cyst
- ☐ High PSA
- ☐ Prostate Infection
- ☐ Prostate Cancer
- ☐ Sexual Problems
- ☐ Testicle Problems
- ☐ Low Testosterone
- ☐ Fertility Problems
- ☐ Other:_____

Explain:_____

_____

My other medical problems <u>are or have been</u>:

- ☐ Heartburn
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots in Leg or Lungs
- ☐ Chronic back pain
- ☐ Cancer; Type _____
- ☐ Chronic Urinary Infections
- ☐ COPD / Emphysema
- ☐ Crohn's
- ☐ Dementia
- ☐ Depression
- ☐ Drug / Alcohol Abuse
- ☐ Sugar Diabetes: # of years ___
- ☐ Other:_____
- ☐ Diverticulitis
- ☐ Enlarged Prostate
- ☐ Glaucoma
- ☐ Gonorrhea / Chlamydia
- ☐ Gout
- ☐ Gynecological problems
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Low Testosterone
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Overweight / Obesity
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease

My Previous Surgeries or Procedures:

Procedure	Date		Date		Date
☐ Appendix surgery		☐ Knee Replacement R / L		☐ Scrotal Surgery	
☐ Back Surgery		☐ Pacemaker		☐ Testicle Removal	
☐ Heart Bypass		☐ C-section, #___		☐ Varicocele Surgery	
☐ Colon Surgery		☐ Hysterectomy		☐ Vasectomy	
☐ Heart Stent		☐ Bladder Sling		☐ Bladder Tumor Surgery	
☐ Cystoscopy		☐ Vaginal Delivery, #___		☐ **Pneumonia Vaccine**	
☐ Gallbladder Removal		☐ Prolapse Surgery		☐ **Colonoscopy**	
☐ Gastric Bypass		☐ Radiation Treatment		☐ Dental Surgery	
☐ Hernia Repair R/L		☐ Prostate Surgery		☐	
☐ Hip Replacement R/L		☐ Prostate Removal		☐	
☐ Kidney Removal R / L		☐ Prostate Biopsy		☐	

My life-style:

Exercise: ☐ No ☐ Yes
Special Diet: ☐ No ☐ Yes: _____
Smoking Tobacco: ☐ Never ☐ Current ☐ Former #_____ packs per day #____ years
Need help quitting? ☐ No ☐ Yes
Alcohol Use: ☐ No ☐ Yes : amount _____ frequency _____
Caffeine drinks per day: _____

Previous or Current Drug use: ☐ No ☐ Yes
What types of drugs? _____
Ok with Blood Transfusions?: ☐ No ☐ Yes
Do you have: Living Will? ☐No ☐Yes
Sexually Active?: ☐ No ☐ Yes
Sexual partner preference:_____
Hobbies: _____

MEDICATION & FOOD ALLERGIES:
☐None ☐Codeine ☐IV dye ☐Latex ☐Penicillin ☐Sulfa Drugs ☐Other:_____

Current Medications, Vitamins & Supplements

	Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency
1				8				15			
2				9				16			
3				10				17			
4				11				18			
5				12				19			
6				13				20			
7				14				21			

Are you on **Blood Thinners** Like:
☐Aspirin ☐Plavix ☐Coumadin/Warfarin ☐Advil ☐Fish Oil ☐Vitamin E ☐Xarelto ☐Pradaxa ☐Eliquis

Review of Systems

CIRCLE the symptoms you are **currently experiencing**.

Constitutional

Fever	Weight Gain (___ lbs)	Sleep Disturbances
Chills	Weight Loss (___ lbs)	Other:

Head, Eyes, Ears, Nose, and Throat

Vision Problem	Congestion	Nosebleed
Decreased Hearing	Snoring	Ringing in Ears
Double Vision	Dry Mouth	Vertigo
Glaucoma	Sore Throat	Earache
Cataracts	Hoarseness	Other:

Cardiovascular

Chest Pain	Cold Hands or Feet	Using Multiple Pillows to Sleep
Palpitations (Heart Racing)	Leg Pain w/ Walking	Other:
Ankle / Leg Swelling	Irregular Heart Beats	

Respiratory

Shortness of Breath	Wheezing	Other:
Cough	Coughing Up Blood	
Rapid Breathing	Coughing Up Sputum	

Gastrointestinal

Abdominal Pain	Black/Tarry Stools	Bowel Incontinence
Blood in Stool	Decreased Appetite	Rectal Pain
Nausea	Yellow Skin	Constipation
Vomiting	Trouble Swallowing	Other:
Diarrhea	Heartburn	

Neurological

Headache	Numbness/ Tingling	Memory Lapses/Loss
Dizziness	Seizures	Other:
Weakness in Legs / Arms	Fainting (Syncope)	
Confusion	Tremor	

Musculoskeletal

Joint Pain	Limb Pain	Muscle Pain
Neck Pain	Joint Swelling	Muscle Weakness
Back Pain	Muscle Cramps	Leg SwellingOther:

Urinary

Frequent Urination	Painful Urination	Urinary Infections
Urinary Leakage / Accidents	Night Time Urination	Other:
Urinary Urgency (can't hold)	Blood in the Urine	

Male Health

Penile Pain	Penile Discharge	Recent STD
Erection Problems	Change in Libido (sex drive)	Foreskin Problems
Premature Ejaculation	Scrotal/Testicular Pain	Other:
Penile/Scrotal Rash	Fertility Problems	

Female Health

Change in Libido (sex drive)	Heavy Period Bleeding Orgasm	Recent STD
Painful Intercourse	Problems	Other:
Vaginal Discharge	Vaginal Dryness	
Vaginal Bleeding	Heavy Period Bleeding	
Irreg. Monthly Cycles	Fertility Problems	

Skin

Rash	Unusual Growth	Other:
Dry Skin	Itching	
Skin Wound	Skin Cancer	

Psychiatric

Depression	Anxiety
Hallucinations	Other:

Hematologic/Lymphatic

Easy Bruising	Swollen Lymph Nodes
Easy Bleeding	Other:

Endocrine

Excessive Thirst	Heat Intolerance	Other:
Cold Intolerance	Changes- Hair/Skin	

Overactive Bladder (OAB) Symptom Quiz

The questions below ask about how bothered you may be by some bladder symptoms. Some people are bothered by bladder symptoms and may not realize that there are treatments available for their symptoms. This quiz is an awareness tool that can help you talk to your doctor about your symptoms. It cannot give you a diagnosis.

Please circle the number that best describes how much you have been bothered by each symptom. Add the numbers together for a total score and record the score in the box provided at the bottom.

How bothered have you been by...	**Not at all**	**A little bit**	**Some-what**	**Quite a bit**	**A great deal**	**A very great deal**
1. Frequent urination during the daytime hours?	0	1	2	3	4	5
2. An uncomfortable urge to urinate?	0	1	2	3	4	5
3. A sudden urge to urinate with little or no warning?	0	1	2	3	4	5
4. Accidental loss of small amounts of urine?	0	1	2	3	4	5
5. Nighttime urination?	0	1	2	3	4	5
6. Waking up at night because you had to urinate?	0	1	2	3	4	5
7. An uncontrollable urge to urinate?	0	1	2	3	4	5
8. Urine loss associated with a strong desire to urinate?	0	1	2	3	4	5
Are you male?	☐		If male, add 2 points to your score			

Adapted from Coyne KS, Zyczynski T. Margolis MK, Elinoff V. Roberts RG. Validation of an overactive bladder awareness tool for use in primary settings. *Adv Ther.* 2005;22:381-394.

Please add up your responses to the questions above ☐

Please hand this page to your physician or healthcare professional when you see him/her for your visit.

Note: You may be asked to give a urine sample. Please ask before going to the bathroom.

BE 21st Century Oncology

NEW PATIENT REGISTRATION PACKET

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: _____ Referring Provider: _____

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: _____

BE 21st Century Oncology

NEW PATIENT
REGISTRATION PACKET

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
☐ Creole	☐ Other	☐ Decline	

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? Survey communications are sent via standard unsecure email and can place your information at risk of being read or accessed by someone else. By checking yes, you agree to receiving the survey via standard unsecure (unencrypted) email.

☐ Yes ☐ No

HOW DID YOU HEAR ABOUT US?

Social Media ☐ FB ☐ Insta ☐ Linkedin	Media ☐ ABC ☐ NBC ☐ Telemundo ☐ WSVN Channel 7
Search Engine ☐ Google ☐ Bing ☐ Yahoo	Print ☐ Newspaper ☐ Magazine ☐ Mailer
☐ Radio ☐ Insurance Referral ☐ Hospital ☐ VA ☐ Physician Referral ☐ Family/ Friend	
☐ Integrative Oncology Essentials ☐ Communications Forum/Seminar ☐ Other:_____	

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

☐ Always	☐ Usually	☐ Sometimes	☐ Never

21st Century Oncology

Telephone Consumer Protection Act [TCPA] Consent Form

Active communication with our patients is a key element in providing high quality health care services. To that end, 21st Century Oncology desires to communicate timely information regarding health care services and functions to you in the most effective means possible, including via automated telephone and text messaging. Federal law requires that we obtain your consent prior to communicating with you via these means. Please read and sign below so that we can communicate with you for these important purposes. We apologize for the formality of this consent, but it is required under law.

I, **ACCOUNT TEST** , authorize the use of my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I consent to receiving multiple messages per day from my healthcare provider, when necessary, and I consent to allowing messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

I also authorize any of **21ST CENTURY ONCOLOGY - FYC** independent contractors agents and/or affiliates ("collectively, "Practice") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice or other messaging system, 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, as well as through any email address or other personal contact information supplied by me. I expressly consent to receive any such automated calls. I understand that, depending on my plan, charges may apply to certain calls or text messages. I also understand that communication platforms may transmit information via unsecure methods which includes a risk that the information could be viewed by an unintended third party. I understand these risks and consent to having these communications sent unsecure.

_____

Patient Signature (or Signature of Patient's Authorized Representative)

_____

Patient Name

_____

Date

21st Century Oncology

PATIENT PERMISSION TO COMMUNICATE INFORMATION WITH DESIGNATED INDIVIDUALS

Our physicians and staff know that communicating with you about your healthcare is important. By completing this form, you give us permission to provide messages, and/or discuss information about your healthcare with the individuals designated below. I understand that I may cancel or update this information at any time by notifying a representative of the physician office.

1. **I give permission** to allow physicians and staff to discuss relevant medical, billing, and insurance information with the individuals listed below (examples, spouse, relatives, friend, etc.). I understand that my healthcare provider will use professional judgment to determine what information about my healthcare may be discussed with the designated individuals below*:

Involved Individual	Relationship to Patient	Phone Number

Patient/Authorized Representative Signature** _____ **Date** _____ **Time** _____

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

***If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.*

*21st Century Oncology expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment or healthcare operations.

BE 21st Century Oncology

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

21st Century Oncology
DBA 21ST CENTURY ONCOLOGY - FYC
PO Box 862152
Orlando, FL 32886-2152

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)

BE 21st Century Oncology

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.

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

NOTICE OF PRIVACY PRACTICES

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.

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

BE 21st Century Oncology

Language Assistance Services for Individuals with Limited English Proficiency

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (833)-796-9684

Spanish / Español:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Por favor, póngase en contacto con su oficina médico o llame al (833)-796-9683.

Mandarin / 繁體中文: 注意：如果您使用繁體中文，您可以免費獲得語言援 助服務。请联系您的医生办公室或 請致電 (833)-796-9680。

Vietnamese/ Tiếng Việt:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Vui lòng liên hệ văn phòng bác sĩ của bạn hoặc gọi số (833)-796-9682.

Korean / 한국어:
주의 : 한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 의사 사무실에 문의하거나(833)-796-9678. 로 전화주십시오.

French Creole / Kreyòl Ayisyen:
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri kontakte biwo doktè ou a oswa rele (833)-590-0265.

Russian / Русский:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Пожалуйста, обратитесь к врачу или офис Звоните (833)-796-9677.

Armenian / Հայերեն:
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Խնդրում ենք կապվել Ձեր բժշկի գրասենյակ կամ Զանգահարեք (833)-796-9675.

Italian / Italiano:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di contattare l'ufficio medico o chiamare il numero (833)-717-5678.

Persian (Farsi) / فارسی:
توجه: اگر شما فارسی، خدمات کمک زبان، رایگان صحبت می کنید در دسترس شما هستند لطفا با دفتر پزشک خود تماس بگیرید و یا بفرمایید (833) 717-5677.

Portuguese / Português:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Entre em contato com seu escritório médico ou ligue para (833)-796-9676.

Arabic / العربية:
تنبيه: إذا كنت تتكلم العربية وخدمك المساعده باللغوية مجانا تتوفر لك. يرجى الاتصال بمكتب الطبيب أو الاتصال(833) 717-5597.

Japanese / 日本語: 注意：あなたが日本語を話す場合は、無償で言語 支援サービスは、あなたにご利用いただけます。 あなたの医師のオフィスにお問い合わせいただくか、(833) 717-5676 までお電話ください。

French / Français:
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. S'il vous plaît contacter votre bureau de médecin ou appelez le (833) 663-6209.

Polish:
UWAGA Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 833-796-9679.

21st Century Oncology

Notice of Non-Discrimination

Discrimination is Against the Law

21st Century Oncology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 21st Century Oncology does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

21st Century Oncology:

- 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, please contact your physician office.

If you believe that 21st Century Oncology 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: Civil Rights Coordinator, 2270 Colonial Blvd, Fort Myers, FL 33907, 866-679- 8944, CivilRightsCoordinator@21co.com. You can file a grievance in person or by mail, phone, or email. If you need help filing a grievance, the 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

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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