Naples Urology
ASSOCIATES
A Division of 21st Century Oncology

Patient Name:_____ Date of Birth:_____ Age:_____

Mailing Address:_____ City:_____ St:_____ Zip:_____

Secondary Address:_____ City:_____ St:_____ Zip:_____

Local Phone:_____ Work Phone:_____ Cell Phone:_____

Social Security #_____ Drivers License #_____

Email:_____

Occupation:_____ Employer:_____

Emergency Contact:_____ Relationship_____ Phone#:_____

How were we recommended to you? _____

Primary Physician:_____ Phone #:_____

Referring Physician_____ Phone #:_____

Other Physician's that you want notes sent to and Phone Numbers:_____

_____

Lifetime Authorization
I certify that the information given by me applying for payment under Title XV11 of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician of organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurance.

***Signature:** X_____ **Date:**_____

If signed by **someone other than beneficiary,** state reason patient unable to sign:_____
Responsible Party **(if different that patient)**
Name:_____ Phone:_____
Address:_____ City:_____ St:_____ Zip:_____
Drivers License #:_____ Employer's Name:_____
Employer's Address:_____ City:_____ St:_____ Zip:_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company.

Method of Payment: [ ] Cash [ ] Check [ ] Credit Card

If payment is not paid in full, I agree to pay all costs of collection, including attorney fees. I authorize Naples Urology Associates, P.A. to furnish information to all insurance carriers concerning my illness and treatment and hereby assign to Naples Urology Associates, P.A. all payments for medical services rendered to myself or my dependents, in the event an insurance claim is filed by the practice. I further agree that a photocopy of this agreement shall be as valid as the original.

***Signature:** X_____ **Date:**_____

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MEDICATION LIST

Name:	Today's Date:	Date of Birth:
Local Pharmacy: Phone:	Secondary Pharmacy: Phone:	

Allergies:	Reaction:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:
Prescriptions and over-the-counter medications and herbals. Include medications taken as needed.

Name of Medication	Dosage	How Often?	Reason for Taking?

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SURGICAL HISTORY

PROCEDURE:	DATE:

MEDICAL HISTORY

PAST UROLOGY HISTORY	OTHER MEDICAL HISTORY
	_____ Cancer: (LIST TYPE)
_____ Bladder Cancer	_____
_____ Hematuria	_____ Arthritis
_____ Kidney Cancer	_____ Asthma
_____ Kidney Stones	_____ Anemia
_____ Prostate Cancer	_____ Atrial Fibrillation
_____ Prostatitis	_____ CHF
_____ Recurrent UTI's	_____ COPD
_____ Renal Failure	_____ Deep Vein Thrombosis
_____ Urinary Incontinence	_____ Depression
_____ Urinary Retention	_____ Diabetes
_____ Other	_____ Diverticulitis
	_____ Gastric Ulcer
	_____ Hepatitis
	_____ Hypertension
	_____ Myocardial Infarction
	_____ Seizures
	_____ Strokes
	_____ Thyroid Disorder
	_____ Other

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FAMILY HISTORY

Please check any of the following medical problems that pertain to your family:

_____ Asthma	_____ Kidney Cancer
_____ Bladder Cancer	_____ Kidney Stone Disease
_____ Bleeding Disorder	_____ Prostate Cancer
_____ Cardiovascular Disease	_____ Renal Disease
_____ Diabetes	_____ Stroke
_____ High Blood Pressure	_____ Other

SOCIAL HISTORY

Please Circle all that apply

MARITAL STATUS:
MARRIED / SINGLE / DIVORCED / WIDOWED / SEPERATED

SMOKING STATUS:
CURRENT EVERYDAY / CURRENT SOME DAYS / FORMER SMOKER /NEVER SMOKED
SMOKER -CURRENT STATUS UNKNOWN / UNKNOWN IF EVER SMOKED

SMOKLESS TOBACCO? YES / NO

WHEN DID YOU QUIT? _____

OF PACKS SMOKED? _____

HOW LONG DID YOU SMOKE? _____

DO YOU DRINK ALCOHOL? YES / NOT ANYMORE / NO

HOW MUCH DO YOU DRINK? _____ DAY / WEEK / MONTH / YEAR

TYPE: BEER / LIQUER / WINE SOCIAL / LIGHT / MODERATE / EXCESSIVE

HOW MANY CAFFEINATED DRINKS DO YOU HAVE PER DAY? 0 / 1 / 2 / 3 / 4+

DO YOU USE RECREATIONAL DRUGS? YES / NO TYPE: _____

HAVE YOU HAD A BLOOD TRANSFUSION? YES / NO

RACE: WHITE / BLACK OR AFRICAN AMERICAN / HISPANIC OR LATINO

OTHER _____

LANGUAGE: ENGLISH / SPANISH / FRENCH / OTHER

PLEASE CIRCLE IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMTOMS:

CONSTITUTIONAL:	FEVER WEIGHT LOSS CHILLS
EYES:	GLAUCOMA DOUBLE VISION CATARACTS
ENT:	HEARING LOSS NASAL STUFFINESS SORE THROAT
CARDIO:	CHEST PAINS SWOLLEN ANKLES IRREGULAR HEARTBEAT
RESPIRATORY:	SHORT OF BREATH WHEEZING CHRONIC COUGH
GI:	ABDOMINAL PAIN NAUSEA/VOMITING CHANGE IN BOWELS
GU:	INCONTINENCE PAINFUL URINATION BLOOD IN URINE
MUSCULOSKELETAL:	CHRONIC BACK PAIN CHRONIC NECK PAIN SORE MUSCLES
SKIN:	RASH PERSISTANT ITCHING SKIN CANCER HISTORY
NEUROLOGICAL:	NUMBNESS TINGLING DIZZINESS
HEME/LYMPHATIC:	SWOLLEN GLANDS ABNORMAL BLEEDING

NONE

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

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, State, ZIP Code)	Telephone Number

I request that my health information or medical 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**

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

_____

_____

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

Restricted Name/Entity	**Relationship to Patient**

Please check the following that apply:

____ OK to leave a message on answering machine/voice mail

____ OK to leave message with person answering phone

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 would violate the law. If we agree to the restriction, 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 X	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:

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21st Century Oncology, LLC
Naples Urology Associates

ACKNOWLEDGEMENT 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.

X_____ _____
Signature of Patient or Representative Date

_____
Print Name

****

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 acknowledgment 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

Naples Urology
ASSOCIATES
A Division of 21st Century Oncology

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

21st Century Oncology, LLC
Naples Urology Associates
PO BOX 86215 ORLANDO, FL 32886-2152

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund 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 instruct 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 will be immediately signed over and sent 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 shall be considered as effective and valid as the original.

X_____ Date:_____
Signature of Patient/Person Legally Responsible

_____
Print Name of Patient/Person Legally Responsible

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

NOTICE OF PRIVACY PRACTICES
21st Century Oncology, LLC

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.

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

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 or call the following number: 239-938-9391.

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

21st Century Oncology

Language Assistance Services for Individuals with Limited English Proficiency

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Please contact your physician office or call 239-938-9391.

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 239-938-9391.

Tagalog / Filipino:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Mangyaring makipag-ugnay sa iyong manggagamot opisina o tumawag sa 239-938-9391.

Chinese / 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
239-938-9391。

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 239-938-9391.

Korean / 한국어:
주의 : 한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 의사 사무실에 문의하거나 239-938-9391로 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 239-938-9391.

Russian / Русский:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Пожалуйста, обратитесь к врачу или офис Звоните 239-938-9391.

Armenian / Հայերեն:
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Խնդրում ենք կապնվել ձեր բժշկի գրասենյակ կամ Զանգահարեք 239-938-9391.

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 239-938-9391.

Persian (Farsi) / فارسی:
توجه: اگر شما فارسی، خدمات کمک زبان، رایگان صحبت می کنند، در دسترس شما هستند. لطفا با دفتر پزشک خود تماس بگیرید و یا پاس خ 239-938-9391.

Portuguese / Português:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Entre em contato com seu escritório médico ou ligue para 239-938-9391.

Arabic / العربية:
تنبيه: إذا كنت تتكلم العربية، وخدمات المساعدة اللغوية، مجانا، تتوفر لك. يرجى الاتصال بمكتب الطبيب أو الاتصال 239-938-9391.

Hindi / हिंदी:
ध्यान दें: आप हिंदी, भाषा सहायता सेवाओं, नि: शुल्क बोलते हैं, तो आप के लिए उपलब्ध हैं। अपने चिकित्सक कार्यालय से संपर्क करे या 239-938-9391 फोन कृपया।

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、239-938-9391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 239-938-9391.