Associates in General & Vascular SURGERY
Part of the GenesisCare network

NEW PATIENT REGISTRATION PACKET

_____ (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: _____

_____ (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: _____

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

Name: _____ Phone: _____

Relationship to Contact: _____ Guardian: _____

Address: _____ Apt/Suite #: _____

City: _____ State: _____ Zip: _____

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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?

☐ Physician Referral	☐ Family or Friend	☐ Insurance Referral
☐ Internet (website, search engine, Facebook, etc.)		☐ Media (newspaper, magazine, billboard, radio, TV)
☐ Hospital	☐ VA	☐ Integrative Oncology Essentials
☐ Communications Forum (Seminar, etc.)		
☐ No Response		

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

☐ Always	☐ Usually	☐ Sometimes	☐ Never

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NOTICE OF PRIVACY PRACTICES

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, «PatientFullName», 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 «PracticeName» 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.

_____

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

_____

Patient Name

_____

Date

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NOTICE OF PRIVACY PRACTICES

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.*

*Associates in General & Vascular Surgery 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.

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NOTICE OF PRIVACY PRACTICES

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

Associates in General
& Vascular Surgery
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)

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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

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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

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

Reason for Visit:

_____

Primary Care Physician:

_____

Other physicians involved in your care:_____

_____

Past Medical History NONE _____

Circle the following conditions for which you have been treated or are currently being treated:

AAA (Abdominal Aortic Aneurysm)	CHF/Congestive Heart Failure	Hernia	Pancreatitis
MI/Heart Attack	Colon Cancer	High BloodPressure	Peptic Ulcer
Anemia	COPD	HIV	Pneumonia
Angina	CVA	Hyperlipidemia	Prostate Cancer
Anxiety	Depression	Hypertension	Peripheral Vascular Disease
Arthritis	Diabetes	Hyperthyroid	Renal Disorders
Asthma	Diverticulitis	Hypothyroid	Rheumatoid Arthritis
Bladder Cancer	Eczema	Kidney Disease	Seizure Disorder
Blood Transfusion	Emphysema	Lymphedema	Syncope (Fainting)
BPH/Enlarged Prostate	Esophagitis	Migraines	Thromboembolic Disease
Breast Cancer	Glaucoma	Neuralgia	Urticaria
Carotid Stenosis	Gerd	Neuritis	
CAD/Coronary Artery Disease	Gout	Obesity	
	Head Injury	Osteoarthritis	
	Heart Disease	Osteoporosis	
	Hepatic Disorders		
	Hepatitis		

Other Conditions:

_____

Last Colonoscopy (year) _____ Last Mammography (year) _____

Have you had the following Immunizations?

Flu: Yes or No Date: _____ Pneumonia: Yes or No Date: _____

Past Surgical History NONE _____

What Operations have you had? (Give approximate year)

Current Medication NONE _____

Coumadin/Warfarin/Plavix or other blood thinner _____? Yes No Dose: _____

Preferred Pharmacy: _____ Address: _____
Phone: _____

List all current medications including INHALERS, HERBAL SUPPLEMENTS, OVER THE COUNTER and dosages:

Medication	Dose	Times/Day	Medication	Dose	Time/Day

Allergies NONE _____

List all medications to which you are allergic & your reaction to the medication:

Allergies	Reaction	Allergies	Reaction

Family History	Living	Age	Deceased	Age @ Death	Cause of Death
Mother					
Father					
Brother (s)					
Sister (s)					
Son (s)					
Daughters (s)					

Social History

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed
Occupation: _____ Employer: _____ □ Retired
Employment Type: None / Desk Based / Light Physical / Moderate Physical / Heavy Physical
Tobacco Use: □ Never □ Former Years since quit? ____ □ Yes Years smoked? _____ # packs/day ____
Alcohol Use: Do you drink alcohol? □ Yes □ No Type _____ Drinks per day _____
Drug Use: □ Yes □ No Substance: _____

SYSTEM REVIEW

Review of Systems (Check any of the following that apply to you)

Constitutional	Gastrointestinal	Neurological	Eyes
□ Feeling fine □ Weight Loss □Weight gain □ Frequent fevers □ Fatigue/tired	□Loss of appetite □Nausea □Vomiting □Abdominal pain □Heartburn □Change in bowel habits □Regular use of laxatives □Blood in stool	□Headache □Dizziness □Seizure □Tremors □Speech problems □Balance problems □Memory loss	□Sensitivity to light □Vision changes □Wears glasses or contacts
Ears/Nose/Throat	**Genito-urinary**	**Psychological**	**Cardiovascular**
□Hearing loss or ringing □Earache □Ear drainage □Nasal stuffiness □Frequent nosebleeds □Mouth sores □Sore throat □Lump/swelling in neck □Difficulty swallowing	□Frequent urination □Painful urination □Blood in urine □Incontinence □Penile discharge □Testicular pain □Testicular lump □Irregular periods □Vaginal discharge	□Feeling nervous □Sleep disturbances □Depression □Psychological symptoms □ thoughts about suicide	□Low exercise tolerance □Chest pain □Heart attack □Palpitations □Edema/swelling
Musculoskeletal	**Endocrine**	**Hematology**	**Respiratory**
□Joint pain □Joint swelling □Joint stiffness □Weakness □Muscle pain □Back pain	□Night sweats □Excessive thirst □Temperature intolerance	□Easy bruising □Swollen glands □Slow to heal after cuts □Past transfusion	□Shortness of breath □Cough □Coughing up blood □Wheezing
Skin	**Allergic/Immunologic**		
□Rashes □Itching □Non-healing lesions □Breast pain or lumps	□Frequent infections □Chemotherapy □X-ray treatments		