**PATIENT INFORMATION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(I HAVE REVIEWED ALL THE INFORMATION BELOW IS ACCURATE)**

**NEW PATIENT REGISTRATION PACKET**

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**: |  |

Are you currently admitted to a hospital or enrolled in a Hospice or Skilled Nursing Facility?

**NEW PATIENT REGISTRATION PACKET**

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?**

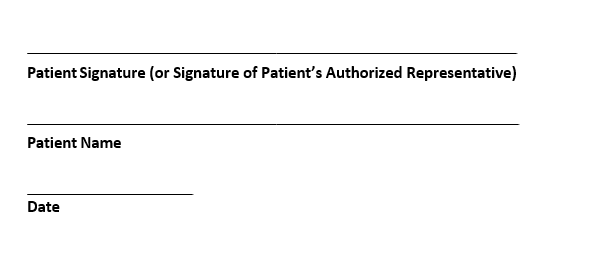
|  |  |  |  |
| --- | --- | --- | --- |
| Always | Usually | Sometimes | Never |

**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 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.

New Patient Packet – 012219

**21st Century Oncology**

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

**DBA**

**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)

**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**

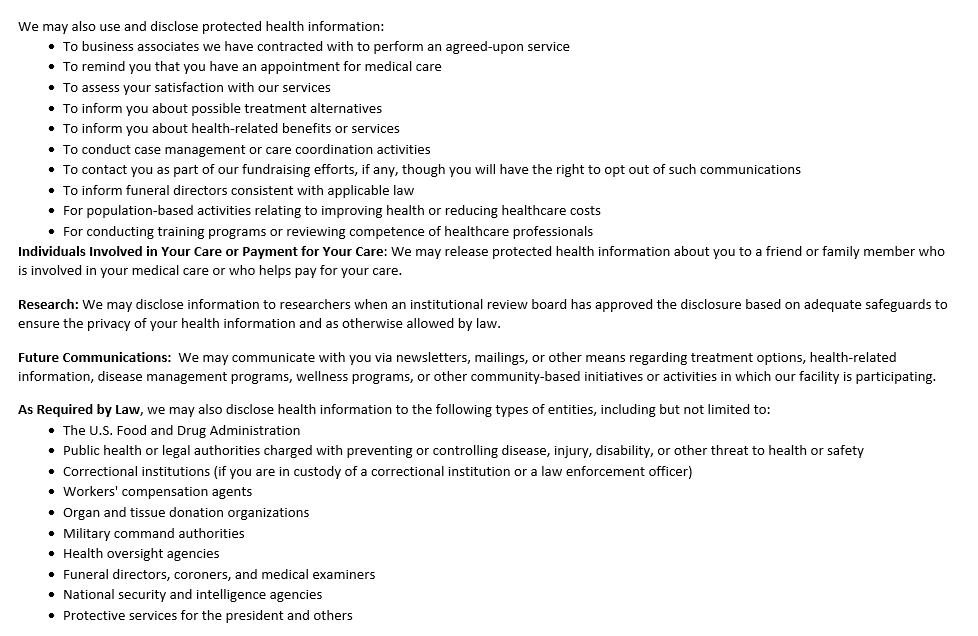
We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to that protected health information, and to notify any affected individuals following a breach of any unsecured protected health information.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



**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.

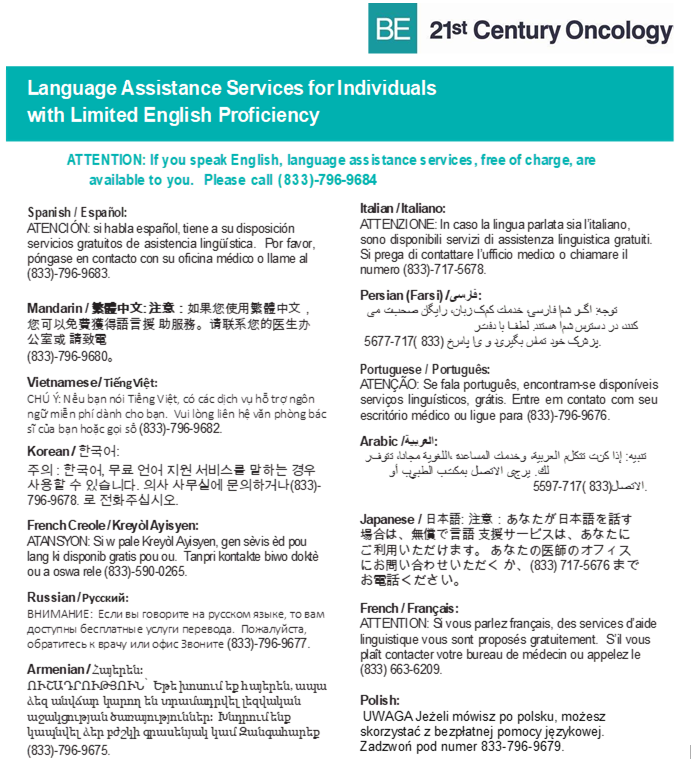
For further information, contact:

Privacy Officer

2270 Colonial Boulevard

Fort Myers, FL 33907

1-866-679-8944 085-H18.1 03/26/2013





**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:

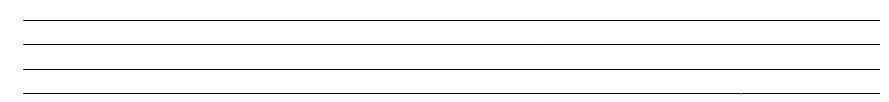
Patient/family member received notice but refused to sign acknowledgment

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