

PATIENT REGISTRATION

(Please Complete ALL Information)

DATE: _____

PATIENT ACCT. # _____

ALLERGIES:

PRINCIPAL PAYOR CODE

A. Medicare	H. Workman's Comp
B. Medicare HMO	I. Champus
C. Medicaid	J. VA
D. Medicaid HMO	K. Other State/Local Govt.
E. Commercial	L. Self-Pay (No Insurance)
F. Commercial HMO	M. Other
G. Commercial PPO	N. Charity

Last Name: _____ Date: _____
 First Name: _____ M.I.: _____ Home Phone #: _____
 Street Address: _____ Work Phone #: _____
 Apartment #: _____ Date of Birth: _____
 City: _____ State: _____ Social Sec. #: _____
 Zip Code: _____ Sex: M / F Marital Status: _____
 Employer: _____ Spouse Name: _____
 Secondary Address: _____ Spouse DOB: _____ SS #: _____
 City: _____ State: _____ Zip: _____ Secondary Phone: _____
 Friend/Family not living with Patient: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

Referring Doctor Name _____

INFORMATION RELEASE

LIFETIME MEDICARE B signature authorization for services beginning _____.
 I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or the billing agent for Urology Treatment Center, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits either to myself or to the party who accepts assignment.

PATIENT'S SIGNATURE: _____ MEDICARE # _____ DATE: _____
If patient is unable to sign, may be signed by someone who is authorized by patient to sign for him/her:
 BY: _____ Relationship to Patient: _____ DATE: _____

IF PATIENT IS A MINOR: I _____, the _____ of _____
hereby personally accept financial responsibility for professional services by Urology Treatment Center, upon the aforementioned child.
 SIGNED: _____ DATE: _____

ASSIGNMENT AND RELEASE

I/We hereby authorize my insurance benefits, including Medicare Gap Fillers, to be paid directly to the physician and I/We hereby agree to be financially responsible for any amount not covered by insurance. I further understand that if this account is referred to an agency or attorney for collection, I will be responsible for all fees associated with collection. I/We also authorize the physician to release any information required. Financial information can be released if the Patient's account number is provided by the person making the request.

PATIENT'S SIGNATURE: _____ DATE: _____
If patient is unable to sign, may be signed by someone who is authorized by patient to sign for him/her:
 BY: _____ Relationship to Patient: _____ DATE: _____
 SPOUSE'S SIGNATURE: _____ DATE: _____

UROLOGY TREATMENT CENTER

A Division of 21st Century Oncology, LLC

3325 S. Tamiami Trail, Suite 200 • Sarasota, FL 34239

(941) 917-8488 • Fax (941) 917-8475

NAME _____ DATE _____

HISTORY

Reason for this visit _____

Duration of above complaint (weeks, months, years) _____

Frequency of urination Daytime _____ Nighttime _____

Strength of Stream Normal _____ Decreased _____ Poor _____

Please Circle YES or NO

Blood in Urine	Yes	No	Leakage of Urine	Yes	No
Urinary Infections	Yes	No	Interruption of Urinary Stream	Yes	No
Kidney or Bladder Stones	Yes	No	Split Stream	Yes	No
Urgent Urination	Yes	No	Burning / Discomfort w/Urination	Yes	No
Dribbling After Voiding	Yes	No	Hesitancy in Initiating Stream	Yes	No

RECENT X-RAYS Yes No If yes, what type of x-rays were performed and where?

CURRENT MEDICATIONS (INCLUDING ASPIRIN) AND DOSE

ALLERGIES

<p><i>TO BE COMPLETED BY PHYSICIAN</i></p> <p><u>HISTORY OF PRESENT ILLNESS</u></p> <p>_____ _____ _____</p> <p><u>SOCIAL HISTORY</u></p> <p>_____ _____</p>

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NAME: _____

PAST MEDICAL HISTORY:

Previous Hospital Admissions and/or Surgery. Please list in chronological order with the approximate dates:

PREVIOUS MEDICAL ILLNESSES- (such as TB, High Blood Pressure, Heart Attack, etc)

FAMILY HISTORY: PLEASE CIRCLE ONE:

Diabetes	Yes	No
Heart Disease	Yes	No
Tuberculosis	Yes	No
Kidney Disease	Yes	No
Cancer	Yes	No

Relationship to You

TRANSFUSION HISTORY:

Have you ever had a blood transfusion Yes ___ No ___
If yes, When _____
How Many? _____

Type of Cancer: _____

Other: _____

ALCOHOL USE PER WEEK: _____

EXPOSURE TO: Dye Industry: Yes No Rubber Industry: Yes No Paint Industry: Yes No

Do You Have Now or Have You Had Problems Relating to the Following Systems? Circle Yes or No

HEENT:

Recent vision changes	Yes	No
Hoarseness	Yes	No
Swallowing changes	Yes	No
Hearing Aids	Yes	No

CARDIOVASCULAR/RESPIRATORY:

Heart Palpitations	Yes	No
History of Heart Attack	Yes	No
Shortness of Breath	Yes	No
High Blood Pressure	Yes	No
Chronic Cough	Yes	No
Asthma	Yes	No
Smoking	Yes	No

If yes, how many _____

If stopped, When _____

How long did you smoke _____

HEMATOLOGIC

History of Bleeding	Yes	No
Easy Bruising	Yes	No

ENDOCRINE

Are you a Diabetic	Yes	No
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PSYCHOLOGIC

History of Depression	Yes	No
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GYNECOLOGIC:

Are you pregnant	Yes	No
Last Menstrual Date	_____	
Menopause if Yes age	_____	

Difficulty Having Intercourse	Yes	No
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GASTROINTESTINAL

Diarrhea	Yes	No
Constipation	Yes	No
Blood in Stool/Black Stool	Yes	No
Abdominal Pain/Indigestion	Yes	No
Nausea/Vomiting	Yes	No
History of Ulcer	Yes	No

NEUROLOGIC

Headaches	Yes	No
History of Fainting/Seizures	Yes	No
History of Numbness/Weakness	Yes	No

INTEGUMENTARY

History of Jaundice	Yes	No
Skin Rash in Genital Area	Yes	No

MUSCULOSKELETAL

Back Pain	Yes	No
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Physician's Signature _____ **Date** _____

Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

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

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

Restricted Name/Entity	Relationship to Patient

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

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

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that 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	Date
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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
Urology Treatment Center**

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.

Signature of Patient or Representative

Date

Print Name

FOR OFFICE USE ONLY

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

Patient's name: _____

Date of attempt to obtain acknowledgement: _____

Reason acknowledgement was not obtained:

- Patient/family member received notice but refused to sign acknowledgement
- 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

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

**21st Century Oncology, LLC
Urology Treatment Center
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.

Date: _____

Signature of Patient/Person Legally Responsible

Print Name of Patient/Person Legally Responsible

Relationship to Patient
(If signed by Person Legally Responsible)

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(941) 917-8488-FAX (941) 917-8475

NAME: _____

DOB: _____

REASON FOR VISIT: _____

PRIMARY PHYSICIAN: _____

REFERRING PHYSICIAN: _____

PHARMACY NAME: _____

PHARMACY PHONE NUMBER: _____

PHARMACY ADDRESS: _____

**Urology Treatment Center
OFFICE POLICY ON TEST RESULTS**

Blood Tests
X-Rays
Ultrasounds
Biopsy Results
Surgical Findings

Your tests results are confidential and will be available only to you and your physician under normal circumstances.

Your tests results will not be given out over the telephone or by the nurses unless the results suggest a possible medical emergency. There are important reasons for this policy, most of which relate directly to the maintenance of good medical practice.

First, all results are reviewed by physicians as they come in, prior to filing in the medical record to screen for emergencies. You will be called if an emergency result is found.

Second, a test can be correctly interpreted only when the patient's age, medical problems and condition are taken in context. This requires a careful review of the chart, prior laboratory results and x-rays and is best done in light of discussion with and examination of the person tested. This is the major purpose of a follow-up visit. Giving out isolated test results over the telephone or by the nurses has resulted in inaccurate or incomplete interpretation and/or misunderstanding by the patient or their family. This is unsatisfactory to all concerned and will not be done except under exceptional circumstances.

Thirdly, our office notes, usually dictated in your presence, will communicate the results of relevant urological laboratory findings to your general medical or referring physician(s).

Finally, we utilize the services of many laboratories and we cannot predict when we will receive results which require sorting and filing once they arrive in our office. Please be patient and we will provide you with the best of urologic care.