UROLOGY TREATMENT CENTER
A Division of 21st Century Oncology, LLC

*VERIFIED BY*_____

PATIENT REGISTRATION

(Please Complete ALL Information)

PATIENT ACCT. #_____ **DATE:**_____

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

_____

_____

_____

TO BE COMPETED BY PHYSICIAN

HISTORY OF PRESENT ILLNESS

_____

_____

_____

SOCIAL HISTORY

_____

_____

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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:

			Relationship to You
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
Tuberculosis	Yes	No	_____
Kidney Disease	Yes	No	_____
Cancer	Yes	No	_____

Type of Cancer: _____

Other: _____

TRANSFUSION HISTORY:

Have you ever had a blood transfusion Yes____No_____

If yes, When_____

How Many?_____

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
PSYCHOLOGIC		
History of Depression	Yes	No

GYNECOLOGIC:		
Are you pregnant	Yes	No
Last Menstrual Date_____		
Menopause if Yes age_____		
Difficulty Having Intercourse	Yes	No
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

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 my 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

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:

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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3325 S. Tamiami Tr., SARASOTA, FL 34239

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

NAME: _____

DOB: _____

REASON FOR VISIT: _____

_____

PRIMARY PHYSICIAN: _____

REFERRING PHYSICIAN: _____

PHARMACY NAME: _____

PHARMACY PHONE NUMBER: _____

PHARMACY ADDRESS: _____

_____