



NEW PATIENT REGISTRATION PACKET

Office: _____ Date: _____
Last Name: _____ First Name: _____
Nickname: _____ DOB: _____ Sex: _____
SSN: _____ Address: _____
Apt/Suite#: _____ City: _____
State: _____ Zip: _____ Home Phone: _____
E-mail: _____ Mobile: _____
Primary Provider: _____ Referring Provider _____
Employer: _____ Work Phone: _____
Marital Status: _____ Is your spouse working or retired? _____
Spouse Name: _____ Spouse DOB: _____
Spouse SSN: _____ Spouse Contact Number: _____
Alternate Address: _____ Apt/Suite#: _____
City: _____ State: _____ Zip: _____

Insurance Information:

Primary: _____ Plan ID: _____
Group#: _____ Phone Number: _____
Policy Holder: _____ Policy Holder DOB: _____
Secondary: _____ Plan ID: _____
Group#: _____ Phone Number: _____
Policy Holder: _____ Policyholder DOB: _____
Guarantor: _____ Guarantor Relationship: _____

Emergency Contact Information:

Name: _____ Phone: _____
Relationship: _____ Guardian: _____
Address: _____ Apt/Suite#: _____
City: _____ State: _____ Zip: _____

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?

<input type="checkbox"/> Asian	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Black / African American		
<input type="checkbox"/> Subcontinent Asian American	<input type="checkbox"/> Asian Pacific American	<input type="checkbox"/> Native American	<input type="checkbox"/> American Indian/ Alaskan Native	
<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> More than one race	<input type="checkbox"/> Other	<input type="checkbox"/> Decline

Please Select one Ethnic Group that Best Describes Your Ancestry:

<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Non-Hispanic or Latino
<input type="checkbox"/> Decline	<input type="checkbox"/> Do not know

What language do you feel most comfortable using when discussing your healthcare?

<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> German	<input type="checkbox"/> French
<input type="checkbox"/> Italian	<input type="checkbox"/> Russian	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Chinese
<input type="checkbox"/> Creole	<input type="checkbox"/> Other	<input type="checkbox"/> Decline	

How did you hear about us?

<input type="checkbox"/> Physician Referral	<input type="checkbox"/> Family or Friend	<input type="checkbox"/> Insurance Referral	<input type="checkbox"/> Hospital
<input type="checkbox"/> Integrative Oncology Essentials	<input type="checkbox"/> Communications Forum (Seminar, etc)	<input type="checkbox"/> Media (newspaper, magazine, billboard, radio, TV)	
<input type="checkbox"/> Internet (website, search engine, Facebook, etc.)		<input type="checkbox"/> No Response	

When conducting your own research, how often do you use the internet for gathering information?

<input type="checkbox"/> Always	<input type="checkbox"/> Usually	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
---------------------------------	----------------------------------	------------------------------------	--------------------------------

At GenesisCare, we know you have a choice in where you receive your medical care and we thank you for choosing GenesisCare. We would like to invite you to share your experience by completing surveys and/or online reviews. Sharing this information can help others who are interested in knowing more about the patient services provided by GenesisCare and can help promote our mission of providing high-quality, patient-centered care. Surveys and/or online review requests may be sent to you via US mail, email, mobile text messaging, and/or telephone calls. Communication platforms using standard email/mobile text messaging may not utilize encryption, which can place your information at risk of being read or accessed by an unintended third party. By checking yes, you agree that you understand these risks and to receive surveys and/or requests for online reviews through standard unsecure (unencrypted) email, and/or mobile text messaging.

Yes No

If you are willing to allow GenesisCare to share your online review or testimonial, please let us know so we can get your written permission.



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, GenesisCare 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, _____, 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 to be 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 GENESISCARE USA OF FLORIDA - UPF 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 receiving any such automated calls. I understand that, depending on my plan, charges may apply to certain calls or text messages. I also understand that communication platforms may transmit information via unsecure methods which includes a risk that the information could be viewed by an unintended third party. I understand these risks and consent to having these communications sent unsecure.

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

Patient Name

Date



PATIENT CONSENT FOR DISCLOSURE TO INVOLVED INDIVIDUALS

Patient Name: _____ Date of Birth: _____.

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.

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.*

Note: GenesisCare USA 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.



Assignment Of Benefits/Right To Payment Authorization, Patient Responsibility, And Release Of Information Form

GenesisCare
DBA GENESISCARE USA OF FLORIDA - UPF
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.

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 time. 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.genescare.com/us/.

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:

Chief Privacy Officer
2270 Colonial Boulevard
Fort Myers, FL 33907
1-866-679-8944



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

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



Language Assistance Services for Individuals with Limited English Proficiency

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (833)-796-9684

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 (833)-796-9683.

Mandarin / 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。請聯系您的醫生辦公室或請致電 (833)-796-9680。

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 (833)-796-9682.

Korean / 한국어: 주의 :

한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 의사 사무실에 문의하거나(833)796-9678. 로 전화하십시오

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 (833)-590- 0265.

Russian / Русский: В И М А Н И Е: Е с л и вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Пожалуйста, обратитесь к врачу или офис Звоните (833)-796-9677.

Armenian / Հայերեն: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Խնդրում ենք կապվել ձեր բժշկի գրասենյակ կամ Զանգահարեք (833)-796-9675.

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 (833)-717-5678.

Persian (Farsi) / ، ف ا ر س ی ف ا ر س ی ا ش م ر ا گ ب ت و ج ه : ، ز ب ا ن ک ک م ت خ د م ا ، م ی ت ص ح ب ن ر ا ی گ ا ک ن ن د ، ب ا ا ل ف ه س ت ن د ا ش م س م س ت ر ر د خ پ ا س ای و د ب گ پ یر ی س ت م ا د خ و . ک پ ز ش ر د ف ت (833) 7175677

Portuguese / Português:

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Entre em contato com seu escritório médico ou ligue para (833)-796-9676.

Arabic / ال عرب یة ال عرب یة مت تکل تکن الذ بت ن ب یه : ، ال م س ا ع د ت و خ د م ا ، ال ل غ و یة م ج ا ن ا ، ا و ب ال ط ب ی ب ب م ک ت ، ل ل ا ل ا ت ص ا ب ی ر ج . ل ک ر ت ت و ف ل ل ا ل ت ص ا (833) 5597-717

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、(833) 717-5676 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 (833) 663-6209.

Polish:

UWAGA Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 833-796-9679.

Notice of Non-Discrimination

Discrimination is Against the Law

GenesisCare USA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GenesisCare USA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GenesisCare USA:

- 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.

If you believe that GenesisCare USA 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@usa.genescare.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/smartscreen/main.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: <https://www.hhs.gov/ocr/complaints/index.html>

Patient Authorization for Disclosure of Health Information

All sections of this authorization form MUST be completed to be considered valid

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____

I request that my protected health information (PHI) from GenesisCare USA be disclosed to:

Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

I request the following PHI to be released from my medical record(s):

Name of Physician: _____
Specific Treatment Dates: _____ to _____
 Consultation Reports Diagnostic Films Dosimetry Records Laboratory Results
 Physician Dictation Portal Films/Simulation Films Progress Notes
 Radiology or Imaging Reports Surgery/Pathology Complete Medical Record
 Billing Records Genetic Records Other (please specify): _____

Purpose for requesting information: Continuation of Care Insurance Legal Personal
 Other: _____

Disclosure Format: US Mail – paper format Fax (healthcare provider only) Secure E-mail
 Other (please specify): _____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. I authorize the release of these records.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 2270 Colonial Blvd, Fort Myers, FL 33907. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

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.

Driver's License or Photo ID (required when records are picked up)

Driver's License State: _____ Number: _____

Witness Signature: _____

Date: _____ Time: _____





General Clinic Guidelines

As a service to our patients, and to help you better understand how our office functions, we have put together the following guidelines. These guidelines are designed to help us provide you with the optimal level of patient care and service. Our number one goal is your satisfaction and to fulfill this goal it is our responsibility to provide you with information that can assist with your care as a patient in our office.

GenesisCare Affiliation: Urology Partners is Part of the GenesisCare network. GenesisCare employs or is affiliated with over 947 physicians globally, including radiation oncologists and other specialists such as urologists, medical oncologists, hematologists, gynecologic oncologists, surgeons and pathologists — working together to deliver the most advanced integrated cancer care. Our doctors practice independently as urologists and GenesisCare functions as a management company.

Appointment Availability: Urology Partners makes every effort to schedule and keep appointments within a reasonable time frame. Once here, an appointment may take longer than planned or an emergency may arise, but every effort is made to stay on schedule. We do value our patients' time and we try our best to stay on schedule. However, there are times where the schedule may be delayed, but please note the Doctor spends as much time as needed with each patient and diagnosis. Should a patient run late, we will do our best to accommodate the patient. However, the appointment may need to be rescheduled. If an appointment is delayed or if the physician encounters a patient emergency, patients may be asked to reschedule as well. Please contact the check-in desk to inquire about the appointment and any delays encountered. Our office strives to provide appointments in a timely manner.

Arrival times: Each patient is provided with an arrival time. The arrival time allows time to process paperwork, review demographics, and collect insurance cards and payment. As a new patient we ask that you arrive at the office 30 minutes prior to your scheduled appointment in order to give you time to complete your new patient's paperwork. If paperwork is completed ahead of the appointment you will need to arrive 15 minutes prior. As an established patient we ask that you arrive 10-15 minutes prior to your scheduled appointment.

Telephone Systems/Appointment Reminders: has implemented a personalized appointment reminder system. This system will provide patients with an electronic courtesy call for upcoming appointments. This will confirm your arrival time for the check-in process. Patients will be prompted to confirm their appointment. If you have provided us with your email address, you will also receive a confirmation reminder via email.

Appointments: Please be prepared to review general demographic information, update some basic medical information, show your current insurance card, and picture D. Insurance cards and photo D must be furnished at time of visit. Copays are required at the time of visit and will be collected at check in. If applicable, deductibles and co-insurance will be collected at the time of service. Payment is expected as services are rendered unless prior financial arrangements have been made.

No-Show or Missed appointments: Our goal is to provide timely access to appointments for patients. When patients fail to keep appointments, routinely arrive late, or have multiple requests for reschedules, other patients needing to be seen on an urgent basis may be denied access to a timely appointment. For late cancellation or no-show, we will charge the patient a \$40 fee

Scheduling: The scheduler will gather key information that needs to be entered at the time of scheduling. This will include demographic and insurance information. Every effort will be made to provide you with the earliest appointment available. There are certain diagnoses that may require prompt attention and those will be brought to the Doctor's attention accordingly.

Appointments need to be scheduled as we do not generally accept walk-ins. However, if you do have an urgent situation and you are an established patient, please try to call the office first: Our clinical staff will then review your symptoms and discuss with the Doctor on how to proceed.



Phone Messages: Calls to our office are received through our automated phone service and then directed to the appropriate department. Every attempt is made to answer incoming calls. However, there are times when a patient will have to leave a voice message. All calls are returned within 24 hours. Please try not to call our office multiple times. Multiple calls can present delays in not only returning your call but other patients as well.

Nurse Calls: All patients are encouraged to call the clinical staff with any medical questions they have related to their care. Our trained and knowledgeable staff work hand in hand with our doctors. They can provide assistance and, in most cases, assist with your immediate concerns. All calls are logged into the Electronic Health Record and reviewed by the Doctors throughout the day. Communication with the clinical staff will be the primary source of information. If the doctor feels an appointment is needed, one will be provided.

Medication Lists: Please bring a complete list of all your medications, as well as the strength and dose of each one. This will help clinical staff will ensure your medications are updated.

Medication Refills: For medication refills please contact the pharmacy first. The pharmacy will fax a prescription refill request to our office. This request will generate a response from the clinical staff. Medication refills, medication requests, and lost prescriptions require 48 hours' notice. If you have not been seen in the office for more than a year you will be asked to schedule an appointment before the refill is approved.

Lab and Imaging Results: Our Clinical department is available to answer medical questions for our patients. However, they are not able to interpret patient lab or imaging results. Results will be discussed with each patient by their physician during a follow-up appointment. It is important for patients to come to their follow-up appointment to have their results interpreted and to ask questions if needed.

****Blood Work: Please notify the schedulers where you will be getting your labs drawn; this will help ensure that the results are sent to us prior to your appointment. Failure to provide this information can delay your results.**

Pathology/Specimens: Based on your diagnosis the Doctor may require additional testing on various specimens. This is discussed with you at the time of service. The specimen is then sent to an outside lab for further analysis. Depending on your health insurance benefits you may receive a bill from the lab.

Procedures performed in the office: Procedure appointment times are subject to change. Calls will be made the day before to confirm and provide the time of arrival. Please allow some flexibility when scheduling as times are subject to change.

Urine Check: Urine drop offs are no longer accepted without speaking to a nurse. **Please call to speak with the nurse before coming to the office.** Urine checks are for established patients only who suspect they may have a urinary tract infection. Therefore, in order to provide you with the best level of care and service it is necessary to collect a urine specimen. **Specimens can be collected between 8:00am to noon.** Urine cups are provided upon check in. Please fill out the provided form to let us know all symptoms you have been having along with your pharmacy's contact information so we can call in medication if needed. Since urine specimens do not require an appointment, patients may be asked to go home. Once specimens are checked and discussed with the Doctors, we will call you with results. It may not be until the end of the day before this is done. If considered necessary by the doctor, the urine may be sent out for further testing. Please note you will be charged for a nurse visit for this testing.



Medical Records: Urology Partners adheres to strict confidentiality guidelines and must receive an original signature and copy of a patient's driver's license prior to the release of medical records to the patient. In order to release your records, you must sign the release form. This is required by law to protect your privacy. A written request must include the patient's full name, date of birth, SS#, physician's name, complete address, and phone number. There is no charge for medical records request sent directly to another physician's office or medical institution. All requests are complete within fifteen (15) days of receipt of the request. A release form is available at 1. Please understand that your records contain protected health information that is highly confidential.

Seasonal residents: It is essential for patients who live here seasonally to bring their medical records from your primary or urologist's office. If you cannot personally bring your records, please arrange for them to be mailed/faxed to our office prior to your appointment. A medical records release will need to be signed prior to the release of your records.

On-Call Physician: A physician is on call 24 hours a day to deal with urological emergencies. If you believe you have a urological emergency, go directly to the emergency room. The emergency room physician will be able to assess the problem and will contact the urologist on call if immediate urological care is needed. The urologist on call will not be able to assess your symptoms on the phone. Accessing care in an urgent care or emergency room setting will help you receive the right care at the right time. On call duties are shared with the local urologists on a rotating basis. If our doctor encounters a patient emergency during his rotation patients may be asked to reschedule.

Surgeries: Will be done at the Ambulatory Surgery Center or at Hospital



Referrals & Authorizations Explained

Referrals

The referral process serves as a way for your Primary Care Physician (PCP) and your specialist to communicate with each other. When a referral is issued to see a specialist, your PCP will tell the specialist the reasons for the referral and the goals for your visit. In other words, your PCP will help coordinate your visit and the referral helps to make sure you receive the proper care when you see the specialist.

Urology Partners is considered a specialist and authorizations and/or referral is needed to be seen by our doctors.

Whose responsibility is it to obtain the referral under my insurance plan?

Your PCP is responsible for issuing the referral for office visits. However, you are responsible for making sure this is done before you see a specialist. We recommend you become familiar with and understand your PCP's specific referral procedures. Every office does this a bit differently, but most offices have a referral coordinator or other staff member dedicated to helping you through the process.

Once you become an established patient at our office as a courtesy our authorizations rep will work on obtaining additional authorizations and/or referrals on your behalf. However, it is still the patient's responsibility to make sure authorizations and referrals have been obtained prior to the appointments.

When you go through the process, make sure you follow the steps listed below (as well as any other steps your office may require):

Make sure Urology Partners is in network with your insurance and your PCP has provided the reason for the referral.

Make sure your appointment is scheduled within the time frame covered by the referral, and that you know how many visits the referral covers.

Make sure you contact the office at least one business day before your appointment(s) to be sure your referral(s) were received and processed.

If your referral covers only one visit but we provide an appointment for additional visits our authorization rep will contact your PCP to extend the referral.

Prior Authorizations

In the prior authorization process, your physician or other health care provider gets approval from your insurance company to provide you with coverage for certain services, such as specific procedures, or medications, please note that prior authorization as well as referrals and authorizations are not a guarantee of payments.

How is a prior authorization different from a referral?

If your physician determines you need a service that requires a prior authorization, your physician will get approval for coverage from the insurance company before this service is provided to you. If your physician determines you need to see another medical professional for specialized services, your physician will give you a referral, which is an approval



from your physician to see the specialist. Both the insurance company and the specialist are told of your physician's approval.

VA Insurance (Veterans Health Insurance)

The VA requires authorization to be obtained for each patient to be seen at our office. As a courtesy to our patients, we try to obtain authorizations for your visits by contacting the primary care physician and/or the VA insurance. Without authorization we can't see you in the office as the VA will deny the charges and the patients will become the responsible party for the bill. This is not an option we want to provide for our patients. We believe if you have insurance, it should be used, and authorizations should be given in a timely manner.

I acknowledge receipt of a copy of the Clinic Guidelines

Date: _____

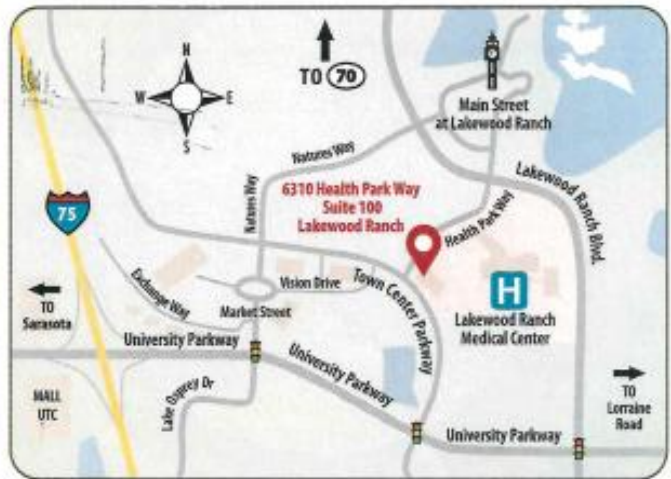
Patient's Name: _____

Patient's Signature



Locations

HMO'S REQUIRE
AUTHORIZATIONS
MEDICARE AND MOST
INSURANCES ACCEPTED



RIVERWALK PROFESSIONAL PARK

200 3rd Avenue West, Suite 210 Bradenton, FL 34205

Directions: From: I-75 take exit 220 West to SR 64-MANATEE AVE. W. approx. 6 miles. Turn RIGHT onto 3RD ST. WEST. Go about .2 miles, (through for the 4-way stop sign at 3rd Ave. and 3rd St.) and make your first right turn into RIVERWALK PROFESSIONAL PARK. Immediately to your right is Building 200. Take the elevator to the second floor; to your right is Suite 210.

LAKEWOOD RANCH

6310 Health Park Way, Suite 100 Lakewood Ranch, 34202

From I-75, take University Parkway Exit 213. Travel East on University Parkway 4 lights to Lakewood Ranch Blvd. Turn left onto Lakewood Ranch Blvd. Then turn left 1/10 of a mile into parking lot. Medical Office Building TWO is located behind Lakewood Ranch Medical Center and Medical Office Building ONE. We share the parking lot with the Lakewood Ranch ER.



PATIENT SELF-HISTORY FORM

Chief Complaint (reason why you are here): _____

Describe your symptoms (duration, location, quality, timing, precipitating/relieving factors):

Past Medical Problems:

- Diabetes, Liver Disease, Lung Disease, Stroke, Kidney Disease, Sickle Cell Anemia, Hepatitis, Cancer, Bleeding Disorder, Heart Disease, Tuberculosis, Hypertension, Blood Transfusion, AIDS, Other (please list)

OB/Menstrual History (for breast cancer risk stratification):

Of pregnancies/# of live births: ___/___ Age first pregnancy ___ Date of last period ___ Any previous breast biopsies? ___/ Year ___ When was the date of your last breast cancer screening or mammogram? ___/N/A

Past Surgical History (list):

Table with 4 columns: Date, Procedure, Hospital, Surgeon

LAST COLONOSCOPY _____

MEDICATION LIST:

Table with 4 columns: Medication, Dose, Frequency, Prescribing Physician

Pharmacy Name: _____ Pharmacy Number _____



PATIENT SELF-HISTORY FORM

ALLERGIES:

Penicillin
 Sulfa

Tape
 Betadine

Other (please list)

Social History:

Marital Status ___ Single ___ Married ___ Widowed _____ Divorced _____

Do you Smoke? _____ if yes, how long? _____ How much per day? _____

Do you drink alcohol? _____ if yes, how much and how often? _____

Occupation: _____

Family History: (Please list significant family medical problems next to each family member)

Mother: _____

Father: _____

Siblings: _____

Other Relatives _____

REVIEW OF SYSTEMS - HAVE YOU HAD ANY OF THE FOLLOWING? Check all that apply.

CONSTITUTIONAL:

- Fever
- Chills
- Night Sweats
- Headache
- Weight Loss
- Excessive Fatigue
- Poor Appetite

GASTROINTESTINAL:

- Change in stool caliber
- Jaundice
- Diarrhea
- Constipation
- Bloody vomit
- Abdominal Pain
- Nausea or vomiting
- History of Hepatitis
- Indigestion or heartburn

VISION:

- Transient Vision Loss
- Blurred Vision
- Double Vision
- Glaucoma

GENITOURINARY:

- Dark urine
- Burning with urination
- Blood in urine
- Difficulty urinating
- Frequent urination at night



PATIENT SELF-HISTORY FORM

Ear, Nose and Throat:

- Ringing in Ears
- Decreased Hearing
- Nose Bleeds
- Sore Throat
- Hoarseness
- Difficulty Swallowing

SKIN:

- Rash
- Itching
- Worrisome sores or moles

RESPIRATORY:

- Wheezing
- Shortness of breath
- Persistent cough
- Asthma
- Coughing up blood
- Emphysema
- Bronchitis
- Tuberculosis

HEMATOLOGICAL:

- Easy/abnormal bleeding
- Swollen Lymph nodes
- Easy bruising
- Immune deficiency

Cardiovascular:

- Shortness of breath with exercise
- Shortness of breath lying down
- History of heart attack
- History of heart disease
- Chest pain
- Calf pain with walking
- Abnormal heart rhythm
- High Blood Pressure
- Rheumatic Fever
- Congestive Heart Failure
- Swelling of the ankles
- Heart murmur
- Heart valve problem

MUSCULOSKELETAL:

- Persistent back pain
- Bone or joint pain
- Difficulty walking
- Spinal disc disease
- Arthritis

GYNECOLOGICAL:

- Vaginal discharge or bleeding

PSYCHOLOGICAL:

- Depression
- Nervousness

Patient Signature: _____ **Date:** _____