URO MEDIX
PROVIDING UROLOGIC CARE & SURGERY
A Division of 21st Century Oncology, LLC

New Patient History Form

Patient ID #: ______________

Name ________________________, ________________________ **Date** _____/_____/______
(*Last*) (*First*)

Date of Birth ____/____/_____ **Age** _______ **Email Address:** ____________________

Referring Physician's Name: ____________ **Primary Care Physician:** ______________

Main Reason for today's visit: ______________________________________

Please give detailed information about the ***Present Problem*** (e.g. When did it start? How long does it last? Does anything make it better or worse? Severity? Is it constant or variable? Location? Etc.):

Any ***Other Urologic Problems***: (Please check those that apply):

- ☐ Urinary Frequency (How many hours can you go without urinating? __________ hours),
- ☐ Urgency to urinate (How many times do you urinate in 24 hours? __________/ day)
- ☐ Nocturia (About how many times do you have to get out of bed to urinate while sleeping?) __________
- ☐ Incontinence (Do you use pads or change underwear?) _________ How many? _________/ day

☐ Decreased Stream	☐ Retention or Sensation of Incomplete Emptying	
☐ Post Void Dribbling	☐ Hesitancy	☐ Dropped Bladder
☐ Urinary Burning/Pain	☐ Frequent Urinary Infections	☐ Blood in Urine
☐ Sexual Problems/Impotence	☐ Sexually Transmitted Disease	☐ Bladder
☐ Kidney Stones	☐ Prostate Problems	☐ Other

Personal Medical History:

☐ Heart Disease	☐ High Blood Pressure	☐ Heart Valve Disease
☐ Diabetes	☐ Hepatitis	☐ Gout
☐ Bleeding Problems	☐ Stroke	☐ Irritable Bowel
☐ Asthma/Emphysema	☐ T.B.	☐ Thyroid Disease
☐ HIV	☐ Cancer	☐ Other

Surgical History and/or Hospitalizations: (Please list approximate date)

Surgery	Month/Year	Surgery
☐ Hernia	______________	______________
☐ Vasectomy	______________	______________
☐ Appendectomy	______________	______________
☐ Other	______________	______________

Last **PSA** (Prostate Cancer Screening Blood Test) Test Result: _____________ Date: _____________

DO NOT WRITE BELOW THIS LINE

CONTINUED ON BACK

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:

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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 ____________________________

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Physician Office Representative: Date:

Notice of Privacy Practices
21st Century Oncology, LLC
Uro-Medix

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.

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

21st Century Oncology, LLC
Uro-Medix
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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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

____
Print Name

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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 acknowledgment 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)

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__________________________________ __________________________
Signature of Employee Date