

BROWARD UROLOGY
Elicer Kurzer, M.D., M.P.H.
Michael Simon, M.D.
1951 SW 172 Ave., Suite 300
Miramar, Florida 33029
Tel (954) 499-7696 | Fax (954) 499-7699
www.browardurology.com

PLEASE PRINT CLEARLY

TODAY'S DATE: _____ Email address: _____
LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____
ADDRESS: _____ APT #: _____
CITY: _____ STATE: _____ ZIP: _____
HOME #: _____ CELL #: _____ WORK #: _____
PCP DOCTOR _____ PCP NUMBER _____
CAN WE LEAVE MESSAGES, RESULTS, APPT CONFIRMATION MESSAGES AT THE ABOVE NUMBERS:
PLEASE CIRCLE HOME: YES NO CELL: YES NO WORK: YES NO
PATIENT PHARMACY NUMBER FOR FUTURE MEDICATIONS _____
SS#: _____ DOB: _____ AGE: _____ SEX: _____
MARITAL STATUS (circle one): SINGLE MARRIED WIDOWED DIVORCED
EMERGENCY CONTACT NAME _____ NUMBER _____
EMPLOYER: _____
EMPLOYER'S ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION

IS CONDITION: WORK-RELATED: _____ DATE OF INJURY: _____
AUTO ACCIDENT: _____ DATE OF INJURY: _____
NAME OF ATTORNEY
RERESENTING PATIENT: _____ PHONE #: _____

PRIMARY INSURANCE:

SECONDARY INSURANCE:

NAME OF INSURED: _____	NAME OF INSURED: _____
INS CO. NAME: _____	INS CO. NAME: _____
ADDRESS: _____	ADDRESS: _____
CITY: _____ ST: _____ ZIP: _____	CITY: _____ ST: _____ ZIP: _____
PHONE: _____	PHONE: _____
POLICY#: _____	POLICY#: _____
GROUP #: _____	GROUP #: _____

FINANCIAL AGREEMENT:

I AUTHORIZE THE RELEASE OF ANY PAYMENT AND MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND RELATED CLAIMS.

I ALSO UNDERSTAND THAT I AM FINCANCIALY RESPONSIBLE FOR THOSE CHARGES NOT PAID FOR BY MY INSURANCE COMPANY.

I ALSO UNDERSTAND IF THIS ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY OR OUR ATTORNEY, ALL FEES WILL BE THE RESPONSIBILITY OF THE PATIENT/GUARANTOR.

SIGNATURE: _____ DATE: _____



Eliecer Kurzer, M.D., M.P.H.
Michael Simon, M.D.

Broward Urology

Patient Chart Portal Access

Date: _____

Patient Name: _____ DOB: _____

Dear patient.

In order to have access to your Broward Urology Patient Portal, we require the following information.

Please PRINT your personal email address: _____

Please provide a user name of your choosing: _____

Once your information is entered, an email will be sent to you with instructions on how to log in to.

<https://patientportal.intrinsiq.com/1038>

Please maintain this information in a private safe place. You will be prompted to change your password again in order to gain access. Should you have any questions please feel free to contact us.

Messages and requests sent to your doctor's office are NOT monitored 24/7.
If you are experiencing a medical emergency, you should call 911 immediately.
Results will not be review under the Patient Portal; you must follow up for results.

BROWARD UROLOGY
1951 SW 172 AVE., SUITE 300, MIRAMAR, FL 33029
TEL: 954.499.7696 FAX: 954.499.7699 NURSES STATION FAX: 954.251.5293

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 Signature (or Signature of Patient's Authorized Representative)

Patient Name

Date

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.

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

21st Century Oncology, LLC
Broward Urology
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)

**21st Century Oncology, LLC
Broward Urology**

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

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)
- _____

Signature of Employee

Date

Name: _____ Date: _____

ALLERGIES - Please list ALL types (Drug, seasonal, pets, environmental foods):

Recent Foreign Travel:

None: _____ Americas: _____ Worldwide: _____

CURRENT MEDICATIONS:

Please list ALL medications you are currently taking including over the counter meds

Drug Name	Strength	Directions/How you take it

(Attach list if necessary)

Pharmacy Name: _____ Phone # _____

By what method did you choose our practice?

____ Referring Physician ____ Friend ____ Yellow Pages ____ Insurance Co. ____ Other

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PATIENT'S NAME: _____ DATE: _____

REVIEW OF SYSTEMS: (Please place a '✓' by all that apply)

<u>Allergic/Immunologic</u>	<u>Ears/Nose/Throat</u>	<u>Genitourinary</u>	<u>Musculoskeletal</u>
<input type="checkbox"/> Seasonal	<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Back Pains
<input type="checkbox"/> Drug	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Joint Pains
<input type="checkbox"/> Animal	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Neck pain /stiffness
<input type="checkbox"/> Environmental	<input type="checkbox"/> Other	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Muscle Cramps
<input type="checkbox"/> Other	<u>Endocrine</u>	<input type="checkbox"/> Burning on Urination	<input type="checkbox"/> Arthritis
<u>Cardiovascular</u>	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Erection Problems	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Chest pain/angina	<input type="checkbox"/> Pituitary Disease	<input type="checkbox"/> Premature Ejaculation	<input type="checkbox"/> Other
<input type="checkbox"/> Dyspnea on exertion	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Flank Pain	<u>Neurological</u>
<input type="checkbox"/> Edema	<input type="checkbox"/> Excess thirst	<input type="checkbox"/> Hesitancy	<input type="checkbox"/> Stroke
<input type="checkbox"/> Hardening of the arteries	<input type="checkbox"/> Tired/Sluggish	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Headache
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heat/Cold Intolerance	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Dizzy spells
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Other	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Balance problems
<input type="checkbox"/> Heart Murmur	<u>Eyes</u>	<input type="checkbox"/> Nocturnal Enuresis	<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Blindness	<input type="checkbox"/> Nocturia	<input type="checkbox"/> Tremors
<input type="checkbox"/> Irregular Heart beat	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Prostate Infection	<input type="checkbox"/> Leg or arm weakness
<input type="checkbox"/> Low exercise tolerance	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Sexual Dysfunction	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Low desire	<input type="checkbox"/> Speech Problems
<input type="checkbox"/> Orthopnea	<input type="checkbox"/> Other	<input type="checkbox"/> Sexually Transmitted Diseases	<input type="checkbox"/> Other
<input type="checkbox"/> Pain/cramps w/exercise	<u>Gastrointestinal</u>	<input type="checkbox"/> Stranguria	<u>Psychological</u>
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Suprapubic Pain	<input type="checkbox"/> Not satisfied with life
<input type="checkbox"/> Skipped Heart beats	<input type="checkbox"/> Indigestion/Heartburn	<input type="checkbox"/> Testes/Scrotal Swelling	<input type="checkbox"/> Anxious
<input type="checkbox"/> Swelling	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Urgency	<input type="checkbox"/> Depressed
<input type="checkbox"/> Other	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Urinary Frequency	<input type="checkbox"/> Considered Suicide
<u>Constitutional</u>	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Urinary Hesitancy	<input type="checkbox"/> Other
<input type="checkbox"/> Aches/Pains	<input type="checkbox"/> Abdominal Cramps	<input type="checkbox"/> Urinary Incontinence	<u>Respiratory</u>
<input type="checkbox"/> Appetite Changes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bruises easily	<input type="checkbox"/> Constipation	<input type="checkbox"/> Urine Retention	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Fever	<input type="checkbox"/> Change in Bowel Habits	<input type="checkbox"/> Urologic Cancer	<input type="checkbox"/> Emphysema/Bronchitis
<input type="checkbox"/> Chills	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Urologic Surgery	<input type="checkbox"/> Environmental Allergies
<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Flatulence	<input type="checkbox"/> Vaginal Bleeding	<input type="checkbox"/> Frequent Cough
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Gas	<input type="checkbox"/> Vaginal Discharge/Problems	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Weak Stream	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Generalized Weakness	<input type="checkbox"/> Tarry stools	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Other	<u>Hematological/Lymphatic</u>	<u>Skin</u>
<input type="checkbox"/> Swollen Glands		<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Acne
<input type="checkbox"/> Anorexia		<input type="checkbox"/> Blood clotting problems	<input type="checkbox"/> Boils
<input type="checkbox"/> Weight loss		<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Persistent Itch
<input type="checkbox"/> Weight gain		<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Other		<input type="checkbox"/> HIV (AIDS)	<input type="checkbox"/> Changing moles
		<input type="checkbox"/> IV Drug Use	<input type="checkbox"/> Pigment changes
		<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Other
		<input type="checkbox"/> Other	

Name: _____ Date: _____

PAST MEDICAL HISTORY

Please place a '✓' by any of the following diseases or conditions you have or have had:

- | | | | |
|--------------------------------------------------|------------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Cholelithiasis | <input type="checkbox"/> GERD | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chronic liver disease | <input type="checkbox"/> Goiter | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Mitral stenosis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Chronic renal insufficiency | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral insufficiency |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Renal Failure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart Valve Problem | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Colon Condition | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Congenital Heart Failure | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pancreatic Cancer |
| <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Peptic Ulcer |
| <input type="checkbox"/> Aortic Stenosis | <input type="checkbox"/> Deafness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Aortic Insufficiency | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Impaired Glucose | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Diabetes—non ins dependent | <input type="checkbox"/> Infertility | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Diabetes—insulin dependent | <input type="checkbox"/> Irritable Bowel Disease | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Diabetes—uncontrolled | <input type="checkbox"/> Inflam. Bowel Disease | <input type="checkbox"/> Rectal Fissure |
| <input type="checkbox"/> Bi-polar disorder | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rectal Cancer |
| <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Sexually Trans. Disease |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Elevated PSA | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Brain tumors | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Laryngeal Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Enlarged Heart | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Testicular Cancer |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cerebrovascular Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cholecystitis | <input type="checkbox"/> Gastric Cancer | <input type="checkbox"/> Lymphoma | |

SURGICAL HISTORY:

Please place a '✓' by any of the following surgeries you have had, and include the date of surgery:

Amputation	_____	Facial Surgery	_____	Orchiectomy	_____
Angioplasty	_____	Foot Surgery (L or R or both)	_____	Pacemaker Insertion	_____
Aortic Aneurysm Repair	_____	Gastric Surgery	_____	Parathyroidectomy	_____
Appendectomy	_____	Hand Surgery (L or R or both)	_____	Penile Implant	_____
Arthroscopic Surgery	_____	Heart Surgery	_____	PEG	_____
Back Surgery	_____	Heart Transplant	_____	Renal Transplant	_____
Bariatric Surgery	_____	Hemorrhoidectomy	_____	Rotator Cuff Surgery	_____
Bladder Surgery	_____	Herniorrhaphy	_____	Septoplasty	_____
Bowel Resection	_____	Hip Surgery	_____	Sinus Surgery	_____
Brachytherapy	_____	Hydrocelectomy	_____	Skin Grafting	_____
Brain Surgery	_____	Iliac Conduit	_____	Spermatocectomy	_____
Breast Surgery	_____	Ileostomy	_____	Splenectomy	_____
Biopsy of Prostate	_____	Indigo Laser Surgery	_____	Stomach Surgery	_____
CABG	_____	Inguinal Herniorrhaphy	_____	Tonsil Surgery	_____
Carotid Artery Surgery	_____	Knee Surgery (L or R or both)	_____	Thyroid Surgery	_____
Carpal Tunnel Surgery (L or R or both)	_____	Laminectomy	_____	TMJ Surgery	_____
Cataract Surgery (L or R or both)	_____	Laparoscopy	_____	TUMT Prostate	_____
Cervical Spine Surgery	_____	Laparotomy	_____	TUR Prostate	_____
Cholecystectomy	_____	Leg Surgery (L or R or both)	_____	Umbilical Hernia	_____
Circumcision	_____	Liver Surgery	_____	Ureteroscopy	_____
Colon Resection	_____	Lumpectomy	_____	Varicocelectomy	_____
Colonoscopy	_____	Lung Surgery	_____	Vasectomy	_____
Corneal Surgery (L or R or both)	_____	Lymphatic Node Dissection	_____	Vein Stripping	_____
Cysto-TUR Fulguration	_____	Lysis Adhesions	_____	Ventral Hernia Repair	_____
Cyst Removal	_____	Mastectomy	_____	VLAPP	_____
Deliveries (Vaginal or C-Section)	_____	Mastoid Surgery	_____	OTHER NOT LISTED :	_____
Ear Surgery (L or R or both)	_____	Meatotomy	_____	_____	_____
EGD	_____	Nasal Surgery	_____	_____	_____
Epididymectomy	_____	Needle Biopsy	_____	_____	_____
ESWL	_____	Nephrectomy	_____	_____	_____
Eye Surgery (L or R or both)	_____	Nephrolithotomy	_____	_____	_____

NAME: _____ Date: _____

FAMILY HISTORY

Please CIRCLE which family member has had any of the following: (Mother, Father, or Siblings)

Arthritis	M	F	S	Kidney Stones	M	F	S
Bedwetting	M	F	S	Laryngeal Cancer	M	F	S
Bladder Cancer	M	F	S	Leukemia	M	F	S
Cancer (site unknown)	M	F	S	Malignant Melanoma	M	F	S
Crohn's Disease	M	F	S	Multiple Sclerosis	M	F	S
Depression	M	F	S	Pancreatic Cancer	M	F	S
Diabetes	M	F	S	Prostate Cancer	M	F	S
Gout	M	F	S	Stroke	M	F	S
Heart Attack	M	F	S	Thyroid Disease	M	F	S
Hypertension	M	F	S	Tuberculosis	M	F	S
Kidney Disease	M	F	S	Other:	M	F	S

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years:

Single: _____ Married: _____ Separated: _____ Divorced: _____
Widowed: _____ Life Partner: _____ Common Law Spouse: _____

Dependants: Please indicate # of each, if you have:

Sons: _____ Daughters: _____ Stepchildren: _____ Adopted: _____ Foster: _____
Parents: _____ Grandparents: _____ Other: _____

Occupation: Please place a '✓' by one that applies:

None _____ Laborer _____ Truck Driver _____ Tradesman _____
Clerk _____ Administrative _____ Executive _____ Professional _____
Part-Time _____ Retired _____ Other _____

Hobbies: Please place a '✓' by any that apply to you:

None _____ Golf _____ Tennis _____ Computers _____ Basketball _____
Football _____ Swimming _____ Soccer _____ Baseball _____

Alcohol Consumption:

None _____ Yes - Occasional/Social _____ # of drinks per day _____

Tobacco use per day:

None _____ Yes _____ # packs/day _____ cigarettes/day _____ smokeless tobacco _____
If previously stopped, when? _____

Recreational Drugs:

None _____ If yes, please list: _____

Caffeinated beverages:

None _____ Low _____ Moderate _____ Excessive _____

Notice of Privacy Practices (Page 2)
21st Century Oncology, LLC
Broward Urology

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 alternative 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

**Notice of Privacy Practices
21st Century Oncology, LLC
Broward Urology**

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.

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 médica 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:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Пожалуйста обратитесь к врачу или офису звоните (833)-796-9677

Armenian / Հայերեն:

ՈՒՇԱԿՆՈՒԹՅՈՒՆ Եթե խոսում եք հայերեն, ասում էք անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Խնդրում ենք կապվել ձեր բժշկի գրասենյակ կամ Ջանգախարեք (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) / فارسی:

توجه: اگر شما فارسی صحبت کنید، رایگان صحبت می کند بر دسترس شما هست لطفاً دفتر پزشکی خود تماس بگیرید و یا پاسخ (833) 5677-717

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 / العربية:

تنبه: إذا كنت تتكلم العربية وحسب، فخدمات الترجمة مجانية تتوفر لك. يرجى الاتصال بكتبك الطبي أو الاتصال (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

21st Century Oncology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 21st Century Oncology does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

21st Century Oncology:

- 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 21st Century Oncology 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@21co.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/portal/lobby.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: <http://www.hhs.gov/ocr/office/file/index.html>

Aviso de No Discriminación

La discriminación es contra la ley

21st Century Oncology cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. 21st Century Oncology no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

21st Century Oncology:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
 - Intérpretes de lenguaje de señas capacitados.
 - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
 - Intérpretes capacitados.
 - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con Administrador de la práctica.

Si considera que 21st Century Oncology no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: Civil Rights Coordinator, 2270 Colonial Blvd, Fort Myers, FL 33907, 866-679-8944, CivilRightsCoordinator@21co.com. Puede presentar el reclamo en persona o por correo postal, o correo electrónico. Si necesita ayuda para hacerlo, Civil Rights Coordinator está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

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)

Puede obtener los formularios de reclamo en el sitio web: <http://www.hhs.gov/ocr/office/file/index.html>