Patient name:_____Account#:_____Staff Initials: _____ 11.5.19

Patient Registration Form

Patient Information

Last Name:_____ First Name:_____ MI:____ Suffix:_____

SS#_____ Sex: ☐ Male ☐ Female Date of Birth: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated Language:_____

Race: ☐ Caucasian/ White ☐ Black/African American ☐ Asian Native American ☐ Other:_____

Ethnicity: ❑ Hispanic ❑ Latino ❑ Spaniard ❑ Mexican ❑ Central American ❑ South American ❑ Latin American ❑ Puerto Rican ❑ Cuban Dominican ❑ Not Hispanic/ Latino ❑ Prefer not to answer

Patient Mailing Address:_____ City:_____ St:_____ Zip:_____

Physical/Alternate Address:_____ City:_____ _____St:_____ Zip:_____

Email: _____ Phone #: _____ Work #: _____ Cell #:_____

Referring Physician:_____ Phone #:_____

Family Physician:_____ Phone #: _____

Pharmacy: _____ Location:_____ Phone #: _____

Emergency Contact:_____ Relationship: _____ Emergency Phone:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student (Full Time) ☐ Student (Part Time)

Employer/School: _____ May we contact you at work: ☐ YES ☐ NO

Spouse/Guarantor/Parent Information

Last Name:_____First Name:_____ MI:_____ Relationship:_____

Date of Birth:_____ Employer:_____ Work Phone #: _____

Insurance Information

Primary Insurance:_____ Policy Holder Name:_____

Policy Holder is: ☐Self ☐Spouse ☐Parent ☐Other: _____ Policy Holder Date of Birth_____

Policy #:_____ Group #:_____

Secondary Insurance:_____ Policy Holder Name:_____

Policy Holder is: ☐Self ☐Spouse ☐Parent ☐Other: _____ Date of Birth _____

Policy #:_____ Group #:_____

Authorization for release of information and to pay insurance benefits: Atlantic Urology Clinics, LLC is hereby authorized to release information to healthcare providers that have referred me to this physician or who may benefit from this information in the future. I authorize release of medical information to my insurance carrier, their utilization management agency, my employer, or any other agency that may be assisting in payment for my care. In the event of hopitalization, I hereby assign payment to Atlantic Urology Clinics, LLC for surgical and/or medical benefits otherwise payable to me.

_____ _____

Signature/Patient/Parent/Guardian Date AUC Staff Signature Date

Patient name:_____Account#:_____Staff Initials: _____ 10.14.19

ATLANTIC UROLOGY CLINICS LLC

Select any of the following medical conditions that you currently have:

Past Medical History: Select any of the following medical conditions you currently have:

- ❑ None
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation (Irregular Heartbeat)
- ❑ Bone Marrow Transplantation
- ❑ BPH/Enlarged Prostate
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD/Reflux
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV / AIDS
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke

❑ Other_____

_____

_____

_____

_____

_____

_____

Past Surgeries: Have you had any surgeries on the following organs?

- ❑ None
- ❑ Appendix (Appendectomy)
- ❑ Bladder Removal (Cystectomy)
- ❑ Breast : Breast Biopsy
- ❑ Breast : Lumpectomy (Left Breast)
- ❑ Breast : Lumpectomy (Right Breast)
- ❑ Breast : Mastectomy (Both Breasts)
- ❑ Breast : Mastectomy (Left Breast)
- ❑ Breast : Mastectomy (Right Breast)
- ❑ Colon (Colectomy) : Colon Cancer Resection
- ❑ Colon (Colectomy) : Diverticulitis
- ❑ Colon (Colectomy) : Inflammatory Bowel Disease
- ❑ Colon: Colostomy
- ❑ Gallbladder (Cholecystectomy)
- ❑ Heart : Biological Valve Replacement
- ❑ Heart : Coronary Artery Bypass Surgery
- ❑ Heart : Heart Transplant
- ❑ Heart : Mechanical Valve Replacement
- ❑ Heart : Stents
- ❑ Hernia
- ❑ Joint Replacement : Hip (Both)
- ❑ Joint Replacement : Hip (Left)
- ❑ Joint Replacement : Hip (Right)
- ❑ Joint Replacement : Knee (Left)
- ❑ Joint Replacement : Knee (Right)
- ❑ Kidney : Kidney Biopsy
- ❑ Kidney : Kidney Stone Removal
- ❑ Kidney : Kidney Transplant
- ❑ Kidney : Nephrectomy
- ❑ Kidney : Partial Nephrectomy
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries (Oophorectomy) : Endometriosis
- ❑ Ovaries (Oophorectomy) : Ovarian Cancer
- ❑ Ovaries (Oophorectomy) : Ovarian Cyst
- ❑ Ovaries: Tubal Ligation

Patient name:_____Account#:_____Staff Initials: _____ 10.14.19

ATLANTIC UROLOGY CLINICS LLC

Select any of the following medical conditions that you currently have: Past Surgeries:

Past Surgeries cont.'d

- ❑ Pancreas: Laser PVP
- ❑ Pancreas: Pancreatectomy
- ❑ Prostate : Prostate Biopsy
- ❑ Prostate : Prostatectomy
- ❑ Prostate : TURP
- ❑ Rectum: Abdominoperineal Resection
- ❑ Rectum: Low Anterior Resection
- ❑ Skin : Basal Cell Carcinoma
- ❑ Skin : Melanoma
- ❑ Skin : Skin Biopsy
- ❑ Skin : Squamous Cell Carcinoma
- ❑ Spleen (Splenectomy)
- ❑ Testicles (Orchiectomy)
- ❑ Uterus (Hysterectomy) : Fibroids
- ❑ Uterus (Hysterectomy) : Uterine Cancer
- ❑ Uterus (Hysterectomy): Cervical Cancer
- ❑ Other_____

_____

_____

_____

_____

_____

Gynecologic History

- ❑ Last Menstrual Period
- ❑ Last Pelvic Exam
- ❑ Last Mammogram
- ❑ Last Pap Smear

Pediatric Patients Only:

- ❑ Gestational Age at Birth (in weeks)
- ❑ Birth Weight _____ lbs ___oz
- ❑ Maternal illness during pregnancy
- ❑ Forceps delivery
- ❑ Past Urological History
- ❑ None

Past Urological History:

- ❑ Prostate Nodule
- ❑ Cancer (Bladder)
- ❑ Cancer (Kidney)
- ❑ Cancer (Penile)
- ❑ Cancer (Prostate)
- ❑ Cancer (Testicular)
- ❑ Cystinuria
- ❑ Elevated PSA
- ❑ Hematuria
- ❑ Hereditary Leiomyomatous Renal Cell Carcinoma
- ❑ Hydronephrosis
- ❑ Infertility
- ❑ Neurogenic Bladder
- ❑ Polycystic kidney disease
- ❑ Priapism
- ❑ Prostatitis
- ❑ Renal Insufficiency
- ❑ Renal Tubular Acidosis
- ❑ Sexual dysfunction
- ❑ Sexually transmitted disease
- ❑ Genitourinary trauma
- ❑ Tuberculosis
- ❑ Tuberous Sclerosis
- ❑ Undescended testis
- ❑ Urethral stricture
- ❑ Urinary incontinence
- ❑ Urinary retention
- ❑ Urinary tract infection
- ❑ Urolithiasis
- ❑ Vesicoureteral Reflux (VUR)
- ❑ Benign Prostatic Hyperplasia (BPH)
- ❑ Hematuria (gross)
- ❑ Hematuria (microscopic)
- ❑ Renal cyst(s)

- ❑ Other_____

_____

_____

_____

_____

Patient name:_____Account#:_____Staff Initials: _____ 11.12.19

ATLANTIC UROLOGY CLINICS LLC

Select any of the following medical conditions that you currently have:

Urological Surgical History

- ❑ None
- ❑ Burch Colposuspension
- ❑ Cryoablation
- ❑ Cystectomy
- ❑ Extracorporeal Shock Wave Lithotripsy
- ❑ Hysterectomy
- ❑ Insertion of artificial urinary sphincter
- ❑ Insertion of penile prosthesis
- ❑ Marshall-Marchetti-Krantz urethropexy
- ❑ Midurethral sling
- ❑ Nephrectomy
- ❑ Orchiectomy
- ❑ Orchiopexy
- ❑ Percutaneous Nephrostolithotripsy
- ❑ Partial Nephrectomy
- ❑ Pelvic Irradiation
- ❑ Penile reconstruction
- ❑ Prostate biopsy
- ❑ Prostate nodule
- ❑ Prostate radiation therapy
- ❑ Prostatectomy
- ❑ Pubovaginal Sling
- ❑ Renal ablation
- ❑ Rezum
- ❑ Transobturator Tape
- ❑ Transurethral Resection of Bladder Tumor
- ❑ Transurethral Resection of Prostate
- ❑ Transvaginal Tape
- ❑ Ureteral stent placement
- ❑ Ureteroscopy
- ❑ Urethroplasty
- ❑ Urolift
- ❑ Other_____

_____

_____

_____

Family History

- ❑ None
- ❑ Cancer Bladder
- ❑ Cancer Kidney
- ❑ Cancer Prostate
- ❑ Cancer Testicular
- ❑ Cystinuria
- ❑ Hereditary Leiomyomatous Renal Cell Carcinoma
- ❑ Polycystic Kidney Disease
- ❑ Renal Insufficiency
- ❑ Renal Tubular Acidosis
- ❑ Kidney Stones (Urolithiasis)
- ❑ Other_____

_____

_____

_____

Current MEDICATIONS: **List ALL MEDS you're currently taking INCLUDING over the counter** (Attach if necessary)

Drug Name:	Strength:	Directions/How you take it:

Pharmacy Name: _____ **Phone:** _____

Allergies- List ALL types (drug, seasonal, pets, environmental foods):_____

_____

_____

Patient name:_____Account#:_____Staff Initials: _____ 10.14.19

ATLANTIC UROLOGY CLINICS LLC

Smoking Status (QM402, QM226)

Last Screened Date: _____

Start Smoking:_____

Quit Smoking: _____

Number of packs per day: _____

Total years smoking: _____

Additional Details :_____

Social History Details

❑ None
❑ Not sexually active
❑ Sexually active with one partner
❑ Sexually active with more than one partner
❑ Same sex partner
❑ Drug use
❑ IV Drug Use (QM387)
❑ IV Drug Use Within Past 12 Months (QM387)
❑ Alcohol none
❑ Alcohol less than 1 drink per day
❑ Alcohol 1-2 drinks per day
❑ Alcohol 3 or more drinks per day
❑ Patient feels safe at home
❑ Patient feels unsafe at home
❑ Other

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? (QM431):_____

Driving Status

❑ Drive Daytime ❑ Drive Night

How often do you exercise? _____

What is your caffeine use? _____

Occupation and Workplace _____

Place of Residence _____

Vaccination Status (QM111)

For patients 65 and older: Have you received a pneumonia vaccination? Yes ❑ No ❑

Advance Care (QM47)

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes ❑ No ❑

Name: _____
Do you have a living will? Yes ❑ No ❑

Which statement(s) best reflects your wishes on advanced care recommendations?

❑Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

❑ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.

❑ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Do you have any implantable devices?Yes ❑ No ❑

If yes, please list it here:_____

_____

Family history of cancer (situation)

❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son ❑ Uncle
❑ Aunt ❑ Nephew ❑ Niece ❑ Grandmother ❑ Grandfather ❑ Grandson ❑ Granddaughter

Family history of diabetes mellitus type 2

❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son ❑ Uncle
❑ Aunt ❑ Nephew ❑ Niece ❑ Grandmother ❑ Grandfather ❑ Grandson ❑ Granddaughter

Other family histories: _____

_____

_____

_____

Patient name:_____Account#:_____Staff Initials: _____ 10.14.19

ATLANTIC UROLOGY CLINICS LLC

Medical Information Form

REVIEW OF SYSTEMS:

Genitourinary (G.U.)
Bedwetting
Blood in Urine
Dribbling
Burning with Urination
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Nocturia
Nocturnal Enuresis
Not Emptying
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine Retention
Weak Stream

Constitutional/Symptom
Fever or chills
Fatigue
Generalized Weakness
Insomnia
night sweats
Sleep Apnea

Eyes
Blurry vision
Glaucoma
Worsening Eyesight

Allergic/Immunologic
Drug Allergies
Environmental Allergies

Neurological
Balance Problems
Dizzy Spells
headaches
Leg or Arm Weakness
Memory Loss
Stroke

Endocrine
Diabetes
Excessive Thirst
Thyroid Disease
Tired/Sluggish

Gastrointestinal (G.I.)
Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Diarrhea
Nausea/Vomiting
Rectal Bleeding
Tarry Stool

Cardiovascular
Chest Pain/Angina
Edema
Heart Attack
Heart Failure
High Blood Pressure
Irregular Heart Beat
Swelling

Musculoskeletal
Arthritis
Back Pain
Gout
Joint Pain
Muscle weakness

ENT/Mouth
Sinus Problem
Sore throat

Respiratory
Frequent Cough
Shortness of breath

Hematologic/Lymphatic
Blood Clotting Problem
Bleeding Problem
Hepatitis
HIV (AIDS)

Psychiatric
Anxiety
Depression

Other:

_____

_____

_____

_____

_____

_____

_____

_____

ATLANTIC UROLOGY CLINICS

Notice of Non-Discrimination (Spanish version available upon request)

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, 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: hhs.gov/ocr/office/file/index.html

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。请联系您的医生办公室或 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 전화주십시오.

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 офис Звоните (833)-796-9677.

Armenian / Հայերեն:
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Խնդրում ենք կապնվել 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) / فارسی:
می‌ت صحب ن‌رایٔ گا ٔزبان کک م‌تخدما ،فارسی ا شم‌راگ :ذ وجه
با الطف .هس ذندا شم‌سدس تر رد ،ک ذند
ت ردفٔ زش کپ خو دما سنٔ گ یری دبو ای اس ٔخٔ (833) 717-5677.

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:
الـ لغوية، ةالمـساعد تـوخدما ،الـ عربـ يةمٔ ذكل تـكن اإذ :ذ ذ بـ يه
أو بـالـ طـ بي بـبـ مـكت الالاذ صـا ىيدرج .لـكـ رذ توف ،مجاذا
(833) 717-5597. الالاذ صـا

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.

ATLANTIC UROLOGY CLINICS LLC

Patient Permission To Communicate Information With Designated Individual

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

_____Date:_____Time:_____
Patient/Authorized Representative Signature**

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.*

ATLANTIC UROLOGY CLINICS

Georgetown County, South Carolina Market
Horry County, South Carolina Market
Marion County, South Carolina Market

Patient Protection and Affordable Care Act of 2010
Patient Disclosure for Diagnostic CT Services

Dear Patient,

If your physician determines that a referral for diagnostic CT services is appropriate as a part or your medical evaluation and treatment; we may have these services available at one of our locations. We will provide you information about those options.

You, however, have the freedom to choose the supplier for this service. To the best of our knowledge, the following providers furnish these services in the area where you reside:

Georgetown County:

Tidelands Health
4070 Highway 17, Murrells Inlet, SC 29576
606 Black River Rd., Georgetown, SC 29440

Lowcountry Medical Associates
180 Wingo Way Ste 105, Mount Pleasant, SC 29464

Horry County:

Palmetto Imaging Inc.
900 21st Ave N, Myrtle Beach, SC 29577

Inmed Diagnostic Services of South Carolina
4701 Oleander Drive, Myrtle Beach, SC 29577

McLeod Seacoast Hospital
4000 Hwy 9 E Little River, SC 29566

Grand Strand Regional Medical Center
809 82od Parkway, Myrtle Beach, SC 29572

Marion County:

MUSC of South Carolina
2829 Hwy. 76 E., Mullins, SC 29574

Patient Signature: _____ Date: _____

Patient name:_____Account#:_____Staff Initials: _____ 10.14.19

ATLANTIC UROLOGY CLINICS LLC

Financial Policy

PATIENT RESPONSIBILITY:
Patients are responsible for payment in full of their account regardless of insurance coverage. Patients are responsible for presenting current insurance information at the time of service, and for understanding the provisions and limitations of their insurance plan. If you have any questions regarding your insurance plan, please contact your insurance company or our billing office. Please do not ask your physician, as our doctors do not usually know what is covered or not covered. *Please note: Many insurance companies DO NOT cover preventative or elective services. Patients are responsible for payment of all non-covered services.*

If Atlantic Urology Clinics (AUC) is a participating provider with the patient's insurance, the patient will be responsible for payment of any deductible and/or co-payment at the time of service. AUC will accept assignment and bill the insurance company for the contracted fee. However, ifthe insurance company denies the charges or fails to pay any portion of the bill, the patient agrees to pay that portion immediately.

If AUC is not a participating provider with the patient's insurance company, the patient will be responsible for payment of all charges in full at the time of service. As a courtesy, AUC will bill the insurance company on the patient's behalf if we have accurate and complete insurance information.

DISCOUNTS:
If you are a member of an insurance plan that Atlantic Urology Clinics participate with, your charges will be adjusted according to your contract with your insurance company. Other discounts may be available on the basis of proof of financial hardship.

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.

NOTE: The waiver of deductibles and co-pays is unlawful and may be construed by the Federal Government as Insurance Fraud.

MEDICARE:
Atlantic Urology Clinics accepts assignment of Medicare benefits. Medicare patients are responsible for their yearly deductible and 20% co-pay, as well as any non-covered services provided. Patients will be responsible for payment in full at time of service.

MEDICAID:
Medicaid is a federal and state funded program designed to provide coverage of medically necessary services for individuals that meet a minimum income criteria. This practice accepts Medicaid as payment in full upon receipt of a valid Medicaid card and proper authorization.

WORKER'S COMPENSATION:
Atlantic Urology Clinics will bill your employer or the Worker's Compensation carrier for services rendered. If you are covered, we will accept the payment made by Worker's Compensation as payment in full. If Worker's Compensation denies payment or goes into litigation, the entire balance will become your responsibility and will be due within 10 days from the date of the denial. It is your esponsibility to provide us with the name and address of your employer and the insurance company at the time of the appointment is made and to provide the office with a copy of your Notice Compensation Payable Letter from Worker's Compensation. All insurance is verified prior to the patient's initial visit, but does not guarantee payment.

RETURNED CHECKS:
Any check that is returned to Atlantic Urology Clinics with insufficient funds will result in a $29.00 charge to the patient.

I have read and agree to the above policy. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits directly to Atlantic Urology Clinics for services rendered:

Patient Signature: _____ Date: _____

This form was explained to you by (AUC Repesentative): _____

Patient name:_____Account#:_____Staff Initials: _____ 11.4.19

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, [insert patient name], 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 [insert practice name] 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:_____

Appointment Policy

Atlantic Urology Physicians and staff are dedicated to providing the highest quality healthcare in a professional and timely manner. In order to provide this level of care it is important that our patients are informed of our office policies regarding appointments and assignment of benefits.

APPOINTMENT POLICY

- Patients should make financial arrangements prior to the appointment to pay co-pays, deductibles and any out of pocket expenses.
- Payment is due prior to services being rendered for deductible, co-pay and out of pocket expenses.
- Patients should arrive at least 15 minutes prior to their scheduled appointment.
- Our physicians are on call at the local emergency rooms. Your Physician may be delayed for a medical emergency. The office staff will give the patient the option to reschedule their appointment or wait for the Physician to return to the office.
- Minors must be accompanied by a parent or legal guardian.

Compliance with these policies will help assure that all patients are seen in a timely fashion.

ASSIGNMENT OF BENEFITS

- I hereby authorize payment of benefits be made directly to Atlantic Urology Clinics. I understand that some services may not be covered by my insurance. Therefore, I will be responsible for payment of any non-covered services as well as any balance not covered by my insurance. _____**Initials**

- I further understand that if my account is turned over to a collection agency a 30% fee will be charged to my account._____**Initials**

I have read and agree to the above policies. I authorize the release of any medical or other information necessary to process insurance claims.

Patient/Guardian Signature: _____ Date: _____

AUC Insurance and Collection Policy

Atlantic Urology Clinics participates with the following insurances:

Absolute Total Care	Humana Choice Care	Railroad Medicare
Aetna	Medcost	Select Health AKA First Choice
BCBS	NC Medicaid	Tricare
Blue Choice	SC Medicaid	United Healthcare
Cigna	NC Medicare	United Healthcare Comm Plan
Coventry Health Care	SC Medicare	
Department of Energy	Multiplan	

Atlantic Urology Clinics will submit claims to your primary carrier on your behalf. We will file a single claim to your secondary insurance as a courtesy. The insurance contract is between the patient and their insurance carrier. After 70 days of non-payment from the secondary carrier the balance will become the patient's responsibility. _____**Initials**

Eligibility is verified prior to your visit. Deductibles, co-pay and coinsurance are due at the time services are rendered. _____**Initials**

Frequently Asked Questions

What is the difference between deductibles, copayments and co-insurance?

A deductible is the amount of covered medical expenses you will pay out of your own pocket each calendar year before benefits begin to be paid by your plan. The deductible amount is set by the insurance carrier. A copayment is the fee charged to you for a covered medical expense. The coinsurance is a percentage due by the patient set forth by your carrier.

How does my out-of-pocket expense work?

An out-of-pocket maximum is the total amount you need to pay on your own before your plan benefits are paid in full.

If I receive a denial from my insurance as a non-covered service who should I contact?

Contact your insurance carrier. The contact information should be on the back of your insurance card.

Who should I contact if I have a billing question?

You may contact our billing office at 843-347-8600. Please listen carefully to the menu so that you reach the representative that is assigned to your account.

ATLANTIC UROLOGY CLINICS LLC

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

21st Century Oncology
DBA Atlantic Urology Clinics, LLC
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

ATLANTIC UROLOGY CLINICS LLC

Notice of Privacy Practices Atlantic Urology Clinics, LLC

Thomas Cerasaro, MD | James Fogarty, DO | Walter Frank, MD | Timothy Gajewski, MD | Glenn Gangi, MD | Robert Jansen, MD | Timothy Quillen, MD
David Rich, MD | Brian Roberts, MD | Neal Shore, MD | Abhishek Srivastava, MD | Joseph Wood, MD | Richard Young, MD | Matthew Young, MD
Vanessa Albury, NP | Svetlana Brusyanina, NP | Rebecca Griggs Crawford, NP | Kerri Barrineau Evans, NP | Lauren Evans, NP | Susan Ferrero, PA-C
Renee Flanegan, NP | Pamela Gilmore, NP | Debra Joyner, PA-C | Melanie Lawrence, NP | Lindsay Nelms, PA-C | Lindsey Rogers, NP | Michelle Wirt, PA-C

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.

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.

ATLANTIC UROLOGY CLINICS LLC

Notice of Privacy Practices Atlantic Urology Clinics, LLC

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 vconfidential 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

ATLANTIC UROLOGY CLINICS LLC

Notice of Privacy Practices Acknowledgment

Atlantic Urology Clinics, LLC | PO Box 602460 Charlotte, NC 28260-2460

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 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