Allergy, Sleep & Lung Care
Division of 21st Century Oncology, LLC

NEW PATIENT REGISTRATION FORM (PLEASE PRINT)

DEMOGRAPHIC INFORMATION

Patient Name:______________________________ Sex: ☐ M ☐ F
Last Name First Name Middle Initial
Street Address: ______________________________
City:______________ State: ____________ Zip Code: ________ Date Of Birth: ____________ (MM/DD/YYYY) Age: ____
Mailing Address: (if different from above) ______________________________
City:______________________________ State: ____________ Zip Code: ______________
Home Phone #: ______________________ Cell Phone #: ______________________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Social Security #: ______________________
Email: ______________________ Employer: ______________________ Work # : ______________
Who is your Primary Care Physician? ______________________________
How were you referred to our practice? ☐Yellow Pages ☐ Hospital Referral ☐Receiving Mail ☐Newspaper
☐Friend/Relative, if so, name ______________________ ☐ Physician, if so, name ______________________

INSURANCE INFORMATION

Primary Insurance:______________________________
Subscriber #: ______________________________ Group#:______________
Claims Address (See Insurance Card) : ______________________________
Guarantor Name (If other than Patient) : ______________________________
Date of Birth:__________ (MM/DD/YYYY) Guarantor SS#:______________ Relationship To Patient:______________

Secondary Insurance:______________________________
Subscriber #: ______________________________ Group#:______________
Claims Address (See Insurance Card) : ______________________________
Guarantor Name (If other than Patient) : ______________________________
Date of Birth:__________ (MM/DD/YYYY) Guarantor SS#: ______________ Relationship To Patient: ______________

Do you have any other Health Insurance? ☐ No ☐ Yes If Yes, Please indicate below
Insurance Name:______________________________ Subscriber #: ______________

EMERGENCY CONTACT INFORMATION

Contact Name: ______________________________ Phone #: ______________________
Relationship To Patient: ______________ Street Address: ______________________
City:______________________________ State: ______________ Zip Code: ______________
To whom, if anyone, may we release information regarding your health? (Please List Below)
______________________________ ______________________________

PHARMACY INFORMATION

Pharmacy Name: ______________________________
Pharmacy Phone #: ______________________ Pharmacy Fax(If Known):______________________
Pharmacy Address If Known):______________________________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with the insurer). I authorize any holder of medical or other information about me to release to the Social security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original, and request payment of medical insurance benefits either to Allergy Sleep and Lung Care or Imtiaz Ahmad, MD (as applicable) who accepts assignments.

I have received notice of this organization's privacy policies

Patient Signature: ______________________________ **Date:**______________

21st Century Oncology, LLC
Imtiaz Ahmad, MD

Financial Policy on Additional Fees

Allergy, Sleep & Lung Care (ASLC) is dedicated to providing you the most efficient care and service possible. The following is a summary of our financial policy; **your understanding of our financial policy is an essential element of your care and services.** If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our staff.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered, unless other arrangements have been made in advance. This includes applicable coinsurance, deductibles and co-payments for participating insurance companies. ASLC accepts cash, personal check, VISA, and MasterCard. There is a service charge of $25.00 for returned checks. Patients with an outstanding balance of 30 days overdue must make arrangements for payment prior to scheduling appointments. **Any balance unpaid after ninety days will be turned over to a collection agency.**

COLLECTIONS / TERMINATION

Balances not paid within ninety days will be reviewed for placement with an outside collection agency. Patients whose accounts are placed with an outside collection agency will be subjected to a $30.00 processing fee and are terminated from Allergy, Sleep & Lung Care. Patients who are terminated from the practice may be reinstated by contacting the Business Office at (239) 369-5443.

MISSED APPOINTMENTS / LATE CANCELLATIONS

We request that all appointments be cancelled or rescheduled at least 1 business day in advance. There will be a $20.00 service charge for all missed appointments with out advance notice. This includes office visits, diagnostic testing, and pulmonary rehabilitation.

I have read and understand the Financial Policy and Appointment Policy of Allergy, Sleep & Lung Care. I hereby agree to the terms outlined within the policy and have been given the opportunity ask questions.

______________________________ ________________

Patient Signature | Date

______________________________ ________________

Patient Name (print) | Witness

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:

085-H17.1
02/01/2012

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

21st Century Oncology, LLC
Imtiaz Ahmad, MD
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

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Relationship to Patient
(If signed by Person Legally Responsible)

21st Century Oncology, LLC

Imtiaz Ahmad, MD

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)

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_________________________ ____________

Signature of Employee Date

Notice of Privacy Practices
21st Century Oncology, LLC
Imtiaz Ahmad, M.D.

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.

Notice of Privacy Practices (Page 2)
21st Century Oncology, LLC
Imtiaz Ahmad, M.D.

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

Lee/Collier Counties, Florida Market

Patient Protection and Affordable Care Act of 2010
Patient Disclosure for Diagnostic MRI, PET or CT Services

Dear Patient,

If your physician determines that a referral for diagnostic MRI, PET or 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:

Name: Radiology Regional Centers
Address: 6100 Winkler Rd, Ft. Myers, FL 33919

Name: Advanced Radiology Imaging Associates, LLC
Address: 13731 Metropolis Ave, Ft. Myers, FL 33912

Name: Florida Radiology Consultants
Address: 6311 Southpointe Blvd, Ft. Myers, FL 33919

Name: Naples Diagnostic Imaging Center
Address: 311 North Tamiami Trail, Ste 104, Naples, FL 34102

Name: Radiology Regional Centers
Address: 700 Goodlette Rd, Naples, FL 34102