CLEARWATER
Radiation Oncology

LAST NAME:_____, FIRST NAME:_____, MI:_____ SEX: _____

ADDRESS:_____, CITY:_____ STATE:_____ ZIP:_____

PERMANENT ADDRESS:_____

_

HOME PHONE #: _____WORK PHONE #: _____CELL #_____

__

DATE OF BIRTH:_____, SS#: _____, AGE:_____

EMAIL: _____ MARITAL STATUS:_____

EMPLOYER'S NAME:_____, ADDRESS:_____

FULL NAME OF SPOUSE:_____, SPOUSE PHONE _____

IN CASE OF EMERGENCY, PLEASE NOFITY: (NAME, ADDRESS & PHONE):

_____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU: (NAME, ADDRESS & PHONE):

_____

WHO REFERRED YOU TO CLEARWATER RADIAION ONCOLOGY? _____

ARE YOU CURRENTLY ENROLLED IN HOSPICE?_____ IF YES, WHAT IS THE DATE OF ENROLLMENT?_____

_____ _____
PRIMARY INSURANCE (OR MEDICARE) I.D. NUMBER

_____ _____
NAME OF INSURED (IF NOT YOURSELF) GROUP NUMBER

_____ _____
SECONDARY INSURANCE COMPANY I.D. NUMBER

_____ _____
NAME OF INSURED GROUP NUMBER

RACE: (PLEASE CIRCLE) PACIFIC ISLANDER AMERICAN INDIAN/ESKIMO/ALEUT CAUCASIAN
HISPANIC AFRICAN AMERICAN OTHER_____

_____ _____ _____
PATIENT'S SIGNATURE DRIVER'S LICENSE NUMBER STATE

CLEARWATER
Radiation Oncology

PATIENT HEALTH INFORMATION SHEET

NAME:_____ **DATE OF BIRTH:**_____ **AGE:**_____

ADDRESS:_____ **PHONE:**_____

INSURANCE:_____

PRIMARY CARE PHYSICIAN:_____

REFERRING PHYSICIAN:_____ **SURGEON (IF APPLICABLE):**_____

REASON FOR REFERRAL:_____

PAST & CURRENT MEDICAL PROBLEMS	ALL MEDICATIONS / VITAMINS (PRESCRIPTION & OVER THE COUNTER)
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____

ALLERGIES:_____

HOSPITALIZATIONS & OPERATIONS (APPROXIMATE DATES AND LOCATION)

1._____

2._____

3._____

4._____

5._____

FAMILY HISTORY

FAMILY MEMBER	AGE	HEALTH PROBLEMS	IF DECEASED/AGE & CAUSE OF DEATH
MOTHER			
FATHER			
SISTERS			
BROTHERS			
CHILDREN			

ANY FAMILY MEMBER WITH CANCER?

RELATIONSHIP:_____ CANCER TYPE (IF KNOWN):_____

RELATIONSHIP:_____ CANCER TYPE (IF KNOWN):_____

ANY FAMILY MEMBER WITH BLOOD PROBLEM?

RELATIONSHIP:_____ BLOOD PROBLEM (IF KNOWN):_____

RELATIONSHIP:_____ BLOOD PROBLEM (IF KNOWN):_____

SOCIAL HISTORY

CIRCLE ONE: SINGLE MARRIED DIVORCED WIDOWED

PLACE OF BIRTH:_____

PERMANENT RESIDENCE:_____

YOUR CURRENT OR PREVIOUS OCCUPATION:_____

SPOUSE'S AGE & CURRENT OR PREVIOUS OCCUPATION:_____

HOW MANY YEARS IN FLORIDA:_____

EVER SMOKE TOBACCO? YES NO

HOW MUCH?_____
HOW LONG?_____
WHEN QUIT?_____

EVER DRINK ALCOHOL? YES NO

HOW MUCH?_____
HOW OFTEN?_____

EVER EXPOSED TO RADIATION, TOXINS, CHEMICALS OR ASBESTOS? YES NO

WHEN & WHERE?_____

REVIEW OF SYSTEMS

PLEASE CIRCLE YES OR NO IF EVER HAD PROBLEM OR IS A CURRENT PROBLEM.

GENERAL:

HEALTH GOOD?	NO	YES
RECENT WEIGHT CHANGE	NO	YES
UNEXPLAINED FEVERS	NO	YES
NIGHT SWEATS	NO	YES

SKIN:

SKIN PROBLEMS	NO	YES
JAUNDICE	NO	YES
RASH	NO	YES
SKIN CANCERS	NO	YES

HEAD & NECK:

CATARACTS	NO	YES
GLAUCOMA	NO	YES
SINUS TROUBLES	NO	YES
HOARSENESS	NO	YES
HEADACHES	NO	YES
TROUBLE SWALLOWING	NO	YES

ENDOCRINE:

THYROID PROBLEMS	NO	YES
DIABETES	NO	YES
BIRTH CONTROL PILLS	NO	YES
ESTROGEN REPLACEMENT	NO	YES

RESPIRATORY:

PNEUMONIA	NO	YES
TUBERCULOSIS	NO	YES
COUGHING BLOOD	NO	YES
CHRONIC COUGH	NO	YES
ASTHMA	NO	YES
EMPHYSEMA	NO	YES
SHORTNESS OF BREATH	NO	YES

CARDIOVASCULAR:

HEART ATTACKS	NO	YES
CHEST PAIN/ANGINA	NO	YES
HIGH BLOOD PRESSURE	NO	YES
LEG SWELLING	NO	YES
NIGHT TIME SMOTHERING	NO	YES
RHEUMATIC FEVER	NO	YES
ABNORMAL RHYTHM	NO	YES
ABNORMAL CHOLESTEROL	NO	YES

GASTROINTESTINAL:

CONSTIPATION	NO	YES
DIARRHEA	NO	YES
VOMITING	NO	YES
VOMITING BLOOD	NO	YES
ULCER	NO	YES
RECTAL BLEEDING	NO	YES
GALLBLADDER TROUBLE	NO	YES
HEPATITIS	NO	YES
HEARTBURN	NO	YES
BLACK STOOLS	NO	YES
CHANGE IN BOWEL HABITS	NO	YES
PENCIL SHAPE STOOLS	NO	YES
CRAMPING	NO	YES
HEMORRHOIDS	NO	YES

GENITOURINARY:

LOSS OF URINE	NO	YES
FREQUENT URINATION	NO	YES
BURNING URINATION	NO	YES
PAINFUL URINATION	NO	YES
BLOOD IN URINE	NO	YES
KIDNEY TROUBLE	NO	YES
KIDNEY STONES	NO	YES
DIALYSIS	NO	YES

NEUROLOGICAL:

STROKE	NO	YES
SEIZURES	NO	YES
FAINTING SPELLS	NO	YES
PARALYSIS	NO	YES
DIZZINESS	NO	YES
MEMORY LOSS	NO	YES
CONFUSION	NO	YES

MUSCULOSKELETAL:

JOINT PAIN	NO	YES
BONE PAIN	NO	YES
ARTHRITIS	NO	YES
GOUT	NO	YES
OSTEOPOROSIS	NO	YES

REVIEW OF SYSTEMS

PLEASE CIRCLE YES OR NO IF EVER HAD PROBLEM OR IS A CURRENT PROBLEM.

HEMATOLOGIC:

BLOOD DISEASE	NO	YES
ANEMIA	NO	YES
DIFFICULTY HEALING	NO	YES
SWOLLEN LYMPH GLANDS	NO	YES
BLOOD CLOTS	NO	YES
PLATELET PROBLEMS	NO	YES
ABNORMAL BRUISING	NO	YES
ABNORMAL BLEEDING	NO	YES
HEAVY SURGICAL BLEEDING	NO	YES
HEAVY BLEEDING GUMS	NO	YES
HEAVY NASAL BLEEDING	NO	YES
BLOOD TRANSFUSIONS	NO	YES

HOW MANY?_____ WHEN?_____

IMMUNITY:

FREQUENT COLDS	NO	YES
ALLERGIES TO DUST/POLLEN	NO	YES
SERIOUS INFECTIONS	NO	YES

PSYCHIATRIC:

SEEN A PSYCHIATRIST	NO	YES
DEPRESSION	NO	YES
THOUGHTS OF SUICIDE	NO	YES
SLEEP TROUBLE	NO	YES
APPETITE CHANGE	NO	YES
ANXIETY ATTACKS	NO	YES

GYNECOLOGICAL:

HEAVY PERIODS NO YES

APPROX. AGE PERIOD STARTED:_____

APPROX. LAST PERIOD:_____

NUMBER OF PREGNANCIES:_____

MISCARRIAGES OR ABORTIONS:_____

DATE OF LAST MAMMOGRAM:_____

DATE OF LAST PAP SMEAR:_____

COMMENTS:_____

CLEARWATER
Radiation Oncology

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, CLEARWATER RADIATION 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, _____, 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 CLEARWATER RADIATION ONCOLOGY 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. I also understand that communication platforms may transmit information via unsecure methods which includes a risk that the information could be viewed by an unintended third party. I understand these risks and consent to having these communications sent unsecure.

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

_____
Patient Name

_____
Date

CLEARWATER
Radiation Oncology

PATIENT PERMISSION TO COMMUNICATE INFORMATION WITH DESIGNATED INDIVIDUALS

In addition to disclosures listed in our NPP.

Our physicians and staff know that communicating with you about your healthcare is important. By completing this form, you give us permission to provide messages, and/or discuss information about your healthcare with the individuals designated below. I understand that I may cancel or update this information at any time by notifying a representative of the physician office.

I give permission to allow physicians and staff to discuss relevant medical, billing, and insurance information with the individuals listed below (examples, spouse, relatives, friend, etc.). I understand that my healthcare provider will use professional judgment to determine what information about my healthcare may be discussed with the designated individuals below*:

Involved Individual	**Relationship to Patient**	**Phone Number**

Patient/Authorized Representative
Signature**_____Date_____Time_____

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

**If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.

*Clearwater Radiation 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.

CLEARWATER
Radiation Oncology

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

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)

CLEARWATER Radiation Oncology

NOTICE OF PRIVACY PRACTICES

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 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 improve 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
- The 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)
- Worker's 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 lime. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and copy protected health information. You may request access to your records by contacting us. You may also ask that we send your health information directly to another person based on your signed written instructions. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records.
- Request an amendment. If you feel that protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information by making a request in writing that explains the reason for the requested amendment. You have the right to request an amendment for as long as the information is kept for or by us. We may deny your request for an amendment; if this occurs, you will be notified of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes.
- Request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you ask us not to disclose your health information to your health plan, we will agree as long as (i) the disclosure would be for the purpose of payment or health care operations and is not otherwise required by law and (ii) the information only relates to items or services that someone other than your health plan has paid for in full.
- Request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will grant requests for confidential communications at alternative locations and/or via alternate means only if the request is submitted in writing and the written request includes a mailing address where you will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.
- A paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Web site at https://www.clearwaterradiation.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 office at 727-966-HOPE (4673) , 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:
Clearwater Radiation Oncology, LLC
3280 McMullen Booth Rd, Ste # 150
Clearwater FL, 33761
727-966-HOPE (4673)

CLEARWATER
Radiation Oncology

Notice of Non-Discrimination

Discrimination is Against the Law

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

Clearwater Radiation 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 **Clearwater Radiation 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, 3280 McMullen Booth Road, Suite 150, Clearwater FL 33761, 727-966-HOPE(4673), admin@clearwaterradiation.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.jfs , 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 www.hhs.gov/ocr/office/file/index.html

CLEARWATER
Radiation Oncology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRATICES

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 acknowledgement 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 specify below)

_____

_____

_____

_____

_____ _____
Signature of Employee Date