ASHEVILLE UROLOGICAL ASSOCIATES

PATIENT INFORMATION SHEET

DATE: _____

PATIENT NAME: _____
FIRST *MI* *LAST*

SOCIAL SECURITY NUMBER: _____-_____-_____ SEX: ☐ MALE ☐ FEMALE

MAILING ADDRESS: _____
STREET

_____
CITY *STATE* *ZIP*

DATE OF BIRTH: _____ / _____/_____ AGE: _____

MARITAL STATUS (CHECK ONE): ☐ *SINGLE* ☐ *MARRIED* ☐ *WIDOWED* ☐ *DIVORCED* ☐ *SEPARATED* ☐ *DOMESTIC PARTNER*

RACE: _____ ETHNICITY: ☐ HISPANIC/LATINO ☐ NON-HISPANIC

HOME PHONE#: (_____) _____ CELL PHONE#: (_____) _____

DO YOU LIVE IN A SKILLED NURSING FACILITY? ☐ YES ☐ NO NAME OF FACILITY: _____

EMPLOYMENT STATUS: ☐ *FULL-TIME* ☐ *PART-TIME* ☐ *UNEMPLOYED* ☐ *RETIRED* ☐ *STUDENT*

EMPLOYER: _____ WORK PHONE: (_____) _____

EMAIL ADDRESS: _____ PATIENT PORTAL: ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN: _____ PHONE#: (_____) _____

WHO REFERRED YOU TO US? REFERRING PHYSICIAN: _____

☐ *ADVERTISMENT* ☐ *FAMILY MEMBER/FRIEND* ☐ *HEALTH FAIR* ☐ *HOSPITAL* ☐ *INTERNET*

☐ *INSURANCE REFERRAL* ☐ *YELLOW PAGES* ☐ *OTHER:* _____

EMERGENCY CONTACT: _____ PHONE#: (_____) _____

IF PATIENT IS A MINOR, PLEASE PROVIDE NAME OF PARENT(S) OR LEGAL GUARDIANS: _____

RELATIONSHIP TO PATIENT: _____ PHONE#: (_____) _____

WE ARE DEDICATED TO PROVIDING THE BEST CARE POSSIBLE TO OUR PATIENTS. WE CAN BETTER ACCOMPLISH THIS GOAL BY OBTAINING YOUR OPINION ON HOW WE ARE DOING. MAY WE CONTACT YOU BY MAIL, E-MAIL, TEXT, OR TELEPHONE FOR OUR SURVEY? ☐ YES ☐ NO

21st Century Oncology

PATIENT CONSENT FOR DISCLOSURE TO INVOLVED INDIVIDUALS

Patient Name: _____ Date of Birth: _____

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.

Dr. Ricky Bare, F.A.C.S.
Dr J.G. Cargill III
Dr. James Brien
Dr. Michael Burris
Dr. H. Brooks Hooper
Dr. Andrew Franklin
Kimberly Bullock, FNP
C. Sydney Pilgrim, PA-C

FINANCIAL POLICY

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, your insurance coverage, and your financial responsibilities.

Professional Fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's education/training , and support costs associated with providing and coordinating your care. We will be happy to provide you with detailed fee information at any time.

Patient Payments: Co-pays, deductibles, services not covered by your insurance plan, and outstanding balances are due at the time of your appointment. Payments may be made with cash, check or credit card. Returned checks will be subject to the fee allowed by state regulations. Please let us know if you are having a particular financial problem and we will try our best to be understanding. Please feel free to discuss mutually acceptable payment arrangements with our in house Financial Coordinator or our Central Billing Office.

Insurance Payments: We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims for you, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays. If your insurance company has not responded to us within 60 days of a filed insurance claim, the charges will be sent to you directly and you will be responsible for their payment as well as for payment of any other charges incurred consistent with this financial policy.

Restricted Service: While we always see patients for emergency care, routine care will only be given to the patients whose accounts are current or who have made financial arrangements with us and are maintaining the conditions thereof.

Medical Forms: The completion of disability forms, FMLA forms, and other supplemental insurance forms all require physician and staff time to complete. Accordingly, a fee of $25.00 will be charged to complete these forms. The fee must be paid by cash or check prior to the completion of the forms.

Clinical Visit: Please note that if a patient comes in with an appointment or has a walk in appointment on the clinical staff schedule, charges will be filed with your insurance for services provided during your visit. As a result of charges being filed with your insurance, it is possible that your insurance may apply a co-payment or coinsurance for the visit.

Acknowledged, agreed, and accepted:

AUA Admin.
MRN #_____

_____ _____
Patient Name (Please Print) *Patient Date of Birth*

_____ _____ _____
Patient Signature or Authorized Person *Date* *Witness*

_____
Relationship to Patient

AUA Admin.
MRN #_____

Radiation Therapy Associates of Western North Carolina, PA
Asheville Urological Associates

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 Patient Date of Birth

****

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

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

AUA Admin.
MRN #_____

Radiation Therapy Associates of Western North Carolina, PA
Asheville Urological Associates
PO BOX 60914 CHARLOTTE, NC 28260-0914

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)

_____
Patient Date of Birth

ASHEVILLE UROLOGICAL ASSOCIATES

Telephone Consumer Protection Act [TCPA] Consent Form

Patient Name: _____

Date of Birth: _____ MRN: _____

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, _____, 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 *Ashville Urological Associates* 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

ASHEVILLE UROLOGICAL ASSOCIATES

Patient Questionnaire

AUA Admin.
MRN #_____

Date: ___/___/___ Patient Name: _____ Date of Birth: ___/___/___ Age: _____

1. What is the main reason you are seeing the doctor today? _____

   _____

2. Was this consultation requested by a Physician? ☐ Yes ☐ No

   If so, by whom? _____

   Who is your Primary Care Physician? _____

3. Have you seen an Urologist before? ☐ Yes ☐ No

   If so, which Urologist have you seen? _____

4. What pharmacy do you prefer to use? Name _____

   Address_____ Phone_____

5. Please list any medications that you are ALLERGIC to: ☐ **No Known Drug Allergies**

6. List the Names (and Dose, if known)of any prescription or over the counter medications you take

   If you have a medication list, please give it to the medical staff

   ☐ **No Medications**

Medications	Strength	Times taken per day

7. Do you take any of the following blood thinners? (Check those that apply) ☐ **No Blood Thinners**

   ☐ Aspirin ☐ Coumadin/Warfarin ☐ NSAIDS
   ☐ Plavix ☐ Xarelto ☐ Pradaxa
   ☐ Other _____

Patient Name: _____ Date of Birth: ___/___/___ Age: _____

Patient Questionnaire Continued

AUA Admin.
MRN #_____

8. Please list all operations you have ever had (if known, list the date). ☐ **No Operations**

9. Please list ALL medical problems (check all that apply) ☐ **No Medical Problems**

☐ Blood Pressure – High or Low (circle one) ☐ High Cholesterol ☐ Diabetes – Type I or Type II (circle one)
☐ Thyroid - High or Low (circle one) ☐ COPD ☐ Heart Disease

Please list any additional medical problems

10. Do you leak urine? ☐ **Yes** ☐ **No**

11. Do you have a family history of any of the following? Place a ☑ in all boxes that apply.

	Father	Mother	Brother	Sister	Children
Bladder Cancer					
Colon Cancer					
Kidney Stones					
Diabetes					
Heart Disease					
High Blood Pressure					
Kidney Cancer					
Kidney Dialysis					
Lung Cancer					

	Father	Mother	Brother	Sister	Children	Aunts/Uncles	Grandparents	First Cousins	Nieces/Nephews
Prostate Cancer									
Breast Cancer									
Ovarian Cancer									
Pancreatic Cancer									

☐ **Family History Unknown**

12. What is your occupation? _____

13. Do you smoke? ☐ Current Every day Smoker ☐ Current Some Day Smoker ☐ Former Smoker
☐ Never Smoked Packs smoked per day_____

Smoking Duration: ☐ 1-5 years ☐ 6-10 years ☐ 11-20 years ☐ over 20 years

Smokeless Tobacco ☐ Yes ☐ No

14. How many caffeinated drinks do you have each day? _____

15. Do you drink alcohol? ☐ Yes ☐ No ☐ Former How much? _____

16. How much do you weigh? _____ How tall are you? _____ft _____inches

Patient Name: _____ Date of Birth: ___/___/___ Age: _____

Patient Questionnaire Continued

AUA Admin.
MRN #_____

17. Have you ever had a serious problem or been treated for any of the following?
(Please check *Yes* or *No* for each symptom

Constitutional Symptoms	Yes	No
Change in appetite		
Weight Change		
Chills		
Fever		

Eyes		
Glaucoma		
Cataracts		

ENT		
Nose Bleed		
Difficulty Swallowing		
Hoarseness		
Hearing Loss		

Respiratory		
Shortness of Breath		
Cough		
Coughing up Blood		

Cardiac		
Chest Pain		
Heart Attack		
Palpitations		
High Blood Pressure		

GI		
Abdominal Pain		
Nausea		
Vomiting		
Diarrhea		
Constipation		

Musculoskeletal		
Arthritis		
Joint Pain		
Joint Replacement		
Back Pain		

Neurological	Yes	No
Dizziness		
Seizure		
Headache		
Loss of Consciousness		

Skin		
Rashes		
Non-Healing Lesions		

Psychiatric		
Nervousness		
Mood Changes		
Depression		

Endocrine		
Thyroid Trouble		
Diabetes		

Hematology		
Anemia		
Easy Bruising		
Swollen Glands		

Genito-Urinary		
Kidney Disease		
Kidney Stones		
Bladder Trouble		
Blood in Urine		
Urinary Infection		
Prostate Gland		
Urinary Incontinence		
Urinary Frequency		

Notice of Privacy Practices
Radiation Therapy Associates of Western North Carolina, PA
Asheville Urological Associates

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.

BE 21st Century Oncology

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:
می ت صحب ن راي گا ،زب ان ک ک م ت خدما ،ف ار سی ا شم راگ :ت وجه
ب ا ال طف .هسد ت ند ا شم س د سد تر رد ،ک ن ند
خ پ اس ای و دب گ یری س ت ما دخو ک پ زش ردف ت (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:
ال لغوية، ةالم ساعد ت وخدما ،ال عرب ية م ت تكل تكن إذ :ت ن ب يه
أو ب ال ط بي بب مكت ل الات صا ى رج .لك رت توف ،مجانا
ل الات صا (833) 717-5597.

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 Privacy Practices (Page 2)
Radiation Therapy Associates of Western North Carolina, PA
Asheville Urological Associates

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

BE 21st Century Oncology

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

21st Century Oncology

Western North Carolina Market
Asheville

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

Dear Patient,

If your physician determines that a referral for diagnostic MRI, PET or CT, Mammography, Bone Density, and Ultrasound 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:

Name: Mission Imaging Services
Address: 534 Biltmore Avenue, Asheville, NC 28801
Phone: (828) 213-0800

Name: Mission Hospital
Address: 509 Biltmore Avenue, Asheville, NC 28801
Phone: (828) 213-1111

Name: Open MRI and Imaging of Asheville
Address: 675 Biltmore Avenue, Suite A, Asheville, NC 28803
Phone: (828) 250-1881