

PATIENT INFORMATION SHEET

DATE:			
PATIENT NAME:			
FIRS	Γ	MI	LAST
SOCIAL SECURITY NUMBER:		SEX:	MALE FEMALE
MAILING ADDRESS:			
	STREET		
CITY	S	STATE	ZIP
DATE OF BIRTH: /]	AGE:	
MARITAL STATUS (CHECK ONE):	SINGLE MARRIED	WIDOWED DIVORC	ED SEPARATED DOMESTIC PARTNER
RACE:	ETHNICITY	: HISPANIC/LATII	NO NON-HISPANIC
HOME PHONE#: ()		CELL PHONE#: ()
DO YOU LIVE IN A SKILLED NURSIN	IG FACILITY? 🗌 YES	NO NAME OF	FACILITY:
EMPLOYMENT STATUS: FULL-1	TIME PART-TIME	UNEMPLOYED	RETIRED STUDENT
EMPLOYER:		WORK PHONE: (_)
EMAIL ADDRESS:		PATIE	NT PORTAL: 🗌 YES 🗌 NO
PRIMARY CARE PHYSICIAN:		PHONE#: ()
WHO REFERRED YOU TO US?	REFERRING PHYSIC	IAN:	
ADVERTISMENT FAMILY N	MEMBER/FRIEND	IEALTH FAIR HOSP	ITAL INTERNET
INSURANCE REFERRAL YELLO	W PAGES OTH	IER:	
EMERGENCY CONTACT:		PHONE#: ()
IF PATIENT IS A MINOR, PLEASE PROVIDE	NAME OF PARENT(S) OR	LEGAL GUARDIANS:	
RELATIONSHIP TO PATIENT: WE ARE DEDICATED TO PROVIDING THE OBTAINING YOUR OPINION ON HOW WE SURVEY? YES			
Address: 1 Doctors Park – Asheville, NC	A Division of 28801 Phone : (828) 25		0434 Web: www.ashevilleurological.com



	Patient Questionnaire	AUA Admin. MRN #
Date:	/ Patient Name: Date of Birth:	//Age:
1.	What is the <u>main reason</u> 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:	nown 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

NSAIDS Pradaxa

Aspirin	Coumadin/Warfarin
Plavix	🗌 Xarelto
🗌 Other	

A Division of RTA of WNC

Pati	Patient Name:				_ Date	_ Date of Birth: <u>/</u> Age:					
	Patient Questionnair					ire Co	ntir	nued		UA Admin.	
8. Please list all operations you have ever had (if known, list the date)							e).). No Operations			
Bloo Thy	od Press roid - H	LL medical pr sure – High or igh or Low (cir y additional m	LOW (cire	cle one)			/) nolestero) [Diabetes Heart Dis	– Type I or T	cal Problems ype II (circle one)
10. Do y 11. Do y		urine? a family hist	Ye sory of a		No e folle		Place a	☑ i	n all boxes t	that apply.	
				Fath	er	Mothe	er Bro	ther	Sister	Children	
		adder Cancer Ion Cancer									
		dney Stones									
	Di	abetes									
		art Disease									
		gh Blood Pressur	e								
		dney Cancer dney Dialysis									
		ng Cancer									
	Fathe	r Mother	Brother	Sister	Ch	nildren	Aunts/U	ncles	Grandparents	First Cousins	Nieces/Nephews
ostate Cancer	Tutile		Diotici	515101	- Ci	indicit	Auntsyo	leies	Grandparents		
east Cancer											
varian Cancer											
ncreatic Cancer									 :etem		
12. Wha	it is you	roccupation) 							Unknowr	l
13. Do y	ou smo	ke? 🗌 Cur	rent Eve	ry day S	mok	er 🗌 (Current	Some	e Day Smoke	er 🗌 Forme	r Smoker
		🗌 Nev	ver Smok	ked		F	Packs sm	oked	d per day		
Smo	oking Du	uration:	1-5 year	s 🗌 6-	10 ye	ears 🗌] 11-20	year	rs 🗌 over 2	20 years	
Smo	okeless	Tobacco 🗌 `	Yes		D						
14. How	many c	affeinated dr	inks do v	you hav	e eac	ch day?					
15. Do y	ou drinl	k alcohol?] Yes 🗌]No [] Fo	rmer	How mu	ich?			
16. How	much c	lo you weigh	?		I	How ta	ll are yo	u?	ft	inch	es
						(611				

2

Patient Name: _____

Patient Questionnaire Continued

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
Change in appetite
Weight Change
Chills
Fever

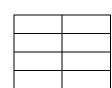
Yes	No	

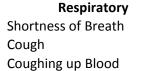
Glaucoma Cataracts

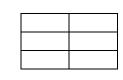


Eyes

Nose Bleed Difficulty Swallowing Hoarseness Hearing Loss

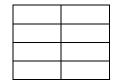




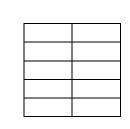


Cardiac

Chest Pain Heart Attack Palpitations High Blood Pressure



GI Abdominal Pain Nausea Vomiting Diarrhea Constipation



Musculoskeletal

Arthritis Joint Pain Joint Replacement Back Pain

Neurological Dizziness Seizure Headache Loss of Consciousness

Date of Birth: / /

Skin Rashes Non-Healing Lesions

Nervousness

Depression

Mood Changes

Yes

Endocrine Thyroid Trouble Diabetes

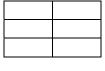
Hematology

Psychiatric

Anemia Easy Bruising Swollen Glands

Genito-Urinary

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



Age: _____

No

AUA Admin. MRN #

International Prostate Symptom Score (IPSS)

Patient Name:	То	day's Date	:			
Determine Your BPH Symptoms	Circ	le your ansv	wers and ac	ld up your	scores at t	he bottom.
Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	I	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	I	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	I	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	I	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	I	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	I	2	3	4	5
Sleeping – How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time I	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	-	+ -	 		 + ·	ł

Total International Prostate Symptom Score =

Quality of Life (QoL)I – 7 mild symptoms8 – 19 moderate symptoms20 – 35 severe symptomsRegardless of the score, if your symptoms are bothersome you should notify your doctor.

		Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
of your life v condition ju	to spend the rest with your urinary st the way it is would you feel	0	I	2	3	4	5	6
Have you t	ried medications t	o help your s	ymptoms?				Yes	No
Did these r	nedications help y	our symptom	ns? (circle)					
ļ	2	3 4	5	6	7	8	9	10
Relief							C	omplete Rel
	be interested in le you to discontinu	•		nvasive optio	n that		Yes	No





Patient Permission To Communicate Information With Designated Individuals

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

 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 Representati Signature**	ve Date	Time
Printed Name of Authorized Repr	esentative:	
Relationship to Patient:		
**If signed by a patient-authorized repre authorization form.	esentative, supporting legal documentati	ion must accompany this

*GenesisCare 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.



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:*

 Patient Name (Please Print)
 Patient Date of Birth
 MRN #_____

 Patient Signature or Authorized Person
 Date
 Witness

 Relationship to Patient
 A Division of RTA of WNC
 Witness

Address: 1 Doctors Park – Asheville, NC 28801 Phone: (828) 253-5314 Fax: (828) 253-0434 Web: www.ashevilleurological.com





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
Printed Name of Patient or Representative	
FOR OFFICE	USE ONLY
If an acknowledgment is not obtained, plea	se complete the information below:
Patient's name:	
Date of attempt to obtain acknowledgment	:
Reason acknowledgement was not obtained	d:
	notice but refused to sign acknowledgment
Emergency treatment situation Patient was incapacitated and no	a family member was present
 Unable to communicate due to la 	-
Other (please describe below)	

Signature of Employee

Date





Assignment Of Benefits/Right To Payment Authorization, Patient Responsibility, And Release Of Information Form

GenesisCare DBA Asheville Urological Associates 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

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



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, 21 st Century Oncology desires to com	municate timely information regarding health care services and
functions to you in the most effective mea	ans possible, including via automated telephone and text messaging.
Federal law requires that we obtain your o	consent prior to communicating with you via these means. Please
read and sign below so that we can comm	unicate 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

	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 promission, in writing, at any line. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written
	Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoend or court order.
	Protective services for the president and others
Fort Myers, FL 33907 1-866-679-8944	Funeral directors, coroners, and medical examiners National security and intelligence according
2270 Colonial Boulevard	Health oversight agencies
For further information, contact: Chief Privacy Officer	 Urgan and ussue condutor organizations -Military command authorities
You will not be penalized for filing a	Workers' compensation agents
If you believe your privacy rights hav	 Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
available on our website and will be p	 Public loss row and any grammination Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health
We reserve the right to change this no we receive in the future. The current r	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. Ecod and Drug Administration
our Web site at <u>www</u> Changes to This Notice	information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is
receive this notice el	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
 A paper copy of this 	Research: We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards
contact you by other	Individuals Involved in your medical case or who hales not for your care. We may release protected health information about you to a friend or family member who is involved in your medical case or who hales not for your care.
submitted in writing and rel	 For conducting training programs or reviewing completence of healthcare professionals For conducting training programs or reviewing completence of healthcare professionals
grant requests for co	 To inform funeral directors consistent with applicable law Encross/Jointo henced on solutions to induct he methods have been been applied on the solution of the sol
 Request confidential in a certain way or at 	 To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
health plan has paid	 To conduct case management or care coordination activities
is not otherwise requ	 To inform you about possible treatment alternatives To inform you about possible treatment alternatives
health plan, we will a	 To assess your satisfaction with our services
to agree to your requ	 To remind you that you have an anopointment for medical care To remind you that you have an anopointment for medical care
friend. For example,	We may allog use and disclose protected health information: We need to be a service to a service of the service
payment, or healthca	memory of the metical start and/or quarky improvement earn may use information in your neutin record to usees 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.
Request restrictions	For Healtheare Operations. We may use or disclose, as needed, your protected health information in order to run our practice. For example, and the destination of the second
purposes other than	will pay us or reimburgs over our for a second of the second
 Request an accounti 	For Payment: We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance commany, or a difficult and wave. For example, we may need to give your insurance commany information about your diagnosis so that it
amendment. You hav	your primary care doctor to plan your treatment and follow-up care.
may ask us to amend	For treatment, we may use proceed near information about you to provide you with reatment of services, we may used serviced intermediate with information about you to decrose, nurses, or other presence who are involved in taking care of you. For example, we may used so communicate with
 Request an amendm 	Uses and Disclosures - How we may use and disclose protected health information about you to show the state of the state o
your request. We will	parentees with respect to this processed meant micrimatori, and or northy any articles of more main source in any missence processes health information. We will abide by the terms of the notice currently in effect.
chosen by us will rev	We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duries and privacy resolves with comparison to characterized by the privacy of your protected health information to provide you with notice of our legal duries and privacy resolves with comparison to characterized by the privacy of your protected health information to provide you with notice of our legal duries and privacy and the privacy of the privacy of your protected health information to privacy provide you with notice of our legal duries and privacy and the privacy of the privacy of your protected health information to provide you with notice of our legal duries and privacy and the privacy of the privacy of your protected health information to provide you with notice of our legal duries and privacy and the privacy of the privacy of your protected health information to provide you with notice of our legal duries and privacy and the privacy of your protected health information to privacy and the privacy of your privacy of your protected health information to privacy and the privacy of your privacy of your protected health information to privacy and the privacy of your privacy and the privacy and and and and and and and and
deny your request to information. vou mav	your care generated by your physician. Our Responsibilities
ask that we send you	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
 Although your health record is the ph Inspect and copy pre 	LEAD time you wild our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination
Your Health Information Rights	AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. FLEASE DEVIEW IF CADEFIT I V
authorization. You understand that we to retain our records of the care that w	THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
GenesisCo	GenesisCare
R	8

are

we are unable to take back any disclosures we have already made with your permission and that we are required we provided to you.

physical property of the healthcure practitioner or facility that compiled it, you have the right to: protected health information. You may request access to your records by contacting us. You may also rour health information directly to another person based on your signed written instructions. We may eview your request and the denial. The person conducting the review will not be the person who denied will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover ay request that the denial be reviewed in some situations. Another licensed healthcare professional to inspect and copy in certain, very limited circumstances. If you are denied access to protected health

nd the information by making a request in writing that explains the reason for the requested Iment. If you feel that protected health information we have about you is incorrect or incomplete, you ig you with a copy of your records.

amendment; if this occurs, you will be notified of the reason for the denial. nting of disclosures. This is a list of certain disclosures we make of your protected health information for nave the right to request an amendment for as long as the information is kept for or by us. We may deny

is or limitations on the protected health information we use or disclose about you for treatment, icare operations. You also have the right to request a limit on the protected health information we in treatment, payment, healthcare operations, or certain other permitted purposes

id for in full. I agree as long as (i) the disclosure would be for the purpose of payment or health care operations and quired by law and (ii) the information only relates to items or services that someone other than your led to provide you emergency treatment. If you ask us not to disclose your health information to your e, you could ask that we not use or disclose information about a surgery you had. We are not required quest, except as described below. If we do agree, we will comply with your request unless the to someone who is involved in your care or the payment for your care, such as a family member or

ial communications. You have the right to request that we communicate with you about medical matters at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will confidential communications at alternative locations and/or via alternate means only if the request is related correspondence regarding payment for services. Please realize that we reserve the right to er means and at other locations if you fail to respond to any communication from us that requires a and the written request includes a mailing address where you will receive bills for services rendered

w.genesiscare.com/us/ is notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at

notice; the revised notice will be effective for information we already have about you as well as any information t notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be provided to you upon your next visit to our facility after the effective date.

ave been violated, you may file a complaint with us by contacting our Privacy Officer toll-free at 1-866-679-y of the U.S. Department of Health and Human Services.

a complaint.



Attention: If you speak English, language assistance services, free of charge, are available to Language Assistance Services for Individuals with Limited English Proficiency

Please call: (833) 796-9684 You.

servicios gratuitos de asistencia lingüística. Por favor, póngase en contacto con su oficina médico o llame al (833)-796-9683. ATENCION: si habla español, tiene a su disposicion Spanish / Español:

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, Mandarin/蒙靂中文:注意:如果您使用繁體中文

Vietnamese/TiếngViệt:

CHÚ Ý: Nều 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 / Krey ol Ayis yen:

ATANUSYON: Si w pale Kreyči Ayjsyen, gen sévis éd pou lang ki disponib gratis pou ou. Tanpri kontakte biwo doké ou a oswa rele (833)-590-0265.

Russian/Русский:

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

Armenian/ Հայերեն։

ձեզ անվճար կարող են տրասնադրվել լեզվական աջակցության ծառայություններ։ Խնդրում ենք կասվակել ձեր բժշկի գրասենյակ կաս Զանգահարեք (833)-796-9675 UPCAJULAUNU Եթե խոսում եք հայերեն, ապա

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.

:فرسی/ (Farsi)

يز فرک خود تعلن بگيري و يا ياسخ (833) 5677-717 توجة اگر شإفارسی خدات کوک ریان، رایگل صحبت می در دسترس شرا هستند لطفا با دفتر کتند در دسترین شم هستند

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 /المربية:

تنبيه: إذا كرنت تتكلم العربية، وخدمك المساعدة باللغرية مجادًا، تتوضر الله. يرجى الاتصال بمكتب الطبيب أو 5597-717(833)Juny!

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が、(833) 7/1-5676まで お電話ください。

French / Français:

Inguistique vous sont proposés gratuitement. S'il vous plait contacter votre bureau de médecin ou appelez le ATTENTION: Si vous parlez français, des services d'aide (833) 663-6209.

Polish:

skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 833-796-9679. UWAGA Jeżeli mówisz po polsku, możesz



Notice of Non-Discrimination

Discrimination is Against the Law

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

GenesisCare USA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Provides free language services to people whose primary language is not English, such as: Qualified sign language interpreters
 Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 0 0 Qualified interpreters

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Information written in other languages

If you need these services, please contact your physician office.

available to help you. grievance in person or by mail, phone, or email. If you need help filing a grievance, the Civil Rights Coordinator is Colonial Blvd, Fort Myers, FL 33907, 866-679-8944, CivilRightsCoordinator@usa.genesiscare.com. You can file a of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, 2270 If you believe that GenesisCare USA has failed to provide these services or discriminated in another way on the basis

https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at: Rights, electronically through the Office for Civil Rights Complaint Portal, available at You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil

Complaint forms are available at: https://www.hhs.gov/ocr/complaints/index.html 1-800-368-1019, 800-537-7697 (TDD) Washington, D.C. 20201 Room 509F, HHH Building Services 200 Independence Avenue, SW U.S. Department of Health and Human



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 with 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: Mission Hospital Address: 509 Biltmore Ave. Asheville, NC 28801 Phone: (828) 213-9729

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

Name: Transylvania Regional Hospital Address: 260 Hospital Drive Brevard NC 28712 Phone: (828) 883-5161

Name: AdventHealth Hendersonville Imaging Address: 100 Hospital Drive Hendersonville, NC 28792 Phone: (828) 681-2180

Name: Mission Hospital McDowell Address: 430 Rankin Dr. Marion, NC 28792 Phone: (828) 681-2180

Name: Pardee UNC Health Care Imaging & Radiology Address: 800 North Justice Street Hendersonville, NC 28791 Phone: (828) 698-7978

Name: Rutherford Regional Medical Center Address: 288 S Ridgecrest St. Rutherfordton, NC 28139 Phone: (828) 286-5000

Form # RTMS 000001 OV.1

Date: 7/17/2015