



## 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: \_\_\_\_\_

ADVERTISEMENT  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

A Division of RTA of WNC

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





*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:***

<b>AUA Admin.</b> MRN # _____
----------------------------------

\_\_\_\_\_  
*Patient Name (Please Print)*

\_\_\_\_\_  
*Patient Date of Birth*

\_\_\_\_\_  
*Patient Signature or Authorized Person*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Relationship to Patient*



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

AUA Admin. MRN # _____
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**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.

\_\_\_\_\_  
Signature of Patient/Person Legally Responsible

Date: \_\_\_\_\_

\_\_\_\_\_  
Print Name of Patient/Person Legally Responsible

\_\_\_\_\_  
Relationship to Patient  
(If signed by Person Legally Responsible)

\_\_\_\_\_  
Patient Date of Birth



**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<sup>st</sup> 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**



## 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**

- |                                      |  |                                  |
|--------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Coumadin/Warfarin | <input type="checkbox"/> NSAIDS  |
| <input type="checkbox"/> Plavix      | <input type="checkbox"/> Xarelto           | <input type="checkbox"/> Pradaxa |
| <input type="checkbox"/> Other _____ |  |                                  |

A Division of RTA of WNC

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

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 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)

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
<b>Constitutional Symptoms</b>			<b>Neurological</b>		
Change in appetite			Dizziness		
Weight Change			Seizure		
Chills			Headache		
Fever			Loss of Consciousness		
<b>Eyes</b>			<b>Skin</b>		
Glaucoma			Rashes		
Cataracts			Non-Healing Lesions		
<b>ENT</b>			<b>Psychiatric</b>		
Nose Bleed			Nervousness		
Difficulty Swallowing			Mood Changes		
Hoarseness			Depression		
Hearing Loss			<b>Endocrine</b>		
<b>Respiratory</b>			Thyroid Trouble		
Shortness of Breath			Diabetes		
Cough			<b>Hematology</b>		
Coughing up Blood			Anemia		
<b>Cardiac</b>			Easy Bruising		
Chest Pain			Swollen Glands		
Heart Attack			<b>Genito-Urinary</b>		
Palpitations			Kidney Disease		
High Blood Pressure			Kidney Stones		
<b>GI</b>			Bladder Trouble		
Abdominal Pain			Blood in Urine		
Nausea			Urinary Infection		
Vomiting			Prostate Gland		
Diarrhea			Urinary Incontinence		
Constipation			Urinary Frequency		
<b>Musculoskeletal</b>					
Arthritis					
Joint Pain					
Joint Replacement					
Back Pain					

# International Prostate Symptom Score (IPSS)

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

## Determine Your BPH Symptoms

Circle your answers and add up your scores at the 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
<b>Incomplete emptying</b> – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
<b>Frequency</b> – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
<b>Intermittency</b> – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
<b>Urgency</b> – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
<b>Weak stream</b> – How often have you had a weak urinary stream?	0	1	2	3	4	5
<b>Straining</b> – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
<b>Sleeping</b> – 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 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
<b>Add Symptom Scores:</b>		+	+	+	+	+

**Total International Prostate Symptom Score = \_\_\_\_\_**

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

## Quality of Life (QoL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Have you tried medications to help your symptoms?	Yes	No
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Did these medications help your symptoms? (circle)									
1	2	3	4	5	6	7	8	9	10

No Relief

Complete Relief

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No
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**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 agencies
- 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.

085-4118.1  
03/26/2013

**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](http://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

085-4118.1  
03/26/2013

**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 médica 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。請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)-796-9678로 전화하십시오.

**French Creole / Kreòl Ayisyen:**

ATANSYON: Si w pale Kreòl 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:**

ՌԻՇԱՐԴՈՒԹՅՈՒՆՆԵՐ ԵՐՅԵՐՆԵՆ, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցությունները: Խնդրում ենք կապվել ձեր բժշկի գրասենյակ կամ մանուսկրիթ (833)-796-9675.

**Italian / Italiano:**

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuita. Si prega di contattare l'ufficio medico o chiamare il numero (833)-717-5678.

**Persian (Farsi) / فارسی:**

میت صحبت زبانو کا کردہ ان کسک متخدمت، ہا آز می اشم راگت بے وجہ بالاطف، ہمد تذا شمد سہ تر دے کند  
 أو بالاطف ہی ہمد مرکت الات صاعی درج، اذ کرت توف سجد  
 717-5677 (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:**

الخدمت، تالم مساعدت خدمت، الهمد بة ىم تكل يمكن ان بة بة  
 أو بالاطف ہی ہمد مرکت الات صاعی درج، اذ کرت توف سجد  
 717-5597 (833) 717-5597

**Japanese / 日本語: 注意**

あなたは日本語を話す場合は、無償で言語支援サービス、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) 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. Si 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 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](mailto: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>



**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 of 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