# Notice of Privacy Practices
# 21st Century Oncology, LLC
# Azeem Sachedina, M.D.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Each time you visit our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by your physician.

**Our Responsibilities**
We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to that protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

**Uses and Disclosures - How we may use and disclose protected health information about you**

**For Treatment:** We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to doctors, nurses, or other personnel who are involved in taking care of you. For example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

**For Payment:** We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

**For Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to run our practice. For example, members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.

We may also use and disclose protected health information:
- To business associates we have contracted with to perform an agreed-upon service
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To inform you about possible treatment alternatives
- To inform you about health-related benefits or services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

**Individuals Involved in Your Care or Payment for Your Care**: We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

**Research**: We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

**Future Communications**: We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

**As Required by Law**, we may also disclose health information to the following types of entities, including but not limited to:
- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

**Law Enforcement / Legal Proceedings**: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

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# 21st Century Oncology, LLC
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**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

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

**21st Century Oncology, LLC**
**Azeem Sachedina, M.D.**
**PO Box 862152 Orlando FL 32886-2152**

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

**Patient Responsibility**

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

**Release of Information**

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ Date: _____
Signature of Patient/Person Legally Responsible

_____
Print Name of Patient/Person Legally Responsible

_____
Relationship to Patient
*(If signed by Person Legally Responsible)*

## 21st Century Oncology, LLC
## Azeem Sachedina, M.D.

### ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**I hereby acknowledge:** A copy of the Notice of Privacy Practices was given to me.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

**********

### FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgment was not obtained:

- ❑ Patient/family member received notice but refused to sign acknowledgment
- ❑ Emergency treatment situation
- ❑ Patient was incapacitated and no family member was present
- ❑ Unable to communicate due to language barriers
- ❑ Other (please describe below)

_____

_____

_____ _____

Signature of Employee Date

**MEDICARE ASSIGMENT ACCEPTED!!! PLEASE PRESENT YOUR MEDICARE CARD UPON ARRIVAL & YOUR SUUPLEMENTAL INSURANCE CARD SO A COPY CAN BE MADE.**

You are liable for the deductible and the 20% not paid by Medicare. If you have a Medigap policy your supplemental insurance will be billed directly. YOU ARE STILL RESPONSIBLE for the payment to the Doctor if your supplement sends you the check and not the Doctor.

**PRIVATE INSURANCE, PLEASE PRESENT CARD & PICTURE ID FOR COPY!**

**REFERRING PHYSICIAN:** _____

**LAST NAME:** _____ **FIRST NAME:** _____ **MI:** ____

**DATE OF BIRTH:** _____ **SOCIAL SECURITY #:** _____ **SEX:** ____

**ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

**HOME PHONE #** _____ **WORK PHONE#** _____

**CELL PHONE # (OR ALTERNATE):** _____

**PLACE OF EMPLOYMENT:** _____

**COMPANY ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

**MARITAL STATUS:** _____ **SPOUSE'S NAME:** _____

**IN CASE OF EMERGENCY CONTACT:** _____

**Name** **Phone Number**

**PLEASE SIGN BELOW:**

**LIFETIME SIGNATURE AUTHORIZATION**

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED. I AGREE THAT SHOULD THIS ACCOUNT BE REFERRED TO AN AGENCY OR ATTORNEY FOR COLLECTION THAT I WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS, ATTORNEY FEES AND COURT COSTS.

_____

**Patient Signature** **Date**

WE ACCEPT ALL MAJOR CREDIT CARDS! VISA AMERICAN EXPRESS DISCOVER

AZEEM SACHEDINA, M.D., P.A.

Telephone: (954) 722-4950
Fax: (954) 722-5008

Please answer the following questions as accurately as possible by circling one answer that applies or filling in the blank as indicated:

Reason for seeing the doctor: _____

How would you describe your flow of urination: Good Fair Poor

Do you experience any pain on urination? Yes No Sometimes

How many times a night do you wake up to urinate: _____

Do you have to wait before being able to pass urine? Yes No

Do you notice any blood in the urine? Yes No

Do you have to rush to get to the bathroom? Yes No

How frequently do you have to urinate? Every _____ hours.

Do you experience any incontinence (uncontrollable leakage) of urine? Yes No

After urinating, do you feel that you empty your bladder? Yes No

Do you or have you had a fever recently? Yes No

Are you sexually active? Yes No

Have you had any urinary tract infections? Yes No

Do you have back pains? Yes No

Is your weight about the same? Yes No

Which of the following best describes your bowel movements.

Normal Constipation Diarrhea Variable

Female patients please answer the following:

Date of last menstrual cycle _____

Number of pregnancies _____

Number of children _____

# AZEEM SACHEDINA, M.D., P.A.

## Review of Systems

Patient's Name _____

Do you now or have you had any problems related to the following systems? Circle Yes or No.

**Please explain any Yes answers here.**

| | | | | | |
|---|---|---|---|---|---|
| **Constitutional Symptoms** | | | | | |
| Fever | Y | N | Headache | Y | N |
| Chills | Y | N | Other _____ | | |
| **Eyes** | | | | | |
| Blurred Vision | Y | N | Double Vision | Y | N |
| Pain | Y | N | Other _____ | | |
| **Ear/Nose/Throat/Mouth** | | | | | |
| Ear infection | Y | N | Sinus problems | Y | N |
| Sore throat | Y | N | Other _____ | | |
| **Respiratory** | | | | | |
| Wheezing | Y | N | Shortness of breath | Y | N |
| Frequent cough | Y | N | Other _____ | | |
| **Gastrointestinal** | | | | | |
| Abdominal Pain | Y | N | Indigestion/Heartburn | Y | N |
| Nausea/Vomiting | Y | N | Other _____ | | |
| **Genitourinary** | | | | | |
| Urine retention | Y | N | Urinary frequency | Y | N |
| Painful urination | Y | N | Other _____ | | |
| **Musculoskeletal** | | | | | |
| Joint pain | Y | N | Back pain | Y | N |
| Neck pain | Y | N | Other _____ | | |
| **Integumentary** | | | | | |
| Skin rash | Y | N | Boils | Y | N |
| Persistent itching | Y | N | Other _____ | | |
| **Neurological** | | | | | |
| Tremors | Y | N | Numbness/tingling | Y | N |
| Dizzy spells | Y | N | Other _____ | | |
| **Endocrine** | | | | | |
| Excessive thirst | Y | N | Tired/sluggish | Y | N |
| Too hot/cold | Y | N | Other _____ | | |
| **Cardiovascular** | | | | | |
| Chest Pains | Y | N | Varicose veins | Y | N |
| High blood Pressure | Y | N | Other _____ | | |
| **Hematologic/Lymphatic** | | | | | |
| Swollen glands | Y | N | Blood clotting problem | Y | N |
| Other _____ | | | | | |
| **Allergic/Immunologic** | | | | | |
| Hay Fever | Y | N | Drug allergies | Y | N |
| Other _____ | | | | | |
| **Psychologic** | | | | | |
| Are you generally satisfied with your life? | | | Y | N | |
| Do you feel severely depressed? | | | Y | N | |
| Have you considered suicide? | | | Y | N | |
| Other _____ | | | | | |

**Physician use only: (Comments/Notes)**

| #Answer Service | Level of |
|---|---|
| 0 - 1 | 1 or 2 |
| 2 - 9 | 3 |
| 10+ | 4 or 5 |

Physician: _____ Date: ____/____/____

**AZEEM SACHEDINA, M.D., P.A.**

NAME: _____

AGE: _____

REASON FOR SEEING DOCTOR: _____

_____

REFERRING PHYSICIAN: _____

MEDICATIONS: _____

_____

_____

_____

ALLERGIES:

MEDICATIONS: _____

_____

IODINE: _____

FOODS: _____

_____

PAST MEDICAL HISTORY: _____

_____

_____

_____

PAST SURGICAL HISTORY: _____

_____

_____

_____

FAMILY HISTORY OF ANY UROLOGICAL PROBLEMS (PLEASE EXPLAIN):

_____

SOCIAL HISTORY:

SMOKING HISTORY - HOW MANY PACKS PER DAY? _____

ALCOHOL CONSUMPTION: _____

OCCUPATION: _____

**Please help us update your information for our records.**

Patient Name _____

Your Cell Phone Number

_____

***** Local Pharmacy phone number*****
**Please list a local pharmacy**

_____

Your E-mail address:
**(You can now view your chart online, check email within 72hrs of visit)**

_____

Primary Care Physicians:

_____

Consulting Physicians:

_____

_____

_____