New Patient Registration

Office			Date	
Last Name		First Name		Nickname
DOB	Sex	SSN		Address
Apt/Suite	City	State		Home Phone
Email			Mobile Phone	
Primary Provider			Referring Provider	
Employer		Work Phone		Marital Status
Is your spouse working or retired?		Spouse Name		Spouse DOB
Spouse SSN	Spouse Phone		Alternative Address	
Apt/Suite	City		State	ZIP

Insurance Information

Primary	Plan ID		Group#
Phone Number	Policy Holder		Policy Holder DOB
Secondary	Plan ID		Group#
Phone Number	Policy Holder		Policy Holder DOB
Guarantor		Guarantor Relationship	

Emergency Contact Information

Name	Phone Number		Relationship	
Address	Apt/Suite	City	State	ZIP

Are you currently admitted to a hospital or enrolled in a hospice or skilled nursing facility?

◯ Yes ◯ No If yes, please fill out the following:

Facility Name		Phone Number		
Address	Apt/Suite	City	State	ZIP

Are you receiving benefits from the Veterans Administration?

◯ Yes ◯ No If yes, please fill out the following:

VA Name		Phone Number		
Address	Apt/Suite	City	State	ZIP

Sex Assigned at Birth (Choose 1)

- ◯ Male
- ◯ Female
- ◯ Intersex
- ◯ Decline to Disclose

Gender Identity

- ◯ Male
- ◯ Female
- ◯ Non-Binary
- ◯ Decline to Disclose
- ◯ Trans-Male
- ◯ Trans-Female
- ◯ Other

Which of the following best describes your race and/or ethnicity (Select all that apply)?

- ◯ Asian
- ◯ Caucasian
- ◯ Black/African American
- ◯ Middle Eastern/ North African
- ◯ Hispanic
- ◯ Native Hawaiian/Pacific Islander
- ◯ American Indian/Alaskan Native
- ◯ Choose Not to Disclose

What language do you feel most comfortable using when discussing your healthcare?

- ◯ English
- ◯ Spanish
- ◯ German
- ◯ French
- ◯ Italian
- ◯ Russian
- ◯ Portuguese
- ◯ Chinese
- ◯ Creole
- ◯ Other
- ◯ Decline

Social History

Have you ever smoked? ◯ Yes ◯ No | If yes, packs per day | For how many years

Have you quit smoking? ◯ Yes ◯ No | If yes, what year?

Have you ever chewed tobacco? ◯ Yes ◯ No | If yes, how much?

Have you quit chewing tobacco? ◯ Yes ◯ No | If yes, when?

Have you ever attended tobacco cessation classes? ◯ Yes ◯ No | If yes, when?

Do you drink alcohol? ◯ Yes ◯ No | If yes, how much and how often?

Have you quit drinking? ◯ Yes ◯ No | If yes, what year did you quit?

Do you use any street drugs? ◯ Yes ◯ No | If so, which? ◯ Marijuana ◯ Cocaine ◯ Methamphetamine | Other

Do you have a medical marijuana card? ◯ Yes ◯ No

Do you need any help with any of the following: coping, financial assistance, nutrition, social work, transportation, home assistance? ◯ Yes ◯ No

Marital Status: ◯ Single ◯ Married ◯ Partnered ◯ Separated ◯ Divorced ◯ Widowed

Do you have a strong social support system? ◯ Yes ◯ No | If so, who?

Do you adhere to any religious beliefs that would like us to know about? ◯ Yes ◯ No

If yes, explain

Are you still working? Yes No If yes, Full-Time Part-Time

If no, Retired Disabled Unemployed

What is or was your primary occupation?

Did you ever work in an occupation that involved exposure to asbestos or any other carcinogens, hazardous chemicals, or toxic fumes ? Yes No

Have you ever served in the military? Yes No If yes, which branch of the military?

Mobility-Fall Risk Assessment

Do you need assistance walking? Yes No

If so, do you use any of the following? Cane Walker Wheelchair

Have you fallen before or been injured because of a fall? Yes No

Do you have foot ulcers, bunions, hammertoes, or calluses that are painful or cause you to adjust your steps while walking? Yes No

Do you feel unsteady on your feet or shuffle when you walk? Yes No

Do you feel dizzy/lightheaded when you stand up? Yes No

How many falls have you had in the past 12 months? Any injuries?

We screen all patients for domestic violence or abuse.

Does anyone at home hurt, hit, or threaten you? Yes No If yes, explain

Social Geographic History

In which state (or country) were you born?

In what area did you live most of your life?

How long have you lived in your current state of residence?

Do you live in this state all year round? Yes No

If no, what is your alternate address and phone number?

Allergies

Are you allergic to latex? Yes No If yes, reaction

Are you allergic to IV Contrast? Yes No If yes, reaction

Are you allergic to any medications? Yes No

If yes, list all

Other allergies (drug, food, tape, etc.)?

Current Medications

Medication	Dose	Frequency	Route	Prescribing Physician

Pharmacy Name | Pharmacy Phone

Radiation Therapy, Chemotherapy, and Hormone Therapy History

Have you ever received radiation therapy? ◯ Yes ◯ No If yes, when?

What part of the body/area was treated?

Have you ever received chemotherapy? ◯ Yes ◯ No If yes, when?

Have you ever received hormone therapy? ◯ Yes ◯ No If yes, when?

Which medication?

Past Medical History (Check all that apply)

◯ Cancer Diagnosis — If so, what type of cancer?

◯ Heart Disease/CAD ◯ Emphysema

◯ Diabetes ◯ Heart Attack ◯ COPD ◯ Thyroid Disorder ◯ Congestive Heart Failure ◯ Pneumonia

◯ Kidney Disease ◯ Atrial Fibrillation ◯ Chronic Bronchitis ◯ Liver Disease ◯ High Cholesterol ◯ Asthma

◯ HIV ◯ Hypertension ◯ Stroke ◯ Anemia ◯ Other

Do you have a history of any of the following? (Check all that apply)

Constitutional

- ◯ Fever/Chills
- ◯ Increased Fatigue
- ◯ Night Sweats
- ◯ Unexplained Weight Loss

If so, how much?

- ◯ Weight Gain

If so, how much?

Current Height

Current Weight

Eyes/Ears/Nose/Throat

- ◯ Cataracts
- ◯ Glaucoma
- ◯ Diminished Eyesight
- ◯ Experienced Hearing Loss
- ◯ Sinus Problems
- ◯ Hoarseness
- ◯ Dentures

Cardiac

- ◯ Angina (chest pain)
- ◯ Irregular Heartbeat

Pulmonary

- ◯ Persistent Cough
- ◯ Coughing Up Blood
- ◯ Shortness of Breath
- ◯ Inability to Lie Flat
- ◯ Positive TB Test

Influenza Vaccine ◯ Yes ◯ No

Date

Pneumonia Vaccine ◯ Yes ◯ No

Date

COVID-19 Vaccine ◯ Yes ◯ No

Date

Rheumatological

- ◯ Systemic Lupus Erythematosus
- ◯ Rheumatoid Arthritis
- ◯ Osteoarthritis/Arthritis
- ◯ Scleroderma/CREST Syndrome
- ◯ Gout
- ◯ Bone Pain
- ◯ Broken Bones

List

Psychiatric

- ◯ Anxiety
- ◯ Depression
- ◯ Psychosis
- ◯ Bipolar Disorder

Gastrointestinal

- ◯ Difficulty Swallowing
- ◯ Decreased Appetite
- ◯ Frequent Vomiting
- ◯ Hiatal Hernia
- ◯ Gastric Reflux
- ◯ Bowel Polyps
- ◯ Dark/Black Stool
- ◯ Diverticulosis
- ◯ Diverticulitis
- ◯ Blood in Stool
- ◯ Frequent Diarrhea
- ◯ Inflammatory Bowel Disease (Ulcerative Colitis/Crohn's)
- ◯ Constipation
- ◯ Hemorrhoids Colonoscopy/ Sigmoidoscopy

◯ Yes ◯ No

Date

Genitourinary

- ◯ Difficulty Starting Stream
- ◯ Stopping and Starting Stream
- ◯ Blood in Urine
- ◯ Pain or Burning on Urination
- ◯ Frequent Urination
- ◯ Getting Up at Night to Urinate
- ◯ Urinary Urgency
- ◯ Leakage of Urine
- ◯ Kidney Stone
- ◯ Elevated PSA
- ◯ Urinary Tract Infections
- ◯ Difficulty with Erections

Are you sexually active? ◯ Yes ◯ No

Neurological

- ◯ Frequent Headaches
- ◯ Dizziness/Lightheadedness
- ◯ Tremors
- ◯ Paralysis
- ◯ Numbness
- ◯ Polio
- ◯ Weakness in Limbs
- ◯ Seizures

Past Surgical History (Please list year in the box)

- ◯ Eye Surgery
- ◯ Tonsillectomy
- ◯ Thyroid Surgery
- ◯ Lung Surgery
- ◯ Breast Surgery
- ◯ Appendectomy
- ◯ Cholecystectomy
- ◯ Hernia Surgery
- ◯ D & C
- ◯ Heart Surgery
- ◯ Coronary Artery By-Pass
- ◯ Heart Valve Replace/Repair
- ◯ Coronary Artery Stent
- ◯ Defibrillator Placement
- ◯ Pacemaker Placement

Type/Model

- ◯ Colon or Rectal Surgery
- ◯ Bladder Surgery
- ◯ Prostate Surgery
- ◯ Hysterectomy or Gynecological Surgery
- ◯ Joint Replacement
- ◯ Other

Female History

Please complete the following information if you are female.

Age 1st Menstrual Period

Last Menstrual Period

Age of Menopause

Any chance you could be pregnant? ◯ Yes ◯ No

Number of Pregnancies

Number of Deliveries

Age 1st Child Was Born

Did you breastfeed?

Did you ever take hormones (estrogen, birth control pills, androgens, etc.)? ◯ Yes ◯ No

If yes, how long?

Bra Cup Size

Nipple Discharge

Vaginal Bleeding

Vaginal Discharge

History of Sexually Transmitted Diseases ◯ Yes ◯ No

Date of Last PAP Smear

Date of Last Mammogram

Male History

Please complete the following information if you are male.

Date of Last PSA

Score of last PSA

Where

History of Sexually Transmitted Diseases ◯ Yes ◯ No

Pain

Pain Measurement Scale

Pain Level Number

Paint Management Questions

Are you in pain now? ◯ Yes ◯ No

When did your pain start?

Location of Pain

Pain Quality

◯ Sharp ◯ Dull

◯ Constant ◯ Intermittent

◯ Cramping ◯ Aching

◯ Stabbing

How long have you been in pain?

How is your pain being managed?

Anything making it better?

Anything making it worse?

Family History of Cancer or Blood Diseases

Father	Mother	Siblings	Children
If living, age	If living, age	How many sisters?	How many daughters?
If deceased, age of death	If deceased, age of death	How many brothers?	How many sons?
Any history of cancer?	Any history of cancer?	Any history of cancer?	Any history of cancer?
Type	Type	Type	Type

Is there any history of cancer of blood diseases in other family members such as grandparents, aunts, uncles, cousins, etc.?

◯ Yes ◯ No If yes, please explain

Please list the names and addresses of physicians you would like correspondence sent to.

Name	Address	Phone

Do you have any of the following: (Please check all that apply)

- ◯ Healthcare Proxy
- ◯ Medical Power of Attorney
- ◯ Living Will
- ◯ Do Not Resuscitate
- ◯ Organ Donor Card
- ◯ Power of Attorney
- ◯ Advanced Directive

Advance Care Planning (ACP) is an ongoing process of learning about the choices we have for our future medical care. Would you like more information about Advance Care Planning?

- ◯ Yes
- ◯ No

If you answered "yes" to any of the above questions, please provide a copy of the document.

As the patient, you acknowledge, that with the completion of this form, it constitutes your complete clinical history summary.

Patient Signature	Date
Nurse Signature	Date
Physician Signature	Date

Conditions of Service for SunState Medical Specialists

In this document, **"Patient"** means the person receiving treatment. **"Patient Representative"** means any person acting on behalf of the Patient and signing as the Patient's representative. Use of the word "I," "you," "your" or "me" may in context include both the Patient and the Patient Representative. With respect to financial obligations "I" or "me" may also, depending on the context, mean financial guarantor "Guarantor."

"Provider" means the practice and may include SunState Medical Specialists' physicians and/or staff, which may include but are not limited to: Oncologists, Radiologists, Radiation Oncologists, Physician Assistants, Nurse Practitioners, Social Workers, Behavioral Health Practitioners, as well as certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors, or assignees acting on their behalf.

1. **Consent to Treatment.** I consent to medical care and procedures recommended by my Provider, including emergency care, lab tests, x-rays, imaging, diagnostics, and other treatments. I also allow residents and supervised trainees to participate in or observe my care as part of their training. I consent to blood-borne disease testing, such as hepatitis, HIV, or AIDS, if ordered by my Provider or protocol, and understand that side effects are usually minor, like brief pain, burning, bleeding, or soreness at the needle site. Test results will be kept confidential in my medical record.

2. **Consent to Treatment Using Telemedicine.** I consent to the use of Telemedicine, which allows my healthcare providers to share my medical information for diagnosis, treatment, follow-up, or education. My information may be shared with third parties as needed, and confidentiality protections still apply. I understand there are risks, such as technical problems or delays, and results cannot be guaranteed. I may withhold or withdraw consent at any time without affecting my care or benefits.

3. **Financial Agreement.** I understand the practice may bill my insurance. I (the Patient or Guarantor) agree to pay any remaining balance not covered by insurance, including coinsurance, deductibles, non-covered services, or unpaid amounts due to policy limits or exclusions. If I overpay, the extra may be applied to other outstanding balances before a refund. I can request a free, itemized billing statement. For patients with government or certain private insurance coverage, payments may be adjusted according to the program or plan rules.

4. **Professional services rendered by independent contractors and practitioners are not part of the practice bill.** I understand and acknowledge that the independent contractors and advanced practice professionals providing services to me at the practice are not agents or employees of the practice. I understand that I may not actually see or be examined by all physicians or other advanced practice professionals participating in my care; for example, I may not see the radiologists or pathologists participating in my care. I understand that, in most instances, there will be a separate charge for professional services rendered by these providers and that I will receive a bill for these professional services that is separate from the bill for practice services.

5. **Legal Relationship between Practice and Physicians and Advanced Practice Professionals.** Independent physicians and advanced practice professionals are responsible for their own actions and the practice shall not be liable for the acts or omissions of any such independent physicians and/or advance practice professionals. To the extent that any duty to perform any care, procedure, service, and/or treatment is imposed upon the practice, the responsibility for the performance of such care, procedure, service, and/or treatment is delegated to the applicable healthcare professionals.

6. **Assignment of Benefits.** I assign my insurance benefits to the Provider and authorize direct payment to the Provider for services, including emergency care. I understand that my insurance may be supplemental to other coverage, and accepting insurance payment does not prevent the Provider from collecting any remaining balance from other sources. I agree to help the Provider collect payment from any responsible party, including allowing the Provider to act on my behalf if needed. If I receive payment directly for my care, I will promptly forward it to the Provider. I also authorize the Provider to pursue claims, appeals, or legal remedies for any unpaid or underpaid benefits on my behalf and to access necessary documents or information from insurers or other parties. This assignment is full and unconditional, but it does not take away my right to recover payment from my insurer or health plan.

7. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the practice or physician by the Medicare or Medicaid program.

8. **Outpatient Medicare Patients.** Medicare does not provide coverage for “self-administered drugs” or drugs that you normally take on your own, with only a few limited exceptions. If you get self-administered drugs that are not covered by Medicare Part B, we may bill you for the drug. However, if you are enrolled in a Medicare Part D Drug Plan, these drugs may be covered in accordance with Medicare Part D Drug Plan enrollment materials. If you pay for these self-administered drugs, you can submit a claim to your Medicare Part D Drug Plan for a possible refund.

9. **Consent to Photographs, Video, Digital, and Audio Recordings.** I acknowledge that the practice’s security, quality improvement, patient care, healthcare operations, and/or risk management activities may involve photographs, video, digital or audio recordings, and/or other images of me, including telephone calls, being recorded, and I consent to such images and recording. I understand that the practice retains the ownership rights to the images and/or recordings. Images and/or recordings in which I am identified will only be used and disclosed as permitted by law.

10. **Consent to Telephone Calls, Email or Text Message.** I authorize the use of any email address or telephone number I provide (including email addresses or telephone numbers that I provide for my family or designated representatives) (whether wireless or a landline and including email addresses and telephone numbers forwarded or transferred from provided information) for receiving information relating to my healthcare services and financial obligations, including healthcare-related information and financial communications. I expressly agree and consent that you or your customer service personnel and collection agents may contact me by telephone, on a recorded line and/or using automated dialing technology, at any telephone number I have provided or obtained, or any number forwarded or transferred from that number, regarding the services rendered or my related financial obligations. I represent (if I am not the patient) that I am authorized by the patient to receive calls, text messages, or email messages on their behalf and that I am involved in assisting in the patient’s care and/or payment. Methods of contact may include pre-recorded/artificial voice messages and/or automated dialing devices. I represent that I am the account holder for any telephone number(s) provided and am responsible for notifying the Provider of any changes or updates.

    I understand that emails and text messaging are unencrypted and that there is some risk that information included in unencrypted messages may be intercepted or received by unintended third parties and/or stored or archived by service providers and system operators. Information included in such messages may include name, date/time of appointments, physician/practice name or specialty, patient account number, or other information related to financial obligation or services. Message and data rates may apply. Message frequency may vary. Additional text messaging terms may be located on the Practice’s website and may be updated. To stop receiving a certain text message type, I understand that I can opt out by notifying SunState Medical Specialists in writing but may continue receiving text messages of other types subject to separate opt-out notification. For assistance or questions, contact SunState Medical Specialists at Practice Phone

11. **Use and Disclosure of Information.** I consent to Providers using and disclosing health information about me for purposes of treatment, payment, healthcare operations, public health, and other purposes permitted by applicable law. Information covered by this consent includes history and physical records, emergency records, laboratory reports, pharmacy claims and prescription history, physician office notes, nurse notes, discharge summaries, genetic, psychological, psychiatric, intellectual disability, and substance abuse disorder information, and information about infectious diseases including blood borne diseases such as HIV and AIDS. This consent applies to uses and disclosures for coordinated care or case management purposes; to any person or entity involved in payment on the Patient’s behalf, including to verify coverage; and to my employer’s designee when services are related to a workers’ compensation claim. If I am covered by Medicare or Medicaid, I authorize the release of my healthcare information to the Social Security Administration or appropriate state agency for payment of a claim. Providers participate, or may participate, in Health Information Exchanges (HIEs) to share health information for purposes permitted by law. Unless I notify Provider in writing that I desire to opt-out, I consent to my health information being shared as described above.

12. **Other Acknowledgments.**

- **Weapons/Explosives/Drugs.** I understand and agree that if the practice at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage on my person or with my belongings, the practice may terminate the practice/patient relationship.

Acknowledgment of Notice of Patient Rights and Responsibilities. I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law. I understand that I can provide an advance directive to the Provider, and I can request information about formulating an advance directive at registration or thereafter.

Acknowledge (Initial)

Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the Provider may use and disclose my health information. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. I understand that I may contact the practice Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge (Initial)

Acknowledgment: I have been given the opportunity to read and ask questions about the information contained in this form, specifically including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers.

Acknowledge (Initial)

I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, certify I have read and understand these Conditions of Physician Practice Services and have signed knowingly, freely, voluntarily, and agree to be bound by its terms. I have received no promises, assurances, or guarantees as to the results of any medical treatment or services. If insurance coverage is insufficient, denied, or unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Date	Time
Patient/Patient Representative Signature	Witness Signature and Title

Additional Witness Signature and Title:
(required for Patients unable to sign without a representative or Patients who refuse to sign)

Additional Signature and Title

If you are not the Patient, please identify your relationship to the Patient. **(Mark relationship(s) from list below):**

○ Spouse ○ Parent ○ Legal Guardian ○ Healthcare Power of Attorney ○ Guarantor ○ Other (Please specify) _____

Authorization of Release of Information

Section A: This section must be completed for all Authorizations.

Patient's Name		Patient's Phone	
DOB		Last 4 Digits of SSN (Optional)	
Recipient's Name		Recipient's Address	
Recipient's Phone		City	State / ZIP
Recipient's Fax (Only to physician/medical office)		Recipient's Email	

Purpose of Disclosure ◯ At the request of the individual; or ◯ Other 3rd party recipient (Please specify purpose) _____

Request Dates of Service | Facility Name(s) and Addresses

Request Delivery (If left blank, a paper copy will be provided) ◯ Paper Copy ◯ Electronic Media (If available) ◯ Encrypted Email ◯ Unencrypted Email

There is some level of risk that a third party could see your information without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Note: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy).

This authorization will expire after 180 days or on the following (Please choose only one) Exp. Date | Exp. Event

Is this request for psychotherapy notes? ◯ No, then you may check as many items below as you need. ◯ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

Description of Information to be Used or Disclosed

◯ **All Pertinent Records** includes those listed below

◯ Consultation ◯ Discharge Summary ◯ ER Report ◯ EKG Report ◯ History & Physical ◯ Clinical/Lab Report

◯ Medication List ◯ Operative Report ◯ Pathology Report ◯ Problem List ◯ Radiology Report

Other Records

◯ Discharge Instructions ◯ Labor & Delivery Record ◯ Specialty Test/Therapy

◯ Progress Notes ◯ Physician Orders Other

For USCDI Release Requests: To include all elements as defined in the United States Core Data for Interoperability. Requires Direct Address or National Provider Identifier.

All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive, such as alcohol, drug abuse, genetic information, psychiatric, HIV testing, or AIDS information. **Specify any information below that you want to exclude:**

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the recipient is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI?

◯ Yes ◯ No If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the Provider receive financial remuneration in exchange for using or disclosing this information? ◯ Yes ◯ No | If yes, describe

May the recipient of the PHI further exchange the information for financial remuneration? ◯ Yes ◯ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative	Date
Print Name of Patient's Representative	Relationship to Patient
	ID Verified by (Initials)

HIPAA Disclosure Release & Communication Preferences Form

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner(s) (Check all that apply):

- ◯ **Cell Phone**
  - ◯ Leave message with detailed information
  - ◯ Only leave message with callback details
- ◯ **Work Telephone**
  - ◯ Leave message with detailed information
  - ◯ Only leave message with callback details
- ◯ **Home Telephone**
  - ◯ Leave message with detailed information
  - ◯ Only leave message with callback details
- ◯ **Written Correspondence**
  - ◯ Mail to my home address on file
  - ◯ Mail to the address listed below:

I hereby authorize one or all of the designated individuals below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand the identity of the designated individual must be verified before release of PHI.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke this authorization in writing.

- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand information disclosed to any of the individuals authorized above, is no longer protected by federal or state law and may be subject to redisclosure by the above individual.

Patient/Legal Representative Print Name	
Patient/Legal Representative Signature	Date

Lee/Collier Counties, Florida Market

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 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: Radiology Regional Centers
Address: 6100 Winkler Road, Fort Myers, FL 33919
Phone: (239) 936-4068

Name: Advanced Radiology Imaging Associates
Address: 2721 Del Prado Blvd., Ste 110, Cape Coral, FL 33904
Phone: (239) 454-2742

Name: Florida Radiology Consultants
Address: 8791 Conference Drive, Fort Myers, FL 33919
Phone: (239) 331-5566

Name: Naples Diagnostic Imaging Center
Address: 311 North Tamiami Trail, Ste 104, Naples, FL 34102
Phone: (239) 624-4443

Name: Radiology Regional Centers
Address: 700 Goodlette Road, Naples, FL 34102
Phone: (239) 936-4068

Name: SimonMed Imaging
Address: 730 Goodlette Road, Naples, FL 34102
Phone: (239) 307-0234

Name: ProScan Open MRI & CT
Address: 260 Tamiami Trail N, Naples, FL 34102
Phone: (239) 261-1227