FLORIDA CANCER SPECIALISTS & Research Institute

Patient Name: _____
DOB: _____
MRN: _____

FOR OFFICE USE ONLY

Dear Patient,

Welcome to Florida Cancer Specialists & Research Institute (FCS)! Our imaging team is committed to providing you with compassionate, safe, and high-quality care close to home.

For your convenience, many of our imaging services are provided within the same clinics where you see your medical providers. Our integrated approach helps to reduce travel and simplify scheduling.

Our imaging teams work closely with your physicians, advanced practice providers (APPs), and care teams to support timely, accurate imaging and seamless coordination of your care. This close collaboration helps ensure your results are shared promptly and used to guide the next steps in your care journey.

Every member of our imaging team is centered on you and committed to making your experience as smooth and reassuring as possible.

Feel free to ask questions and let us know how we can help you. Thank you for entrusting your care to us.

Sincerely,

Your Florida Cancer Specialists & Research Institute Imaging Team
FLCancer.com

FLORIDA CANCER SPECIALISTS & Research Institute

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First Name:	Middle:	Last:	Suffix:
Preferred / Nick Name:		Date of Birth:	
Primary Address:		SSN:	
City, State, Zip:		Gender at birth: ☐ Male ☐ Female Gender Identity (Select one) ☐ Male ☐ Other _____ ☐ Female ☐ Prefer not to say	
Secondary Address:			
City, State, Zip: From: _____ To: _____		Preferred Pharmacy: _____ Phone Number: _____ Pharmacy Address: _____	
Preferred Language: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Race (Select all that apply): ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other:_____		Phone Numbers Home: _____ Mobile: _____ Other: _____ Preferred Contact: ☐ Home ☐ Cell May we leave a voicemail? ☐ Yes ☐ No If yes: ☐ Home ☐ Cell ☐ Both May we text you? ☐ Yes ☐ No	
Have you served or currently are serving in the US Military? ☐ Veteran ☐ Active Duty		Emergency Contact: _____ Phone Number: _____ Relationship: _____	
Primary Care Physician: _____ Phone Number: _____ Do you see your PCP at least yearly? ☐Yes ☐No		Email: May we email you? ☐ Yes ☐ No	
Referring Provider (if different from PCP) Name: _____ Phone Number: _____		Would you like access to the online patient portal? ☐ Yes ☐ No If yes, provide email address above.	

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INSURANCE INFORMATION

Patient Name: _____ DOB: _____

Primary Insurance Carrier: _____

Name of primary policy holder: _____ Policy holder's DOB: _____

Policy number/group ID: _____

Policy holder's employer: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier: _____

Name of secondary policy holder: _____ Policy holder's DOB: _____

Policy number/group ID: _____

Policy holder's employer: _____ Policy holder's SSN: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Pharmacy Insurance Carrier: _____

Name of pharmacy policy holder: _____ RX policy number/RX BIN number: _____

I certify that the information provided is accurate. I will notify Florida Cancer Specialists & Research Institute (FCS) of any changes as soon as they become available. I understand that it is my responsibility to update FCS of any changes to my insurance plan, or I may be held liable for the full balance of my treatment.

Patient Name (Print) _____ Date of Birth _____

Patient or Guarantor (Signature) _____ Date _____

MEDIGAP

Only applicable for patients with secondary insurance to Medicare

I request that payment of authorized Medigap benefits be made on my behalf to Florida Cancer Specialists & Research Institute or Rx To Go for any services furnished by _____. I authorize any holder of medical information about me to release to _____ any information concerning this Medicare claim because my signing this authorization will cause Medicare payment information to cross over automatically.

Patient Name (Print) _____ Date of birth _____

Patient or Guarantor (Signature) _____ Date _____

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GENERAL & FINANCIAL CONSENT

Dear Valued Patient,

Thank you for choosing Florida Cancer Specialists & Research Institute (FCS) as your healthcare provider. Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge FCS' patient general and financial policies:

- You consent to the rendering of medical care in compliance with healthcare surrogacy laws, which may include diagnostic procedures, next-generation sequencing testing and such medical treatment as your physician(s) or other FCS medical staff consider to be necessary. You may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location. You consent to initiating and/or receiving technology-based communications with FCS and my providers, including consulting services from a specialist performed virtually. You understand that my medical care and treatment may be provided by physicians, including fellows and residents, medical and allied health students, physician assistants, nurses and other health care providers. You have read and understand this General Consent for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.
- You agree to provide FCS with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify FCS if your coverage changes.
    - You understand that FCS patient financial policies are available online at FLCancer.com. You agree that these policies apply to you and may change from time to time without notice.
    - You acknowledge that FCS will bill your insurance plan or program for services provided by FCS and you agree you are assigning your right to receive payment or benefits from such insurer or program to FCS and you are authorizing payment to be made directly to FCS.
- You agree you are responsible for payment to FCS of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any "advance beneficiary notice" (ABN) which may be applicable under Medicare).
- You authorize FCS and its agents to review your insurance, financial, and demographic information for the purposes of identifying potential financial assistance programs for which you may qualify. This review may include the use of 3rd party services to help determine eligibility for financial support.
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other healthcare providers, FCS will use your personal health information internally and will share such information with your insurance policy and certain business associates of FCS in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.

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- FCS owns and operates Rx To Go, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your FCS physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use Rx To Go and may have your prescriptions filled wherever you choose. However, if you select Rx To Go to fill FCS-issued prescriptions, then this policy and all other FCS patient financial responsibility policies will also apply to the items and services provided to you by Rx To Go.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by FCS clinicians at FCS' own facilities. In some cases, services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside provider.
- If you make a payment to FCS that results in a surplus on your account (i.e., a credit balance), FCS may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and FCS may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of FCS' care a credit balance remains which is not subject to return to your insurer or other payer, FCS will refund the credit balance to you. However, you agree that any refund under $10.00 will be made only if you make a written request and, in any event, any credit balance under $10.00 will be forfeited if a refund request is not received within five (5) years after the conclusion of your care.

☐ I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PATIENT FINANCIAL POLICIES.
A copy is available to the patient upon request.

_____ _____
Patient Name (Print) Date of birth

_____ _____
Patient or Guarantor (Signature) Date

For office use:

_____
Name (Print)

_____
FCS Employee (Signature)

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GENERAL CONSENT FORM

SMS Communication Consent

☐ I consent to receive text messages from Florida Cancer Specialists & Research Institute (FCS), Rx To Go, LLC, and any authorized texting service vendor for appointment reminders, billing notices, and other health-related updates. I understand message/data rates may apply and I may opt out at any time by replying "STOP."

☐ I do not consent to receive text messages.

Photo Authorization for Medical Record

☐ I consent to FCS photographing me (digital/photo/video) for inclusion in my electronic medical record (EMR) for identification and documentation purposes.

☐ I do not consent to be photographed for medical record purposes.

Consent Disclosure of Medical Information

☐ I authorize FCS to discuss my medical information with the following individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ I request that all my Protected Health Information be disclosed ONLY to me and to no other family members or friends.

Patient (Print Name) _____ Date of birth _____

Patient (Signature) _____ Date _____

Notice of Privacy Policies

Genetic Information

We may collect and use genetic information (such as results from genetic tests) as part of your medical record.
We use and disclose genetic information as permitted by HIPAA Privacy Rule, including for:

- •Treatment (such as diagnosis and care decisions)
- •Health care operations (such as quality improvement and care coordination)
- •Certain research activities, when allowed by law

We may share this information with other third-parties (business associates) who help us operate our practice. These parties are also required to comply with HIPAA safeguard to protect your information.
In some cases, we may use or share de-identified information for research, analytics, or other lawful purposes, including collaborations with third parties. These activities may involve commercial uses. De-identified information does not identify you and cannot reasonably be linked back to you.
Participation in genetic testing is voluntary. Please speak with your provider if you have questions about whether genetic testing is right for you.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Florida Cancer Specialists & Research Institute (FCS) Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any FCS facility or by submitting a request in writing to the corporate office at Florida Cancer Specialists & Research Institute, 2890 Center Pointe Drive, Fort Myers, FL 33916.

You may also obtain a copy of the Notice of Privacy Practices by visiting the FCS website at FLCancer.com, select the Patient Guide tab, select New Patient Forms and click on Notice of Privacy Policies.

☐ Accepted ☐ Declined

Patient Name (Print) _____ Date of Birth _____

Patient or Guarantor (Signature) _____ Date _____

Relationship to Patient: _____

REQUEST FOR RELEASE OF RECORDS

I authorize Florida Cancer Specialists & Research Institute (FCS) to request a copy of my complete medical record from the provider listed below:

Name of Provider/Facility: _____

Address: _____

City/State/Zip: _____

Phone/Fax: _____

I understand that by signing this authorization, I permit FCS to receive my medical, psychiatric, HIV, drug/alcohol, and other sensitive health records, unless otherwise restricted by law. I also understand this authorization is valid until revoked in writing.

Patient Name (Print): _____ Date of Birth: _____

Patient or Guarantor Signature: _____ Relationship: _____ Date: _____

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HEALTH HISTORY

ALLERGIES

Drug name:	Reaction you have:
Other Allergens:	
☐ CT Dye	
☐ Iodine	
☐ Latex	
☐ Other _____	

MEDICATIONS

Please list all medications you are currently taking, include dosage and frequency. If you have a printed list, you may provide a copy to the office instead.

Name of Medication:	Strength:	Frequency Taken: