DANIEL N. EAD MD
A division of GenesisCare
1216 N. University Drive, Plantation, FL 33322 PHONE: 954-472-4072

Patient Legal Name_____ Sex ☐ Male ☐ Female □ Other
Birthdate _____ Age _____ Marital Status: ☐ S ☐ M ☐ W ☐ D
Social Security # _____

How did you hear about Dr. Ead? _____

Required by the US Department of Health:

Race: ☐White ☐Black/African American ☐Asian ☐Latino ☐American Indian/Alaska Native ☐Decline
Ethnic Group: _____ or ☐Decline Preferred Language: _____
Address: _____ Apt ____ City _____ State ____ Zip _____
Preferred Phone Number: _____ Secondary Phone number: _____
E-Mail: _____May we send information regarding your appointment □Y □ N
Family Doctor: _____ Family Doctor Phone: _____
Employer: _____ Phone: _____

EMERGENCY CONTACTS

Name: _____ Phone: ( ) _____ Relationship:_____ Can we speak to this person regarding information related to your medical condition, insurance, etc? □ YES □ NO

Name: _____ Phone: ( ) _____ Relationship:_____ Can we speak to this person regarding information related to your medical condition, insurance, etc? □ YES □ NO

Name: _____ Phone: ( ) _____ Relationship:_____ Can we speak to this person regarding information related to your medical condition, insurance, etc? □ YES □ NO

If Patient Is a Minor, Please Complete the Following:

Mother's Name: _____
Employed By: _____
Phone: _____

Father's Name: _____
Employed By: _____
Phone: _____

PLEASE READ CAREFULLY

I accept and acknowledge that that I am solely responsible for knowing the providers and facilities in my insurance company's network, and what their referral policies are. I understand that any information given to me by an Employee of Daniel N Ead, MD, is based on the best of the employee's ability and does not guarantee that DANIEL N EAD MD PA is covered under your particular insurance plan nor do they have knowledge of what is covered under your plan. If I accept a referral to a provider or facility outside my insurance network, I accept and acknowledge that I am responsible for any charges not covered by my insurance company or Medicare**. I also understand that ONLY** my insurance company can determine what my financial responsibility will be, and that any financial information given to me by an employee is an **estimate** and that I may owe more money, or may be entitled to a refund.

I understand, accept and acknowledge that any testing performed in the office may be subject to deductibles, coinsurance and/or copays, and that I am responsible for any additional charges my insurance company states is patient responsibility. I understand that the staff of Dr. Ead does not know in advance if this testing will be subject to additional patient financial responsibility.

Pathology Consent: I hereby authorize Dr. Daniel Ead to order any pathology testing deemed medically necessary in connection with office visits or surgeries. I also understand that I am financially responsible for any tests not covered by my insurance.

_____ _____ _____
Printed Name of Patient or Guardian Signature Date

NAME: _____ Date of Birth: _____/_____/_____ Age: _____

PHARMACY NAME REQUIRED_____PHARMACY PHONE REQUIRED:_____

Who is your primary care doctor? _____

WHAT BRINGS YOU IN TODAY? _____

Where is problem located? _____How long has it been going on? _____How bad on a scale of 1 to 10? _____

Are your symptoms constant or intermittent? _____What makes your symptoms better or worse? _____

Are you presently having any of the following Urological symptoms:

_____ Blood in Urine	_____ Burning on urination	_____ Frequency of Urination
_____ Leakage of Urine/incontinence	_____ Urgency	_____ Getting up at night to urinate
_____ Straining to Urinate	_____ Abdominal Pain	_____ Flank Pain
_____ Groin Pain	_____ Genital pain	_____ Fever or chills

List all medical conditions (Circle):

Diabetes-Hypertension-Cholesterol-Hypothyroidism-Coronary Artery Disease-Arthritis-Atrial Fibrillation-Stroke

Other: _____

List all prior surgeries: (Circle):
Hernia Repair – Gallbladder – Appendectomy – Cardiac Stent – Tonsillectomy – Knee surgery – Kidney stone surgery – Hip surgery – Pacemaker – Cataract – Vasectomy – Circumcision – TURP – Coronary Artery Bypass Graft – C Section - Hysterectomy
Other: _____

FAMILY HISTORY: Does anyone in your family have a history of ☐ prostate cancer, ☐ kidney cancer or ☐ bladder cancer**?**
If Yes, who? _____

MEDICATION ALLERGIES: Do you have any allergies IF YES, PLEASE LIST THEM _____

SOCIAL HISTORY Are you married? Yes / No **Do you have children?** Yes / No **How many?** _____
Smoking: □ Yes □ No **Alcohol**: □ Yes □ No Your O**ccupation**:_____

YOUR HEIGHT: _____ YOUR WEIGHT: _____

Do you have any of the following complaints today? (Please circle)

Fever	Yes___ No___	Palpitations	Yes___No___	Muscle aches	Yes___No___
Weight loss	Yes___No___	Shortness of breath	Yes___No___	Skin rash	Yes___No___
Visual changes	Yes___No___	Diarrhea	Yes___No___	Dizziness	Yes___No___
Hearing changes	Yes___No___	Constipation	Yes___No___	Headaches	Yes___No___
Sore throat	Yes___No___	Nausea/Vomiting	Yes___No___	Abnormal bleeding	Yes___No___
Chest pain	Yes___No___	Joint pain	Yes___No___	Swollen glands	Yes___No___

Office use only: HPI
_____
_____
_____
_____
_____
_____
_____
_____

FEMALE:
Office Use Only: Obese / Overweight/Normal weight
External Normal Y/N;
Cystocele Y/N
Uretheral Meatus Ample Y/N
Bimanual Exam: Mass Y/N

MALE:
Office Use Only: Obese / Overweight/Normal weight
Penis Lesion Y/N; Circumcised Y/N
Scrotum: Rash Y/N, Hydrocele Y/N
Varicocele Y/N
Testis; Mass Y/N;
Epididymis Cyst Y/N
DRE: Smooth Y/N Nodule Y/N; Size _____
Symmetric Y/N; Tender Y/N

CURRENT MEDICATIONS -

Patient Name_____ **DOB**_____

Are you currently taking any medication? No_____ **Yes** _____ If yes please list all medications below and **include over the counter medication(s and any dietary, herbal or vitamin supplements)** This office may import current filled medications from your pharmacy.

_____

Medication Name	**Dosage**	**HOW DO YOU TAKE YOUR MEDICATION? Circle One**	**Frequency (how often)**	**OFFICE COMMENTS (Changes, Stop date etc.)**
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		

Are you **allergic** to any medications? **No**_____ **Yes** _____ **If yes, please list**:_____

Patient Signature:_____Date:_____ (Signature Required)

FOR OFFICE USE ONLY – Please do not write below this line

Above list reviewed with patient with any changes noted, dated and initialed to the right.

PATIENT MANDATORY QUESTIONAIRRE – PLEASE COMPLETE EACH SECTION OF EACH QUESTION IN ITS ENTIRETY IF IT APPLIES TO YOU

PATIENT NAME: _____ DATE OF BIRTH: _____ AGE: _____

DATE OF VISIT: _____

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1. **EVERYONE** - Do you currently use any type of tobacco products? **Yes _____ No _____**

2. If you are **65 years or older**:

   a. **Do you have an Advanced Care Plan or Living Will? _____Yes _____ No**

   b. **Do you have a Medical Surrogate? _____Yes ____NO** (This cannot be a Health Insurance Plan)

      If YES, Name of Health Care Surrogate:_____ Phone: _____

IF No, would you like to discuss an Advance Care Plan or Medical Surrogate with your provider? **Yes ___No ___**

3. **WOMEN** between the ages of **50-75, please answer the following**

   Date of last Mammogram: _____ Results: _____Normal _____Abnormal
   _____Never had a mammogram

Patient Signature:_____Date:_____ (Signature Required)

FOR OFFICE USE ONLY – Please do not write below this line

_____ Patient unable to provide a copy of Advance Care Plan today. Patient asked to provide copy at next visit.

_____ Patient provided information on Advanced Care Plan and Medical Surrogate, questions if any were answered and advised to follow-up with Primary Care Physician as needed.

_____ Verbally counseled patient on tobacco cessation during today's visit.

Staff's Initials_____ Signature_____Date_____
Physician's Initals_____Signature_____Date_____

47: _____ 112: _____ 225: S / NS **48: _____ 50: _____**

Daniel N. Ead, M.D., F.A.C.S.
Diplomate, American Board of Urology
A Division of GenesisCare
1216 N. University Drive
Plantation, FL 33322
Phone: (954) 472-4072 Fax: 844-749-9804

RADIOLOGY / LAB RESULT POLICY

Patient Name: _____ Date of Birth: _____

I understand that Dr. Daniel Ead may order lab work or radiology studies on my behalf as part of my urological care. I understand that it is **MY RESPONSIBILITY** to have the requested tests as well as follow up in the office to receive my test results. Radiology and biopsy results **will not** be given over the phone. Thank you.

_____ Date: _____

Patient Signature

PATIENT PERMISSION TO COMMUNICATE INFORMATION WITH DESIGNATED INDIVIDUALS (WHO CAN WE TALK TO?)

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

1. **I give permission** to allow physicians and staff to discuss relevant medical, billing, and insurance information with the individuals listed below (examples, spouse, relatives, friend, etc.). I understand that my healthcare provider will use professional judgment to determine what information about my healthcare may be discussed with the designated individuals below*.

Involved Individual	Relationship to Patient	Phone Number

Patient/Authorized Representative Signature_____Date:_____Time: _____**

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.

Telephone Consumer Protection (TCPA) Consent Form

Active communication with our patients is a key element in providing high quality health care services. To that end, 21st 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 Dr. Daniel Ead's 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 test messages.

_____

Patient Signature (or Signature of Patient's Authorized Representative)

_____

Patient printed Name

_____

Date

General Medical Records Release and Authorization for Use or Disclosure for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

_____

Phone: _____ Cell: _____

SSN: _____ _____ DOB: _____/_____/_____

I authorize the release the following information* (check all that apply)

□ All Records □ Billing Records □Laboratory / Pathology records

□ X-ray / radiology records □Pharmacy / prescription records □ Other: _____

***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted disease, you are hereby authorizing disclosure of that information.**

These records are for services provided on the following date(s) _____.

Please send the records listed above to (use additional sheets if necessary)

Dr. Daniel Ead
1216 N. University Drive
Plantation, FL 33322

FAX: 844-749-9804 or 954-472-4044

The information may be used/disclosed for each of the following purposes:

- At my request
- For my health care
- For payment/insurance
- For employment purposes
- Legal, Disability, Social Security

This authorization will be valid for one year from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization if **VOLUNTARY** and I may refuse to sign this authorization. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and there are no claims or orders pending or in effects that would prohibit limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Patient or patients Representative Name Printed Date

_____

Patient or Patients representatives' signature

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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

_____ _____

Signature of Patient or Representative Date

_____

Printed Name

****

FOR OFFICE USE ONLY

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

Patient's name: _____

Date of attempt to obtain acknowledgement: _____

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

PO Box 862152, Orlando, FL 32886-2152

ASSIGNMENT OF BENEFITS/RIGHT TO PAYMENT, PATIENT RESPONSIBILITY AND RELEASE OF INFORMATION FORM

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)

Notice of Privacy Practices
Dr. Daniel Ead
Ead Urology

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND ISCLOSED 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 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 you 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 associated 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 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.

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 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 limitation 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 of 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 disclose 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 confidential 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
Ft. Myers, FL 33907
1-866-679-8944

Discrimination is Against the Law

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

GenesisCare:

- 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 GenesisCare 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. 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

La discriminación es contra la ley

GenesisCare cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. GenesisCare no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

GenesisCare:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lenguaje de señas capacitados.
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
  - Intérpretes capacitados.
  - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con Administrador de la práctica.

Si considera que GenesisCare no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: Civil Rights Coordinator, 2270 Colonial Blvd, Fort Myers, FL 33907, 866-679-8944, CivilRightsCoordinator@21co.com. Puede presentar el reclamo en persona o por correo postal, o correo electrónico. Si necesita ayuda para hacerlo, Civil Rights Coordinator está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

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)

Puede obtener los formularios de reclamo en el sitio web:
http://www.hhs.gov/ocr/office/file/index.html

BE 21st Century Oncology

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 médico 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。请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)-796-9678. 로 전화주십시오.

French Creole / Kreyòl Ayisyen:
ATANSYON: Si w pale Kreyòl 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:
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Խնդրում ենք կապնվել ձեր բժշկի գրասենյակ կամ Զանգահարեք (833)-796-9675.

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

Persian (Farsi) / فارسی:
توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات زبانی رایگان برای شما فراهم است. لطفا با دفتر پزشک خود تماس بگیرید یا به (833) 717-5677 تماس بگیرید.

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:
تنبيه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية، مجانا، متوفرة لك. اتصل بمكتب طبيبك أو بالاتصال (833) 717-5597.

Japanese / 日本語:
注意：あなたが日本語を話す場合は、無償で言語支援サービスは、あなたにご利用いただけます。あなたの医師のオフィスにお問い合わせいただくか、(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. S'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.