NEW PATIENT REGISTRATION PACKET

Office: ____________ Date: ____________
Last Name: ____________ First Name: ____________
Nickname: ____________ DOB: ____________ Sex: ____________
SSN: ____________ Address: ____________
Apt/Suite#: ____________ City: ____________
State: ____________ Zip: ____________ Home Phone: ____________
E-mail: ____________ Mobile: ____________
Primary Provider: ____________ Referring Provider ____________
Employer: ____________ Work Phone: ____________
Marital Status: ____________ Is your spouse working or retired? ____________
Spouse Name: ____________ Spouse DOB: ____________
Spouse SSN: ____________ Spouse Contact Number: ____________
Alternate 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: ____________ Policyholder DOB: ____________
Guarantor: ____________ Guarantor Relationship: ____________

Emergency Contact Information:

Name: ____________ Phone: ____________
Relationship: ____________ Guardian: ____________
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:____________
Address:____________
City:____________ State:____________ Zip:____________

Are you receiving benefits from the Veterans Administration?

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

VA Name:____________ Phone:____________
City:____________ State:____________ Zip:____________

Which of the following best describes your race:

☐ Asian	☐ Caucasian	☐ Black / African American	
☐ Subcontinent Asian American	☐ Asian Pacific American	☐ Native American	☐ American Indian/ Alaskan Native
☐ Hawaiian	☐ Pacific Islander	☐ More than one race	☐ Other ☐ Decline

Please Select one Ethnic Group that Best Describes Your Ancestry:

☐ Hispanic or Latino	☐ Non-Hispanic or Latino
☐ Decline	☐ Do not know

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

☐ English	☐ Spanish	☐ German	☐ French
☐ Italian	☐ Russian	☐ Portuguese	☐ Chinese
☐ Creole	☐ Other	☐ Decline	

How did you hear about us?

☐ Physician Referral	☐ Family or Friend	☐ Insurance Referral	☐ Hospital
☐Integrative Oncology Essentials	☐ Communications Forum (Seminar, etc)	☐ Media (newspaper, magazine, billboard, radio, TV)	
☐ Internet (website, search engine, Facebook, etc.)		☐ No Response	

When conducting your own research, how often do you use the internet for gathering information?

☐ Always	☐ Usually	☐ Sometimes	☐ Never

At GenesisCare, we know you have a choice in where you receive your medical care and we thank you for choosing GenesisCare. We would like to invite you to share your experience by completing surveys and/or online reviews. Sharing this information can help others who are interested in knowing more about the patient services provided by GenesisCare and can help promote our mission of providing high-quality, patient-centered care. Surveys and/or online review requests may be sent to you via US mail, email, mobile text messaging, and/or telephone calls. Communication platforms using standard email/mobile text messaging may not utilize encryption, which can place your information at risk of being read or accessed by an unintended third party. By checking yes, you agree that you understand these risks and to receive surveys and/or requests for online reviews through standard unsecure (unencrypted) email, and/or mobile text messaging.

☐ Yes ☐ No

If you are willing to allow GenesisCare to share your online review or testimonial, please let us know so we can get your written permission.

I. ALLERGIES:

Are you allergic to latex? ☐ Yes ☐ No

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

Are you allergic to any medications? ☐ Yes ☐ No If yes, list all the medications and the reactions:

____

____

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

II. CURRENT MEDICATIONS:

Medication	Dose	Frequency	Route	Prescribing Physician

Pharmacy Name: ___________________________________ **Pharmacy Phone:** ________________________

III. 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 chemo therapy? ☐ Yes ☐ No If yes, when?_______________________________

Have you ever received hormone therapy? ☐ Yes ☐ No If yes, when?____________________________
Which Medication?____

IV. 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

V. 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: ____________________

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

PSYCHIATRIC:

☐ Anxiety

☐ Depression

☐ Psychosis

☐ Bipolar disorder

RHEUMATOLOGICAL:

☐ Systemic lupus erythematosus

☐ Rheumatoid arthritis

☐ Osteoarthritis/arthritis

☐ Scleroderma/CREST syndrome

☐ Gout

☐ Bone pain

☐ Broken bones: _____________

VI. PAST SURGICAL HISTORY: Please list when (year)

☐ Eye surgery ______________________________

☐ Tonsillectomy______________________________

☐ Thyroid surgery____________________________

☐ Heart surgery______________________________

☐ Coronary artery by-pass_____________________

☐ Heart valve replace/repair__________________

☐ Coronary artery stent______________________

☐ Defibrillator placement_____________________

☐ Breast surgery_____________________________

☐ Appendectomy_____________________________

☐ Cholecystectomy____________________________

☐ Hernia surgery_____________________________

☐ Colon or rectal surgery______________________

☐ Bladder surgery____________________________

☐ Prostate surgery____________________________

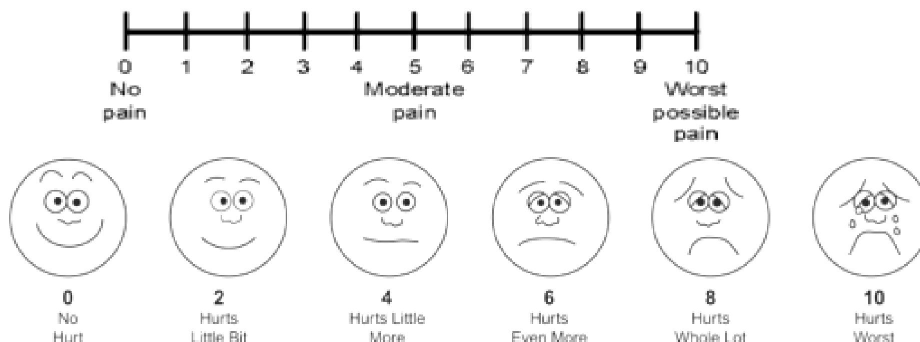
☐ Hysterectomy or gynecological surgery _______

GenesisCare

☐ Pacemaker placement________________________
Type/Model:___________________________________
☐ Lung surgery_________________________________
☐ D & C____
☐ Joint replacement___________________________
☐Other____

VII. 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

VIII. PAIN



Are you in pain now? ☐ Yes ☐ No When did you pain start? _________________________________
On a scale of 1-10 with 10 being the worse pain, how severe is your pain?_________________________
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?_________________

IX. 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?_____________

XI. WE SCREEN ALL PATIENTS FOR DOMESTIC VIOLENCE OR ABUSE:
Does anyone at home hurt, hit or threaten you? ☐ Yes ☐ No
If yes, explain:____

XII. 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? _______________________________________
____

XIII. SOCIAL HISTORY:
Have you ever smoked? ☐ Yes ☐ No How long? _____________ How many packs a day?_________
Have you quit smoking? ☐ Yes ☐ No If yes, when? ____
Have you ever chewed tobacco? ☐ Yes ☐ No How much?_____________________________________
Have you ever quit chewing tobacco? ☐ Yes ☐ No If yes, when?____________________________
Have you ever attended tobacco cessation classes? ☐ Yes ☐ No When?_________________________
Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often?_________________________
Have you quit drinking? ☐ Yes ☐ No If yes, when did you quit?___________________________
Do you use any street drugs? ☐ Yes ☐ No
If so, which street drugs? ☐ 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 Please explain:________________________________
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 you would like us to know about?_______________________
Are you still working? ☐ Yes ☐ No If no, explain:____
What is/was your primary occupation?____
Have you served in the military? ☐ Yes ☐ No If so, which branch of military?__________________
Did you ever work in an occupation that involved exposure to asbestos or any other cancerous chemicals, fumes, or carcinogens? ☐ Yes ☐ No Please explain:______________________________

XIV. FAMILY HISTORY OF CANCER OR BLOOD DISEASES:
Father: If living, age _______ If deceased, age of death_____________________________________
Any history of cancer?______________ Type:____
Mother: If living, age____________________ If deceased, age of death_________________________
Any history of cancer?________________Type:____

Siblings: How many sisters?____________________ How many brothers?_______________________
Any history of cancer?________________Type:____
Children: How many daughters?__________________ How many sons?_______________________
Any history of cancer?_____________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:______________________________________

XV. PLEASE LIST THE NAMES AND ADDRESSES OF PHYSICIANS YOU WOULD LIKE CORRESPONDENCE SENT TO

Name	Address	Phone

Do you have a medical Durable Power of Attorney? ☐ Yes ☐ No

Do you have an Advanced Directive? ☐ Yes ☐ No

Do you have a Living Will? ☐ 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:**_______________________

Telephone Consumer Protection Act [TCPA] Consent Form

Active communication with our patients is a key element in providing high quality health care services. To that end, GenesisCare 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, «PatientFullName», 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 «PracticeName» independent contractors agents and/or affiliates ("collectively, "Practice") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice or other messaging system, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods even if I am charged for the call, as well as through any email address or other personal contact information supplied by me. I expressly consent to receive any such automated calls. I understand that, depending on my plan, charges may apply to certain calls or text messages. I also understand that communication platforms may transmit information via unsecure methods which includes a risk that the information could be viewed by an unintended third party. I understand these risks and consent to having these communications sent unsecure.

____

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

____

Patient Name

____

Date

PATIENT CONSENT FOR DISCLOSURE TO INVOLVED INDIVIDUALS

Patient Name: ______________________________________ Date of Birth: ____________________.

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.

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.*

Note: GenesisCare USA expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment, or healthcare operations.

Assignment Of Benefits/Right To Payment Authorization, Patient Responsibility, And Release Of Information Form

GenesisCare
DBA «PracticeName»
PO Box 862152
Orlando, FL 32886-2152

I, the undersigned, assign to the provider/entity referenced above ("Provider"), my rights and benefits in any medical insurance plan, health benefit plan, 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 authorize 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 are owed to Provider and I agree to remit those funds 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/Authorization shall be considered as effective and valid as the original.

______________________________________ ______________________________
Signature of Patient/Person Legally Responsible Date

______________________________________ ______________________________
Print Name of Patient/Person Legally Responsible Date

____
Relationship to Patient (if signed by Person Legally Responsible)

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 respons

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 lime. 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 alternate 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.genesiscare.com/us/.

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:
Chief Privacy Officer
2270 Colonial Boulevard
Fort Myers, FL 33907
1-866-679-8944

Acknowledgement 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 of Patient or Representative

- -

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 acknowledgement 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

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 / Р у с с к и й: В И М А Н И Е: Е с л и в ы г о в о р и т е н а р у с с к о м я з ы к е, т о в а м д о с т у п н ы б е с п л а т н ы е у с л у г и п е р е в о д а. П о ж а л у й с т а, о б р а т и т е с ь к в р а ч у и л и о ф и с З в о н и т е (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) / :توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. لطفا با دفتر پزشک خود تماس بگیرید یا با شماره 7175677(833) 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 / ال عرب ية ال عرب ية مت تكل تكن اذ ت ن ب يه: ةالم ساعد توخدما ، ال لغوی ة مجان ا ، أو بال ط بي بب مكت ، لاالات صا ی رج .ل ك رت توف لاالات صا (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.

Notice of Non-Discrimination

Discrimination is Against the Law

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

GenesisCare USA:

- 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.

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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/smartscreen/main.jsf, or by mail or phone

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: https://www.hhs.gov/ocr/complaints/index.html