



Patient Name: _____ D.O.B: _____

Temp : _____ Symptoms: Yes / No _____

1. Have you traveled in the last 14 days?

Yes ___ No ___

2. Fever in the last 24 hours of 100 degrees or higher?

Yes ___ No ___

3. Recent loss of taste or smell?

Yes ___ No ___

4. Cough / Sore Throat / Shortness of Breath?

Yes ___ No ___

5. Have you had any contact with someone who has recently been tested for novel coronavirus or is under investigation for COVID-19?

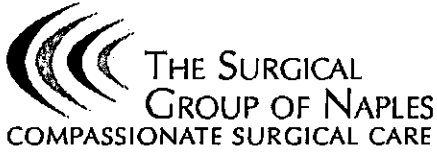
Yes ___ No ___

• Okay to Proceed with office visit: Yes _____ No _____

Patient Signature: _____

Signature of Patient or Legal Representative: _____

Relationship to Patient: _____



Tiffany Davis-Garcia, MD
General and Robotic Surgery

NEW PATIENT REGISTRATION

DATE: _____ PRIMARY DOCTOR: _____

NAME: _____ SSN: _____

SEX: MALE FEMALE AGE: _____ DATE OF BIRTH: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

LOCAL ADDRESS: _____ APT/UNIT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

PREFERRED PHARMACY: _____

Pharmacy Name	Location	Phone
---------------	----------	-------

ALTERNATIVE ADDRESS: _____ APT/UNIT #: _____
CITY: _____ STATE: _____ ZIP CODE: _____

PATIENT'S EMPLOYER: _____
(CIRCLE ONE) FULL TIME PART TIME SELF RETIRED UNEMPLOYED

INSURANCE INFORMATION *PLEASE PROVIDE ALL INSURANCE CARD(S) FOR OUR RECORDS*

PRIMARY INSURANCE : _____

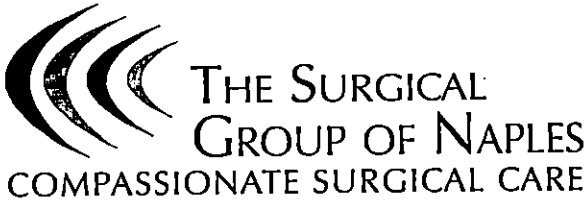
POLICY HOLDER NAME : _____ DOB: _____

SECONDARY INSURANCE : _____

POLICY HOLDER NAME : _____ DOB: _____

EMERGENCY CONTACT: _____
RELATIONSHIP: _____ PHONE NUMBER: _____

Patient Signature: _____ Date: _____



Justin D. Warner, M.D. F.A.C.S.
Board Certified by American Board of Surgery

Tiffany Davis-Garcia, MD
General and Robotic Surgery

HEALTH HISTORY FORM

Date: _____

Age: _____

Last Name _____ First Name _____ MI _____

Referring doctor: _____ Primary doctor: _____

Reason you are here: _____

OPERATIONS: (when, type of surgery)

HOSPITALIZATIONS: (when, where, why?)

MEDICATIONS:

ALLERGIES: Circle if you have an allergy to any of the following. Please describe reactions.

Dye _____
Foods _____
Penicillin _____
Sulfa _____
Iodine _____

Codeine _____
Tape _____
Latex _____
Erythromycin _____
Other _____

PERSONAL HISTORY AND HABITS: Married Single Widowed

Employed: No Yes, occupation: _____

Children: No Yes, number of children: _____

Tobacco Use: Current, # packs daily: _____ Past, date stopped: _____ Never

Alcohol Use: Current, type/frequency: _____ Past Never

Immunization: Influenza: _____ **Date** _____

FAMILY HISTORY: Check all that apply.

M=Mother F=Father GM=Grandmother GF=Grandfather A=Aunt U=Uncle

Cancer: M F GM GF A U **Cancer Type:** _____

Heart Disease: M F Diabetes: M F Stroke: M F High Blood Pressure: M F

Are parents still living: Yes No, cause of death: _____

Name: _____

GENERAL

- Good general health lately No Yes
- Chills or sweats No Yes
- Fever No Yes
- Fatigue No Yes

EYES

- Recent visual problem No Yes
- Blurred vision No Yes

EARS/NOSE/THROAT

- Decreased hearing No Yes
- Ear pain No Yes
- Nasal congestion No Yes
- Sore throat No Yes

LUNGS/RESPIRATORY SYSTEM

- ⊕ Shortness of breath No Yes
If yes: At rest With activity Both
- Chronic/frequent cough No Yes
- ⊕ Sleep apnea No Yes
- ⊕ Blood clots in lungs No Yes
- ⊕ Asthma No Yes
- ⊕ COPD No Yes
- ⊕ Tuberculosis No Yes

HEART/CARDIOVASCULAR SYSTEM

- Chest pain No Yes
- ⊕ Palpitations No Yes
- Swelling of the legs No Yes
- Frequent fainting No Yes
- ⊕ Mitral valve prolapse No Yes
- ⊕ Coronary artery disease No Yes
- ⊕ Heart failure No Yes
- ⊕ Heart attack No Yes, at age _____
- Rheumatic fever No Yes
- ⊕ High blood pressure No Yes

DIGESTIVE/G.I. SYSTEM

- Nausea and vomiting No Yes
- Diarrhea No Yes
- Constipation No Yes
- ⊕ Heartburn/GERD No Yes
- Abdominal pain No Yes
- Stomach ulcers No Yes
- ⊕ Hepatitis No Yes
- ⊕ Diverticulitis No Yes
- ⊕ Crohn's disease No Yes
- ⊕ Ulcerative colitis No Yes
- Colon polyps No Yes
- ⊕ Colon cancer No Yes

URINARY SYSTEM

- ⊕ Prostate disease or cancer No Yes
- Blood in urine No Yes
- Painful urination No Yes
- Frequent urinary tract infection No Yes
- Kidney failure No Yes

BLOOD/HEMATOLOGIC SYSTEM

- Bruises easily No Yes
- ⊕ Blood clots in legs No Yes

ENDOCRINE

- ⊕ Thyroid disease No Yes
- ⊕ Diabetes No Yes
- Heat intolerance No Yes
- Cold intolerance No Yes
- Adrenal disease No Yes
- Pituitary disease No Yes

MUSCULOSKELETAL SYSTEM

- Gout No Yes
- Osteoporosis No Yes
- Arthritis No Yes
- Back pain No Yes

SKIN/INTEGUMENTARY SYSTEM

- Rash No Yes

NERVOUS SYSTEM

- Frequent or recurring headaches No Yes
- Lightheaded or dizziness No Yes
- ⊕ Stroke No Yes
- ⊕ Seizures No Yes
- Neuropathy No Yes

PSYCHIATRIC

- ⊕ Anxiety No Yes
- Depression No Yes
- Alcohol/drug withdrawal No Yes

BREAST

- Fibrocystic breasts No Yes
- ⊕ Breast cancer No Yes

OTHER

**PATIENT PERMISSION TO COMMUNICATE INFORMATION WITH
DESIGNATED INDIVIDUALS**

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.*

*21st Century Oncology 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.

21st Century Oncology, LLC
The Surgical Group of Naples

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

21st Century Oncology
PO Box 862152
Orlando, FL 32886-2152

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



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

**21st Century Oncology
DBA 21ST CENTURY ONCOLOGY - SGN
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)

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, 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 Surgical Group Of Naples 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.

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

Patient Name

Date



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



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

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

Our Responsibilities

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

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

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

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

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

We may also use and disclose protected health information:

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

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

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

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

As Required by Law, we may also disclose health information to the following types of entities, including but not limited to:

- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

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

Other Uses of Your Protected Health Information That Require Your Authorization

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses and disclosures not described in this notice or required by law will be made only with your separate written permission.

If you give us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- inspect and copy protected health information. You may request access to your records by contacting us. You may also ask that we send your health information directly to another person based on your signed written instructions. We may deny your



request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records.

- Request an amendment. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information by making a request in writing that explains the reason for the requested amendment. You have the right to request an amendment for as long as the information is kept for or by us. We may deny your request for an amendment; if this occurs, you will be notified of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes.
- Request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you ask us not to disclose your health information to your health plan, we will agree as long as (i) the disclosure would be for the purpose of payment or health care operations and is not otherwise required by law and (ii) the information only relates to items or services that someone other than your health plan has paid for in full.
- Request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will grant requests for confidential communications at alternative locations and/or via 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.genescare.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

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 médica 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。請聯系您的醫生辦公室或請致電 (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 전화하십시오.

French Creole / Kreyòl Ayisyen:

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis ed pou lang ki disponib gratis pou ou. Tanpri kontakte biwo dokè 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:

ՌԵՇՄԱՆՔԻՑՈՒՆԸ: Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են արանադրվել լեզվական աջակցության ծառայություններ: Խնդրում ենք կապվել ձեր բժշկի գրասենյակ կամ Ջանգուհարեք (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 شما فارسی صحبت میکنید، خدمات کمک زبان رایگان صحبت می کنند بر دسترس شما هستند. لطفاً با دفتر پرتریک خود، صلن بگورید و یا شرح (833) 5677-717.

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، وخدمات المساعدة اللغوية مجانية متوفرة لك. يرجى الاتصال بـ مكتب طبيبك أو الاتصال (833) 5597-717.

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. Si 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.

If you believe that GenesisCare USA 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@usa.genescare.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/smartscreen/main.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: <https://www.hhs.gov/ocr/complaints/index.html>