Assignment of Benefits

Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to **Choose Center Location** (the "Provider") for any services furnished me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian Signature: _____ Date: _____

Medigap (Medicare supplemental insurance) Assignment of Benefits

I request payment of authorized Medigap benefits be made to the Provider and also authorize any holder of medical information about me to release to the Medigap insurer listed below any information needed to determine benefits payable for services from the Provider.

Medigap Insurance Name: _____

Patient/Guardian Signature: _____ Date: _____

General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature: _____ Date: _____

Receipt of HIPAA Patient Privacy Rights Notification

My signature below indicates that I have received the HIPAA Patient Privacy Rights Notification and that I have been made aware of my privacy rights and how I may exercise those rights. I understand that all contact phone numbers listed on the Patient Registration Form may be used to contact me for treatment or payment purposes unless I submit a written request to restrict the use of any/all contact phone numbers listed.

Patient/Guardian Signature: _____ Date: _____

Fundraising Communications Op-Out

By checking the box below I indicate that I do not want to receive any fundraising communications from my Provider.

☐ I do not want to receive any fundraising communications

Patient/Guardian Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information is being requested for:

_____ _____ _____/_____/_____
Last Name MI First Name Maiden/Other Name Date of Birth

_____ _____
Phone# Address City State Zip

Date(s) of service requested: _____/_____/_____ _____/_____/_____
From To

Release the medical information from:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Disclose the medical information to:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Requested medical information authorized to be released: (check items authorized to be released)

____ Consult/H&P
____ OP Report/Procedure Report
____ Follow-up notes
____ Progress Notes
____ Discharge Summary
____ Weekly CBC reports
____ PSA scores
____ All Labs
____ Tumor Markers
____ Pathology Reports
____ Pathology Slides
____ EKG
____ All CT scans /X-rays /Ultrasound
____ Mammograms
____ Previous radiotherapy tx record
____ Entire chart
____ Chemotherapy Flow Sheet
____ Other_____

Note: While every attempt will be made to protect the privacy of your medical information, please note that release of your medical information to an authorized person or organization could be the subject of re-disclosure by the recipient and therefore no longer protected by the Health Insurance Portability and Accountability Act ("HIPAA") or other federal or state laws. This authorization will expire within 90 days unless you specify otherwise. You have the right to revoke this authorization in writing except to the extent that we have released information prior to a revocation.

_____ _____ _____/_____/_____
Signature of Patient or Representative* Relationship to Patient* Date

_____ _____/_____/_____
Signature of Parent/Guardian (minors age 0-17) Date

**** Supporting documentation must be provided***

Attention Staff: This form may only be completed when there is a need to request medical records/films and must be completed in full for each entity from which you are releasing records or to which you are sending records.

Under HIPAA, this form is not necessary in order to share or obtain medical information for treatment or payment purposes of the current medical illness.

Authorization for Release of PHI to Care Givers

(For individuals directly involved in the patient's care or payment for care)

I, _____, authorize the following persons(s) (spouse, partner, sibling, child, friend, etc.) access to my private health information (PHI).

Name (Printed) _____ Relationship _____ Date of Birth _____ Phone Number _____
Name (Printed) _____ Relationship _____ Date of Birth _____ Phone Number _____
Name (Printed) _____ Relationship _____ Date of Birth _____ Phone Number _____

I understand that these persons are authorized to access my information until that authorization is revoked. Authorization can be revoked verbally or in writing at any time by me (patient) or an appointed Durable Health Care Power of Attorney.

Signature of Patient _____

Name (Printed) _____ Date _____

Personal Representative

I,_____, attest that I can act on behalf of _____ (patient) for purposes of treatment authorization and or Use and Disclosure of the patients PHI through rights afforded to me by the state. I will provide all legal documentation required to support the above statement. (Please attach legal documentation to this form).

Examples:

- Durable Power of Attorney for Health Care
- Health Care Proxy
- Court-Appointed Guardian
- Letters of Testamentary/Administration

Signature _____

Name (Printed) _____ Date _____

Date: _____ Patient RT#: _____

_____ _____/_____/_____ _____

First Name MI Last Name Date of Birth Age

_____

Address Apt# City State Zip County of Residence

_____

❑ Home Phone ❑ Work Phone ❑ Cell Phone

_____

❑ Secure e-mail ❑ Mail (to address above) *Check your preferred method of contact*

Attention: We will use all phone numbers listed above to contact you as necessary for treatment and payment purposes unless you place a restriction on the use of these numbers in writing.

Social Security # (*optional):* _____ Sex: **M F** Marital Status: **S M W D**

Preferred Language: _____

Ethnicity: □-Hispanic/Latino □-Not Hispanic/Latino □-Do not want to provide □-Do not know

Race: □-American Indian or Alaska Native □-Asian □ Black or African American □-Native Hawaiian or Pacific Islander □-White

Employed: **N Y** Retired: **N Y** _____ (Date) Disabled: **N Y** _____ (Date)

Employer: _____ Occupation: _____

Are you currently staying in a SNF, Convalescent Home or enrolled in Hospice? _____ Yes _____ No

NOTE: If NO, Patient or Caregiver must immediately notify staff if Patient is admitted to a hospital, SNF, Convalescent Home, or Hospice.

_____

Name of Facility Phone

_____

Address City State Zip

INSURANCE INFORMATION

_____

Primary Insurance Medical Group (HMO) ID# Group #

_____

Name/Relation of Policy Holder Social Security # of Policyholder Date of Birth of Policyholder

_____

Secondary Insurance Medical Group (HMO) ID# Group#

_____/_____/_____

Name/Relation of Policy Holder Social Security # of Policyholder Date of Birth of Policyholder

_____

Primary Care Physician Phone

_____

Referring Physician Phone

EMERGENCY CONTACT

_____

Name Phone Relationship

PHARMACY INFORMATION

Pharmacy Name: _____ Phone Number: _____

Patient/Guardian Signature _____ **Date** _____

Patient Request for Email Communications

Communications to patients over the Internet or to patients' personal email generally are not encrypted and are inherently insecure. There is no assurance of confidentiality of information, except when using messaging secured through Vantage's web-based patient portal. Nevertheless, you may request that we communicate with you via email. To do so, you must complete and return this form.

Please be advised that:

1. **This Request applies only to the health care provider or office that you indicate below. If you would like to request to communicate via email with another health care provider or office, you must complete a separate Request for that office.**
2. We will not communicate any personal health information including health information that is specially protected under state and federal law (*e.g.*, HIV/AIDS information, substance abuse treatment records information, mental health information) via email even if we agree to communicate with you via email.
3. Your Request will not be effective until you receive and respond appropriately to a test email message from us. Please select the test question you want to use below, and provide us with your answer.

Please provide the following information:

Patient Name: _____ Date of Birth: _____

Phone number: _____

Address: _____

Please specify the email address to which communications should be addressed:

_____

Please specify the health care provider or office from which you are requesting email communications:

_____

Please select the question you want to use (by checking the one of the boxes below) for your test email and provide your answer (**Please print clearly**).

- □ My mother's maiden name: _____
- □ My middle name: _____
- □ The street number of my residence: _____

Please read and then initial each blank and sign below:

____ I certify the email address provided on this Request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.

____ I have received a copy of the IMPORTANT INFORMATION ABOUT PROVIDER/PATIENT EMAIL form, and I have read and understand it and agree to its terms and conditions.

____ I understand and acknowledge that communications over the Internet and/or using personal email are not encrypted and are inherently insecure; and that there is no assurance of confidentiality of information, **except when using messaging secured through Vantage's web-based patient portal (Vision Tree Optimal Care)**.

____ I understand that all email communications in which I engage may be forwarded to other providers, including providers not associated with our practice, for purposes of providing treatment to me.

____ I agree to hold harmless the Provider, his/her medical practice, Vantage Oncology & its affiliates and individuals associated with it harmless from any and all claims and liabilities arising from or related to this Request to communicate via email.

____ I wish to receive emails regarding special events, alumni reunions, lectures, and educational material (*Do not initial if you do not wish to receive these types of email communications*)

_____ _____

Signature of Patient or Personal Representative Date

_____

Personal Representative Relationship to Patient (***Supporting documentation must be provided)***

Patient Reported History

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

Instructions: Please answer these questions as accurately as possible. This will help your physician evaluate your illness. All information is confidential and will not be released without your written permission.

List of Chronic Medical Illnesses or Problems

Have you ever had any of the following?	Yes	No	Have you ever had any of the following?	Yes	No
Prior Cancers – Type			Kidney Failure		
Angina			Kidney Stones		
Heart Attacks			Cystitis or Bladder Infections		
Heart Failure			Prostatitis (Men Only)		
Irregular Heart Beat			***Have you had more than 2 episodes within 3 years:***		
Heart Murmur			TURP (Men Only) ***If Yes, date of TURP _____***		
Arthritis			Other Urological Operations/Procedures ***If Yes, please list in "surgeries" section below***		
High Blood Pressure ***If Yes, year of onset _____***			BPH/Enlarged Prostate		
Elevated Cholesterol			Lupus		
Stroke or Paralysis			Scleroderma		
Asthma			Other Collagen Vascular Disease		
Anemia			Blood Clots or Clotting Disorder		
Chronic Bronchitis/Emphysema			Tuberculosis		
Hernia ***If Yes, please circle: Inguinal? Hiatal?***			HIV or AIDS		
Diverticular Disease			Diabetes ***If Yes, year of onset _____***		
Hemorrhoids			Thyroid Disease or Goiter		
Rectal Bleeding			Glaucoma/Cataracts		
Ulcers of Stomach or Small Intestine			Seizures or Epilepsy		
Gallbladder Disease			Parkinson's Disease		
Hepatitis or Liver Disease			Multiple Sclerosis		
Pancreatitis			Other Neurologic Problems		
Crohn's Disease			Skin Condition(s)		
Colitis			Severe Anxiety		
Irritable Bowel Syndrome					

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

Medical History:

Do you have a pacemaker or internal defibrillator?	☐ **Yes**	☐ **No**
Have you ever had hip surgery?	☐ **Yes**	☐ **No**

Surgeries, Procedures & Hospitalizations

Type of Procedures or Hospitalizations	Where	Year

Important: Prior Cancer Treatments

Have you ever had any radiation (ex: seeds, cobalt, external radiation, radioisotopes including treatment for birthmarks, acne, cancer etc.?)
☐ Yes ☐ No
If Yes, where (name of institution) was this performed, what for, and when?

Have you ever received Chemotherapy? ☐ Yes ☐ No
If Yes, what drugs and when?

Have you received hormone therapy for cancer? ☐ Yes ☐ No
If Yes, what drugs (i.e. Tamoxifen, Femara, Lupron, Casodex)?

Hormone Therapy Name/Dose/Frequency	Date

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

For Women: (Gynecological History)

Menarche (First Menstrual Period)(Age):_____ Last Menstrual Period (Date): _____
How many days does the period usually last: _____ Age at menopause: _____

Are you or could you be pregnant? ☐ Yes ☐ No Age at first pregnancy? _____

Pregnancies (Number): _____ Miscarriage (Number): _____ Deliveries (Number): _____

Are you currently on Birth Control: ☐ None ☐ Yes, if so what _____

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

If yes, how long? _____

Medications

List the medications you are presently taking, including OTC, Vitamins and Supplements:

Prescription	Dosage	Frequency	For What?

Allergies (Drug, Food, Iodine etc.)

Do you have any allergies? ☐ Yes ☐ No

If Yes, what are you allergic to and what type of reaction do you get?

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

Family History

Relation	Age	Medical Problems	If Deceased, Age and Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Comments:			

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Partnered

Spouse/Partner's Name: _____

Patient Occupation: _____

Work Situation: ☐ Full Time ☐ Part Time ☐ Medical Leave ☐ Disability ☐ Retired

Did you ever work in an occupation that involved exposure to cancer causing chemicals, fumes or other carcinogens? ☐ Yes ☐ No

What? _____ For how many years? _____

Living Situation: ☐ House ☐ Apartment ☐ Mobile Home ☐ Who lives with you? _____

Transportation: ☐ Able to drive self ☐ Driver required

Do you follow any special diet? ☐ Regular ☐ Vegan/Vegetarian ☐ Renal ☐ Diabetic

Patient Name:_____ Medical Record #: _____

Form Completion Date:_____

REVIEW OF SYSTEMS

Please circle any of the following symptoms <u>that you are currently experiencing</u>. If you do not have any of the listed symptoms in each section, please circle [NONE] at the top of each section.

<u>GENERAL/CONSTITUTIONAL</u>: **If none of the following apply, circle here [NONE]**

Loss of Appetite	Fatigue	Fever	Night Sweat
Chills/Rigors/Tremors	Problems Sleeping	Dizziness	

Weight Loss/Change: If yes, _____ pounds over _____ months. Intentional? _____

<u>EYES</u>: **If none of the following apply, circle here [NONE]**

Blurred Vision	Double Vision	Increased Tearing	Night Blindness
Sensitivity to Light	Visual Difficulties		

<u>HEAD & NECK (ENTM)</u>: **If none of the following apply, circle here [NONE]**

Difficulty Swallowing	Ear pain	Nose Bleeds	Painful Swallowing
Difficulty Hearing	Mouth Dryness	Bleeding in Mouth	Ear Infections
Sinusitis	Sputum Production	Mouth Sores	Taste Alterations
Ringing in the Ears	Masses or Lumps		

<u>SKIN</u>: **If none of the following apply, circle here [NONE]**

Hair Loss	Blisters	Bruising	Dry Skin
Facial Burning	Nail Changes	Sensitivity to Sun	Itching
Rash	Hives		

<u>BREAST</u>: **If none of the following apply, circle here [NONE]**

Lump or Mass in Breast	Nipple Discharge	Nipple Inversion	Pain in Breast

<u>CARDIOVASCULAR</u>: **If none of the following apply, circle here [NONE]**

Irregular Heartbeat	Chest Pain	Shortness of Breath	Edema/Swelling of Feet
Sleep Sitting or Propped up	Palpitations		

<u>RESPIRATORY</u>: **If none of the following apply, circle here [NONE]**

Cough Cough Up Blood: How Long?_____ Cough Up Sputum: Color?_____

Hiccoughs	Difficult/Painful Breathing	Wheezing	Chest Wall Pain

Are you able to lie flat? ☐ Yes ☐ No Oxygen Use _____ L/min

Shortness of Breath on Exertion: What Activity causes or makes it worse?_____

Patient Name:_____ Medical Record #: _____

Form Completion Date:_____

GASTROINTESTINAL: **If none of the following apply, circle here [NONE]**

Abdominal Pain/Cramping | Change in Bowel Habits | Constipation | Diarrhea

Heartburn/Dyspepsia | Vomiting Blood | Symptomatic hemorrhoids

Bloody Stools/ Black Stools/GI Bleeding | Nausea | Satiety/Feel Full Quickly | Vomiting

GENITOURINARY: **If none of the following apply, circle here [NONE]**

Pain or Burning on Urination | Frequent Urination | Blood in Urine | Impotence

Leakage or Loss of Bladder Control | Get up at Night to Urinate: How Often? _____

Kidney Stones | Urgent Urination | Change in Sexual Function

MUSCULO-SKELETAL: **If none of the following apply, circle here [NONE]**

Arthritis | Bone Pain | Painful Joints | Weak Muscles

Decreased Range of Motion

NEUROLOGIC: **If none of the following apply, circle here [NONE]**

Disorientation | Dizziness | Gait Changes | Frequent Headaches

Difficulty Sleeping | Memory Loss | Numbness or Tingling: Where? _____

Weakness in Part of Body: Where? _____ | Seizure | Sensory Problems

Stroke | Claustrophobia

PSYCHIATRIC: **If none of the following apply, circle here [NONE]**

Delusions | Hallucinations | Depression | Change in Personality

Mood Swings

If you check yes to any of these, how long have you had these problems? _____

Have you seen other doctors for these problems? _____

ENDOCRINE: **If none of the following apply, circle here [NONE]**

Diabetes | Hot Flashes | Menstrual Irregularities | Thyroid Disease

HEMATOLOGICAL/LYMPHATIC: **If none of the following apply, circle here [NONE]**

Excessive Bruising | Swollen Lymph Glands

OB-GYN (For Women): **If none of the following apply, circle here [NONE]**

Unusual Vaginal Bleeding | Unusual Vaginal Discharge | Painful/Difficult Intercourse

Vaginal Spotting

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights and your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Vantage Oncology, Attention: Director of Health Information Management, 53 Perimeter Center E., Suite 500, Atlanta, GA, 30346

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS.

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice including, but not limited to, our doctors and nurses may use or disclose your PHI in order to treat you or to assist others in your treatment. For example, we may disclose information to a referral physician. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment, services or refills or in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you, as long as our practice does not receive direct or indirect financial remuneration for such disclosure.

7. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care or payment for your care, or who assists in taking care of you, including following your death. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

9. Public health reporting. Your health information may be disclosed to public health agencies as requires by law. For example, we are required to report certain communicable diseases to the state's public health department. We are also required to report your health information to state cancer registries.

10. Business Associates. We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company, or we may share your health information with an accounting firm or law firm that provides professional advice to us. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information. If our business associate discloses your health information to a subcontractor or vendor, the business associate will have a written contract to ensure that the subcontractor or vendor also protects the privacy of the information.

11. Proof of Immunization. We may disclose proof a child's immunization to a school, about a child who is a student or prospective student of the school, as required by State or other law, if a parent, guardian, other person acting in loco parentis, or an emancipated minor, authorizes us to do so, but we do not need written authorization.

12. Fundraising. We may use or disclose your demographic information, including, name, address, other contact information, age, gender, and date of birth, dates of health service information, department of service information, treating physician, outcome information, and health insurance status for fundraising purposes. With each fundraising communication made to you, you will have the opportunity to opt-out of receiving any further fundraising communications. We will also provide you with an opportunity to opt back in to receive such communications if you should choose to do so.

13. Other uses and disclosure require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision and has been relied upon by our practice.

D. USE AND DISCLOSURE OF YOUR PHI CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths, reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic

violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information

- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct, or regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process, or to identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

8. Serious Threats to Health or Safety .Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement officials. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/ or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

We may **NOT** use or disclose your health information for the following purposes without a signed authorization:

Marketing. We may not disclose any of your health information for marketing purposes if our medical group will receive direct or indirect financial remuneration not reasonably related to our medical group's cost of making the communication.

Sale of Protected Health Information. We will not sell your protected health information to third parties. The sale of protected health information, however, does not include a disclosure for public health purposes, for research purposes where our medical group will only receive remuneration for our costs to prepare and transmit the health information, for treatment and payment purposes, for the sale, transfer, merger or consolidation of all or part of our medical group, for a business associate or its subcontractor to perform health care functions on our medical group's behalf, or for other purposes as required and permitted by law.

If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our medical group. You may also initiate the transfer of your records to another person by completing a written authorization form.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must submit a written request to the address provided in this notice, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. You have the right to request that your health information not be disclose to a health plan if you have paid for the services in full and the disclosure is not otherwise required by law. The request for restriction will only be applicable to that particular service. You will have to request a restriction for each service thereafter. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

In order to request a restriction in our use or disclosure of your PHI, you must submit a written request to the address provided in this notice**.** Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a paper or electronic copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit a written request to the address provided in this notice in order to inspect and/or obtain a paper or electronic copy of your PHI. If you would like an electronic copy of your health information, we will provide you a copy in electronic form and format as requested as long as we can readily produce such information in the form requested. Otherwise, we will cooperate with you to provide a readable electronic form and format as agreed. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, you must submit a written request to the address provided in this notice. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit a written request to the address provided in this notice**.**

All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, you must submit a written request to the address provided in this notice. You can also obtain a copy of this Notice on our website.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice you must submit it in writing to the address provided in this notice**.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law, including HIV/AIDS, sexually transmitted diseases, genetic health information, mental or behavioral health, and drug/alcohol abuse treatment. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care.

9. Right to Receive Notification of a Breach. You have the right to be notified if there is a probable compromise of your unsecured protected health information within sixty (60) days of the discovery of the breach. The notice will include a description of what happened, including the date, the type of information involved in the breach, steps you should take to protect yourself from potential harm, a brief description of the investigation into the breach, mitigation of harm to you and protection against further breaches and contact procedures to answer your questions.

F. ELECTRONIC COMMUNICATION (EMAIL) & YOUR PHI

1. Electronic Communication with Patient. We will not share any PHI electronically through unsecure means. We do not make it a practice to transmit PHI via email unless an encryption system is in place between the sender and receiver. PHI will not be transmitted electronically in an unsecure manner. Before we will contact you through electronic communication (email) we must first receive authorization from you. You may grant authorization by filling out our *Email Request Form and our Important Information About Provider/Patient Email Form.* You may revoke this authorization at any time by submitting a written request to the address provided in this notice.

2. Request of Email Address. You may be asked to provide your email address for the sole purpose of sending you information about events, educational seminars, reminders about your questionnaire, etc. If you wish to not receive information from us via email you may decline to provide your email address. You may also ask to have your email address removed from our mailing list at any time by submitting a written request to the address provided in this notice.

Again, if you have any questions regarding this notice, your privacy rights, or our health information privacy policies, please contact:

Vantage Oncology
Attention: Director of Health Information Management
53 Perimeter Center E.
Suite 500
Atlanta, GA 30346
770-682-2099

Patient Referral Source Form

(Please return completed form to front desk)

Patient Name:_____

Medical Record #: _____Form Completion Date: _____
(Office Only)

How did you hear about us? (check all that apply)

☐ Doctor: _____
Name

☐ Internet: _____
Blog, Website, Search

☐ Family/Friend: _____
Name (Optional)

☐ Magazine/Newspaper: _____
Name

☐ Prior Patient: _____
Name (Optional)

☐ Radio/TV: _____
Station/Program

☐ Insurance Company: _____

☐ Other:
_____
Billboard, Event, etc.

☐ Patient Navigation Center: _____

Patient Request for Email Communications

Communications to patients over the Internet or to patients' personal email generally are not encrypted and are inherently insecure. There is no assurance of confidentiality of information, except when using messaging secured through Vantage's web-based patient portal. Nevertheless, you may request that we communicate with you via email. To do so, you must complete and return this form.

Please be advised that:

1. **This Request applies only to the health care provider or office that you indicate below. If you would like to request to communicate via email with another health care provider or office, you must complete a separate Request for that office.**
2. We will not communicate any personal health information including health information that is specially protected under state and federal law (*e.g.*, HIV/AIDS information, substance abuse treatment records information, mental health information) via email even if we agree to communicate with you via email.
3. Your Request will not be effective until you receive and respond appropriately to a test email message from us. Please select the test question you want to use below, and provide us with your answer.

Please provide the following information:

Patient Name: _____ Date of Birth: _____

Phone number: _____

Address: _____

Please specify the email address to which communications should be addressed:

_____

Please specify the health care provider or office from which you are requesting email communications:

_____

Please select the question you want to use (by checking the one of the boxes below) for your test email and provide your answer (**Please print clearly**).

- □ My mother's maiden name: _____
- □ My middle name: _____
- □ The street number of my residence: _____

Please read and then initial each blank and sign below:

____ I certify the email address provided on this Request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.

____ I have received a copy of the IMPORTANT INFORMATION ABOUT PROVIDER/PATIENT EMAIL form, and I have read and understand it and agree to its terms and conditions.

____ I understand and acknowledge that communications over the Internet and/or using personal email are not encrypted and are inherently insecure; and that there is no assurance of confidentiality of information, **except when using messaging secured through Vantage's web-based patient portal (Vision Tree Optimal Care)**.

____ I understand that all email communications in which I engage may be forwarded to other providers, including providers not associated with our practice, for purposes of providing treatment to me.

____ I agree to hold harmless the Provider, his/her medical practice, Vantage Oncology & its affiliates and individuals associated with it harmless from any and all claims and liabilities arising from or related to this Request to communicate via email.

____ I wish to receive emails regarding special events, alumni reunions, lectures, and educational material (*Do not initial if you do not wish to receive these types of email communications*)

_____ _____

Signature of Patient or Personal Representative Date

_____

Personal Representative Relationship to Patient (***Supporting documentation must be provided)***

Physician List

Patient Name: _____ Date: _____

Please list the names, addresses and phone numbers of physicians that you are seeing. If you do not have all the information with you at the time of your visit, please call us when you get home. This information is very important so that we can inform your physicians of your progress.

Primary Physician: _____

Address: _____

_____

Phone: _____

Referring Physician: _____

Address: _____

_____

Phone: _____

Medical Oncologist: _____

Address: _____

_____

Phone: _____

Surgeon: _____

Address: _____

_____

Phone: _____

OB/GYN: _____

Address: _____

_____

Phone: _____

Other Physician: _____

Address: _____

_____

Phone: _____