Patient Name_____ **Account #** _____
Please Print TXO will complete

Why are we asking these questions? In 2009 Congress passed the HITECH Act to create uniformity among electronic health records. Asking for your language ensures you and your healthcare providers will be able to communicate clearly. We will be asking about race & ethnicity because some groups are at a higher risk of developing certain diseases. This information will be updated in your medical record and will remain confidential.

Please circle below:

Preferred Language: English Spanish Other:_____

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Preferred Method of Contact: Home Phone Cell Phone Work Phone

Email Mail Home Address

Additional Phone number: _____ Home/Cell/Work

Email address: _____

CIRCLE RACE:

AFRICAN AMERICAN	HMONG	PACIFIC ISLANDER NOS
ASIAN INDIAN PAKISTANI SRI LANKAN	JAPANESE	POLYNESIAN NOS
CAUCASIAN	KAMPUCHEAN CAMBODIAN	SAMOAN
CHAMORRAN	KOREAN	TAHITIAN
CHINESE	LAOTIAN	THAI
FIJI ISLANDER	MELANESIAN NOS	TONGAN
FILIPINO	MICRONESIAN NOS	VIETNAMESE
GUAMANIAN NOS	NATIVE AMERICAN	UNKNOWN
HAWAIIAN	NEW GUINEAN	OTHER
HISPANIC	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS	

TEXAS BREAST SPECIALISTS

Higher Standards. Greater Hope.

Patient Name: _____ Date of Birth: _____

Today's Date: _____ MRN#: _____

Any new breast issues?

_____

_____

Any changes to your overall health?

_____

_____

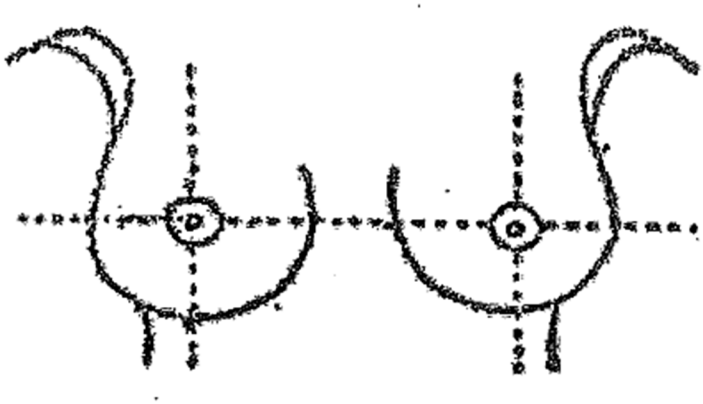
Date of most recent mammogram? _____

Any other breast imaging? _____

Referring Physician: _____

Primary Care Physician: _____

_____PLEASE DO NOT WRITE BELOW_____



Impression / Plan:

TEXAS BREAST SPECIALISTS

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ESAS PATIENT EDUCATION TOOL PI

Patient Name: _____Date of Birth __/_____/_____ Today's Date: _____

Your overall well-being is important to us. Below are some concerns common to many patients. Please take a few moments to complete the following so that we can understand your concerns and support you.

How you are feeling and your symptoms that you are experiencing is very important and helpful to us!

Your healthcare team cares for your overall well-being and wants to know how you are feeling each time you come into a Texas Oncology center. This will assist us in providing you with the best possible care.

Only you can tell us about your symptoms. By letting us know how you are feeling at each visit, we are better able to help you.

ESAS: Edmonton Symptom Assessment Scale

Please **CIRCLE** the number that best describes how you feel **TODAY:**

No Tiredness	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Depression	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
No Drowsiness	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
Best Wellbeing	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ (other problem)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain

What happens after I complete the ESAS?

ESAS answers are entered into your medical chart so they are available to your health care team. All ESAS responses are strictly confidential. Because your symptom scores are kept as part of your medical record, your health care team is able to trend your symptoms over time for better planning of your care. ESAS results will be used as one part of your overall medical review. When you identify a symptom or concern, your health care team will do a further assessment.

Be sure that all of your concerns are discussed at your appointment with your health care team, including those that are not part of the ESAS questions.

Thank you for allowing us to be a part of your care.

For office use only

IKM#_____ Physician's Name_____

TEXAS BREAST SPECIALISTS

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Aimee Mackey, MD **PI**

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Please indicate any symptoms you are currently experiencing:

General:
- ☐ chills
- ☐ fatigue
- ☐ night sweats
- ☐ weight gain ≥ 10 lbs
- ☐ weight loss ≥ 10 lbs

Skin:
- ☐ bruising
- ☐ rash
- ☐ color changes

HEENT:
- ☐ headache
- ☐ hearing change
- ☐ vision changes
- ☐ sore throat

Neck:
- ☐ mass
- ☐ lumps
- ☐ swollen glands

Female Genitourinary:
- ☐ abnormal vaginal bleeding
- ☐ menstrual irregularities
- ☐ pelvic pain
- ☐ urinary complaints

Male Genitourinary:
- ☐ lump in testicle
- ☐ penile discharge
- ☐ prostate conditions

Cardiovascular:
- ☐ chest pain
- ☐ irregular heart beat
- ☐ rapid heart beat
- ☐ swelling of extremities

Respiratory:
- ☐ chronic cough
- ☐ shortness of breath
- ☐ wheezing

Gastrointestinal:
- ☐ abdominal pain
- ☐ change in bowel habits
- ☐ constipation
- ☐ diarrhea
- ☐ nausea / vomiting

Musculoskeletal:
- ☐ muscle pain
- ☐ bone pain
- ☐ joint pain

Psychiatric:
- ☐ anxiety
- ☐ depression
- ☐ insomnia
- ☐ panic attacks

Endocrine:
- ☐ cold intolerance
- ☐ heat intolerance
- ☐ hair changes
- ☐ hot flashes
- ☐ libido changes

Hematology:
- ☐ anemia
- ☐ easy bruising
- ☐ prolonged bleeding
- ☐ enlarged lymph nodes
- ☐ nose bleeds

Neurologic:
- ☐ numbness
- ☐ weakness
- ☐ tremors

Other symptoms:

_____

_____

_____

_____

_____

_____

TEXAS BREAST SPECIALISTS

Higher Standards. Greater Hope.

PI

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Please indicate any medical problems you have:

- ☐ Hypertension
- ☐ Diabetes Mellitus
- ☐ Heart Disease
- ☐ Psychiatric History
- ☐ Asthma
- ☐ Reflux / indigestion
- ☐ Thyroid Problem
- ☐ Bleeding Problems
- ☐ Prior cancer (please describe below)

Any Other Medical Problems:

_____

_____

_____

Please List any Prior Surgeries:

_____

_____

_____

Social History:

Occupation: _____

Tobacco Use: ☐ Yes ☐ No Packs per day: _____ Years: _____

Alcohol Use: ☐ Yes ☐ No Drinks per week: _____

Illicit Drug Use: ☐ Yes ☐ No Describe: _____

Please give the dates of the most recent:

Colonoscopy_____ Bone Density Exam: _____

Pelvic Exam _____

Allergies to Medications:

_____

_____

_____

Medications / Vitamins / Supplements:

_____

_____

_____

Pharmacy:

Will you allow Texas Breast Specialists to obtain your medication history electronically from your pharmacy?

☐ Yes ☐ No

Name _____

Address / Cross Streets _____

I certify that this information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

TEXAS BREAST SPECIALISTS

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PI

Name: _____ Date of Birth: _____

Please state in your own words the reason for your visit:

_____

_____

_____

Breast/Gynecological History:

Last menstrual period: _____ Age of first period: _____

Number of Pregnancies: _____ Number of births: _____

Any miscarriages/abortions: _____ Age of first delivery: _____

Have you ever:

Breastfed: ☐ Yes ☐ No Total months: _____

Used Oral Contraceptives: ☐ Yes ☐ No For how long: _____

Used Hormone Replacement Therapy: ☐ Yes ☐ No For how long: _____

Had Chest Wall Radiation Therapy: ☐ Yes ☐ No For how long: _____

Family History:

Please list **any** relatives and **age of diagnosis** with the following:

Breast Cancer:

_____

_____

_____

Ovarian Cancer:

_____

_____

_____

Other Cancers:

_____

_____

_____

Physicians:

Referring: _____ OB/Gyn: _____

Primary Care: _____ Others: _____

TEXAS ONCOLOGY
More breakthroughs. More victories.™

Prescription History Consent

I voluntarily consent to provide Texas Oncology access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Texas Oncology may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this **Prescription History Consent** will be valid and remain in effect as long as I attend or receive services from Texas Oncology unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I certify that I have read this form or it has been read to me.

Date: _____

Print Name (Patient): _____ DOB: _____

Signature of Patient / Legally Authorized Representative:

_____

Relationship to Patient (if patient not signing):

_____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader / Translator Signature: _____ Date: _____

_____

Notice of Privacy Practices

I acknowledge that the Texas Oncology Notice of Privacy Practices provides information about how the practice and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand that Texas Oncology cannot be responsible for use or re-disclosure of information by third parties.

I acknowledge that I have received a paper copy of the Texas Oncology Notice of Privacy Practices.
_____ **(Patient's Initials)**

TEXAS BREAST SPECIALISTS

Higher Standards. Greater Hope.

Photographic Consent

Dr. Mackey routinely photographs patients in order to follow their exam and results over time. All photos are digital and stored securely, and are only used for medical records, treatment planning, documenting the course of treatment, and education.

My signature below indicates that I consent to my photographs being taken and used in this manner.

_____

Printed Name

_____

Signature (Patient or Legal Guardian)

_____

Date

Aimee Mackey, MD

Breast Surgical Oncology and Oncoplasty

Texas Breast Specialists

TEXAS ONCOLOGY

P I

Supportive Care Screening Questionnaire

Today's Date:

Patient Name: Date of Birth: MR#:

Part A

Your overall well-being is important to us. Below are some common concerns to many patients. Please take a few moments to complete the following questions so that we can understand your concerns and support you.

Emotional Concerns (check all that apply)

☐ Fear / Worry / Anxiety ☐ Guilt ☐ Changes in Appearance ☐ Sadness ☐ Loneliness ☐ Intimacy / Sexuality

Social / Family Concerns (check all that apply)

☐ Feeling a burden to others ☐ Safety concerns ☐ Support for Caregiver ☐ Support for Children / Teens ☐ Communicating with my Healthcare Team ☐ Help at Home ☐ Relationship Difficulties

Practical Concerns (check all that apply)

☐ Insurance / Financial ☐ Advance Care Planning (Medical Power of Attorney / Living Will)
☐ Transportation

☐ Guidance on Social Security / Disability ☐ Employment Concerns Are there any additional services you require?

Would you like to be contacted regarding these concerns at this time? ☐ Yes ☐ No

Part B

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle number that applies)

Circle number that applies	Not at all	2-3 days	4-5 days	Every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

TEXAS BREAST SPECIALISTS

Higher Standards • Greater Hope

Check List

- **Are you claustrophobic? _____**

Do you have any metal in your body? Pacemaker/ Implantable cardio-defibulator/ Stents? :

_____

Some of the test that you may have may include a breast MRI. It is important that you let us know.

- **Do you have breast implants? : _____**
- **Who implanted the breast implants? : _____**
- **Are you allergic to any pain medications? : (example hydrocodone)**
  _____
  ___

_____

Dr. Mackey may prescribe a pain medication after surgery.

- **Do you see a Cardiologist? _____**
- **If yes, who is your Cardiologist:_____**
- **Phone number to reach the cardiologist office: _____**
- **If yes, please list the reason why you see the cardiologist:**
  _____
- **Are you on any Blood thinners? : _____**
- **If yes, please list the name of the blood thinner you are on:**
  _____
- **Do you have a history of MRSA? :**
  _____
- **If yes, when? _____**

Is there anything else you can think of that it is important that we should know during your visit?

_____
_____
_____
_____

TEXAS ONCOLOGY

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____) **EMAIL** _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

TEXAS ONCOLOGY

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Internal Use Only		
	Name	
	DOB	
	MRN	
	Text Opt In: ☐ Yes ☐ No	PHI/ROI Update: ☐ Yes ☐ No

Patient Billing

"What our patients and families need to know."

Texas Oncology provides both quality medical and financial care to our patients. Patient confidentiality is maintained while receiving appropriate payment for the medical care provided. The following is a detailed summary of our policies and procedures regarding patient billing.

1. Patients will receive a cost estimate from a Business Office representative upon request if the insurance will not fully cover all services and/or the patient is underinsured or declared indigent.
2. Patients must pay co-pays at the time of service.
3. Primary, secondary, and tertiary insurance claims for services rendered will be filed by the Business Office.
4. After a payment is made by the insurance company, the Business Office will reconcile the explanation of payment. The patient will be billed for the unpaid amount unless a contract with an insurance carrier prohibits it.
5. Any claim denied due to patient ineligibility, benefit limits, or services not covered will be billed directly to the patient unless a contract with the insurance carrier prohibits it.
6. Patients should promptly notify the Business Office of any changes in insurance coverage, billing address, legal name, or referring physician.
7. Patients may request an alternative billing address.
8. Patient billing statements will be mailed out every 30 days with a return envelope.
9. Patients receiving treatment should inform the office when admitted to a Skilled Nursing Facility.
10. A patient may request a patient statement of billed charges and payments at any time.
11. Patients may pay balances online using the Online Bill Pay portal at www.texasoncology.com.
12. All payments received will be electronically processed.
13. Any patient balance over 45 days will receive a letter and/or phone call to either collect or to arrange a payment plan.
14. Texas Oncology does not charge interest for amounts past due; however, we reserve the right to submit any unpaid accounts over 120 days to a third-party collection agency. The third-party collection agents may utilize all contact information provided in manual or automated efforts to communicate regarding unpaid balances. This includes, but is not limited to, home telephone, cellular telephone, employment telephone, and any form of digital communications including, but not limited to, text messages, emails, and/or automatic telephone dialing systems.
15. Any patient may receive text notifications, regarding their outstanding balance, to their mobile device. A patient may request to opt in or out of text notifications at any time by contacting their physician's Business Office. Message and data rates may apply.
16. If a patient receives direct payment from an insurance company or a patient advocacy program, specifically indicated as payment for services rendered, Texas Oncology reserves the right to submit the balance due to an outside collection agency.
17. Any billing questions regarding oral medications are addressed by the pharmacist/pharmacy staff.
18. All Medicare beneficiaries are provided a copy of the Medicare Oncology Care Model Beneficiary Notification.
19. A patient may provide consent to release financial information in order to have others act on their behalf. Consent may be updated at any time by contacting their physician's Business Office.

Questions or complaints should be directed to the Texas Oncology Business Office at (____) ____-_____.

Patient Initials _____

Internal Use Only		
	Name	
	DOB	
	MRN	
	Text Opt In: ☐ Yes ☐ No	PHI/ROI Update: ☐ Yes ☐ No

TEXAS ONCOLOGY

Financial Release of Information

As the patient, you are in control of the financial records pertaining to your medical care. We will not disclose financial information without your presence or advanced consent unless there is evidence of legal authority for another individual to act on your behalf. If you would like to provide advanced consent to disclose and discuss financial matters of your account with other individuals, please indicate in the fields below:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Please note that staff will ask for key identifying elements that assist in establishing the proper individual. This may include the patient's legal name, date of birth, gender, address, telephone number, guarantor, subscriber, or other unique personal identifiers. To revoke consent at any time for any individual indicated above please contact our Business Office directly. You may be required to complete another Release of Financial Information form.

Texas Oncology collects Social Security Numbers (SSNs) for claim and reimbursement practices. Your privacy and confidentiality are important. Your personal information is maintained securely and accessed only to complete essential business functions. Please indicate your government issued Social Security Number in the field below:

_____ - _____ - _____

Please acknowledge the following statements:

☐ I consent to the individuals listed above to have access to my financial record and act on my behalf.

☐ I consent to receive text notifications of my financial statements at _____ - _____ - _____

☐ I have reviewed a copy of the Patient Billing form (page 1) and accept the terms.

Please sign and provide date and time stamps below:

_____ _____
Patient Signature Date/Time

_____ _____
Responsible Party Signature Date/Time

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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.

About Us
In this Notice, we use terms like "we," "us," "our," or "Practice" to refer to **Texas Oncology**, its physicians, employees, staff and other personnel. All of the sites and locations of **Texas Oncology** follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

Purpose of This Notice
This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities
We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information without your written authorization:
For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another health care provider to be sure they have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company, or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third-party "business associates" that perform various services on our behalf, such as transcription, billing, and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

We may ask you to sign your name to a sign-in sheet at the registration desk, and we may call your name in the waiting room when we call you for your appointment.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Individuals Involved in Your Care or Payment for Your Care and Notification: If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

If you would like us to refrain from releasing your health information to a family member or friend who is involved in your care, you must make your request in writing and submit it to the Medical Records Manager of your local Texas Oncology office.

We may use or disclose your information to notify or assist in notifying a family member, personal representative, or any other person responsible for your care regarding your physical location within the Practice, general condition, or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status, and location.

We are also allowed to the extent permitted by applicable law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state, or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:
- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the identity, description, and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:
- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- Activities related to the quality, safety, or effectiveness of FDA-regulated products;
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement authorities to identify or apprehend an individual.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation, or banking of organs, eyes, or tissues.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the president and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing your health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.
- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.
- Sale of Your Health Information: We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information
You have the following rights regarding the health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment, or health care operations. **In most circumstances, we are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to your local Texas Oncology office. We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to your local Texas Oncology office. We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to your local Texas Oncology office. You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to your local Texas Oncology office.

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to your local Texas Oncology office. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact your local Texas Oncology office. You may also obtain a paper copy of this Notice at our website, www.TexasOncology.com

Changes to This Notice
We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the waiting area of your local Texas Oncology office. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, www.TexasOncology.com

Complaints
If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: **Texas Oncology at 1-888-864-ICAN (4226) and ask for the Privacy Officer**. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

Questions
If you have questions about this Notice, please contact **Texas Oncology at 1-888-864-ICAN (4226) and ask for the Privacy Officer**.