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HIPAA RELEASE OF INFORMATION

Patient name: _____ Date of birth: ____/___/_____

☐ I authorize the release of information including my diagnosis and records
☐ I authorize the release of claims information

The above information may be released to the following:

Spouse _____Phone Number _____

Significant other _____Phone Number _____

Child (ren) _____ Phone Number _____

Other _____ Phone Number _____

☐ I **DO NOT** authorize information to be released to anyone.

Phone Calls/Messages/E-Mail

Primary Phone #_____ Alternate Phone#_____

Email address: _____

If unable to reach me:

☐ you **MAY** leave a detailed message
☐ please leave a message asking me to return your call
☐ you **MAY NOT** leave a message

Advanced Directive: Yes or No Living Will: Yes or No
Medical Power of Attorney: Yes or No DNR: Yes or No

This release of information will remain in effect until terminated by me in writing.

Signature: _____ Date: ____/____/____

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Name: _____ Age: _____ Referred by: _____

Primary Care Physician: _____ Phone #:_____

Would you like today's visit sent to this provider? Yes or No Any other providers? _____

Reason for your visit today? _____

_____

Please circle if you are having any of the following issues and which breast:

(RT-Right Breast LT-Left Breast B-Both Breasts)

Nipple Discharge RT - LT - Both	Discomfort or Soreness RT - LT - Both	Injury to Breast RT - LT - Both Describe:
Breast Biopsy RT - LT - Both	Breast Implants RT - LT - Both	Previous Breast Surgery and Date Mastectomy - Lumpectomy - Lift Date:

Have you had imaging on the area of concern? Yes or No Where and when was it done:_____

Have you ever had genetic testing done? Yes or No Date and Result:_____

Are you Diabetic: Yes or No **Claustrophobic:** Yes or No

Pain level: 0 1 2 3 4 5 6 7 8 9 10 **- 0 being no pain and 10 being high pain**

Occupation: _____**Type of work:** _____**Work outside of the home?** Yes / No

Do you use any of the following:

Alcohol Yes / No What type? _____ How often? Rare Occasional Heavy

Tobacco Yes / No What type? _____ How often? _____ Packs per week? _____

Caffeine Yes / No What type? _____ How often? Rare Occasional Heavy

For Office Use Only

_____

_____

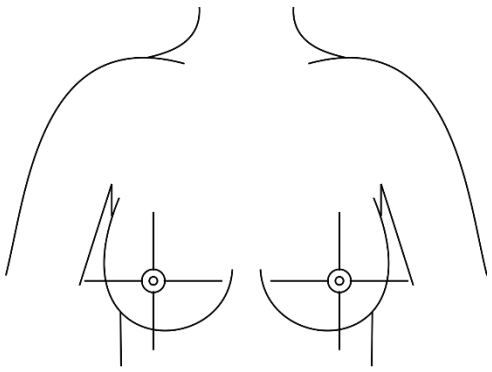
_____

_____

_____

Height: _____ Weight: _____

BP: _____ Pulse: _____



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FAMILY CANCER HISTORY

(**M**) Maternal – Mother (**P**) Paternal – Father – Include age of diagnosis for family member.

Family Member	Living Status	Age at Diagnosis	Type of Cancer	Family Member	Living Status	Age at Diagnosis	Type of Cancer
Mother	Living / Deceased			**Grandmother (P)**	Living / Deceased		
Father	Living / Deceased			**Grandfather (P)**	Living / Deceased		
Children	Living / Deceased			**Grandmother (M)**	Living / Deceased		
Sister	Living / Deceased			**Grandfather (M)**	Living / Deceased		
Sister	Living / Deceased			**Aunt (P)**	Living / Deceased		
Brother	Living / Deceased			**Aunt (M)**	Living / Deceased		
Brother	Living / Deceased			**Uncle (P)**	Living / Deceased		
Other: Cousin	Living / Deceased			**Uncle (M)**	Living / Deceased		

REPRODUCTIVE HISTORY

Number of pregnancies: _____ Number of children: _____ Age at first birth: _____

Did you breastfeed? **Yes / No** If yes, for how long? _____ Number of children breastfed? _____

Age at first period? _____ Age of menopause? _____ Last menstrual period? _____

Do you do self breast exams? **Yes / No** Hysterectomy? **Yes (total or partial) / No** Fertility treatments? **Yes / No**

Hormone use? **Yes / No** If yes, type and duration taken _____

Have you ever taken or are you currently taking birth control? **Yes / No** If yes, type and duration taken: _____

Preventative Health

Annual mammogram? **Yes / No** Last mammogram: _____ Last pap smear: _____

Last colonoscopy: _____ Last Bone Density_____

Last flu vaccine: _____ Pneumonia vaccine: _____ Shingles vaccine: _____

Annual physical: Yes or No Last prostate exam: _____ Last PSA screening: _____

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IF YOU ARE CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS, PLEASE LIST BELOW OR ATTACH AN UPDATED MEDICATION LIST.

Preferred Pharmacy: _____ **Phone #:** _____

Medication Name	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Allergies

Medication allergies and reaction: _____

_____

Any skin allergies/sensitivities (tape, adhesive, etc.)? _____

Additional Medical History / Other illness

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Surgery History

Previous Surgeries	Date Occurred
1.	
2.	
3.	
4.	
5.	

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Patient Name: _____ Date of Birth: _____/____/_____

Review of Systems – Check symptoms you curre ntly are having or have had in the past 3 months

BREAST	**ENDOCRINE**
☐ Breast cancer Right or Left ☐ Breast mass Right or Left ☐ Breast pain Right or Left ☐ Breast swelling Right or Left ☐ Nipple discharge Right or Left ☐ Nipple pain Right or Left	☐ Cold/Hot intolerance ☐ Libido changes ☐ Thyroid problems
GENERAL	**HEMATOLOGY**
☐ Chills ☐ Fatigue ☐ Fever ☐ Night sweats ☐ Weight gain (10 lbs.) ☐ Weight loss (10 lbs.)	☐ Abnormal bleeding ☐ Enlarged lymph nodes ☐ HIV or AIDS, Hepatitis A, B, or C
SKIN	**GASTROINTESTINAL**
☐ Bruising ☐ Rash ☐ Skin color changes	☐ Abdominal pain ☐ Change in bowel habits ☐ Nausea ☐ Vomiting
CARDIOVASCULAR	**MUSCULOSKELETAL**
☐ Chest pain ☐ Difficulty breathing ☐ Irregular heartbeat ☐ Pacemaker	☐ Muscle pain ☐ Bone pain ☐ Lymphedema

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made on this form.

Patient Signature: _____ Date: _____/_____/_____

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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 payors 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 manager may be viewable by designated 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 continue to receive services from Texas Oncology, unless revoked by me in writing. Such written notice will be provided to each practice site I attend or from which I received services.

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

Print Name: _____ DOB: _____/_____/_____

Today's Date: _____/_____/_____

Signature of patient/legally authorized representative: _____

Relationship to patient (if patient is 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: _____/_____/_____

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RELEASE OF MEDICAL RECORDS AUTHORIZATION

I, _____ give my authorization to:

- ◯ Pathology Department
- ◯ Dr. _____

to disclose my medical records to:

Texas Breast Specialists–Dallas
7777 Forest Lane, C-614
Dallas, Texas 75230
T: 972-566-7499 F: 972-566-6428

Please include the following information as follows:

- ◯ Mammogram and Sonogram Reports
- ◯ Pathology Reports
- ◯ Progress Notes
- ◯ Other: _____

For the purpose of:

- ◯ Insurance Change/Network Provider
- ◯ Second opinion
- ◯ Moving
- ◯ Continuation of Care
- ◯ Other: _____

- ✓ The patient has the right to revoke this consent in writing up to the time that records have been sent. This consent is valid for 30 days from the date of signature. I understand that there may be a fee for preparing this information.
- ✓ I hereby release Texas Breast Specialists for any/all legal liability that may arise from the release of this information to the party described above.
- ✓ Party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without a specific written consent from whom it pertains to, or those permitted by such regulations. Authorization for release of medical or other information is not sufficient for this purpose.

Patient's Printed Name: _____

Address: _____ City: _____ Zip Code: _____

Patient's D.O.B: _____/_____/_____ Home Phone: _____ Cell Phone: _____

Patient Signature: _____ Date: _____/_____/_____

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Patient name: _____ Date: _____/_____/_____

Why are we asking these questions? We ask about race and ethnicity as some groups are at a higher risk of developing certain diseases. This information is updated in your medical record and will remain confidential. If you wish to not answer the following questions, please initial below.

DECLINE _____

CIRCLE RACE:

African American Caucasian Chinese Hispanic

Japanese Korean Vietnamese

Other _____

The following questions are asked to provide your physician with the important medical information to help determine your best treatment plan.

- Would you consent to the use of blood products if medically necessary? YES or NO
- For genetic testing purposes, do you identify as an Ashkenazi Jew? YES or NO
  - Studies have shown 1 in 40 Ashkenazi Jewish women have a genetic mutation that can make them more susceptible to certain types of cancers.

CIRCLE PREFERRED LANGUAGE:

Our office has the capability to provide a translator via telephone while you are in the office, if necessary. Please provide your preferred language.

American Sign Language Arabic Chinese English German

Italian Korean Norwegian Portuguese Russian

Spanish Thai Vietnamese Other _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Breast Specialists is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights regarding your health information.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Breast Specialists OR have been offered a copy of the Notice.

Print Name: _____

Signature: _____

Date: _____ /_____ /_____

Print name of personal representative (if not patient):

_____

Signature of personal representative (if not patient):

_____

Date: _____ /_____ /_____

Office use only:

Date acknowledgement received: _____ /_____ /_____

-OR-

Reason acknowledgement was NOT obtained:

_____

_____

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USER ELECTRONIC MAIL AUTHORIZATION FORM PATIENT PORTAL: MY CARE PLUS

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health records. You, the patient, are in control of your portal record. We will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute the User Electronic Mail Authorization Form, you will not be able to access the portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password to access the portal. Please look for an email from "MY CARE PLUS" after submitting this form. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office to provide your new email contact information so that you will continue to receive updated and other pertinent information about the portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the portal, please contact your physician's office.

TERMS

You are receiving access to the Portal; the terms and conditions of the portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

Patient Name: _____ **Date of Birth:** _____/_____/_____

Email Address: _____ **Doctor's Name:** _____

Authorized user is: Patient Patient's Designee

Designee's Name (printed) _____

Patient's Signature: _____ Date: _____/_____/_____

Designee's Signature: _____ Date: _____/_____/_____

Signature of Office Staff: _____ Date: _____/_____/_____

(confirming user's identity and authority)

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person understands and agrees to use the listed email address for this purpose. Please make a copy for patient.

Staff use only: Email in PMS of IKM _____	MRN _____ IKM consent _____

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New option for you to view your health information

Why?

New Medicare requirement to give patients the option to view their information using a 3rd party application. This is in addition to our patient portal, My Care Plus.

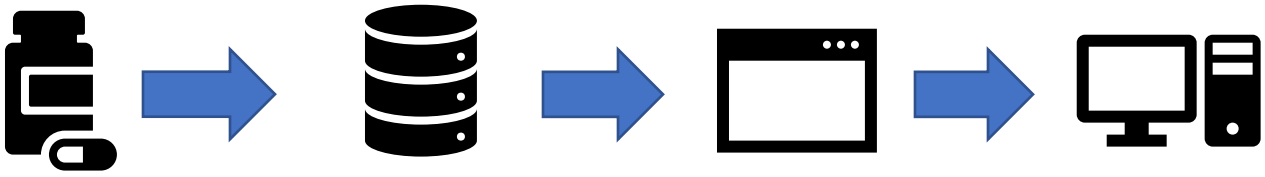
What is a 3rd party API?

An application you can access using a computer, phone, or tablet to view the health information in your chart. Depending on the type of app, you will be able to view information such as your diagnosis, lab results and medication lists. Some apps may be able to help you keep track of your medications. You may also be able to view information from your other doctor's in the same application.

Registration is open for patients as of 9/3/2019 as 3rd party applications become available they will be added to websites.

How does my health information get in the app?

You will be given instructions on how to set up your account and find apps that meet the requirements to connect with your medical record.



Information in your medical record

Interface (FHIR)

App of your choice that meets security and technical requirements.

Computer, phone or tablet dependent on application

When accessing, you will need to use Chrome as your browser to access the iKNOWMed API portal.

If you ever need assistance with your password, please email apiaccess@mckesson.com.

Please sign your name below, provide your date of birth and circle yes or no. If you are interested, you will be provided an access code.

Patient Name:_____ Date of Birth: _____/_____/_____

YES, I AM INTERESTED

NO, I AM NOT INTERESTED

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Texas Oncology and Texas Breast Specialists Patient Billing

What our patients and family 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. If you have primary and secondary insurance coverage, you need to contact both insurance plans to let them know about the other plan. Failure to do so could result in your insurance not paying for your medical services.

1. Patients will receive a cost estimate from a financial counselor upon request if the insurance does 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 an 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 also request an alternative billing address.
8. Patient billing statements will be mailed out every 30 days with a return envelope.
9. Patients under current treatment should inform the business office when admitted to a Skilled Nursing Facility.
10. A patient may request a patient ledger of billed charges and payments at any time.
11. Patients may pay balances online using www.texasoncology.com.
12. Checks received will be electronically processed.
13. Texas Oncology does not charge interest for amounts past due; however, the physician reserves the right to submit any unpaid accounts over 120 days to an outside collection agency.
14. Any patient balance over 60 days will receive a letter and/or phone call to either collect or to arrange a payment plan.
15. If a patient receives direct payment from an insurance company or a patient advocacy program specifically indicated as payment for services rendered, the physician reserves the right to submit the balance due to an outside collection's agency.
16. Any billing questions regarding oral medication are addressed by the pharmacists/pharmacy staff.
17. All Medicare beneficiaries are provided a copy of the Medical Oncology Model Beneficiary Notification.

Questions or complaints should be directed to your physician's business office at 972-566-7499.

_____ _____ Date: _____/_____/_____

Patient Name (print) Signature