Texas Oncology, P.A.
Surgical Specialists
214-826-9797 or 214-826-9873

In an effort to better help you understand your insurance benefits and introduce our office staff.

Practice Manager
Jan Pinkston

Physician Assistant
Jessica Howard, MPAS, PA-C

RN
Emily Brown

LVN
Sara Jasso

Medical Assistants
Melissa Cox-Bridgewater
Yesennia Baza

Insurance Coordinator

Our insurance coordinator will contact your insurance prior to a procedure being perform and obtain your benefits. She will check if pre-authorization is required for in or out patient procedures and obtain the authorization if require or a referral.

What to expect before Surgery

Before your surgery you will be contacted by your physician's assistant regarding any instructions prior to the surgery. You will also receive a phone call from our practice manager regarding your co-insurance or deductible. If your insurance deductible or co-insurance has not been met you will be expected to pay the required amount prior to your surgical procedure.

When do you need to alert us of a change?

- New insurance policies
- Any changes of benefits
- Transitioning to Cobra
- Termination
- New employment
- Retirement
- Medicare/Medicaid Eligible

Options for Paying your bill

Please note that all copayments and estimates for office visits, services provided in the office or surgeries are due at time of your visit or prior to your surgical procedure. ***We can only give a cost estimate prior to surgical procedures.*** In the event that you over paid on a surgical procedure you will be issued a refund. In the event that an additional amount is due by you after your insurance has processed the claims(s), the following payment options are available:

- Pay in person
- Call our office and make a payment by check or credit card
- Mail a check or credit card information to

  Texas Oncology, P.A.
  Lock Box 732175
  Dallas, TX 75391

- Go to www.texasoncology.com once on the website: click the "Patients" tab. On the left side, toward the bottom, click "Billing and Online Payment" Follow the instructions to make your payment.

I have read the follow information and agree to the terms and conditions of these policies set forth by Texas Oncology in regards to payment(s).

_____ _____

Patient signature Date

TEXAS ONCOLOGY

Assignment of Benefits and Financial Responsibilities

Patient Name: _____ (Last) _____ (First) _____ (M.I.) Date of Birth _____ Age _____

Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Home Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Mailing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Email Address: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

In 2009, Congress passed the HITECH Act to create uniformity among electronic health records. Asking for language ensures you and your healthcare providers will be able to communicate clearly. Race and ethnicity are asked because some groups are at a higher risk of developing certain diseases. This information will be in your medical record and will remain confidential. Options/Values were selected by HITECH Act and Texas State Tumor Registry.

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian/Indian/Pakistani/Sri Lankan ☐ Chamorran ☐ Chinese ☐ Fiji Islander ☐ Filipino ☐ Guamanian NOS ☐ Hawaiian ☐ Hmong ☐ Japanese ☐ Kampuchean / Cambodian ☐ Korean ☐ Laotian ☐ Melanesian NOS ☐ Micronesian NOS ☐ Native American ☐ New Guinean ☐ Other Asian, including Asian NOS and Oriental NOS ☐ Pacific Islander NOS ☐ Polynesian NOS ☐ Samoan ☐ Tahitian ☐ Thai ☐ Tongan ☐ Vietnamese ☐ Other _____

Preferred Language: ☐ English ☐ Spanish ☐ American Sign Language ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employer: _____

Responsible Party: _____ (Name) _____ (Relationship) (____) _____ (Telephone)

Emergency Contact/Spouse/Next of Kin: _____ (Name) _____ (Relationship) (____) _____ (Telephone)

Alternate Emergency Contact: _____ (Name) _____ (Relationship) (____) _____ (Telephone)

Referring Physician: _____ Phone # Primary Care Physician: _____ Phone #

Primary Insurance: _____ Telephone: (____) _____

Subscribers Name: _____ DOB: _____ Employer: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____ Telephone: (____) _____

Subscribers Name: _____ DOB: _____ Employer: _____

Policy Number: _____ Group Number: _____

Tertiary Insurance: _____ Telephone: (____) _____

Subscribers Name: _____ DOB: _____ Employer: _____

Policy Number: _____ Group Number: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Texas Oncology P.A.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Texas Oncology P.A. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Texas Oncology P.A.
4. I understand that I have the right to request and receive a Notice of Privacy Practices from Texas Oncology P.A.

Notice to Patients: By submitting your check for payment, you are authorizing Texas Oncology, PA, or its agent, upon receipt of your check to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to your account, in accordance with the same terms and conditions as your check.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ Patient Signature _____ Date/Time _____ AM or PM (*circle one*)

_____ Responsible Party Signature _____ Relationship _____ Date/Time _____ AM or PM (*circle one*)

PHYSICIAN:	ACCT #	LOC:	EMPLOYEE INITIALS:

CONFIDENTIALITY FORM

WHO REFERRED YOU TO OUR OFFICE?

□ Doctor/Address/phone_____

□ Friend_____

□ Other Source_____

*The "Texas Oncology- Surgical Oncology office @ Baylor Sammons Dallas /has my permission to send correspondence to the following **PHYSICIANS (MD's or D.O.'s only)** concerning my medical information:*

PHYSICIAN'S Full Name Specialty Address Phone

1. _____

2. _____

3. _____

*I give my permission allowing "Texas Oncology- Surgical Oncology office @ Baylor Sammons Dallas" to discuss my medical information with the **FOLLOWING INDIVIDUALS:***

Name Relationship Phone

1. _____

2. _____

3. _____

I give my permission to contact me via email regarding my medical information.

Email Address: _____

May we leave a voice message at the following locations?

Home ☐

Work ☐

Mobile ☐

_____ _____

Patient or Legal Guardian Signature Relationship

_____ _____

Printed Name Date

Texas Oncology, P.A.
Surgical Oncology
3410 Worth Street
Ste. 160
Dallas, Texas 75246
214-826-9797
Fax: 214-828-2089

Date: _____

NAME: _____

I give my permission for the Surgical Oncology office with Texas Oncology to check with my pharmacy concerning my medication history. _____ Yes _____No

Name of Pharmacy: _____

Address: _____ City _____ State ___ Zip ____

Phone: _____

Fax: _____

Patient Signature: _____

Patient: _____ No. _____

Date of Request: _____ Date of Birth: _____

Social Security Number: _____

To Whom It May Concern:
I hereby authorize: _____

to release to _____
Any medical, surgical, psychiatric and/or substance (drug or alcohol) abuse information on the above named patient for the following hospitalizations:

_____

_____

I also authorize you to furnish the above named party or parties, transcripts or photocopies of the medical records (written or verbal).

Information to be released:

_____ Outpatient Records
_____ Operative Reports
_____ History & Physical Exam
_____ Fact Sheet
_____ Pathology Reports
_____ Emergency Records
_____ X-Ray Reports and/or Film
_____ Consultations
_____ Psychological Evaluation
_____ Lab
_____ Discharge Summary
_____ EKG Interp.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this authorization expires automatically as described below. The purpose for which this information is being released is for medical care of patient.

This authorization will expire in one year from the date of my signature otherwise specified by date, event or condition as follows:

_____

Date: _____ Signed: _____

Time: _____ am/pm Witness: _____

Relationship to Patient: _____

Texas Oncology, P.A.
Surgical Oncology
3410 Worth St.
Ste. 160
Dallas, TX 75246

TEXAS ONCOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Oncology 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 with regard to your health information. **Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.**

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Oncology.

Name (Please Print): _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

(Texas Oncology) Use Only

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

_____

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

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

About Us

In this Notice, we use terms like "we," "us" or "our" 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 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 provide you notice of our legal duties and privacy practices with respect to your 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:

For Treatment: We may use your health information to provide you with medical treatment or services. For example, your health information will be disclosed to the oncology nurses 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 physician or another healthcare provider to be sure those parties 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.

With your permission, we may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities.

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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.

We may disclose your health information to a third party that performs services, such as billing and collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

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.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or e-mail you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

Fundraising Activities: We may use your demographic information, such as name, address and phone number, and the dates you received services from us, to contact you in an effort to raise money for the practice. We may also disclose this information to a foundation related to the practice so that the foundation may contact you to raise money for the practice. **If you do not want the practice or foundation to contact you for fundraising activities, please notify the practice.**

Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a family member or friend, please notify *[insert name/title and phone number of a department or person to contact]*.** We may also disclose your health information to disaster relief organizations so that your family can be notified about your condition, status and location.

We are also allowed by 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. Formatted: Bullets and Numbering

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 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, 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;
- To report adverse events, product defects or problems;
- To track FDA-regulated products;
- To notify people and enable product recalls; and
- 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.

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.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

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 for workers' compensation or similar programs. These programs 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 you 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 limited research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project, assesses a number of specific issues, and determines that appropriate privacy safeguards are in place to allow the use of health information in the research project. We may, however, disclose your health information to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the practice.

Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, 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 health information we maintain about you: Formatted: Bullets and Numbering

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. **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 practice.

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 practice. 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. Usually, this includes medical and billing records, but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. 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 practice. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.

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 practice.

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.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we make of your health information. Please note that certain disclosures, such as those made for treatment, payment or health care operations, 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. 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 practice. You may also obtain a paper copy of this Notice at our website, www.texasoncology.com.

Right to Complain: If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to your practice. You may also file a complaint with the Secretary of the Department of Health and Human Services.

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 patient areas. 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.