MOHC MEDICAL ONCOLOGY HEMATOLOGY CONSULTANTS, PA | The US Oncology Network

Patient Name: _____
Last First Middle Initial

/ / ❒ Male ❒ Female ❒ Transgender ❒ Other:
Birthdate Last four of SSN Gender Expression (Sex)

Relationship Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Long-term Commitment

Partner's Name: _____ Phone #: _____

United States Citizenship: ❒ Citizen ❒ Permanent Resident ❒ VISA ❒ Other: _____

Address: _____
Street City State Zip

Please list your mailing address here *if it is not the same as where you live*:

( ) | ( )
Preferred Phone #1 Type | Preferred Phone #2 Type

Email: _____

( )
Emergency Contact #1: Name Phone # Relationship

( )
Emergency Contact #2: Name Phone # Relationship

Do you have an Advance Directive (living will)? ❒ Yes ❒ No
Do you have a Power of Attorney for medical decisions? ❒ Yes ❒ No
* Please provide copies if you have either of these

Primary Care Physician_____ Phone #: _____
Whom may we thank for referring you to MOHC?

Primary Insurance:	Secondary Insurance:
ID#:	ID#:
Group#:	Group#:
Subscriber:	Subscriber:

*Pharmacy Name: _____ Phone #: _____
Prescription Drug Plan Name: _____
Drug Plan ID #: Phone #:

Patient or Representative Signature Date Relationship

MOHC has limited retail pharmacy services available for use with obtaining medications prescribed by MOHC providers. Our pharmacist is available for education about medications and to help determine your insurance coverage and copayment for the medication. *However, you are always able to use your pharmacy of your choice.

1. I understand that I am responsible for charges not covered or reimbursed by my insurance carrier. 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 MOHC. I also authorize agents of any hospital, treatment center or previous physician to furnish MOHC copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or report related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within MOHC.

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 MOHC. 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 MOHC.

4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with US Oncology.

Privacy Practice

MOHC, PA. 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 confirm that I have had the opportunity to, and have read, the privacy policy provided to me by MOHC.**

Who may we speak with or release information regarding your care?

_____ _____

Primary Spokesperson **Relationship**

_____ _____

Additional Spokesperson **Relationship**

Patient or Representative Signature: _____ **Date:**_____

PATIENT RIGHTS AND RESPONSIBILITIES

1. Receive an explanation of my diagnosis, benefits of treatment, alternatives, recuperation, risks and an explanation of consequences if treatment is not pursued.
2. An explanation of all services provided by MOHC, the days and hours of service and provisions for possible emergency care, including telephone numbers.
3. Participate in development of a plan of treatment.
4. Make known Advance Directives or a Living Will, if I wish.
5. Refuse participation in any protocol or aspect of care including investigational studies, and freely withdraw my previous given consent for further treatment.
6. Disclosure of any teaching programs, research or experimental programs in which the facility is participating.
7. Full financial explanation and payment schedule prior to beginning treatment.
8. Receive professional care without discrimination, regardless of race, creed, color, religion, national origin, sexual preference, handicap, sex or age.
9. Be treated with courtesy, dignity and respect of my personal privacy by all employees of MOHC
10. Complain or file grievances with representatives of MOHC without fear of retaliation or discrimination.
11. Confidential treatment of my condition, medical record and financial information.
12. Access to my personal records and obtain copies upon written request.

As a PATIENT, I have the RESPONSIBILITY to:

1. Disclose accurate and complete information related to physical condition, hospitalizations, medications, allergies, medical history and related items.
2. Assist in maintaining a safe, peaceful and efficient ambulatory environment.
3. Provide new/changed information related to my health insurance to the business office and be prepared to meet my agreed co-pay during my office visit.
4. Contact the office when unable to keep a scheduled appointment.
5. Cooperate in the planned care and treatment developed for me.
6. Request more detailed explanations for any aspect of service I don't understand.
7. Inform my physicians and nurses of any changes in my condition or any new problems or concerns.
8. Communicate any temporary or permanent change in my address or telephone number which might hinder contact by the office staff.

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NOTICE OF PRIVACY PRACTICES

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 **Medical Oncology Hematology Consultants, Inc (MOHC)**, its physicians, employees, staff and other personnel.

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 healthcare 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 during 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.

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.

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 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 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: Psychotherapy notes will only be disclosed with your written authorization except in limited situations involving the threat of harm to self or others. If you participate in psychotherapy services provided through our office you will be given a separate informed consent for that purpose.
- 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.

Right to Information: You have the right to request copies of your records.