Assignment of Benefits

Patient Name:______________________________________ **Date of Birth:**________________

Medicare Lifetime Assignment of Benefits

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

Patient/Guardian Signature:______________________________ Date: ______________________

Medigap (Medicare Supplemental Insurance) Assignment of Benefits

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

Medigap Insurance Name: ____

Patient/Guardian Signature:______________________________ Date: ______________________

General Assignment of Benefits

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

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

Patient/Guardian Signature:______________________________ Date: ______________________

Receipt of HIPAA Patient Privacy Rights Notification

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

Patient/Guardian Signature:______________________________ Date: ______________________

AOCancer.com

New Patient Packet

Patient Name (as it appears on Primary Insurance Card [include suffix]) ____________ Date of Birth ___/___/___

Address ____________ City ____________ State ____________ Zip Code ____________

Home Phone Number (   ) ____________ Cell Phone Number (   ) ____________ Social Security Number (optional) ____________

Email Address ____________

Sex: ☐ Male ☐ Female **Marital Status:** ☐ S ☐ M ☐ D ☐ W **Preferred Language:** ____________

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Do Not Want to Provide ☐ Do Not Know

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Middle Eastern

PHYSICIANS:

Primary Care Physician ____________ Phone Number (   ) ____________

Referring Physician ____________ Phone Number (   ) ____________

PHARMACY INFORMATION:

Pharmacy Name ____________ Location ____________

Phone Number (   ) ____________

Are you currently enrolled in any of the following:
Skilled Nursing Facility (SNF): ☐ Yes ☐ No **Convalescent Home:** ☐ Yes ☐ No **Hospice:** ☐ Yes ☐ No

Name of Facility ____________ Phone Number (   ) ____________

Address ____________ City ____________ State ____________ Zip Code ____________

Affiliated Oncologists
AOCancer.com

Advance Directives

Do you have any of the following Advance Directives?

	Yes	No
1. Medical Power of Attorney?	☐	☐
2. DNR?	☐	☐
3. Living Will?	☐	☐

If you have answered "yes" to any of the above, please bring a copy on your next visit so that we may update your records.

If you answered "no" to any of the above information, would you like an Advance Directives informational packet?

☐ Yes ☐ No

Patient Name: ______________________________

Patient Signature: ______________________________

Date: ____________________

Notice of Privacy Practices Form 2022

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or made available in the office.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving a written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

HIPAA Consent to Share Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communication or that communication be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Name:____ DOB:__________________

Please indicate your preferred method of contact:

☐ Home: (______)______________________________ May we leave a detailed message? ☐ Yes ☐ No

☐ Cell: (______)______________________________ May we leave a detailed message? ☐ Yes ☐ No

☐ Work: (______)______________________________ May we leave a detailed message? ☐ Yes ☐ No

I authorize Affiliated Oncologists, LLC to release my medical information to the person(s) listed below. I understand that the person(s) named on this authorization will be given access to obtain results/information on my behalf. I authorize the person(s) indicated to pick-up materials pertinent to my medical care:

Name	**Relationship to Patient**	**Phone Number**

Patient Signature:____ Date:____________________

In lieu of patient signature, I, ________________________, as a staff member of Affiliated Oncologists, LLC, state that________________ has been provided with current notice of privacy practices.

Staff Signature:____ Date:____________________

Affiliated Oncologists
AOCancer.com

HIPAA NOTICE OF PRIVACY PRACTICES
EFFECTIVE 7/1/2020

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.

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary or your health information, usually within 30 days or your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree with you request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C.20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the cases we never share information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Bill for your services

- We can use and share your health information to bill and get payment for health plans or other entities,

How else can we use or share your health information?

- We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court order or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security or your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and in our office.