

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Request for Confidential Communications**

Please indicate the methods of contact and appropriate numbers you authorize us to use in order to reach you: (check and complete all that apply)

<input type="checkbox"/> Home Phone Number _____	<input type="checkbox"/> Work Phone Number _____
<input type="checkbox"/> Cell Phone Number _____	<input type="checkbox"/> Fax Number _____
<input type="checkbox"/> Email Address _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> It is OK to leave a message at this number if I can't be reached _____	

**Emergency and HIPAA Contact Information**

In our effort to adhere to HIPAA guidelines, TCA needs your authorization to release information connected with your care to your family members, friends, or other designated persons. We also need to identify person's we may contact on your behalf in the event of an emergency. Please indicate your emergency contacts below and to whom we may release information.

- Do not discuss any of my confidential information with anyone other than myself.
- Release information to the following people as necessary:

Primary Emergency Contact Name: \_\_\_\_\_

Relationship to me: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Type of Information that TCA can provide to them: \_\_\_ Medical \_\_\_ Financial \_\_\_ Both \_\_\_ Neither

Secondary Emergency Contact Name: \_\_\_\_\_

Relationship to me: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Type of Information that TCA can provide to them: \_\_\_ Medical \_\_\_ Financial \_\_\_ Both \_\_\_ Neither

Name: \_\_\_\_\_ Relationship to me: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Type of Information that TCA can provide to them: \_\_\_ Medical \_\_\_ Financial \_\_\_ Both

Name: \_\_\_\_\_ Relationship to me: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Type of Information that TCA can provide to them: \_\_\_ Medical \_\_\_ Financial \_\_\_ Both

**Acknowledgement of Receipt of  
Notice of Privacy Practices and Consent for Professional Services**

I acknowledge that I have been presented with a copy of the Texas Cancer Associates Notice of Privacy Practices. I understand that it explains how my medical information will be used and disclosed as well as my rights pertaining to the use and disclosure of my health information.

I consent to treatment/services necessary for the care of my present medical condition. I authorize holder of medical or other information about me to release any information needed to determine benefits.

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### **Texas Cancer Associates Financial Policy**

1. Payment is due at the time of service unless arrangements have been made in advance by you or your insurance carrier. We accept cash, personal checks, Visa, MasterCard, and Discover.
2. As a service to you, Texas Cancer Associates will file your insurance claim if you assign the benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, you are responsible for payment.
3. Our practice has made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay any co-payment, co-insurance and/or deductible at the time of your visit. As dictated by the terms of our contracts with insurers, we cannot waive any of the above payments.
4. Secondary insurance filing will be determined on a case by case basis.
5. If you do not have insurance, payment arrangements must be made prior to service. If you first saw the Physician in the hospital, payment arrangements must be made immediately after hospital discharge.
6. Medicare: We accept assignment on Medicare claims. You are required to pay your 20% co-insurance and deductible at the time of service unless we have verified with Medicare that your deductible has been met.
7. Patient Responsibility: You will be billed for services designated by your insurance company as patient responsibility. Payment of your charges is ultimately your responsibility and you as the patient agree to comply with our policy.
8. If there are any changes to your insurance during or throughout the year, it is your responsibility to notify TCA.
9. I hereby assign, transfer and set over to Texas Cancer Associates my assignment of benefits for reimbursement of services rendered.

This consent will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for any charges not paid by said insurance carrier(s).

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Date

# TCA Health Questionnaire

Date completed: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
 Gender: \_\_ Male \_\_ Female  
 Referring Physician: \_\_\_\_\_  
 Other Physicians: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_  
 Race/Ethnicity: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_  
 (if different from Referring Physician)

**Primary reason for your visit:** \_\_\_\_\_

**Medical History**

<b>Have YOU ever been diagnosed with...</b>	<b>YES</b>	<b>NO</b>	<b>Year</b>	<b>Treatment</b>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney problems What type? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver problems What type? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Respiratory disease What type? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer What type? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Strokes/ TIAs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Clotting disorder/DVT	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Strokes/ TIAs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**Family History**

Is your Mother alive? \_\_ Yes \_\_ No  
 If not, what age was she when she died? \_\_\_\_  
 What did she die of? \_\_\_\_\_

Is your Father alive? \_\_ Yes \_\_ No  
 If not, what age was he when he died? \_\_\_\_  
 What did he die of? \_\_\_\_\_

How many siblings do you have? Brothers \_\_\_\_ Sisters \_\_\_\_  
 Significant Medical Problems for any of them? (please list) \_\_\_\_\_

**Hospitalizations, Prior Lab results, Biopsies, or Surgeries:**

<b>Recent Hospitalization? Yes/No</b>	<b>When</b>	<b>Where Performed?</b>
Last Laboratory results performed		
Blood		
Urine		
Recent Biopsy? Yes/No		
Prior Surgeries (please list)		
1. _____		
2. _____		
3. _____		

Date of Last Chest X-ray: \_\_\_\_\_  
 Date of Last Colonoscopy: \_\_\_\_\_  
 Date of Last Mammogram: \_\_\_\_\_

Where Performed? \_\_\_\_\_  
 Where Performed? \_\_\_\_\_  
 Where Performed? \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Do you have any Allergies to Medications? (Circle)**

**No(skip next section)      Yes (please list)**

Medication	Type of Reaction	Approximate Date of Reaction
1. _____	_____	_____
2. _____	_____	_____

**Medications: Please list all prescription and non-prescription medicines including, vitamins, supplements, herbs, and aspirin.**

	<u>Name</u>	<u>Dose/Strength</u>	<u>Frequency</u>
Example	Lasix	40 mg	2 in AM / 1 in PM
1.	_____	_____	_____ / _____
2.	_____	_____	_____ / _____
3.	_____	_____	_____ / _____
4.	_____	_____	_____ / _____
5.	_____	_____	_____ / _____
6.	_____	_____	_____ / _____
7.	_____	_____	_____ / _____
8.	_____	_____	_____ / _____

**Social History**

Marital Status:      Married      Separated      Divorced      Widowed      Single  
 Number of Children: \_\_\_\_\_ With Whom do you live? \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Retired?  Yes  No

Have you ever smoked?

Never \_\_\_\_\_  
 Yes, but I quit YEAR \_\_\_\_\_ # of packs per day when you smoked \_\_\_\_\_  
 Yes, active since YEAR \_\_\_\_\_ # of packs per day currently \_\_\_\_\_

Do you drink alcohol?

Never \_\_\_\_\_  
 Yes, but I quit YEAR \_\_\_\_\_  
 Yes, # of drinks/glasses per week \_\_\_\_\_

Have you worked with or been exposed to any Hazardous Chemicals?  Yes  No

**For Women Only**

How old were you when you started having Menstrual cycles? \_\_\_\_\_ Are you still having periods? Y/N  
 How many times pregnant? \_\_\_\_\_ Number of live births? \_\_\_\_\_ Age at first delivery? \_\_\_\_\_  
 Have you had a Hysterectomy? (Uterus removed)  Yes  No When? \_\_\_\_\_  
 Have your Ovaries been removed?  Yes  No When? \_\_\_\_\_  
 Are you currently taking Birth control Pills? Y/N Have you taken birth control pills in the past? Y/N  
 Are you currently taking Hormones? Y/N Have you taken Hormones in the past? Y/N How long?

## Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**HIV/AIDS:** I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The information you may release subject to this signed release form is as follows:**

- Complete Records     History & Physical     Progress Notes     Care Plan
- Lab Reports     Radiology Reports     Pathology Reports     Treatment Record
- Operative Reports     Hospital Reports     Medication Record     Other (please specify below)

**Release my protected health information to the following physician/person/facility/entity:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**The purpose/reason for this release of information is as follows:**

**I understand that Texas Cancer Associates will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.**

**Signature:**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Patient Date of Birth or Social Security Number

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

# Notice of Privacy Practices

This Notice describes how information about you may be use and/or disclosed as well as how you may gain access to this information. Please review it carefully.

## Introduction

In this Notice, we use terms such as “we”, “us” and “our” to refer to Texas Cancer Associates, its physicians, employees, staff and other personnel. All of the sites and locations of Texas Cancer Associates follow the terms of this Notice and may share health information with each other for treatment, payment or healthcare operations purposes as described in this Notice.

## Purpose of this Notice

At Texas Cancer Associates, we are committed to protecting your privacy and ensuring that your health information is not used inappropriately. This Notice describes the personal information we collect as well as how and when we may use and/or disclose your health information to carry out treatment, payment or healthcare 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 describes your rights as they relate to your health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

## Understanding Your Health Information

Each time you visit Texas Cancer Associates a record of your visit is made. Typically, this record contains your symptoms, physical examination, lab and diagnostic test results, diagnosis, current treatment and a plan for future care or treatment. In addition to medical information, the record also contains demographic information such as your address and telephone number as well as billing information such as insurance information and billing records. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating heath professionals
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
- A source of data for medical research
- A source of data for our planning and marketing
- A source of information for public health officials charged with improving the health of this state and the nation
- Legal document describing the care you received

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Make more informed decisions when authorizing disclosure to others
- Better understand who, what, when, where, and why others may access your health information

## Your Health Information Rights

Although your health record is the physical property of Texas Cancer Associates the information belongs to you. You have the right:

*To Obtain a Paper Copy of This Notice:* You have the right to a paper copy of this Notice at any time. A copy may be obtained from our receptionist. We are obligated by federal regulations to obtain your signature documenting your receipt of this Notice.

*To Inspect and Copy:* You have the right to inspect and copy your health information. 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. If you request a copy of your health information, we are permitted by state law to charge a fee for the costs of copying, mailing or preparing the requested documents. 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 our Privacy Officer.

Texas law requires us to provide copies or a denial of access within 15 days of your request. We may only deny your request to inspect and copy your health information under very limited circumstances. If you are denied access to your health information you may request that the denial be reviewed by a licensed healthcare 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.

*To Amend:* You may request that we amend your health information if you feel that it is incorrect or incomplete. We must respond to your request within 60 days of your request. We may deny your request for an amendment for the following reasons:

- The information in question was not created by this practice or the physicians in this practice
- The information in question is not part of the medical record
- The information in question is accurate and complete

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 to be placed in the medical record. To request an amendment you must make your request in writing by filling out the appropriate form provided by us and submitting it to our Privacy Officer.

*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 disclosures made for treatment, payment or healthcare operations will not be included in the accounting we provide to you. Your request must state a time period that may not exceed six years and cannot include dates prior to April 14, 2003. The first accounting of disclosures within a 12-month period will be free. We are permitted by federal regulations to charge for subsequent requests. 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 our Privacy Officer.

*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. We will attempt to accommodate all reasonable requests. To request confidential communications you must make your request in writing and submit it to our Privacy Officer.

*To Request Restrictions:* You have the right to request restrictions on how we use and disclose your health information for treatment, payment or healthcare 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 our Privacy Officer.

*To Revoke Your Authorization:* Uses and disclosures of your health information not covered by the Notice or the laws that apply to us will be made only with your authorization. You may revoke an authorization at any time in writing. If you revoke your authorization we will no longer use or disclose your health information as specified by the revoked authorization as of the date the revocation is received and processed. To request a revocation, you must make your request in writing and submit it to our Privacy Officer.

*To Complain:* If you believe your privacy rights have been violated, you may file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

## **Our Responsibilities**

Texas Cancer Associates is required to:

- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this Notice
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Notify you if we are unable to agree to a requested restriction
- Maintain the privacy of your health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we currently maintain as well as any health information we receive in the future. If our privacy practices change we will post statement that the Notice has been updated and that a copy is available on request.

## **Examples of How We May Use and/or Disclosures Your Health Information**

### ***We will use your health information for treatment.***

**For example:** We may use and disclose your health information in order to provide you with medical treatment or services. Information obtained by a physician, physician assistant, nurse practitioner, nurse, medical assistant or other member of your healthcare team will be recorded in your record. This information, as well as information supplied by you and other physicians, will be used to determine our recommended treatment plan. Your physician will document the appropriate medical information, observations and medical orders in your record. In addition, members of your health care team will record the actions they took and their observations (this includes documenting vital signs, treatments given and lab results). In this way, your physician will be aware of each visit to our office.

We will provide copies of your medical records to physicians outside of our office if the physician is directly involved with your care and treatment or if you are in an emergent medical situation.

We may discuss your health information with another physician for the purpose of consultation. We may also disclose necessary health information to pharmacies in order to facilitate prescription refills and to call in prescribed medication.

**For the purposes of community support the infusion areas are open and/or semi-private areas. You may request a private area in which to receive your treatment if you so desire.**

***We will use your health information for payment.***

**For example:** We may use and disclose your health information in order to receive payment for services rendered. A bill may be sent to you, your insurance company or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We may disclose your health information to pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for services rendered.

***We will use your health information for regular healthcare operations.***

**For example:** We may use and disclose your health information in order to support our day-to-day business activities. Members of the medical staff, process improvement committee members or members of the management team may use information in your medical record to evaluate and promote quality, to assess the care and outcomes in your case and others like it and/or to support budgeting and financial reporting. We may also use or disclose your health information for training of medical students, for necessary credentialing and for other essential business activities.

We may ask you to sign your name to a sign-in sheet at the reception desk and we may call your name in the waiting room.

***Business associates:*** We may disclose your health information to a third party that performs services on our behalf (business associate). In these cases, we will enter into a written agreement with the third party to ensure the protection and 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.

***Treatment Alternatives and Health Related Benefits and Services:*** We may use and disclose your health information in order 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, to supply product information or to inform you of a new patient assistance program that may be available to you.

We may **NOT** provide your name or other demographic information (such as name, address, phone number and dates of services rendered) to persons outside of our employment or to non-business associates for such services or programs without your prior authorization.

***Persons Involved in Your Care or Payment for Your Care:*** We may release your health information to a family member or friend who is involved in your medical care or who helps pay for your care **ONLY** if you have given us authorization to do so. You will be asked to complete a form documenting who we are authorized to speak to and what information we are permitted to discuss.

***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.

*Judicial and Administrative Proceedings:* We may disclose your health information in response to a court or administrative order if you are involved in a legal proceeding. 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 inform you of the request and/or to obtain an order protecting the information requested.

*Law Enforcement:* We may disclose your health information to law enforcement officials for many 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
- To report a crime, the location of a crime and the identity, description and location of the individual who committed the crime
- To report the victim of a crime, if unable to obtain the victim's agreement
- To report a death we suspect may have resulted from criminal conduct
- To report criminal conduct we believe in good faith to have occurred on our premises

*Correctional Institution/Inmate:* Should you be an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the institution, agents thereof or law enforcement officials to assist them in providing you care, protecting your health and safety and the safety of others as well as for the safety of the institution.

*Victims of Abuse, Neglect or Domestic Violence:* We may disclose your health information to the appropriate government agency if we believe you have been the victim of abuse, neglect or domestic violence. Texas law requires us to report child abuse or neglect. Texas law also requires us to report abuse, neglect or exploitation of the elderly and disabled. If we suspect abuse, neglect or domestic violence and are not permitted by law to report the suspicion we will only make this disclosure if you allow us to do so.

*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 disclose your health information to someone able to help prevent the threat.

*Public Health:* We may use and disclose your health information for public health activities. Federal, state or local government mandates public health activities for many different purposes:

- To prevent or control disease, injury or disability
- To report disease reports to the tumor registry
- To report births or deaths
- To report adverse events and/or product defects or problems
- To report child abuse or neglect
- To track FDA regulated products
- To notify people and enable product recalls
- 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

*Health Oversight Activities:* We may use and disclose your health information to health oversight agencies for activities authorized by law. Examples of these activities include audits, investigations licensure applications and inspections. These oversight activities are necessary for the government to monitor the healthcare system, government benefit programs, and compliance with government regulatory programs and/or civil rights laws.

*Workers Compensation:* We may disclose your health information for workers compensation or similar programs; these programs provide benefits for work-related injuries or illness.

*Organ Procurement Organizations:* If you are an organ donor we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of donation and transplant.

*Coroners, Medical Examiners and Funeral directors:* We may use and disclose your health information to a coroner, medical examiner or funeral director.

*Research:* We may use and disclose your health information for certain limited research purposes. All research projects 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. However, we may 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:* Uses and disclosures of your health information not covered by the Notice or the laws that apply to us will be made only with your authorization. You may revoke an authorization at any time in writing. If you revoke your authorization we will no longer use or disclose your health information as specified by the revoked authorization as of the date the revocation is received and processed. To request a revocation, you must make your request in writing and submit it to our Privacy Officer.

## **Questions and Contact Information**

If have questions and would like additional information or to execute any of your rights regarding your health information, please contact our Privacy Officer:

Christy Barrett  
8440 Walnut Hill Lane, Suite 600  
Dallas, Texas 75231  
Phone: 214-739-1706  
Fax: 214-368-0056

