Oncology Consultants
Overcoming Cancer.™

## Patient Authorization to Use or Disclose Protected Health Information

**Patient Name:** ______________________ **Date of Birth:** ______________________

I authorize the use or disclosure of the above named individual's health information as described below.
The following individual or entity is authorized to make the disclosure:

______________________ ______________________

Name Address

______________________

The type and amount of information to be used or disclosed is as follows:

For dates of ______________ to ______________

- ○ Physician Progress Notes
- ○ Nurse Progress Notes
- ○ Radiology Reports/Films
- ○ Consults
- ○ Laboratory/Diagnostic Results
- ○ Entire Medical Record
- ○ Other: ______________________

I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or entity:

Name: Oncology Consultants

Address: ______________________ Telephone #: ______________

______________________ Fax #: ______________

For the purpose of: Continued Care

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Oncology Consultants. I understand that the revocation will not apply to information that has already been used or released in reliance upon this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ______________________
If I fail to specify an expiration date, event or condition, **this authorization will expire in one year from the date of signature.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that if I refuse to sign this authorization, Oncology Consultants, P. A. cannot refuse to provide, or condition the provision of treatment to me. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Oncology Consultants, P. A. Compliance Officer at 713-800-0660. I understand that I have the right to receive a copy of this authorization.

______________________ ______________________

Signature of Patient or Legal Representative Date

______________________

Relationship to Patient (if Legal Representative)

Release of Protected Health Information

Please list below name(s), relationship and contact information for any person(s), example: relatives, caregivers, friends, etc., you want to be able to receive protected health information about you. This will enable our staff to communicate with persons involved in your health care.

Patient Name: ______________________________ Date: ____________________
(Please print)

This information will be stored in your file. If you wish to add someone or take someone off your list, please let our staff know.

| Name | Relationship | Contact Information Telephone/Cell Phone | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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# Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Oncology Consultants, P. A. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that Oncology Consultants, P. A., its agents, employees and contractors may use and disclose my health care information for these and other treatment, payment and health care operations.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Oncology Consultants, P. A. reserves the right to change its notice and practices. Oncology Consultants, P.A. will provide each patient with a copy of the revision of its notice and practices at the time of the patient's next visit, or mail a copy to the patient at their last known address if there is a need to use or disclose any protected health information of the patient. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Oncology Consultants, P. A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions for the use or disclosure of my health information:

________________________________________________

________________________________________________

________________________________________________

**I fully understand and accept / decline (CIRCLE ONE) the terms of this consent.**

| ____________________________ | ________________ |
|---|---|
| Printed Name of the Patient/Legal Representative | Relationship to Patient |
| Patient's Signature | Date |

Reason for Patient Refusal to Sign: ______________________________

________________________

Witness/Date for Refusal

V2.8-26-11

## Oncology Consultants, P.A.

## Financial Policy

Oncology Consultants, P.A. is committed to providing the highest level of medical care and service to our patients. In order for us to maintain the highest level of care and service to our patients, it is necessary for us to have the following financial policies. Please read this policy carefully and do not hesitate to ask a member of our team if you have any questions.

It is understood that treatment of cancer and blood disorders is costly. You will be responsible to assist Oncology Consultants in working with your insurance company as well as making time payments that are identified as your responsibility.

Please be prepared to present your current insurance card(s) and driver's license at your initial visit and periodically throughout your time at our clinic(s).

- It is your responsibility to supply all current insurance and demographic information.
- Failure to properly inform us of any insurance changes will result in the patient being responsible for any resulting unpaid balances.
- Please note that while Oncology Consultants continually verifies your insurance benefits, verification of benefits is not a guarantee of payment.

It is your responsibility to understand the terms and conditions of your (or the insured) insurance coverage including in-network/out-of-network, co-payment and co-insurance responsibilities, benefit maximums, and non-covered services.

- It is understood that your insurance company may not pay for the total bill for the care received.
- If your insurance requires a referral, you are expected to be responsible for obtaining them unless we tell you otherwise.
- Your visit may need to be rescheduled if there is not a proper referral at the time of your visit, as we are unable to get referrals after you have been seen.

**Assignment of Medical Benefits:** I authorize Oncology Consultants to file my medical claims to my insurance and release any medical information necessary to process those claims. I authorize payment of medical benefits to Oncology Consultants for the services rendered.

In the event that my insurance company denies payment to Oncology Consultants, P.A., or no insurance coverage is available to me, I agree that I will assume responsibility for payment of my account.

- Payment for services is due at the time of your visit. This may include co-payments, co-insurance, deductibles, and amounts for services that may not be covered by your insurance company.
- Oncology Consultants may ask for a deposit if you have a high deductible or do not have health insurance.
- Should you not fulfill your financial obligations at the time service is rendered, your services may be rescheduled as medically appropriate to allow you to make necessary financial arrangements.
- Oncology Consultants accepts cash, personal checks, and all major credit cards.
- There will be a $35.00 service charge for all returned checks. Future appointments will require cash payments
- Please be aware that our physicians and clinical staff do not discuss financial matters.
- Our financial counselors are trained to discuss these matters and will be happy to assist you. The primary contact for addressing financial matters is 713-275-3219 or finco@oncologyconsultants.com.

I have read and understand the Patient Financial Policy of Oncology Consultants, P.A. and agree to all of the terms stated herein.

______________________________
Full Name (please print)

______________________________ ____________________
Signature of Patient Date

V2.8-29-2011
V4.9-13-2011, v5.9-22-11

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## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Oncology Consultants' Notice of Privacy and Information Practices.

______________________________________________ ____________________

Signature of patient or personal representative Date

______________________________________________

If signed by personal representative, relationship to patient

**Submit Form to Oncology Consultants**

**Office Use Only:**

Our organization has made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy and Information Practices provided to the individual named below.

Patient Name: ______________________________________________

- o Refused to sign
- o Physically unable to sign

Other:______________________________________________

______________________________________________

______________________________________________

______________________________________________

Employee Signature: ______________________________ Date: ____________________

V I 4.27.2011

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# Advance Directives Survey

**For All Oncology Consultants Patients**

## WHAT ARE ADVANCE DIRECTIVES?

Advance Directives are legal documents that afford patients the opportunity to exercise their right to make determinations regarding their medical care in advance in the event they become incapable of active participation in health care decisions. Through these documents, individuals can make decisions and communicate their wishes to their healthcare providers and loved ones.

NOTE: In the state of Texas you do not need a lawyer to complete your advance directives. However, you should be aware that each state has its own laws for creating advance directives.

## TYPES OF ADVANCE DIRECTIVES

**Living Will (also known as Directive to Physicians)**:
A legal document that lets patients state their wishes about medical care in the event that they develop a terminal or irreversible condition and can no longer make their medical decisions. The Directive becomes effective when the attending physician certifies that the patient has a terminal or irreversible condition.

**Texas Medical Power of Attorney**:
A document signed by a competent adult, i.e., "principal," designating a person that the principal trusts to make health care decisions on the principal's behalf should the principal be unable to make such decisions. The individual chosen to act on the principal's behalf is referred to as an "agent."

## ADVANCE HEALTHCARE DIRECTIVE DECISION OPTIONS

TO BE COMPLETED BY PATIENT

**Please check the appropriate box(es):**

1. I have an advance health care directives:
   ____A current copy of my advance health care directives has been given to Oncology Consultants
   ____ A current copy of my advance health care directives has not been given to Oncology Consultants. I understand that it is my responsibility to provide Oncology Consultants a copy of my care directives.

2. I **do not** have advance directives. I understand that I can ask for more help and information about advance directives. NOTE: We can provide you with a free packet containing these forms)
   ____ I'm not sure what advance directives are—I would like to have someone contact me later to discuss
   ____I would like to request a free copy of the Texas Advance Directives Packet
   ____ I don't have advance directives at this time. But I will complete and sign the one I received today and will bring back on my next visit.

3. ____ **I DON'T** have advance directives and I prefer **NOT** to receive informational material at this time.

Patient Name: ______________________________ Date: ______________
(Please Print)

We need your assistance!

In order to properly communicate with the physicians that are involved with your care please complete accordingly

Patient Name ______________________________

Primary Care Doctor: ______________________________ Phone Number: ____________________

Other Physicians that are involved in your care:

Physicians Name: ______________________________ Phone Number: ____________________

Physicians Name: ______________________________ Phone Number: ____________________

Physicians Name: ______________________________ Phone Number: ____________________

PHARMACY CONTACT INFORMATION

Pharmacy Name: ______________________________ Phone Number: ____________________

Address: ______________________________ Fax Number: ____________________

**Patient Authorization for Greater Houston Healthconnect**

____________________[NAME OF PARTICIPANT] participates in Healthconnect, a non-profit organization that provides a secured electronic network for Healthconnect participants, including doctors' offices, hospitals, labs, pharmacies, radiology centers and payers of health claims such as health insurers to share your protected health information. ("PHI") A list of current Healthconnect participants is available at www.ghhconnect.org. When you join Healthconnect, your doctors can electronically search all Healthconnect participants for your PHI and use it while treating you. Healthconnect does not change who gets to see your information—it allows your information to be shared in a new way. All Healthconnect participants must protect your privacy in accordance with state and federal laws.

Your treatment and eligibility for benefits will not be affected in any way should you choose not to join Healthconnect.

By signing this Authorization, you agree that Healthconnect and its current and future participants may use and disclose your protected health information electronically through Healthconnect **for the limited purposes of treatment, payment and health care operations**. You understand that Healthconnect may connect to other health information exchanges in Texas and across the country that also must protect your privacy in accordance with state and federal laws, and you authorize Healthconnect to share your information with those exchanges for the same limited purposes.

Your health information that may be shared through Healthconnect includes:

- Diagnosis (disease or problem)
- Clinical summaries of treatment and copies of documents in your medical record
- Results of lab tests, x-rays and other test
- Medication (current and in the past)
- Personal information such as name, address, telephone number, gender, ethnicity and age
- Names of providers and dates of services
- Alcohol, drug abuse, mental and behavioral health treatment
- HIV/Acquired Immune Deficiency Syndrome (AIDS) test results and treatment
- Hepatitis B or C test results and treatment
- Genetic test results and treatment
- Genome information, if provided
- Family medical history, if provided

This authorization remains in effect unless and until you revoke it. You can revoke this authorization at any time by giving written notice to any healthcare provider who participates in Healthconnect. Your revocation will be effective within three (3) days. You understand that revoking this authorization does not impact PHI previously shared when your authorization was in effect.

Patient Name:______________________________________________

Signature of Authorized Person:______________________________ Date: ______________

Name (if different from Patient):____________________ Relationship to Patient: ______________

Initial here if you do NOT want your providers to see your records through Healthconnect. _____

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# patient **FAQs**

**What is an HIE?**
A health information exchange is a network of electronic health records designed to link all providers in a specific region. With this network your patient information moves electronically between the physicians, hospitals, labs and pharmacies that you visit.

**Who is able to see my health information?**
Only members of your health team will have access to your information in the health information exchange. This may include doctors, nurses, medical assistants, pharmacist and other clinical staff involved in your care.

**How can I find out if my doctor or local hospital is taking part in Healthconnect's network?**
Visit our Connected Providers page online at www.ghhconnect.org/connectedproviders to see a full list of participating provider. New providers are joining the system all the time.

**What if I receive care at a health care organization that is not participating in Healthconnect's network?**
Only providers participating in Healthconnect's health information exchange can access and update your HIE records. However, Healthconnect's goal is to have all providers in the Greater Houston area connected in the future.

**Do I need to do anything to participate in the regional health information exchange? Is there a fee?**
If your provider is already connected to the health information exchange then you will have the option to "opt-in" during your office visit. Patients will complete the "opt-in" process by signing a form in their provider's office. There is no fee for patients to participate in the HIE.

**What if I change my mind about participating in the HIE?**
If at anytime you change your mind about participating in the health information exchange you can "opt-out." Opting-out will prevent providers from accessing records outside of their office with the Healthconnect network. Patients may opt-out by signing an opt-out form (available online at ghhconnect.org) with their providers.