Virginia Oncology Care, PC

405 Chatham Heights Road • Fredericksburg, VA 22405
Phone: (540) 300-6182 • Fax: (540) 301-2294

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent changes and modifications, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and care among multiple providers
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications
- Provide information to referring physicians or other medical professionals providing treatment

I have received and reviewed Virginia Oncology Care, PC (VOC) NOTICE OF INFORMATION PRACTICES which contains a more complete description of the uses and disclosures of my health information. I understand that Virginia Oncology Care, PC has the right to change its NOTICE OF INFORMATION PRACTICES from time to time and that I may contact them at any time to obtain a current copy. I understand that I have the right to revoke this authorization in the future. In order to be effective, the request must be in writing and will take effect when both the patient and the practice have signed the revocation. The revocation must include the patient's name, address, phone number, patient signature, date the revocation submitted, and reason for the request.

This authorization permits Virginia Oncology Care, PC to discuss my Personal Health Information (PHI) to ONLY those individuals I have listed below (VOC **cannot** discuss your PHI with anyone not listed below):

☐ Spouse ______________________________ ☐ Mother_________________________________

☐ Father ______________________________ ☐ Adult Children ____________________________

☐ Other _______________________________ ☐ Other ___________________________________

I may elect to have this authorization expire on a date I specify in the future. The date I have entered below represents the date I wish this authorization to expire:

☐ Check box to the left if you do not wish this authorization to expire; however, I may notify the practice in writing at a future time with an expiration date.

DATE OF AUTHORIZATION EXPIRATION:________/ ______/ ______

I fully understand and accept the terms of this authorization. I understand when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

NAME (print): ____________________________________ DOB:_______________ DATE: _____________________

SIGNATURE OF PATIENT OR GUARDIAN: _____________________________________

OFFICE USE ONLY

Date Received: ______________________________ By: ___________________________________

** Patient declined to sign the Authorization Form for the following reason: ________________________________

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PATIENT REGISTRATION FORM

Patient's Name____ Social Security #__________________
Last First Middle Initial

Reason for Visit_____________________________________Referring MD_____________Primary MD_____________

Date of Birth______________Age_________ Marital Status_____________Home Phone #__Cell Phone # ____________

Ethnicity:____________________Race:____________________Primary Language: _________________

Preferred Pharmacy____________________Pharmacy Address ____

Home Address____E-mail Address ___________________

Mailing Address (if different from above) ____

Employer____Occupation ______________________________

Work Address____Work Phone #_________________

Spouse's Name_________________________________Date of Birth__________Phone # _________________________

Emergency Contact____________________Relationship_____________________Phone # ______________________

INSURANCE INFORMATION

PRIMARY____
Name of Insurance Co. Subscriber # Group # Relationship to Insured

SECONDARY____
Name of Insurance Co. Subscriber # Group # Relationship to Insured

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO OBTAIN OR RELEASE PATIENT INFORMATION: I hereby authorize the physician's office to release such information as may be necessary for claims to the insurance companies listed above. I also hereby authorize payment directly to Virginia Oncology Care,PC for any benefits otherwise payable to me, but not to exceed the regular charges for this period. I understand that I am financially responsible to the above physicians for charges not covered by this assignment. Patients not covered by insurance are responsible at the time of service for charges incurred or arrangements for payment must be made with the business office. I also authorize the physician's office to release or obtain such information as may be necessary to assist in my medical treatment, as well as obtain prescription history via electronic RX database. This form will be placed in your chart and be applicable until such information is changed. If this account is turned over to an attorney or collection agency for collection services, the undersigned agrees to pay all costs of collections, inclusive of 29% in collection agency fees, interest at 18% per annum, court costs, and any additional costs associated with collection of outstanding balances to Virginia Oncology Care, PC.

Signature:____ Date: _______________________________

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Patient Financial Responsibility Form

By my signature below, I am entering into an agreement with Virginia Oncology Care, PC, as follows:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician and is not a substitute for payment. Some companies pay fixed allowances for certain procedures; others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or other balance not paid for by your insurance company.

IN ORDER TO CONTROL YOUR COSTS OF BILLING, WE REQUEST PAYMENT AT THE TIME OF SERVICE. If this account is assigned to collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees, cost of collections and/or collection agency fees, to which may be added pre-judgment and/or post-judgment interest at the current legal rate. Ninety (90) days after date of service, any unpaid amounts will be assessed later payment charges of 0.5% monthly.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of the pertinent portion of the patient's record. I hereby assign all medical and/or surgical benefits under the terms of my insurance payable to: Virginia Oncology Care, P.C.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I authorize Virginia Oncology Care, P.C. to release information regarding my medical condition and treatment to my insurance company, attorney, employer, and/or any other health care professional involved in my medical care.

I authorize Virginia Oncology Care, P.C., or their representative to take clinical photographs of me to be kept as part of my medical record.

Patient Signature:___________________________________ Date: ______________________________

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REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

PATIENT NAME: ______________________ DOB: ____________________________ DAYTIME PHONE: ___________________	SSN: __________________ Relationship to Patient: ________________________________ Requestor's Name (if not patient): _______________________

Reason for Request: ☐ Continuing Care ☐ Moving ☐ Legal ☐ Other ________________

Release Information To: Organization/Name: ____
Address: ____
Phone/Fax: ____

RECORDS REQUESTED (Charges for copies of records may be associated with your request)

☐ Health information related to condition: ___________________________________
☐ Records associated with date range: _______________________________________
☐ Office notes
☐ Pathology report, labs, imaging results
☐ Other: ____

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the practice. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express written revocation, the authorization will automatically expire upon initial release of medical records, unless indicated differently below.

This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure
of the above information to the extent indicated and authorized herein.

Signature:___________________________________ **Date:**__________________

If signature is different from patient, please note authority to sign:
☐ POA ☐ Administrator for Deceased ☐ Parent of Minor
(Note: POA and Administrator for Deceased will require authenticating documentation prior to release of records)

Office Use Only:

Identification Verified by: ☐ Driver's License ☐ Picture ID Fee: $___________ Released by: _______________________

Records Sent Via: ☐ US Mail ☐ Fax ☐ Pickup by Patient ☐ Other______________ Date: _______________________

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HEALTH HISTORY FORM

(All information will remain confidential)

Name____Today's Date ______________________

Age_______________Date of Birth______________ Sex ________________

Reason for Visit____Weight____________Height ______________

CURRENT PROVIDERS & SPECIALISTS (i.e. primary care physician, gastroenterologist, cardiologists, etc.)

PCP:______________________________ Pulmonologist:__________________________
Gastroenterologist:_____________________ Surgeon:______________________________
Urologist:___________________________ Nephrologist:___________________________
Cardiologist:_________________________ Rheumatologist:_________________________
Other:______________________________ Other: ______________________________

PAST MEDICAL HISTORY (Please check items where previous history applies)

☐ High Blood Pressure (HTN)
☐ Heart Disease (CAD)
☐ Diabetes Mellitus 2
☐ Asthma
☐ Atrial Fibrillation
☐ Stroke
☐ High Cholesterol
☐ Bowel Obstruction
☐ Breast Cancer
☐ Arthritis
☐ Clotting/Bleeding Disorder
☐ Carotid Artery Stenosis
☐ Cataracts
☐ Depression
☐ Ischemic Heart Disease
☐ Migraine Headaches
☐ Colon Cancer
☐ Gallstones
☐ Crohn's Disease
☐ Congestive Heart Failure
☐ COPD
☐ Degenerative Disc Disease
☐ Diabetic Complications
☐ Diabetes Mellitus, Type 1
☐ Diabetic Neuropathy
☐ Diverticulitis of Colon
☐ Heartburn
☐ End Stage Renal Disease
☐ Rectal Abscess
☐ Hiatal Hernia
☐ Gout
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Lung Cancer
☐ Kidney Stone
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Pilonidal Cyst
☐ Previous Heart Attack
☐ Wound Infection Post Surgery
☐ Sleep Apnea
☐ Spastic Colon/Irritable Bowel
☐ Ulcerative Colitis
☐ Venous (Vein) Disease
☐ DVT or Pulmonary Embolus

List other conditions here:

PAST SURGICAL HISTORY Please check or list all previous operations; insert year of surgery adjacent to operation.

☐ Abdominal Aneurysm
☐ Abdominal Hernia
☐ Anal Fissure/Ulcer
☐ Appendectomy
☐ Arterial Bypass, Leg
☐ Back Surgery
☐ Cardiac Stents
☐ Cataract Surgery
☐ C-Section
☐ Cholecystectomy (Gallbladder)
☐ Colectomy
☐ Coronary Artery Bypass
☐ Dialysis Access
☐ Dilation and Curettage (D&C)
☐ Bowel Surgery
☐ Heart Valve Replacement
☐ Hemorrhoidectomy
☐ Hysterectomy
☐ Inguinal Hernia
☐ Knee Surgery
☐ Lithotripsy
☐ Lung Resection
☐ Mastectomy
☐ Neck Surgery
☐ Ovarian Cyst Drainage
☐ Prostate Surgery
☐ Rectal Abscess
☐ Thyroidectomy
☐ Tonsillectomy
☐ Tubal Ligation
☐ Umbilical Hernia
☐ Pacemaker/Defibrillation
☐ Hip Replacement

List other surgeries here:

MEDICATION LIST

List all current prescription and over-the-counter (non-prescription) medications such as vitamins, Aspirin, Tylenol, and herbals (ex: Ginseng, Gingko Biloba, St. John's Wort). Include prescription meds taken as needed, (ex. Viagra, Nitroglycerin.)

Name of Medication	Dose	How Often Do You Take?	Reason For Medication?

ALL INFORMATION IS IMPORTANT. PLEASE COMPLETE ALL SECTIONS.

DRUG ALLERGY LIST Please check/list all medications or vaccinations that have caused an allergic reaction in the past:

☐ Penicillin ☐ Sulfa Drugs ☐ IV/Dye ☐ Novocaine/Lidocaine ☐ Codeine

☐ No Known Drug Allergies

☐ Other ____

LATEX ALLERGY? Are you allergic to latex? ☐Yes ☐ No

PREGNANCY? Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly ☐ N/A

FAMILY HISTORY

Check if any of your blood relatives have had any of the following conditions:

	Indicate Relationship to You (Maternal or Paternal)		Indicate Relationship to You
☐ Hypertension		☐ Stroke	
☐ Breast Cancer		☐ Kidney Disease	
☐ Colon Cancer		☐ Lung Cancer	
☐ Other Cancers		☐ High Cholesterol	
☐ Diabetes Mellitus		☐ Thyroid problems	
☐ Heart Disease		☐ Other:	
☐ Other:		☐ Other:	

SOCIAL HISTORY

Check which substances you use and how much you use:

☐ Alcohol, no use	☐ Alcohol, heavy use	☐ Tobacco, 1 ppd	☐ Other
☐ Tobacco, no use	☐ Chewing Tobacco	☐ Tobacco, 1.S ppd	
☐ Alcohol, rare use	☐ Tobacco, former smoker Yrs	☐ Tobacco, 2.0 ppd	☐ Illegal Drugs, specify:
☐ Alcohol, moderate use	☐ Tobacco, % ppd	☐ Tobacco, > 2 ppd	

Review of Systems

In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **please circle the ones that apply**. If you have any questions about this, please ask one of the staff or your clinician.

Constitutional (Health in General) ❑ No Problems
Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats

Head, Eyes, Ears, Nose, Mouth & Throat/Neck ❑ No Problems
Headache, head injury, dizziness, change in vision, tearing of eyes, eye pain, difficulty with hearing, vertigo, ringing in ear, sinus problems, runny nose, post-nasal drip, nose bleeds, mouth sores, bleeding gums, loose teeth, sore throat, neck stiffness/pain, neck tenderness

Cardiovascular (Heart & Blood Vessels) ❑ No Problems
Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, fainting

Respiratory (Lungs & Breathing) ❑ No Problems
Shortness of breath, wheezing, cough, bloody sputum, sputum production

Gastrointestinal (Stomach & Intestines) ❑ No Problems
Change in appetite, constipation, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools

Genitourinary (Kidney & Bladder) ❑ No Problems
Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence

Musculoskeletal (Muscles, Bones, Joints) ❑ No Problems
Joint pain, aching muscles, swelling of joints, joint deformities, back pain, limited range of motion

Skin / Hair / Breast ❑ No Problems
Rash, itching, new skin lesion, change in existing skin lesion, hair loss, breast changes

Neurologic (Brain & Nerves) ❑ No Problems
Weakness, tremors, seizures, change in mentation, change in sensation, problems with walking or balance

Psychiatric (Mood & Thinking) ❑ No Problems
Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, difficulty coping

Hematologic (Blood/Lymph) ❑ No Problems
Easy bleeding, easy bruising, unexplained swollen areas

Additional Comments/Concerns:

____

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NOTICE OF INFORMATION PRACTICES

1. This notice describes how Personal Health Information (PHI) about you may be used and disclosed and how you can gain access to this Information. Please review it carefully.
2. VOC is required by law to maintain the privacy of PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured protected health information.
3. VOC may use and disclose protected health information for treatment, payment and healthcare operations, including appointment reminders. Examples of these include, but are not limited to, requested preschool, or sports physicals, referral to nursing homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers or collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records and providing records to business associates, i.e. internal ancillary services.
4. Although VOC will not sell or disclose PHI for marketing, fundraising, or other purposes, we are required to notify you that your authorization would be required for us to do so.
5. VOC is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
6. VOC will not make any other use or disclosure of a patient’s protected health information without the individual’s written authorization. Such authorization may be revoked at any time. Revocation must be written and submitted to address of record on this form.
7. VOC will abide by the terms of this notice currently in effect at the time of the disclosure.
8. VOC reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Virginia Oncology Care, PC will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
9. You have the right to restrict disclosures of PHI to your health plan if you pay out of pocket in full for services rendered.
10. Any patient, guardian or personal representative has the right to inspect and obtain copies of their medical record.

11. Any patient, guardian or personal representative has the right to request amendments be made to their medical record.

12. Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.

13. Any patient, guardian, or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested, but if the Practice does agree, the Practice must abide by those restrictions.

14. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number: Virginia Oncology Care, PC, 406 Chatham Square Office Park, Fredericksburg, VA 22405, For inquiries or additional information, contact Administrator/Privacy Officer: Telephone 540-300-6182 Fax 540-301-2294. All complaints will be addressed, and the results will be reported to the Privacy Officer.

15. It is the policy of VOC that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

16. VOC may call the patient's home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance items and any call pertaining to the patient's clinical care, including laboratory results among others.

17. VOC may mail to the home or other designated location any items that assist with carrying out the patient's treatment plan, such as appointment reminders and other material.

18. VOC will accept revocations of the Authorization to disclose Protected Health Information by certified mail only. This revocation must be sent to the attention of the Privacy Officer, 406 Chatham Square Office Park, Fredericksburg, VA 22405.

19. The signature of patient or guardian on this privacy form authorizes VOC to release Personal Health Information on the respective patient via all FMLA documents, documents provided by the patient’s employer, or documents submitted by disability or insurance carrier on behalf of the patient.