# Northwest Alabama Cancer Center, P.C.

HEMATOLOGY/ONCOLOGY

101 Dr. W.H. Blake, Jr. Drive • Muscle Shoals, AL 35661 • (256) 381-1001 • 1-800-223-3064

rick Daugherty, M.D., Ph.D.
ant K. Patel, M.D.
T Hagler, M.D.
erly Canaday, CRNP


Dear ______________________________

You have an appointment with us on ________________at______________.

Please fill out the enclosed forms and bring with you on the day of your appointment.

**Please bring the following with you:**

*Completed forms.
*Drivers license or other photo ID showing current address (if you do not have a photo ID please bring a utility bill or other correspondence showing current address.
*All insurance cards.
*List of medications.

All co-pays are due at time of service.

Thank you,

________________________

Patient Care Coordinator

## NORTHWEST ALABAMA CANCER CENTER

203 W. Dr. Hicks Blvd Florence, AL 35630     101 Dr. W. H. Blake Jr. Drive Muscle Shoals, AL 35661

Patient: ______________________ Social Security #: ______________________

Address: ______________________ City: ______________ State: _____ Zip: _______

Date of birth: ____________ Sex: ________ Marital status: __________ Race: ______________

Home phone: ______________ Cell : ______________________

Spouse: ______________ DOB: ____________ Social Security #: ______________

Referring physician: ______________ Primary Care physician: ______________

Insured's employer: ______________________ phone: ______________

**Please read carefully:** It is the policy of Northwest Alabama Cancer Center that the person receiving treatment is responsible for payment of the account. Routine office charges are due at the time of service unless other arrangements are made in advance. Medical insurance is filed as a convenience to the patient. If a problem arises, it is the patient's responsibility to communicate with the insurance company to help resolve the problem. If you have any questions, please do not hesitate to ask the business office. We will be glad to help in anyway possible. **COPIES OF ALL INSURANCE CARDS MUST BE MADE BEFORE YOU RECEIVE TREATMENT.** THANK YOU.

Primary insurance: ______________ ID#: ______________ Subscriber: ______________

Secondary insurance: ______________ ID#: ______________ Subscriber: ______________

Prescription drug (Medicare part D): ______________ ID#: ______________

Cancer policy: ______________________________________________

All cancer policies must be listed on this sheet. It will be at the discretion of NWACC if assignment will be held on this policy.
I have read and fully understand that I am responsible for payment for the services rendered by Northwest Alabama Cancer Center I promise to pay Northwest Alabama Cancer Center any monies due on this account including reasonable attorney fees or collection charges.

SIGNATURE OF GUARANTOR: ______________________________ DATE: ______________
(Signature of person responsible for bill)

I request that payment of authorized insurance benefits be made on my behalf to Northwest Alabama Cancer Center.

PATIENT SIGNATURE: ______________________________ DATE: ______________

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### PATIENT AUTHORIZATION FOR USE, DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use or disclosure of my individually identifiable health information for my condition or billing to the following person(s)

______________________________________________.

Patient Signature: ______________________ This HIPAA authorization expires: ______________.

Revised 3-5-12

# PATIENT INFORMATION - INITIAL OFFICE VISIT

DATE: ____________________

*DR. J. PATRICK DAUGHERTY • DR. HEMANT PATEL • DR. KARL HAGLER*

NAME ______________________________________

AGE __________ ❒ MARRIED ❒ SINGLE ❒ WIDOWED ❒ DIVORDED

REFERRED BY ______________________________

WHAT SYMPTOMS OR PROBLEMS MADE YOU COME TO THE DOCTOR'S OFFICE?

______________________________________

______________________________________

WHAT MEDICATIONS ARE YOU NOW TAKING (PRESCRIPTION AND OVER THE COUNTER)?

| NAME | AMOUNT | HOW OFTEN TAKEN | WHEN STARTED |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

ARE YOU ALLERGIC TO ANY MEDICATIONS: ❒ YES ❒ NO IF SO, LIST DRUG AND TYPE OF REACTION: ____________________

______________________________________

ARE YOU ALLERGIC TO ANY MEDICATIONS: ❒ YES ❒ NO IF SO, PLEASE LIST: ____________________

______________________________________

DO YOU SMOKE OR USE ANY FORM OF TOBACCO? ❒ YES ❒ NO PACKS OR AMOUNT PER DAY ____________________

DO YOU DRINK ALCOHOLIC BEVERAGES? ❒ YES ❒ NO TYPE AND AMOUNT ____________________

| | DATE OF LAST | | DATE OF LAST |
|---|---|---|---|
| CHEST X-RAY | | TB SKIN TEST | |
| ELECTROCARDIOGRAM (EKG) | | TESTICULAR EXAM (IF MALE) | |
| PAP SMEAR (IF FEMALE) | | PROSTATE EXAM (IF MALE) | |
| MAMMOGRAM | | TEST FOR BLOOD IN STOOL | |
| COLONOSCOPY | | CT SCAN | |
| FLU VACCINE | | BONE SCAN | |
| PNEUMONIA VACCINE | | OTHER | |

## SURGERIES: PLEASE CHECK IF YOU HAVE HAD SURGERIES ON ANY OF THE FOLLOWING:

| | YEAR | | YEAR |
|---|---|---|---|
| ❒ TONSILS | | ❒ UTERUS (HYSTERECTOMY) | |
| ❒ GALLBLADDER | | ❒ BREAST | |
| ❒ STOMACH | | ❒ PROSTATE GLAND | |
| ❒ COLON | | ❒ MOLES/WARTS | |
| ❒ TUBES OR OVARIES | | ❒ OTHER | |

## PLEASE CHECK OR ANSWER THE FOLLOWING AS IT APPLIES TO YOU:

WOMEN ONLY

- ❒ Vaginal Discharge
- ❒ Pain with Periods
- ❒ Lump of Pain in Breasts
- ❒ Number of Pregnancies ____________
- ❒ Number of Stillbirths ____________
- ❒ Number of Miscarriages ____________
- ❒ Date of Last Period ____________
- ❒ Number of Premature Babies ____________
- ❒ Problems During Pregnancy? ____________

______________________________________

MEN ONLY

- ❒ Trouble Starting Stream
- ❒ Reduced Urinary Stream
- ❒ Prostate Problems
- ❒ Discharge from Penis
- ❒ Rupture
- ❒ Enlarged, Swollen or Tender Testicle

## SYMPTOMS: PLEASE CHECK BY SYMTOMS YOU ARE NOW HAVING:

- ❒ Headaches
- ❒ Changes in Vision
- ❒ Fainting Spells
- ❒ Dizziness
- ❒ Pain in Eyes
- ❒ Recent Change in Hearing
- ❒ Draining from Ears
- ❒ Ringing or Buzzing in Ears
- ❒ Nose Bleeds
- ❒ Sinus Problems
- ❒ Hoarseness
- ❒ Lumps or Swelling in the Neck
- ❒ Trouble Swallowing
- ❒ Goiter
- ❒ Coughing
- ❒ Sputum (Color & Amount) ________
- ❒ Coughing Up Blood
- ❒ Short of Breath
- ❒ Night Sweats
- ❒ Fever or Chills
- ❒ Hay Fever
- ❒ Sleep on m ore than once pillow
- ❒ Chest Pain
- ❒ Swelling of your Feet
- ❒ Fast or Irregular Heart Beat
- ❒ Heart Mumur
- ❒ Pains in Legs When Walking
- ❒ Blood Clots
- ❒ High Blood Pressure
- ❒ Low Blood Pressure
- ❒ Indigestion or Heartburn
- ❒ Stomach Pains
- ❒ Vomiting Blood
- ❒ Changes in Bowel Movements
- ❒ Constipation
- ❒ Rectal Pain or Bleeding
- ❒ Hemorrhoids
- ❒ Ulcers
- ❒ Jaundice or Yellowing of the Skin
- ❒ Loss of Appetite
- ❒ Loss of Taste
- ❒ Recent Weight Loss
- ❒ Recent Weight Gain
- ❒ Frequent Urination at Night
- ❒ Pain or Burning with Urination
- ❒ Blood in the Urine
- ❒ Boils
- ❒ Easy Bruising
- ❒ Moles that have Recently Changed
- ❒ Rash
- ❒ Loss of Hair
- ❒ Increased Thirst
- ❒ Any Food Cravings
- ❒ Sensitive to Heat
- ❒ Sensitive to Cold
- ❒ Gout
- ❒ Stiffness or Pain of Joints
- ❒ Paralysis or Weakness
- ❒ Back Pain
- ❒ Numbness or Tingling
- ❒ Trouble with Coordination
- ❒ Loss of Memory
- ❒ Change in Speech
- ❒ Difficulty with Words
- ❒ Difficulty Falling Asleep
- ❒ Presently Under Stress
- ❒ Recent Family Illness or Death
- ❒ Feel Unhappy or Depressed
- ❒ Nervous Breakdown

## ILLNESSES: HAVE YOU PREVIOUSLY HAD OR ARE YOU CURRENTLY BEING TREATED FOR ANY OF THE FOLLOWING MEDICAL CONDITIONS?

| CONDITION | YEAR | TREATMENT | CONDITION | YEAR | TREATMENT |
|---|---|---|---|---|---|
| ❒ ARTHRITIS | | | ❒ TB | | |
| ❒ ASTHMA | | | ❒ ULCERS | | |
| ❒ HIGH BLOOD PRESSURE | | | ❒ HEPATITIS | | |
| ❒ ANGINA (CHEST PAIN) | | | ❒ COLITIS | | |
| ❒ STROKE | | | ❒ KIDNEY STONES | | |
| ❒ HEART ATTACK | | | ❒ CANCER | | |
| ❒ EMPHYSEMA | | | ❒ BLOOD DISEASES | | |
| ❒ DIABETES | | | ❒ GLAUCOMA | | |
| ❒ ANEMIA | | | ❒ OTHER | | |

## FAMILY HISTORY: HAS MOTHER, FATHER, BROTHER, OR SISTER HAD ANY OF THE FOLLOWING?

- ❒ TB
- ❒ Rheumatic Fever
- ❒ Diabetes
- ❒ Thyroid Disease
- ❒ Cancer
- ❒ Heart Disease
- ❒ High Blood Pressure
- ❒ Stroke
- ❒ Stomach Problems
- ❒ Bleeding Problems
- ❒ Anemia
- ❒ Arthritis
- ❒ Glaucoma
- ❒ Lung Disease
- ❒ Kidney Disease
- ❒ Mental Illness
- ❒ Other

| | AGE IF LIVING | AGE AT DEATH | MEDICAL PROBLEMS OR CAUSE OF DEATH |
|---|---|---|---|
| FATHER | | | |
| MOTHER | | | |
| BROTHERS | | | |
| | | | |
| | | | |
| SISTERS | | | |
| | | | |
| | | | |
| CHILDREN | | | |
| | | | |
| | | | |
| | | | |

Medicare Part B

# Extended Patient Signature Authorization

## TO BE COMPLETED BY PROVIDERS OF SERVICE—Please PRINT or TYPE

| Provider's Name *(If you are a DMA supplier, please complete certification at bottom of page)* NW Alabama Cancer Center, P.C. 101 Dr. W.H. Blake Jr. Drive | | Provider's I.D. Code |
|---|---|---|
| Provider's Address *(Street, City, state, ZIP Code)* Muscle Shoals, AL 35661 | | |
| Beneficiary's Name | Medicare HI number | Applicable MEDIGAP Group Number |

## TO BE COMPLETED BY BENEFICIARY OR AGENT—Directions For Payment Of Benefits And Release Of Medical Information

STATEMENT FOR PAYMENT OF MEDICARE BENEFITS

***I request that payment of authorized Medicare benefits be made either to me or on my behalf to***

***Dr. ______________ or to NWACC (the Supplier) for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to Health care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.***

•••••••••

STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS

***I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to***

***NWACC for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to (name of MEDIGAP Insurer)***

***______________ any information needed to determine these benefits or the benefits payable for related services.***

Signature of Beneficiary of person signing for Beneficiary ______________ Date signed ______________

| Address of Person Signing For Beneficiary *(Street, City, State, ZIP Code)* | Relationship Of Agent To Beneficiary |
|---|---|
| Reason Beneficiary Is Unable To Sign | |

## IMPORTANT INFORMATION FOR PHYSICIANS

In submitting claims under this procedure, PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment-even those in which the physician has not accepted assignment.
2. To incorporate, by stamp of otherwise, information to the following effect on any bills they send to Medicare patients: "DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF." This requirement is neces sary to prevent patients from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

## IMPORTANT INFORMATION FOR SUPPLIERS

1. Only use this extended patient signature authorization for assigned claims.
2. Renew the patient signature agreement if a new item is rented or purchased.
3. Place alongside the beneficiary's signature the following statement: "RESPONSIBILITY FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED."

## DURABLE MEDICAL EQUIPMENT SUPPLIERS AGREEMENT

**NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OF DURABLE MEDICAL EQUIPMENT IN ASSIGNMENT CASES.**

***This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of the return of, or the end of need for the rental of equipment, or the death or institutionalization of the Beneficiary.***

Signature of Durable Medical Equipment Supplier ______________ Date Signed ______________

**NORTHWEST ALABAMA CANCER CENTER**
**HEMATOLOGY/ONCOLOGY**
**101 DR. W. H. BLAKE JR., DRIVE**
**MUSCLE SHOALS, ALABAMA 35661**
**256-381-1001 1-800-223-3064**

**J. PATRICK DAUGHERTY, M.D., Ph.D. HEMANT K. PATEL, M.D. KARL HAGLER, M. D.**

## PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

* Your insurance policy is a contract between you and your insurance company, the doctor is not involved.

* As a courtesy, we will file your insurance for you. According to our information you have ________________________________ **insurance. Your co-pay is ____________ it is due and payable the day of service. The co-insurance is ________________ and will be due 15 days after receipt of statement.**

* In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. Payment is due 15 days after receipt of statement.

* For all services provided in the hospital, as a courtesy we will bill your health plan. Any balance due is payable 15 days after receipt of statement.

* All services rendered to minor patients, we will look to the parent/guardian or person with custody for payment.

* If your address or insurance changes notify the Business Office immediately.

* If you have any questions regarding this patient financial policy please contact the business office.

I have read and understand the financial policy of Northwest Alabama Cancer Center and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the Practice.

______________________________ ______________________________
Signature of patient/responsible party Date

______________________________
Printed name of patient

______________________________ ______________________________
Witness Date

"Where Compassion Meets Technology"

# PAIN MANAGEMENT AGREEMENT

The purpose of this Pain Management Agreement is to provide an understanding about the pain medications that I, the undersigned patient, may be taking. This agreement will allow Northwest Alabama Cancer Center, P.C., an Alabama professional corporation (hereinafter "NWACC") to provide care for me and attempt to avoid problems that can accompany the taking of controlled substances. I agree to the following terms and conditions of this agreement:

1. I agree to tell any physician employed by NWACC the character and intensity of my pain, the effect the pain has on my daily life, and the effectiveness of my current medication(s) in relieving pain.
2. I agree that I am not currently taking, or will I take, any illegal controlled substances including, but not limited to, marijuana, cocaine, etc.
3. I agree not sell or trade with any other individual, my prescribed medication(s).
4. I agree that I will not attempt to obtain any controlled medications including, but not limited to, opioid pain medications, controlled stimulants, or anti-anxiety medications from any other physician, unless NWACC authorizes another physician to prescribe said medications for me.
5. I agree that NWACC will not be held liable for the loss or theft of my medication(s), and I acknowledge that my medication(s) will not be replaced in the event they are lost or stolen.
6. I agree to refill my medication(s) only at the time of a scheduled office visit or during regular office hours. I acknowledge that no refills will be available during evenings or weekends. I agree to assume the responsibility to ensure that I have sufficient medications until a refill can be obtained pursuant to these rules.
7. I agree that I will only use the services of ______________________________ Pharmacy, located at ______________________________ to fill my prescriptions for any pain medication(s) prescribed by any physician employed by NWACC.
8. I agree to use my medication(s) at a rate no greater than the rate prescribed. If I use this medication more frequently, I realize that I will be without said medication for a period of time.
9. I acknowledge that if I am determined to be at high risk for medication abuse or if I have a history of substance abuse, I will be subject to a urine/serum medication levels screening if requested by NWACC.
10. I authorize NWACC and the pharmacy listed in Section 7 above to cooperate fully with any city, state, or federal law enforcement agency, including the Alabama Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medication. I also authorize NWACC to provide a copy of this Agreement to the pharmacy listed in Section 7 above. I waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
11. I acknowledge that if I violate any of the above conditions, NWACC may no longer prescribe controlled medications to me. If NWACC terminates this agreement, I understand that NWACC will gradually reduce my dosage of medications over a period of several days in an attempt to reduce my withdrawal symptoms. I agree to attend a drug dependency treatment program if that is what is recommended by NWACC.

I agree to follow the above guidelines, and acknowledge that said guidelines have been fully explained to me along with the risks and benefits related to taking the medication(s) prescribed to me. I acknowledge that all of my questions and concerns regarding treatment have been adequately answered, and that a copy of this agreement has been given to me.

This agreement is entered into this __________ day of ________________________,

______________________________ ______________________________

Witness [Patient's Name]

Northwest Alabama Cancer Center
101 Dr. W. H. Blake Jr., Drive
Muscle Shoals, Alabama 35661
Phone-256-381-1001 Fax-253-381-3604

Northwest Alabama Cancer Center
302 W. Dr. Hicks, Blvd
Florence, Alabama 35630
Phone-256-764-4200 Fax-256-764-2327

## AUTHORIZATION FOR THE RELEASE AND/OR DISCUSSION OF PROTECTED HEALTH INFORMATION

Patient Name:________________________________ SS#:_______-______-_______ Birth Date: ________________

I, ____________________________________________________________, hereby authorize the following
(Name of Patient or Patient's Legally Authorized Representative)

person(s) or organization(s):

1. Person or Organization:________________________________________________

   Street Address:________________________________________________

   City, State, Zip:________________________________ Phone: (    )____________

2. Person or Organization:________________________________________________

   Street Address:________________________________________________

   City, State, Zip:________________________________ Phone: (    )____________

to release and/or discuss the following information: Complete Medical Record, Pathology Results, Radiological Results, Lab Results, Treatment Plan Update, Outpatient Care, InPatient Care; also if my record contains the following information it is released if CHECKED:

_______Substance Abuse _______Mental Health _____HIV Testing or Treatment

to: **Northwest Alabama Cancer Center, 101 Dr. W. H. Blake Jr., Drive, Muscle Shoals, Alabama 35661 or Northwest Alabama Cancer Center, 302 West Dr. Hicks Blvd., Florence, Alabama 35630**

This information release is at my request for the purpose of medical treatment and/or assistance.

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or organizations named above. I understand that, if the person(s) or organization(s) that I have authorized to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws. I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun. This authorization expires on:______________________________.

I authorize the use of a copy of this form for the disclosure of the information described above.

Signed:________________________________ Relationship:____________________ Date:________________

"Where Compassion Meets Technology"

NORTHWEST ALABAMA CANCER CENTER, P.C.
HEMATOLOGY/ONCOLOGY
101 Dr. W.H. Blake Jr., Drive Phone: (256) 381-1001 Fax: (256) 381-3604
Muscle Shoals, Alabama 35661

J. Patrick Daugherty, M.D., Ph.D. Hemant K. Patel, M.D. Karl Hagler, M.D.


## TO ALL PATIENTS OF NORTHWEST ALABAMA CANCER CENTER

**We have established new policies and procedures in order to better serve you.**
**Please note the following guidelines:**

- Treatments will begin at 7:30 a.m. Monday through Friday and office visits will start at 9:00 a.m. At this time, any necessary lab work and brief assessments by the nurse will be done. If you need any medication refills, please tell the RN at this time.
- All patients will be seen according to their appointment time, not by the time of their arrival. In case of an emergency and you do not have an appointment, please phone the receptionist and every effort will be made to see you as soon as possible. Those who need to be worked in will be scheduled after the last appointment for the day.
- All visitors are asked to remain in the main waiting area while patient is having vital signs, injections, or port flushes. The patient will return to the lobby before seeing the doctor and we ask that only one visitor accompany them.
- For the consideration of our patients, who are undergoing chemotherapy, we ask that only one person accompany them to the infusion room. No children under the age of 12 years will be allowed in the treatment area.
- Injections and weekly lab work will be scheduled during the afternoon. All port flushes will be scheduled after 2:00 in the afternoons only.
- All phone calls will be returned between the hours of 3:00 p.m. and 5 p.m. after the nurses finish seeing patients in the office.

We appreciate your cooperation, and we look forward to being of service to you. Please feel free to offer any suggestions that you think would be beneficial in helping our office run smoothly and efficiently.

I have read and understand the above guidelines.

__________________________________
Patient's Signature Date

*"Where Compassion Meets Technology"*

**Cancer policy / printouts**

There are two options available for your printout needs:

Option 1: Request in person or by phone a printout after all of your appointments for the month. One printout will be done free of charge per month.

Example: if you have only one appointment scheduled for the month you can request a printout the following week. Should you have more than one appointment scheduled – wait until at least one week after the last appointment for the month to request a printout. This option prints on plain white paper and not on HCFA 1500 forms.

Option 2: Give the business office your cancer policy info. Let them know if you want the claim filed directly to your cancer policy insurance company or mailed to your home address. Forms will print as soon as the charges are entered for your appointment and mailed to the address you chose. This option prints on HCFA 1500 forms. There is no need to request a printout each month – it will print automatically.

Thank you for your cooperation.

# NORTHWEST ALABAMA CANCER CENTER, P. C

and **NORTHWEST ALABAMA CANCER CENTER RADIOLOGICAL SERVICES, INC**

**(an affiliated covered entity hereinafter referred to as *ACE*)**

## PRIVACY NOTICE

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.

We are required under the federal health care privacy rules (the "Privacy Rules"), to protect the privacy of your health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history (collectively, "Health Information"). We are also required to provide you with this Privacy Notice regarding our legal duties, policies and procedures to protect and maintain the privacy of your Health Information. We are required to follow the terms of this Privacy Notice unless (and until) it is revised. We reserve the right to change the terms of this Privacy Notice and to make the new notice provisions effective for the Health Information that we maintain and use, as well as for any Health Information that we may receive in the future. Should the terms of this Privacy Notice change, we will make a revised copy of the notice available to you. Revised Privacy Notices will be available at our office for individuals to take with them and we will post a copy of revised Privacy Notices in a prominent location in our office.

### PERMITTED USES AND DISCLOSURES OF YOUR HEALTH INFORMATION.

1. **General Uses and Disclosures.** Under the Privacy Rules, we are permitted to use and disclose your Health Information for the following purposes, without obtaining your permission or Authorization:

   - **Treatment.** We are permitted to use and disclose your Health Information in the provision and coordination of your health care. For example, we may disclose your Health Information to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment.

   - **Payment.** We are permitted to use and disclose your Health Information for the purposes of determining coverage, billing, and reimbursement. This information may be released to an insurance company, third party payor, or other authorized entity or person involved in the payment of your medical bills and may include copies or portions of your medical record which are necessary for payment of your bill. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

   - **Health Care Operations.** We are permitted to use and disclose your Health Information during our health care operations, including, but not limited to: quality assurance, auditing, licensing or credentialing activities, and for educational purposes. For example, we can use your Health Information to internally assess our quality of care provided to patients.

   - ***Uses and Disclosures Related to Affiliated Covered Entity (ACE)***

*"The entity participating in the ACE and listed in this Notice will use and disclose your Health Information as permitted by this Notice arrangement".*

- **Uses and Disclosures Required by Law.** We may use and disclose your Health Information when required to do so by law, including, but not limited to: reporting abuse, neglect and domestic violence; in response to judicial and administrative proceedings; in responding to a law enforcement request for information; or in order to alert law enforcement to criminal conduct on our premises or of a death that may be the result of criminal conduct.

- **Public Health Activities.** We may disclose your Health Information for public health reporting, including, but not limited to: child abuse and neglect; reporting communicable diseases and vital statistics; product recalls and adverse events; or notifying person(s) who may have been exposed to a disease or are at risk of contracting or spreading a disease or condition.

- **Abuse and Neglect.** We may disclose your Health Information to a local, state, or federal government authority, if we have a reasonable belief of abuse, neglect or domestic violence.

- **Regulatory Agencies.** We may disclose your Health Information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs, and compliance with civil rights.

- **Judicial and Administrative Proceedings.** We may disclose your Health Information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request, or similar legal request.

- **Law Enforcement Purposes.** We may disclose your Health Information to law enforcement officials when required to do so by law.

- **Coroners, Medical Examiners, Funeral Directors.** We may disclose your Health Information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

- **Research.** Under certain circumstances, we may disclose your Health Information to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your Health Information.

- **Threats to Health and Safety.** We may use or disclose your Health Information if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual.

- **Specialized Government Functions.** If you are a member of the U.S. Armed Forces, we may disclose your Health Information as required by military command authorities. We

may also disclose your Health Information to authorized federal officials for national security reasons and the Department of State for medical suitability determinations.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your Health Information to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety, or the health or safety of others; or for the safety and security of the correctional institution.

- **Workers' Compensation.** We may disclose your Health Information to your employer to the extent necessary to comply with Alabama laws relating to workers' compensation or other similar programs.

- **Fundraising.** We may use or disclose your Health Information to make a fundraising communication to you, for the purpose of raising funds for our own benefit. Included in such fundraising communications will be instructions describing how you may ask not to receive future communications.

- **Marketing.** We may use or disclose your Health Information to make a marketing communication to you that occurs in a face-to-face encounter with us or which concerns a promotional gift of nominal value provided by us.

- **Appointment Reminders/Treatment Alternatives.** We may use and disclose your Health Information to the tumor registry, to remind you of an appointment for treatment and medical care at our office or to provide you with information regarding treatment alternatives or other health-related benefits and services that may be of interest to you. If you have voicemail or an answering machine we will leave limited information on them.

- **Business Associates.** We may disclose your Health Information to business associates who provide services to us. Our business associates are required to protect the confidentiality of your Health Information.

- **Other Uses and Disclosures.** In addition to the reasons outlined above, we may use and disclose your Health Information for other purposes permitted by the Privacy Rules.

2. **Uses and Disclosures Which Require Patient Opportunity to Verbally Agree or Object.** Under the Privacy Rules, we are permitted to use and disclose your Health Information: (i) for the creation of facility directories, (ii) to disaster relief agencies, and (iii) to family members, close personal friends or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. Except in emergency situations, you will be notified in advance and have the opportunity to verbally agree or object to this use and disclosure of your Health Information.

   *[If any of the uses and/or disclosures described in Sections 1 and 2 of the Privacy Notice are prohibited or materially limited by more stringent State law,we will abide by the more stringent state law.]*

3. **Uses and Disclosures Which Require Written Authorization.** As required by the Privacy Rules, all other uses and disclosures of your Health Information (not described above) will be made only with your written Authorization. For example, in order to disclose your Health Information to a company for marketing purposes, we must obtain your Authorization. Under the

Privacy Rules, you may revoke your Authorization at any time. The revocation of your Authorization will be effective immediately, <u>except</u> to the extent that: we have relied upon it previously for the use and disclosure of your Health Information; if the Authorization was obtained as a condition of obtaining insurance coverage where other law provides the insurer with the right to contest a claim under the policy or the policy itself; or where your Health Information was obtained as part of a research study and is necessary to maintain the integrity of the study. We will need a written authorization to release print-out of charges to anyone other than the patient.

## PATIENT RIGHTS.

You have the following rights concerning your Health Information:

1. **Right to Inspect and Copy Your Health Information.** Upon written request, you have the right to inspect and copy your own Health Information contained in a designated record set, maintained by or for us. A "designated record set" contains medical and billing records and any other records that we use for making decisions about you. However, we are not required to provide you access to all the Health Information that we maintain. For example, this right of access does not extend to psychotherapy notes, or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding. Where permitted by the Privacy Rules, you may request that certain denials to inspect and copy your Health Information be reviewed. If you request a copy or summary of explanation of your Health Information, we may charge you a reasonable fee for copying costs, including the cost of supplies and labor, postage, and any other associated costs in preparing the summary or explanation.

2. **Right to Request Restrictions on the Use and Disclosure of Your Health Information.** You have the right to request restrictions on the use and disclosure of your Health Information for treatment, payment and health care operations, as well as disclosures to persons involved in your care or payment for your care, such as family members or close friends. We will consider, but do not have to agree to, such requests.

3. **Right to Request an Amendment of Your Health Information.** You have the right to request an amendment of your Health Information. We may deny your request if we determine that you have asked us to amend information that: was not created by us, unless the person or entity that created the information is no longer available; is not Health Information maintained by or for us; is Health Information that you are not permitted to inspect or copy; or we determine that the information is accurate and complete. If we disagree with your requested amendment, we will provide you with a written explanation of the reasons for the denial, an opportunity to submit a statement of disagreement, and a description of how you may file a complaint.

4. **Right to an Accounting of Disclosures of Your Health Information.** You have the right to receive an accounting of disclosures of your Health Information made by us within six (6) years prior to the date of your request. The accounting will not include: disclosures related to treatment, payment or health care operations; disclosures to you; disclosures based on your Authorization; disclosures that are part of a Limited Data Set; incidental disclosures; disclosures to persons involved in your care or payment for your care; disclosures to correctional institutions or law enforcement officials; disclosures for facility directories; or disclosures that occurred prior to April 14, 2003.

5. **Right to Alternative Communications.** You have the right to receive confidential communications of your Health Information by a different means or at a different location than currently provided. For example, you may request that we only contact you at home or by mail.

6. **Right to Receive a Paper Copy of this Privacy Notice.** You have the right to receive a paper copy of this Privacy Notice upon request.

If you want to exercise any of these rights, please contact our Privacy Officer. All requests must be submitted to us in writing on a designated form (which we will provide to you), and returned to the attention of our Privacy Officer at the address below.

## CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATION.

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

| | |
|---|---|
| Address: | **Northwest Alabama Cancer Center, P.C.** |
| | **101 Dr. W.H. Blake Jr., Drive**<br>**Muscle Shoals, Al 35661** |
| | **Attn: Privacy Officer** |
| Telephone: | **256-381-1001** |
| Fax: | **256-381-3604** |

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. The Secretary has delegated to the Office for Civil Rights ("OCR") the authority to receive and investigate complaints as they may relate to the privacy rules. Written complaints may be filed by mail, fax or e-mail to: **Region IV, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW., Atlanta, GA 30303-8909. Voice Phone (404)562-7886. Fax (404)562-7881. TDD(404)331-2867. E-mail OCRComplaint@hhs.gov**. Name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and file within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

**The Effective Date of this Privacy Notice is April 14, 2003**

*"As an ACE, the following entity is covered by this Privacy Notice:"*

*NORTHWEST ALABAMA CANCER CENTER RADIOLOGICAL SERVICES, INC*

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

______________________________ ______________

Printed Name of Patient Date

______________________________

Signature of Patient or Patient's Representative

______________________________

Printed Name of Patient's Representative (*if applicable*)

______________________________

Representative's Relationship to Patient (*if applicable*)

***To be completed by Northwest Alabama Cancer Center, P.C. /ACE***

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s) ______________________________

______________________________

______________________________

______________________________ ______________

Signature of Northwest Alabama Cancer Center, P.C.,/ACE Representative Date