MEANINGFUL USE INTAKE FORM

Please take a minute to complete this form to assist us in updating our records. Thank you.

Patient Information

Name (Please Print): _____

Date of Birth: _____ Sex (circle one): M F

Race (optional): _____

Ethnicity (optional, circle one or leave blank): Hispanic/Latino Not Hispanic/Latino

Preferred language (optional): _____

Have you had a flu vaccine this flu season (Sept-March) (circle one): Yes No

Were you in a hospital, skilled nursing facility, emergency room, or other setting of care before your visit today (circle one): Hospital Skilled nursing facility ER Other_____

Contact Information

Home phone: _____ Cell phone: _____ Work phone: _____

Email address: _____

Note: Your email address will only be used by the practice to notify you of specific reminders or how to access personal information. It will not be used for two-way communication regarding your medical care. Please contact our office if you have any questions or concerns related to your medical care.

Preferred method of contact (circle one): Home phone Cell phone Work phone Email Mail

Emergency Contact Name: _____ Relationship: _____

Phone number: _____ Alternate phone number: _____

Preferred Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____ City: _____ Zip code: _____

Pharmacy Phone: _____

NEW PATIENT & FAMILY HISTORY

Patient Name: _____ _____

Last First M.I. Today's Date

_____ _____ _____ _____ _____

Referred By DOB Marital Status Height Weight

_____

Reason for Visit

PAST HISTORY: Please list the following. If you need additional space, it is provided on the last page.

Surgeries (with dates)

_____

_____

_____

_____

_____

_____

_____

_____

Medical Conditions (with dates)

		Date			Date
ADD/ADHD	☐ Y ☐ N	_____	Bipolar Disorder	☐ Y ☐ N	_____
AIDS/HIV	☐ Y ☐ N	_____	Collagen Vascular Disease	☐ Y ☐ N	_____
Anemia	☐ Y ☐ N	_____	COPD/Emphysema	☐ Y ☐ N	_____
Anxiety/Depresssion	☐ Y ☐ N	_____	Coronary Artery Disease - MI or Angina	☐ Y ☐ N	_____
Arthritis (degenerative or Osteoarthritis)	☐ Y ☐ N	_____	Crohn's Disease/ Ulcerative Colitis	☐ Y ☐ N	_____
Athsma	☐ Y ☐ N	_____			
Benign Prostatic Hypertrophy (BPH)	☐ Y ☐ N	_____			

NEW PATIENT & FAMILY HISTORY

Medical Conditions Cont... (with dates)

		Date			Date
Deep Venous Thrombosis/ Pulmonary Embolism	☐ Y ☐ N		Lupus	☐ Y ☐ N	
Dementia	☐ Y ☐ N		Migraine Headaches	☐ Y ☐ N	
Diabetes Mellitus Type I or II	☐ Y ☐ N		Multiple Sclerosis	☐ Y ☐ N	
Diverticulitis	☐ Y ☐ N		Neurological Disorder	☐ Y ☐ N	
Dysfunctional Uterine Bleeding	☐ Y ☐ N		OCD	☐ Y ☐ N	
Eating Disorder	☐ Y ☐ N		Osteopenia/Osteoporosis	☐ Y ☐ N	
Endometriosis	☐ Y ☐ N		Other Endocrinological Disorder	☐ Y ☐ N	
Fibromyalgia	☐ Y ☐ N		Pacemaker	☐ Y ☐ N	
GERD/Hiatal Hernia	☐ Y ☐ N		Parkinson's	☐ Y ☐ N	
Gout	☐ Y ☐ N		Past History of Cancer	☐ Y ☐ N	
Heart Arrhythmia	☐ Y ☐ N		Peripheral Vascular Disease	☐ Y ☐ N	
Heart Failure/Dilated Cardiomyopathy	☐ Y ☐ N		Polycystic Ovarian Disease	☐ Y ☐ N	
Hepatitis A/B/C	☐ Y ☐ N		Post Traumatic Stress Syndrome	☐ Y ☐ N	
Herpes Simplex	☐ Y ☐ N		Psoriasis/Rosacea Skin Disorder	☐ Y ☐ N	
High Blood Pressure	☐ Y ☐ N		Pulmonary Embolism	☐ Y ☐ N	
High Cholesterol	☐ Y ☐ N		Restless Leg Syndrome	☐ Y ☐ N	
Hives	☐ Y ☐ N		Rheumatoid Arthritis	☐ Y ☐ N	
HTN	☐ Y ☐ N		Seizure/Epilepsy	☐ Y ☐ N	
Irritable Bowel Syndrome	☐ Y ☐ N		Sleep Apnea	☐ Y ☐ N	
Kidney Disease	☐ Y ☐ N		Stomach Reflux	☐ Y ☐ N	
Kidney Stones	☐ Y ☐ N		Stroke	☐ Y ☐ N	
Liver Disease	☐ Y ☐ N		Thyroid Disorder	☐ Y ☐ N	
Lung Disease	☐ Y ☐ N		Ulcers	☐ Y ☐ N	

NEW PATIENT & FAMILY HISTORY

Allergies Adverse Drug Reactions (types of reactions, be specific)

_____

_____

_____

_____

Have you:

Ever had a blood transfusion: ☐ Y ☐ N **If yes, when?** _____

Reproductive History:

Number of pregnancies: **Number of children:** _____ **Age at first pregnancy:** _____

Did you breast feed? ☐ Y ☐ N **If yes, how many months?** _____

Age at first period: _____ **Age at menopause:** _____ **Age at last period:** _____

Hysterectomy: ☐ Y ☐ N **Ovaries Intact?** ☐ Y ☐ N **If no, please explain:** _____

Hormone Use: ☐ Y ☐ N **Sex Drive:** ☐ Y ☐ N **Birth Control Method:** _____

Preventative Health Maintenance: Please provide dates for each answer or write "none".

Last Mammogram: _____

Last Pap Smear: _____

Last Breast MRI: _____

Last Breast Biopsy: _____

Last Bone Density Scan: _____

Last Colonoscopy: _____

Last Upper Endoscopy: _____

Last Pneumonia Vaccine: _____

Last Prostate Exam: _____

Last PSA Screening: _____

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NEW PATIENT & FAMILY HISTORY (CONT.)

SOCIAL & ENVIRONMENTAL REVIEW (If Yes, plese fill out type, qty, how often, etc...)

Substance	Do you use?	What Type?	How Much?	How Often?	If quit, when?
Alcohol:	☐ Y ☐ N				
Tobacco:	☐ Y ☐ N				
Caffeine:	☐ Y ☐ N				
Recreational Drugs:	☐ Y ☐ N				

Do have an Advance Directive, also known as a Living Will? ☐ Y ☐ N

If yes, please provide us with a copy for your medical record when you are next in our offices.

If no, please consider completing an Advance Directive, as recommended for all adults regardless of health status. An advance Directive form is included in your new patient information packet.

If you were ever unable to speak for yourself, who would the doctors speak to on your behalf?

Name: _____ **Phone:** _____

Level of Education: _____ **Occupation:** _____

FAMILY HISTORY: Please list any illnesses in your family, including all cancers (e.g., breast cancer, colon cancer, ovarian cancer, etc.) and blood disorders (e.g., anemia, blood clotting disorders, etc.).

Relationship	Illness	Diagnosis Age	Deceased?	Relationship	Illness	Diagnosis Age	Deceased?
Mother:			☐ Y ☐ N	**Brothers:**			☐ Y ☐ N
Father:			☐ Y ☐ N	**Sisters:**			☐ Y ☐ N
Grandmother (P):			☐ Y ☐ N	**Children:**			☐ Y ☐ N
Grandfather (P):			☐ Y ☐ N	**Cousins:**			☐ Y ☐ N
Grandmother (M):			☐ Y ☐ N	**Aunts:**			☐ Y ☐ N
Grandfather (M):			☐ Y ☐ N	**Uncles:**			☐ Y ☐ N

REVIEW OF SYSTEMS

Constitutional		
Weight Loss	☐ Y	☐ N
Poor Energy Level	☐ Y	☐ N
Fever	☐ Y	☐ N
Chills	☐ Y	☐ N
Night Sweats	☐ Y	☐ N

Breast		
Mass	☐ Y	☐ N
Pain	☐ Y	☐ N
Nipple Discharge	☐ Y	☐ N
Change in Size	☐ Y	☐ N
Change in Shape	☐ Y	☐ N

Skin		
Rash	☐ Y	☐ N
Nodules	☐ Y	☐ N
Itchiness	☐ Y	☐ N
Lesions	☐ Y	☐ N

Eyes		
Double Vision	☐ Y	☐ N

Gastrointestinal		
Nausea	☐ Y	☐ N

Neurological		
Confusion	☐ Y	☐ N

NEW PATIENT & FAMILY HISTORY (CONT.)

Eyes (cont.)

Vision Loss	☐ Y	☐ N
Flashing Lights	☐ Y	☐ N

ENT/Mouth

Ringing in Ears	☐ Y	☐ N
Oral Ulcers	☐ Y	☐ N
Nasal Drip	☐ Y	☐ N
Hearing Loss	☐ Y	☐ N
Bleeding Gums	☐ Y	☐ N
Mouth Pain	☐ Y	☐ N
Nose Bleeds	☐ Y	☐ N
Sore Throat	☐ Y	☐ N
Difficulty Swallowing	☐ Y	☐ N
Hoarseness	☐ Y	☐ N
Sinus Pain	☐ Y	☐ N

Cardiovascular

Chest Pain	☐ Y	☐ N
Leg Swelling	☐ Y	☐ N
Palpitations	☐ Y	☐ N
Calf Discomfort	☐ Y	☐ N
Fainting Spells	☐ Y	☐ N
Arm Swelling	☐ Y	☐ N

Respiratory

Cough	☐ Y	☐ N
Wheezing	☐ Y	☐ N
Shortness of Breath	☐ Y	☐ N
Coughing Blood	☐ Y	☐ N
Pain w/Breathing	☐ Y	☐ N

Gastrointestinal

Vomiting	☐ Y	☐ N
Jaundice	☐ Y	☐ N
Abdominal Pain	☐ Y	☐ N
Maroon/Black Stool	☐ Y	☐ N
Constipation	☐ Y	☐ N
Abdominal Cramping	☐ Y	☐ N
Diarrhea	☐ Y	☐ N
Stomach Pain	☐ Y	☐ N
Vomiting Blood	☐ Y	☐ N
Difficulty Swallowing	☐ Y	☐ N

Urinary

Painful Urination	☐ Y	☐ N
Blood in Urine	☐ Y	☐ N
Increased Frequency	☐ Y	☐ N
Loss of Control	☐ Y	☐ N
Impotence	☐ Y	☐ N

Gynecological

Vaginal Discharge	☐ Y	☐ N
Pelvic Pain	☐ Y	☐ N
Abnormal Bleeding	☐ Y	☐ N
Vaginal Dryness	☐ Y	☐ N

Musculoskeletal

Muscle Pain	☐ Y	☐ N
Spine Tenderness	☐ Y	☐ N
Swollen Joints	☐ Y	☐ N
Joint Redness	☐ Y	☐ N
Bone Pain	☐ Y	☐ N

Neurological (cont.)

Seizures	☐ Y	☐ N
Fainting Spells	☐ Y	☐ N
Tremors	☐ Y	☐ N
Speech Change	☐ Y	☐ N
Headache	☐ Y	☐ N
Hiccups	☐ Y	☐ N
Abnormal Gait	☐ Y	☐ N
Weakness	☐ Y	☐ N
Sensory Change	☐ Y	☐ N

Psychiatric

Depression	☐ Y	☐ N
Anxiety	☐ Y	☐ N
Lack of Concentration	☐ Y	☐ N

Endocrine

Excessive Urine	☐ Y	☐ N
Excessive Thirst	☐ Y	☐ N
Hot Flashes	☐ Y	☐ N
Heat/Cold Intolerance	☐ Y	☐ N

Hematological

Nose Bleeds	☐ Y	☐ N
Bleeding Gums	☐ Y	☐ N
Purple Spots on Hands	☐ Y	☐ N
Bruising	☐ Y	☐ N

Lymphatic

Enlarged Lymph Nodes	☐ Y	☐ N
Swelling in Arms	☐ Y	☐ N

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NEW PATIENT & FAMILY HISTORY (CONT.)

REFERRING PHYSICIANS: Please list all referring physicians and those you are currently seeing.

Physician	Address	Phone Number

MEDICATIONS: Please list all medications, including prescription, non-prescription, and other (including herbal) that you are currently taking. Please include dosage and frequency taken.

Medication	Dosage	Frequency

PHARMACY: Please list your pharmacy information.

Pharmacy	Address	Phone Number

ADDITIONAL NOTES: Please use this space to complete any additional notes that were not completed above. Please mark what section they correspond to.

Patient Signature: _____

Patient Printed Name: _____

Date: _____

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ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

Patient Name: _____ _____
Last *First* *M.I.* *Today's Date*

( ) _____ ( ) _____
Home Telephone *Cell phone*

Home Address: _____ Mailing Address: _____

_____ _____
City *State* *Zip* *City* *State* *Zip*

DOB: _____ Age _____ ☐ M ☐ F SS# _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Sex

Employer: _____ ( ) _____
Name *Telephone*

_____ _____
Address *Occupation*

Responsible Party: _____ _____ ( ) _____
Name *Relationship* *Telephone*

Emergency Contact:
Spouse/Next of Kin: _____ _____ ( ) _____
Name *Relationship* *Telephone*

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone: ( ) _____

Subscriber Name: _____ DOB: _____

Subscriber Employer: _____ Group #: _____ Policy #: _____

Secondary Ins: _____ Telephone: ( ) _____

Subscriber Name: _____ DOB: _____

Subscriber Employer: _____ Group #: _____ Policy #: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Virginia Cancer Specialists, P.C. I also authorize agents of any hospital, treatment center or previous physician to furnish Virginia Cancer Specialists, P.C. copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or report related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Virginia Cancer Specialists, P.C.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Virginia Cancer Specialists, P.C. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Virginia Cancer Specialists, P.C.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with US Oncology.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____
Patient Signature Date/Time AM or PM (circle one)

_____ _____
Responsible Party Signature Relationship Date/Time AM or PM (circle one)

PHYSICIAN _____
ACCT NBR _____ LOC _____
FOR OFFICE USE ONLY

EMPLOYEE INITIALS _____

RIGHTS AND RESPONSIBILITIES OF PATIENTS

As a Patient, I have the RIGHT to:

1. Full information of my rights and responsibilities as a patient of Virginia Cancer Specialists.
2. Receive an explanation of my diagnosis, benefits of treatment, alternatives, recuperation, risks and an explanation of consequences if treatment is not pursued.
3. An explanation of all services provided by Virginia Cancer Specialists, the days and hours of service and provisions for possible emergency care, including telephone numbers.
4. Participate in development of a plan of treatment.
5. Make known Advance Directives or a Living Will, if I wish.
6. Refuse participation in any protocol or aspect of care including investigational studies, and freely withdraw my previous given consent for further treatment.
7. Disclosure of any teaching programs, research or experimental programs in which the facility is participating.
8. Full financial explanation and payment schedule prior to beginning treatment.
9. Receive professional care without discrimination, regardless of race, creed, color, religion, national origin, sexual preference, handicap, sex or age.
10. Be treated with courtesy, dignity and respect of my personal privacy by all employees of Virginia Cancer Specialists.
11. Be free of physical/mental abuse and/or neglect by all employees of Virginia Cancer Specialists.
12. Complain or file grievances with representatives of Virginia Cancer Specialists without fear of retaliation or discrimination.
13. Confidential treatment of my condition, medical record and financial information.
14. Access to my personal records and obtain copies upon written request.

As a PATIENT, I have the RESPONSIBILITY to:

1. Disclose accurate and complete information related to physical condition, hospitalizations, medications, allergies, medical history and related items.
2. Assist in maintaining a safe, peaceful and efficient ambulatory environment.
3. Provide new/changed information related to my health insurance to the business office and be prepared to meet my agreed co-pay during my office visit.
4. Contact the office when unable to keep a scheduled appointment.
5. Cooperate in the planned care and treatment developed for me.
6. Request more detailed explanations for any aspect of service I don't understand.
7. Inform my physicians and nurses of any changes in my condition or any new problems or concerns.
8. Communicate any temporary or permanent change in my address or telephone number which might hinder contact by the office staff.

NOTICE OF PRIVACY PRACTICES

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.

About Us

In this Notice, we use terms like "we," "us," "our" or "Practice" to refer to **Virginia Cancer Specialists, P.C.,** its physicians, employees, staff and other personnel. All of the sites and locations of **Virginia Cancer Specialists, P.C.** follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care 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 explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information without your written authorization:

For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another healthcare provider to be sure they have all the information necessary to diagnose and treat you.

NOTICE OF PRIVACY PRACTICES (cont.)

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

Individuals Involved in Your Care or Payment for Your Care and Notification: If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

We may use or disclose your information to notify or assist in notifying a family member, personal representative or any other person responsible for your care regarding your physical location within the Practice, general condition or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status and location.

We are also allowed to the extent permitted by applicable 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: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. 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 tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for

NOTICE OF PRIVACY PRACTICES (cont.)

the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several 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;
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- Activities related to the quality, safety or effectiveness of FDA-regulated products;
- 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 as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

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 use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement authorities to identify or apprehend an individual.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation or banking of organs, eyes, or tissues.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

NOTICE OF PRIVACY PRACTICES (cont.)

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- **Psychotherapy Notes:** We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.
- **Marketing:** We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.
- **Sale of Your Health Information:** We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or

NOTICE OF PRIVACY PRACTICES (cont.)

disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. In most circumstances, 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 Virginia Cancer Specialists, P.C., Privacy Official, 3040 Williams Dr., Suite 100, Fairfax, VA 22031. We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

Right 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. To request confidential communications, you must make your request in writing and submit it to Virginia Cancer Specialists, P.C., Privacy Official, 3040 Williams Dr., Suite 100, Fairfax, VA 22031. We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. 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 Virginia Cancer Specialists, P.C., Privacy Official, 3040 Williams Dr., Suite 100, Fairfax, VA 22031. You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care 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.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information . You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Virginia Cancer Specialists, P.C., Privacy Official, 3040 Williams Dr., Suite 100, Fairfax, VA 22031.

NOTICE OF PRIVACY PRACTICES (cont.)

We may deny your request for an amendment. 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 that will become part of your medical record.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

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 Virginia Cancer Specialists, P.C., Privacy Official, 3040 Williams Dr., Suite 100, Fairfax, VA 22031. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact Virginia Cancer Specialists, P.C., Privacy Official, 3040 Williams Dr., Suite 100, Fairfax, VA 22031. You may also obtain a paper copy of this Notice at our website, http://www.virginiacancerspecialists.com.

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the reception area of each Virginia Cancer Specialists, P.C. office. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, www. http://www.virginiacancerspecialists.com.

Complaints

If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: Virginia Cancer Specialists, P.C., Privacy Official, 3040 Williams Dr., Suite 100, Fairfax, VA 22031. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing a complaint.

Questions

If you have questions about this Notice, please contact Virginia Cancer Specialists, P.C., Privacy Official, 3040 Williams Dr., Suite 100, Fairfax, VA 22031 (703) 280-5390.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Virginia Cancer Specialists, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Virginia Cancer Specialists.

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

Virginia Cancer Specialists Use Only

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained and employee signature:

_____

_____

_____

Patient Request for Health Information Copies at Time of Visit

Routine, Ongoing Disclosure

Please complete this form if you would like routine copies of your labs or other protected health information when you come for your appointment. Completion of the form is totally voluntary. If you do not complete this form and you want a copy of your lab report, we will ask you to complete a "Health Information Access Request Form" each time you request one. The State of Virginia has decreed that medical records are the property of the practice rather than the individual. We encourage you to remain informed about your health and associated health in formation.

Please indicate, specifically, the information to which you are requesting access:

_____

_____

Please indicate the form or format in which you would like to receive your requested information:

_____

_____

Please indicate the means by which you wish to review or obtain a copy of the requested information (fax, mail, on-site, etc.), and provide the necessary phone number or address:

_____

_____

I authorize Virginia Cancer Specialists, P.C. to use and disclose my health information in the manner described above. I understand that I am responsible for protecting the privacy of the information once it is received. This authorization will remain in effect until I revoke it, which may be done at any time by notifying Virginia Cancer Specialists, P.C. in writing.

_____ _____
Patient Name Date of Birth

_____ _____
Signature Date

_____
Name of Personal Representative (if appropriate)

_____
Signature of Personal Representative (if appropriate)

For Virginia Cancer Specialists, P.C. Use Only:

Date Received: _____ _____Accepted _____Denied

If denied, check reason for denial:

_____Excepted Information _____Inmate Request _____Confidentiality Issues

_____Research _____Privacy Laws _____Other

_____

Date and method of informing individual of original decision: _____

If denied, was review requested? _____ Yes _____ No

Name of reviewing official: _____ Decision on review: _____

Date and method of informing individual of review decision: _____

_____

Comments: _____

_____ _____
Staff Member Signature Date

User Electronic Mail Authorization Form

My Care Plus ~ Portal Consent

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. For your protection, the link is designed to expire quickly if not used.

If you should change email addresses, please contact our office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust. If you wish to discontinue utilizing the Portal, please contact our office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. ***Please write legibly.***

_____
Patient Name (First Name, Middle Initial, Last Name)

_____
Email Address of Patient or Authorized

_____
Date of Birth of Patient

_____
Physician's Name

Authorized User is:

❑ Patient
❑ Patient's Designee

_____
Patient's Designee's Name (Printed)

_____
Patient's Designee's Signature

_____
Patient's Signature

_____
Date

_____
Signature of Practice Staff
[Confirming user's identity and authority]

_____
Date

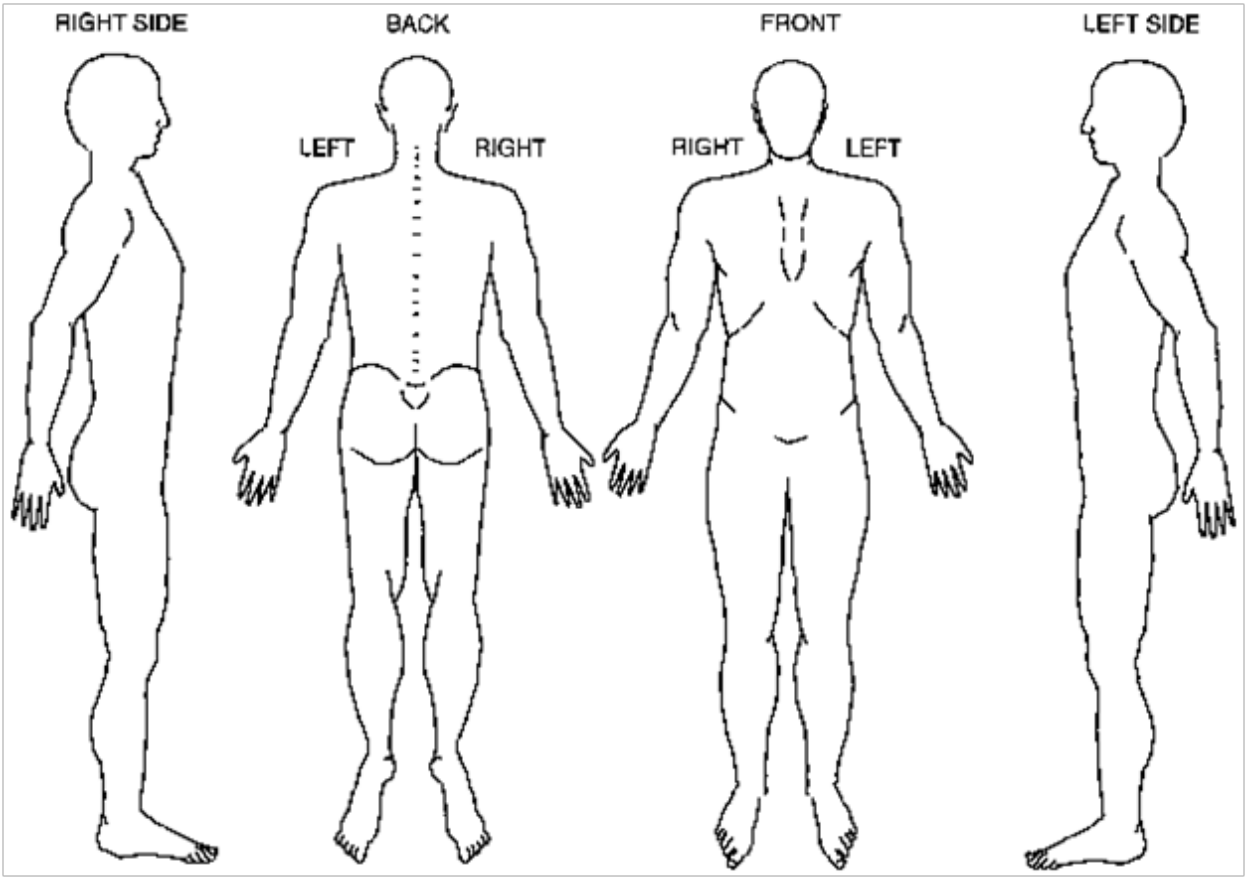
Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose.

Your pain: Pain Diagram and Visual Analog Scale

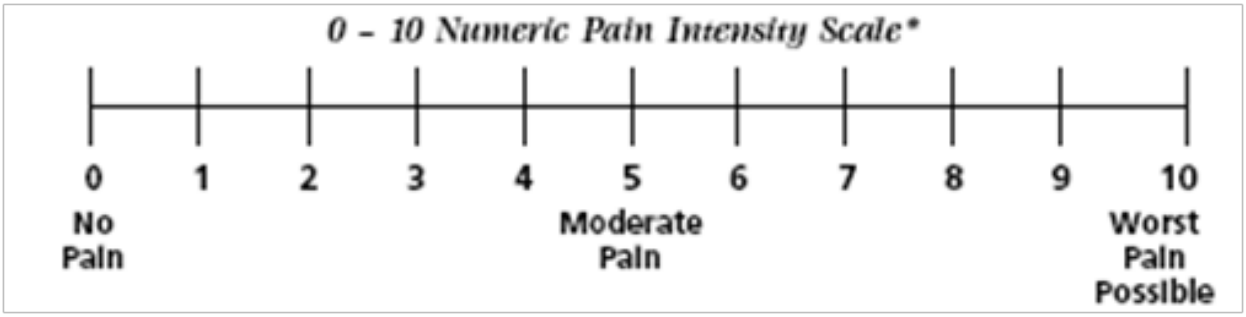
Mark the areas with the symbols on the diagram that matches your pain. Include all areas. If your pain spreads out, draw and (→) from where the pain starts.

ACHING: XXXX **NUMBNESS:** **** **PINS AND NEEDLES:** 0000

BURNING: >>>> **STABING:** //// **THROBBING**: ++++



For each area of pain, put a number beside it that matches your pain. The scale below describe the number your pain



Previous Imaging Studies:

Test	Date
X-Ray	
CT	
MRI	
Bone Scan	
Other	

Preferred Pharmacy:

Pharmacy	Address	Phone #

Physicians:

Physicians	Phone/fax #
Referring MD:	
Primary Care:	
Orthopedic Surgeon:	
Medical Oncologist:	
Other:	

Patient Signature _____ **Date** _____