

NEW PATIENT & FAMILY HISTORY

PATIENT INFO:

Last Name

First Name

M.I.

Today's Date

DOB

Marital Status

Height

Weight

Home Phone

Mobile Phone

Work Phone

Patient Address (street)

City

State

Zip Code

Email Address

Preferred method of contact (circle/pick one):

Home Phone

Mobile Phone

Work Phone

E-mail

Race (optional): _____

Ethnicity (circle or leave blank): Hispanic/Latino or Non Hispanic/Latino

Preferred Language (optional): _____

Emergency Contact Name: _____

Relationship: _____

Emergency/Phone: _____

Emergency/Alternate Phone: _____

REFERRING DOCTOR (If not known, list primary care physician):

Referring Doctor Name

Practice Name

Phone Number

Address

City

State

Zip Code

REASON FOR PHYSICIAN REFERRAL (please provide details with dates):

TOGETHER: A BETTER WAY TO FIGHT CANCER

VirginiaCancerSpecialists.com



Virginia Cancer
Specialists



The US Oncology
Network

NEW PATIENT & FAMILY HISTORY

MEDICAL CONDITIONS	Date of Diagnosis	Date of Diagnosis
Psychological		
ADD/ADHD	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Anxiety/Depression	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Bipolar Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Dementia	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Eating Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
OCD	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Post-Traumatic Stress Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Communicable/Infectious Disease		
AIDS/HIV	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Herpes Simplex	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Autoimmune Disorders		
Rheumatoid Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Lupus	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Multiple Sclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Pulmonary/Respiratory		
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
COPD/Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Lung Disease	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Sleep Apnea	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Genitourinary		
Benign Prostatic Hypertrophy (BPH)	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Hematological		
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Deep Venous Thrombosis	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Pulmonary Embolism	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Chronic Disease		
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Fibromyalgia Osteopenia/Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Past History of Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
If Yes, Type of Cancer: _____		
Gastro/Intestinal		
Crohn's/Ulcerative Colitis	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Diverticulitis	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
GERD/Hiatal Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Hepatitis A/B/C	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Irritable Bowel Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Reflux	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N _____	



NEW PATIENT & FAMILY HISTORY

MEDICAL CONDITIONS CONT.	Date of Diagnosis	Date of Diagnosis
Cardiovascular		
Collagen Vascular Disease	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Coronary Artery Disease/MI or Angina	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Heart Arrhythmia	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Peripheral Vascular Disease	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Endocrine		
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Thyroid Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Other Endocrinological Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Gynecological		
Dysfunctional Uterine Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Endometriosis	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Polycystic Ovarian Disease	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Nephrology		
Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Kidney Stones	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Neurological		
Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Neurological Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Parkinson's	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Dermatological		
Psoriasis	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Other		
Gout	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Hives	<input type="checkbox"/> Y <input type="checkbox"/> N _____	
Restless Leg Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N _____	



NEW PATIENT & FAMILY HISTORY

HEALTH HISTORY AND PREVENTATIVE HEALTH MAINTENANCE

Have you:

Ever had a flu vaccine this flu season (Sept-March)?: Y N

Have you:

Ever had a blood transfusion: Y N

If yes, when? _____

Reproductive History:

Number of pregnancies: _____

If yes, when: _____

Age at first pregnancy: _____

Number of children: _____

Did you breast feed? Y N

If yes, how many months? _____

Age at first period: _____

Age at last period: _____

Age at menopause: _____

Hysterectomy: Y N

Ovaries Intact? Y N

If no, please explain: _____

Hormone Use: Y N

Sex Drive: Y N

Birth Control Method: _____

Are you taking Estrogen, Birth Control Pills or Testosterone? Y N

If no, please explain: _____

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: _____



NEW PATIENT & FAMILY HISTORY (CONT.)

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

Do you drink alcoholic beverages: Y N How Many drinks per week/month: _____

Have you ever smoked cigarettes? Y N Are you currently smoking? Y N

Packs per day? _____ How many years? _____ When did you quit? _____

Do you use caffeine? Y N What caffeinated beverages? _____

Do you use recreational drugs? Y N How often? _____ How much? _____

What type? _____ If quit, when? _____

Marital Status (Married, Single Widowed, Divorced)? _____

With whom do live? _____ 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	If yes, which cancer or blood disorder	Age of diagnosis	Are they deceased?
Mother:	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Brothers:	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Father:	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Sisters:	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Cousins:	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Children:	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandmother (P):	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandfather (P):	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandmother (M):	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Grandfather (M):	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Aunts (M):	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Aunts (P):	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Uncles (M):	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
Uncles (P):	<input type="checkbox"/> Y <input type="checkbox"/> N _____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N



NEW PATIENT & FAMILY HISTORY (CONT.)

SYMPTOMS: Please list any symptoms you may have in the categories below.

Constitutional

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

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 or Pressure upon Exertion Y N
 -If yes explain: _____

Arm/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

Breast

Mass Y N
 Pain Y N
 Nipple Discharge Y N
 Change in Size Y N
 Change in Shape 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
 Vomiting Blood Y N
 Change in Swallowing Y N
 Nausea 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
 Vaginal Dryness Y N
 Unexplained or Heavy Bleeding Y N
 -If yes explain: _____

Musculoskeletal

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

Neurological

Confusion Y N
 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
 -Upper Extremity Y N
 -Left Side Y N
 -Lower Extremity Y N
 -Right Side Y N
 Sensory Change Y N
 Abnormal Numbness/Tingling Y N
 -If yes explain: _____

NEW PATIENT & FAMILY HISTORY (CONT.)

SYMPTOMS: Please list any symptoms you may have in the categories below.

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 Intolerance Y N
 Cold Intolerance Y N

Lymphatic

Enlarged Lymph Nodes Y N
 Swelling in Arms Y N

Hematological

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

Skin

Rash Y N
 Nodules Y N
 Itchiness Y N
 Lesions Y N

-If yes explain: _____

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

Physician	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHARMACY: Please list your pharmacy information.

Pharmacy	Address	Phone Number
_____	_____	_____

ADVANCE DIRECTIVE

Do you 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:** _____

Patient Signature: _____ **Date:** _____



NEW PATIENT & FAMILY HISTORY (CONT.)

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: _____



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 (Self Y/N): _____ () _____
Name Relationship Telephone

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

Referring Physician: _____ Primary Care Physician: _____

Do you have Insurance Y/N
 Primary Ins: _____ Telephone: () _____

Subscriber Name: Subscriber _____ DOB: _____
 Employer: _____ Group #: _____ Policy #: _____

Do you have Secondary Insurance Y/N
 Secondary Ins: Subscriber Name: _____ Telephone: () _____
 Subscriber Employer: _____
 _____ Group #: _____ Policy #: _____

- 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).
- 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.
- 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.
- 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 _____ <small>FOR OFFICE USE ONLY</small>	EMPLOYEE INITIALS _____
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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](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 information.

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 Signature

Patient’s Designee’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.



PERMISSION FOR VERBAL COMMUNICATIONS

To protect the patient's privacy and to ensure that our clinic staff and physicians know whom they have permission to communicate with regarding the patient's protected health information, it is helpful for patients to have a Permission for Verbal Communications form on file at Virginia Cancer Specialists.

Patient's Name

I permit Virginia Cancer Specialists to discuss health information with the following individuals involved in my medical care or payment of my care:

List individuals and state the person's relationship to the patient.

Name	Phone Number	Relationship
1. _____		
2. _____		
3. _____		

This authorization is limited to discussions regarding the following medical condition(s):

If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.

This authorization is limited to the following timeframe from

_____ (date) to _____ (date).

If no dates are indicated, this form will remain in effect for an unlimited amount of time.

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

Patient's Signature

Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

Name of Personal Representative

Relationship to Patient

Witness

Date

PATIENT CONSENT FORM - 3rd PARTY API

A new option for you to view your health information

What is a 3rd Party API?

An application you can access using a computer, phone or tablet to view the health information in your chart. Depending on the type of app, you will be able to view information such as diagnoses, lab results and medication lists. Apps may offer different features, so you can pick what best meets your needs.

Why?

New Medicare requirement to give patients the option to view their information using a 3rd Party Application. This is in addition to our patient portal, My Care Plus.

How?

- Complete consent for 3rd party API.
- Request a registration access code from our office. (**Codes expire after 7 days.)
- Access the iKnowMed API Portal website to enter your code and create an account. <https://apiaccess.mckesson.com>
- You will need to use Chrome to access the iKnowMed API Portal.
- Applications that meet the iKnowMed security and technical requirements will be listed.
- You may select any applications from the list, and depending on the application, access them from a computer, phone or tablet.

Registration is open for patients as of 9/3/18, as 3rd party applications become available they will be added the website.

By signing below, I hereby consent to use of the 3rd party API technology. At any point in time, it is my right to decline the use of 3rd party API.

Patient's Name (PRINT)

Patient's DOB

IKM ID

Patient's Signature

Date

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

Date

Staff: Complete consent process in IKM then scan document.