

# Austin/Georgetown Cancer Centers<sub>sm</sub>

## ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_  
Last First M.I.

SS# \_\_\_\_\_ DOB: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Other \_\_\_\_\_ Religion: \_\_\_\_\_

Sex:  Male  Female Ethnicity:  Non-Hispanic  Hispanic  American Indian  Asian  Black/African American  
Race:  Native Hawaiian  White  Other \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_  Primary (\_\_\_\_) \_\_\_\_\_  Primary (\_\_\_\_) \_\_\_\_\_  Primary  
Home Cell Work

Home Address: \_\_\_\_\_  
Street City State Zip Code

Patient Employer: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Telephone Number

\_\_\_\_\_ Address Occupation

Responsible Party: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Relationship Telephone Number

Emergency Contact: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Relationship Telephone Number

Referring Physician: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Address Telephone Number

Primary Care Physician: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Address Telephone Number

The following person(s) may have access to my treatment and payment information:

Please give Name and Relationship: \_\_\_\_\_

Primary Ins: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Subscriber SS# \_\_\_\_\_ DOB: \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Claims Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Subscriber SS# \_\_\_\_\_ DOB: \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Claims Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

**Advanced Directives:** This includes a Living Will, Medical Power of Attorney, and Out of Hospital Do Not Resuscitate order and allows you to state your choice for healthcare if you become unable to make decisions. Advanced directives are not required in order to receive proper medical treatment at this facility, but if you have executed advanced directives you must provide a copy to us to be put in your medical chart to ensure that your wishes are honored. If you are interested in learning more about advanced directives, ask your nursing professional for information.

**Please check at least one box.**

- I have a Durable Power of Attorney for Health Care.
- I have a Living Will (directive to physicians)
- I have an Out of Hospital **Do Not Resuscitate** directive. I understand I must wear an approved ID device or carry the original document in a visible manner in order for the document to be honored.
- At this time, I have not executed any of the above directives and understand that in an emergency situation the medical staff will be responsible for making decisions regarding my care.

**HIPAA Consent for Treatment, Payment, and other Healthcare Operations**

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 Austin Cancer Centers. I also authorize agents of any hospital, treatment center, and/or previous physicians to furnish Austin Cancer Centers copies of any records of my medical history, services, or treatments. I also authorize the release of any medical information and/or reports 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 Austin Cancer Centers.
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 Austin Cancer Centers. 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 Austin Cancer Centers.
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 payors; (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 Austin Cancer Centers.
5. I consent to the disclosure of my protected health information to any physician or facility that is currently or will be participating in my diagnosis, evaluation, treatment or follow-up care.

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 the original.

**THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNTIL SUPERCEDED BY AN UPDATED AOB BY ME IN WRITING.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Time AM or PM (circle one)

\_\_\_\_\_  
Patient Representative Signature

\_\_\_\_\_  
Date Time AM or PM (circle one)

\_\_\_\_\_  
Austin Cancer Centers Representative Signature

\_\_\_\_\_  
Date Time AM or PM (circle one)

### History and Physical

Patient Name:		Date:
Date of Birth:	Age:	Sex:      Male      Female
Primary Care Physician:	<b>Drug Allergies:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Please List:	
Medical Oncologist:		
Surgeon:		
Other Physicians:		

### Medical History

Please list dates of each instance.

Major Medical Problems (ie. Diabetes, Heart Problems, etc)	Surgeries (Please list approximate dates)	Hospitalizations (Please list approximate dates)

### Current Medications

Include vitamins and/or herbal products

Name of medication	Dose	Frequency

### Family History

Is there a history of cancer in your family?

- No  
 Yes, please list below:

Relationship	Type of Cancer

### Immunizations

When were your most recent immunizations?

Type	Date
<input type="checkbox"/> Hepatitis A	
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Influenza (flu shot)	
<input type="checkbox"/> Measles	
<input type="checkbox"/> Pneumovax	
<input type="checkbox"/> Rubella	
<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Varicella (chicken pox)	

<b>Social History</b>
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired
Occupation (current or former):
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other:
Number of people in household:
Do you now or have you ever smoked? <input type="checkbox"/> No <input type="checkbox"/> Yes, I started at age _____, quit at age _____ <input type="checkbox"/> Cigarettes, _____ packs per day <input type="checkbox"/> Other tobacco, _____ packs per day
Do you want information on smoking cessation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes, please check a box below: <b>Women:</b> <input type="checkbox"/> < 7 per week <input type="checkbox"/> > 7 per week <input type="checkbox"/> < 3 drinks/occasion <input type="checkbox"/> > 3 drinks/occasion <b>Men:</b> <input type="checkbox"/> < 14 per week <input type="checkbox"/> > 14 per week <input type="checkbox"/> < 4 drinks/occasion <input type="checkbox"/> > 4 drinks/occasion
Have you been treated for drug/alcohol abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been exposed to hazardous materials? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Treatment Options</b>
Have you had past experience with cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes, type of cancer _____ When were you diagnosed? _____
Have you had any prior radiation treatments? <input type="checkbox"/> No <input type="checkbox"/> Yes, in year _____
Have you ever had chemotherapy? <input type="checkbox"/> No <input type="checkbox"/> Yes, in year _____
Will chemotherapy be a part of your treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Screenings</b>			
When were your most recent screening tests?			
Type	Date (Please list approximate dates)	Results	Report Received
Lipid (Cholesterol screening)			<input type="checkbox"/>
PSA (Prostate Cancer screening)			<input type="checkbox"/>
Stool test for occult blood			<input type="checkbox"/>
Sigmoidoscopy/Colonoscopy			<input type="checkbox"/>
Mammogram			<input type="checkbox"/>
Ever abnormal?			<input type="checkbox"/>
Pap Smear			<input type="checkbox"/>
Ever abnormal?			<input type="checkbox"/>
DEXA scan (osteoporosis screening)			<input type="checkbox"/>

**Patient Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_



## **Accidental Exposures**

**In the course of care and treatment, health care workers may be accidentally exposed to a patient's blood or body fluids. Communicable diseases, including the HIV virus that causes AIDS, are known to be transmitted through accidental exposures.**

**I understand that, in the event a health care worker is exposed to my blood or body fluids, my blood will be tested for the HIV antibody and other communicable diseases at no cost to me. My initials below signify that I understand the information and agree to your proposal.**

**On behalf of Austin Cancer Centers, we thank you for your cooperation.**

**Patient Initials \_\_\_\_\_ Date \_\_\_\_\_**

## **Pregnancy**

**Female patients, please let us know if there is any possibility that you may be pregnant.**

**Yes**                       **No**

**Patient Initials \_\_\_\_\_ Date \_\_\_\_\_**

# AUSTIN CANCER CENTER

## NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

**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" or "our" to refer to Austin Cancer Center, its physicians, employees, staff and other personnel. All of the sites and locations of Austin Cancer Center follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations 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 provide you notice of our legal duties and privacy practices with respect to your 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:

For Treatment: We may use your health information to provide you with medical treatment or services. For example, your health information will be disclosed to the oncology nurses 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 physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat you.

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 share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. 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 ask you to sign your name to a sign-in sheet at the registration desk and we may call your name in the waiting room when we call you for your appointment.

We may disclose your health information to a third party that performs services, such as billing and collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or e-mail you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a family member or friend, please contact our Health Information Management Director at (512) 623-5246** We may also disclose your health information to disaster-relief organizations so that your family can be notified about your condition, status and location.

We are also allowed by 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 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: the following:

- 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 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, 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

- \* To prevent or control disease, injury, or disability;
- \* To report births or deaths;
- \* To report child abuse or neglect;
- \* To report adverse events, product defects or problems;
- \* To track FDA-regulated products;
- \* To notify people and enable product recalls; and
- \* 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.

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.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

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 for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

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 limited research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project, assesses a number of specific issues, and determines that appropriate privacy safeguards are in place to allow the use of health information in the research project. We may, however, disclose your health information to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the practice.

Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, 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 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. **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 **Austin Cancer Center, Attn: Health Information Management Director, 2211 W Braker Lane, Austin, Texas 78758 (512) 623-5246.**

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 **Austin Cancer Center, Attn: HIPAA Privacy Officer, 2211 W Braker Ln, Austin, Tx 78758.** 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. Usually, this includes medical and billing records, but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. 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 **Austin Cancer Center, Attn: Health Information Management Director, 2211 W Braker Lane, Austin, Texas 78758 (512) 623-5246.** If you request a copy of your health information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.

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 **Austin Cancer Center, Attn: Health Information Management Director, 2211 W Braker Lane, Austin, Texas 78758 (512) 623-5246.**

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.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we make of your health information. Please note that certain disclosures, such as those made for treatment, payment or health care operations, 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 **Austin Cancer Center, Attn: Health Information Management Director, 2211 W Braker Lane, Austin, Texas 78758 (512) 623-5246.** 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 **Austin Cancer Center, Attn: HIPAA Privacy Officer, 2211 W Braker Ln, Austin, Tx 78758. (512) 623-5246.**

Right to Complain: If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to **Austin Cancer Center, Attn: HIPAA Privacy Officer, 2211 W Braker Ln, Austin, Tx 78758.** . 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.**

#### **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 patient waiting area at each facility. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our web site, [www.austincancercenters.com](http://www.austincancercenters.com).

**NOTICE OF PRIVACY PRACTICES  
Acknowledgment of Receipt**

Austin Cancer Centers 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 Austin Cancer Centers

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Name of Personal Representative (if appropriate):** \_\_\_\_\_

**Signature of Personal Representative (if appropriate):** \_\_\_\_\_

**Date:** \_\_\_\_\_

-----  
Austin Cancer Centers Office Use Only  
\_\_\_\_\_

Date acknowledgement received: \_\_\_\_\_

-OR-

Reason acknowledgement was not obtained:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Staff signature

\_\_\_\_\_  
Date