NEW HOPE

cancer and research institute - a medical corporation
www.newhopecancerinstitute.com

Patient Information

Name (Last, First Init.)		SS#	
Address		City, State	Zip Code
Home Phone	Cell Phone	Work Phone	Marital Status S / M / D / W
Birth Date	Age	☐ Male	☐ Female

Preferred Way To Contact You:
☐ Home Phone ☐ Cell Phone ☐ Work Phone

*By making a contact selection you are giving us permission to contact you.

Employer		
Emergency Contact	Relationship	Phone
How did you hear about us?		

Financial Responsibility

Person Responsible for Account		Relationship to Patient	
Address (if different)		City, State	Zip Code
Home Phone	Cell Phone	Work Phone	Employer
Birth Date	SS#	☐ Male	☐ Female

Primary Insurance

Insurance Company	Phone #	
Address	City, State	Zip Code
Subscriber Name	ID#	Group #
Birth Date	SS#	

Secondary Insurance

Insurance Company	Phone #	
Address	City, State	Zip Code
Subscriber Name	ID#	Group #
Birth Date	SS#	

Consent to Treatment

☐ I am the patient or ☐ I am the parent/guardian of the patient or ☐ Other Relationship _____

I hereby authorize such medical care, treatment, and diagnostic tests as may be recommended and understand there is no warranty or guarantee of result or cure. This consent will remain in effect until I withdraw my consent in writing.

Signature of Patient/Parent/Guardian: **Date:**

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ADVANCE DIRECTIVE QUESTIONNAIRE

1. Have you formulated an Advance Directive YES_____ No _____

2. If you have formulated an Advance Directive, please check the type that you have.

    a) Durable Power of Attorney for Health Care_____

    b) California Natural Death Act: _____

    c) Living Health Care Will: _____

    d) Other: _____

3. If you have formulated an Advance Directive, you hereby agree to furnish _____with a copy within _____days.

4. If you change, amend alter or cancel your Advance Directive, you hereby agree to notify _____and provide _____with a copy as soon as possible so that your physician will be able to comply with your wishes.

5. Expiration date of Advance directive, if any _____
(If the Advance directive was formulated before 1991, it is "good" for only seven years. Advance Directive formulated after 1991, as "good" indefinitely; unless you change/amend/cancel the Advance Directive.)

6. I would like more information about Advance Directives: YES_____NO_____

Patient Signature: _____ Date: _____

Patient Name: _____DOB:_____

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I. PATIENT INFORMATION:

Patient Name:		
Date of Birth:	SS#:	
Patient Mailing Address:		
Work #:	Home #:	Cell #:
My family physician is:		

II. INFORMATION TO BE DISCLOSED:

I authorize _____to disclose my health information as follows, for service dates: _____:

- ☐ All paper chart records
- ☐ Entire medical record/outpatient clinical record
- ☐ History and physical(s)
- ☐ Operative report(s)
- ☐ Discharge summary(ies)
- ☐ Films and pictures
- ☐ All electronic medical records
- ☐ Laboratory results
- ☐ Radiology and imaging reports
- ☐ Pathology slides, blocks or reports
- ☐ Other test results: _____
- ☐ Other: _____

I understand that information used or disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

III. INFORMATION IS TO BE DISCLOSED TO/FROM:

Disclose to:	Disclose from:
New Hope Cancer & Research Institute	
909-620-5502 Office Phone	
909-629-0552 fax	
626-914-5639 fax	

IV. PURPOSE OF USE OR DISCLOSURE: _____

V. I authorize the disclosure of health information as described above. I understand:

- This authorization is valid for 180 days unless otherwise stated here: _____
- A photocopy or fax of this authorization is as valid as the original.
- I may revoke this authorization at any time by submitting a revocation in writing to Methodist Family Medicine Group.
- If I revoke this authorization, the revocation will not apply to information that has already been released in good faith before the revocation was received.
- Treatment or payment may not be conditioned on my completion of this authorization form.

_____ _____

Signature of Patient or Qualified Personal Representative* **Date**

*If signed by a Qualified Personal Representative, the following must be completed:
Printed name of Qualified Personal Representative: _____
Legal Documentation showing Authority to Act on Behalf of the Patient: _____

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Welcome to our office. Please help us complete your medical record by furnishing the information below. If you have any questions regarding this form, please feel free to discuss these with the receptionist, nurse or physician.

NAME _____ **DOB** _____ **DATE** _____

Current Medications with doses:

Prescription
1 _____ 6 _____
2 _____ 7 _____
3 _____ 8 _____
4 _____ 9 _____
5 _____ 10 _____

Nonprescription:
1 _____ 3 _____
2 _____ 4 _____

Do You Have Any Allergies to the Following?

Medications:
1 _____ 3 _____
2 _____ 4 _____

Food or Other:
1 _____ 2 _____

Past Medical History (Do you have a history of any of these disorders)

	Yes	No		Yes	No
Alcoholism			Hepatitis		
Anemia			High Blood Pressure		
Arthritis			Kidney disease/Stones		
Asthma			Liver Disease		
Bleeding Problems			Lung Disease		
Blood Clots			Mental Illness		
Blood Transfusion			Migraine Headaches		
Cancer			Osteoporosis		
Cholesterol Elevation			Pneumonia		
Depression			Seizures		
Diabetes			Stroke		
Drug Abuse			Thyroid Problems		
Gallstones			Tuberculosis		
Glaucoma			Ulcers		
Heart Disease			Other: _____		

Childhood Illnesses

	Yes	No		Yes	No
Chicken pox			Whooping cough		
Measles			Scarlet fever		
Mumps			Rheumatic Fever		

NAME _____ **DOB** _____ **DATE** _____

Past Surgeries and biopsies (Please list dates)

1 _____ 3 _____

2 _____ 4 _____

Hospitalizations (Please list dates)

1 _____ 3 _____

2 _____ 4 _____

Gynecologic History

Number of : Pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Age at first Period _____ Age at menopause _____

Do you do monthly breast self exams? Yes _____ No _____

Please list yes or no if you have ever had:

	Yes	No		Yes	No
Abnormal mammogram	_____	_____	Hormone replacement therapy	_____	_____
Abnormal pap smear	_____	_____	Birth Control Pills	_____	_____
DES exposure	_____	_____	Sexually transmitted disease	_____	_____
Endometriosis	_____	_____	Pelvic inflammatory disease	_____	_____
Hysterectomy	_____	_____	Uterine fibroids	_____	_____

Lifestyle

Occupations _____

Have you ever been exposed to:

	Yes	No		Yes	No
Asbestos	_____	_____	Radiation	_____	_____
Smoke	_____	_____	Chemicals	_____	_____

Smoking

Have you ever smoked? _____

If yes, how old were you when you started _____

If you are a former smoker, when did you quit? _____

How many packs per day do you or did you smoke? _____

Alcohol:

How many drinks in a typical week? _____

Caffeine:

How many cups of caffeinated beverages per day? _____

Do you:	Yes	No		Yes	No
Use recreational Drugs	_____	_____	Use Sunblock	_____	_____
Exercise regularly	_____	_____	Use Seat Belts	_____	_____

NAME _____ **DOB** _____ **DATE** _____

Family History

Please list ages and health status:
Father _____ Mother _____
Brothers _____
Sisters _____
Sons _____
Daughters _____
Grandfathers _____
Grandmothers _____

Please list yes or no if a blood relative has had any of the following. If yes, indicate which relative (i.e., maternal aunt):

	Yes	No		Yes	No
Alcoholism	_____	_____	Leukemia	_____	_____
Anemia	_____	_____	Liver Disease	_____	_____
Arthritis	_____	_____	Lung Cancer	_____	_____
Asthma	_____	_____	Lymphoma	_____	_____
Bleeding Problems	_____	_____	Melanoma	_____	_____
Breast Cancer	_____	_____	Mental Illness	_____	_____
Colon Cancer	_____	_____	Migraine Headache	_____	_____
Cholesterol Elevation	_____	_____	Osteoporosis	_____	_____
Depression	_____	_____	Ovarian Cancer	_____	_____
Diabetes	_____	_____	Prostate Cancer	_____	_____
Heart Disease	_____	_____	Skin Cancer	_____	_____
Hepatitis	_____	_____	Stroke	_____	_____
High blood pressure	_____	_____	Tuberculosis	_____	_____
Hodgkin's disease	_____	_____	Ulcers	_____	_____
Kidney disease	_____	_____	Others	_____	

Preventive Health History

Immunizations (Please list dates)
Flu Shot _____
Hepatitis A _____
Hepatitis B _____
Measles (MMR) _____
Pneumococcal _____
Tetanus _____

Please list the date-of-your-last:
Pap test _____
Mammogram _____
Sigmoidoscopy _____
Eye exam _____
Prostate exam _____
Cholesterol _____
TB skin Test
Colonoscopy _____

NAME _____ DOB _____ DATE _____

Review of Symptoms (Please list yes or no if you have had any concerns about the following)

	Yes	No
General		
Weight loss	_____	_____
Weight gain	_____	_____
Fever	_____	_____
Sweats	_____	_____
Swollen glands	_____	_____
Loss of appetite	_____	_____
Fatigue	_____	_____
Skin		
Rash	_____	_____
Bruising	_____	_____
Change in mole or freckle	_____	_____
Eyes		
Blurry vision	_____	_____
Red eyes	_____	_____
Double vision	_____	_____
Blindness	_____	
Eye pain	_____	_____
Ears		
Deafness	_____	_____
Ear drainage	_____	_____
Ear pain	_____	_____
Ringing	_____	_____
Nose & Throat		
Sinus pain	_____	_____
Hoarseness	_____	_____
Sore throat	_____	_____
Lungs		
Shortness of breath	_____	_____
Cough	_____	_____
Coughing Blood	_____	_____
Wheezing	_____	_____
Heart		
Chest pain	_____	_____
Palpitations	_____	_____
Ankle swelling	_____	_____
Breasts		
Lumps	_____	_____
Pain	_____	_____
Nipple discharge	_____	_____

	Yes	No
Gastrointestinal		
Difficulty swallowing	_____	_____
Vomiting	_____	_____
Nausea	_____	_____
Abdominal pain	_____	_____
Constipation	_____	_____
Diarrhea	_____	_____
Change in bowel habits	_____	_____
Blood in Stool	_____	_____
Hemorrhoids	_____	_____
Jaundice	_____	_____
Urinary		
Blood in urine	_____	_____
Painful urination	_____	_____
Incontinence	_____	_____
Gynecologic		
Vaginal discharge	_____	_____
Heavy menstrual periods	_____	_____
Bleeding between periods	_____	_____
Musculoskeletal		
Joint swelling or pain	_____	_____
Back Pain	_____	_____
Swollen leg	_____	_____
Leg cramps	_____	_____
Neurological		
Headache	_____	_____
Weakness	_____	_____
Fainting spells	_____	_____
Dizzy spells	_____	_____
Memory loss	_____	_____
Paralysis	_____	_____
Convulsions	_____	_____
In-coordination	_____	_____
Trouble talking	_____	_____
Psychological		
Anxiety	_____	_____
Depression	_____	_____
Sleep disturbance	_____	_____

NOTICE OF PRIVACY PRACTICES

Your rights under the Health Insurance Portability & Accountability Act of 1996 (HIPAA)

How Your Medical Information May Be Used and Disclosed &
How You Can Get Access To This Information
PLEASE REVIEW CAREFULLY.

If you have any questions about this notice, please contact the Facility Privacy Officer by dialing the main facility number.

Who Will Follow This Notice: This notice describes the facility's practices and that of:
- Any health care professional authorized to enter information into your facility chart
- All departments and units of the facility
- Any member of a volunteer group allowed to help you while you are receiving services from the facility
- All employees, staff, agents and other facility personnel
- All entities, sites and Locations within this facility's system will follow the terms of this notice, They also may share medical information with each other for treatment, payment and health care operations purposes.

Our Pledge Regarding Medical Information: We understand that medical information about you-and your health care-is personal. We are committed to protecting medical information about you. A record is created of the care and services you receive at this facility. This record is needed to provide the necessary care and to comply with legal requirements. This notice applies to all of the records of your care generated by the facility. Your personal physician may have different policies or notices regarding the physician's use and disclosure of your medical information in the physician's office or clinic.

This notice will tell about the ways in which the facility may use and disclose medical information about you. Also described are your rights and certain obligations we have regarding the use and disclosure of medical information.

The law requires the facility to:
- Make sure that medical information that identities you is kept private;
- Inform you of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW THE FACILITY MAY USE and DISCLOSE YOUR MEDICAL INFORMATION:
The following categories describe different ways the facility uses and discloses medical information. Each category will be explained. Not every possible use or disclosure will be listed. However, all the different ways the facility is permitted to use and disclose information will fall within one of these categories.

- **Treatment:** Your medical information may be used to provide you with medical treatment or services. This medical information may be disclosed to physicians, nurses, technicians, or other agents of the facility who are involved in your care at the facility. Your medical information may also be disclosed to healthcare students, interns and residents.
  For example: A doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The doctor may need to tell the dietitian about the diabetes so appropriate meals can be arranged. Different departments of the facility may also share medical information about you in order to coordinate your different needs, such as prescriptions, lab work and x-rays. The facility also may disclose medical information about you to people outside the facility who may be involved in your medical care after you leave the facility, such as family members, home health agencies, or others used to provide services that are part of your care.
- **Payment:** Your medical information may be used and disclosed so that the treatment and services received at the facility may be billed and payment may be collected from you, the insurance company and/or a third party.
  For example: The health plan or insurance company may need information about the care you received from the facility so they can provide payment for the surgery. Information may also be given to someone who helps pay for your care. Your health plan or insurance company may also need information about a treatment you are going to receive to obtain prior approval or to determine whether they will cover the treatment.
- **Health Care Operations:** Your medical information may be used and disclosed for purposes of furthering day-to-day facility operations. These uses and disclosures are necessary to run the facility and to monitor the quality of care our patients receive.
  For example: Your medical information may be:
  1. Reviewed to evaluate the treatment and services performed by our staff in caring for you.
  2. Combined with that of other facility patients to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are effective,
  3. Disclosed to doctors, nurses, technicians, and other agents of the facility for review and learning purposes.
  4. Disclosed to healthcare students, interns and residents.
  5. Combined with information from other facilities to compare how we are doing and see where we can improve the care and services offered. Information that identifies you in this set of medical information may be removed so others may use it to study health care and health care delivery without knowing who the specific patients are.
- **Business Associates:** There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.
- **Directory:** We may include certain limited information about you in the facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (*e.g.* good, fair) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory please request the Opt Out Form from the admission staff or Facility Privacy Official.
- **Census Information:** Limited information about you may be used in the census report while you are a patient of the facility. This information may include your name, location of the facility, admission date and address.
- **Clergy Members:** While you are a patient in the facility, upon written consent, information about you may be disclosed to your specific clergy. This information may include your name, address, and admission date.

- **Appointment Reminders:** Your medical information may be used to contact you as a reminder of an appointment you have for treatment or medical care from the facility.
- **Future Communications:** We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities our facility is participating in.
- **Organized Health Care Arrangement:** This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time,
- **Affiliated Covered Entity:** Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.
- **Individuals Involved in Your Care:** With your permission, your medical information may be released to a family member, guardian or other individuals involved in your care. They may also be told about your condition unless you have requested additional restrictions. In addition, your medical information may be disclosed to an entity assisting in a disaster relief effort so your family can be notified about your condition, status, and location.
- **Research:** Under certain circumstances, your medical information may be used and disclosed for research purposes.
  For example: A research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same conditions. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, balancing the research needs with the patients' need for privacy of their medical information. Your medical information may be disclosed to people preparing to conduct a research project; for example, helping them look for patients with specific medical needs, so long as the medical information they review does not leave the facility. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.
- **As Required by Law:** Your medical information will be disclosed when required to do so by federal, state, or local authorities, laws, rules and/or regulations.
  - **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, your medical information will be disclosed in response to a court or administration order, subpoena, discovery request, or other lawful process by someone else involved in the dispute when we are legally required to respond.
  - **Law Enforcement:** Your medical information will be released if requested by a law enforcement official:
    1. In response to a court order, subpoena, warrant, summons or similar process;
    2. To identify or locate a suspect, fugitive, material witness, or missing person;
    3. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    4. About a death we believe may be the result of criminal conduct;
    5. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
  - **National Security and Intelligence Activities:** Your medical information will be released to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
  - **Protective Services for the President and Others:** Your medical information may be disclosed to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
  - **To Alert a Serious Threat to Health or Safety:** Your medical information may be used and disclosed when necessary to prevent a serious threat to your health and safety and that of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
  - **Health Oversight Activities:** Your medical information may be disclosed to a health oversight facility for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Private Accreditation Organizations:** Your medical information may be used to fulfill this facility's requirements to meet the guidelines of private facility accreditation organizations such as JC, NCQA, etc.

SPECIAL SITUATIONS:

- **Organ and Tissue Donation:** If you are an organ or tissue donor, your medical information may be released to organizations that handle organ procurement or organ, eye and tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Medical Devices:** Your social security number and other required information will be released in accordance with federal laws and regulations to the manufacturer of any medical device(s) you have implanted or explanted during a hospitalization and to the Food and Drug Administration, if applicable. This information may be used to locate you should there be a need with regard to such medical device(s).
- **Military and Veterans:** If you are a member of the armed forces, your medical information may be released as required by military command authorities. If you are a member of the foreign military personnel, your medical information may be released to the appropriate foreign military authority.
- **Workers' Compensation:** If you seek treatment for a work-related illness or injury , we must provide full information in accordance with state-specific laws regarding workers' compensation claims. Once state-specific requirements are met and an appropriate written request is received, only the records pertaining to the work-related illness or injury may be disclosed.
- **Public Health Risk:** Your medical information may be used and disclosed for public health activities. These activities generally include the following:
  1. To prevent or control disease, injury or disability;
  2. To report births and deaths;
  3. To report child abuse or neglect;
  4. To report reactions to medications or problems with products;
  5. To notify people of recalls of products they may be using;
  6. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  7. To notify 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.
- **Coroners, Medical Examiners, and Funeral Directors:** Your medical information may be released to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the facility to funeral directors as necessary to carry out their duties.
- **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the following reasons:
  1. For the institution to provide you with health care;
  2. To protect the health and safety of you and others;
  3. For the safety and security of the correctional institution.

ADDITIONAL SITUATIONS:

- **Other Uses of Medical Information:** Other uses and disclosures of medical information not covered by this notice or the laws that apply to this facility will be made only with your written permission. If you provide the facility permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your medical information for the reasons covered in your written authorization.You understand that we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the care that the facility provided to you.

ADDITIONAL INFORMATION CONCERNING THIS NOTICE:

- **Changes To This Notice:** We reserve the right to change this notice and make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The facility will post a current copy of the notice with the effective date. In addition, each time you are admitted to the facility for care/services, as an inpatient or outpatient, we will offer you a copy of the current notice in effect.
- **Complaints:** You will not be penalized for filing a complaint. If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services. To file a complaint with the facility, contact the System Privacy Officer. All complaints must be submitted in writing.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights regarding medical information the facility maintains about you:

**** NOTE: All Requests Must Be Submitted in Writing to the Facility Medical Records Department.***

- **Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care.

  To inspect and copy medical information or to receive an electronic copy of the medical information that may be used to make decisions about you, you must submit a written request.

  If you request a paper copy of the information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.

  If the facility uses or maintains an electronic health record with respect to your medical information, you have the right to obtain an electronic copy of the information if you so choose.
  1. You may direct the facility to transmit the copy to another entity or person that you designate provided the choice is clear, conspicuous, and specific.
  2. The facility may charge a fee equal to its labor cost in providing the electronic copy.

  We may deny your request to inspect and copy in some limited circumstances, If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional, other than the person who denied your request, will be chosen by the facility to review your request and the denial. The facility will comply with the outcome of the review.
  1. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
  2. The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person.
  3. The request for access is made by the individual's personal representative, and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.
- **Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment to information kept by or for the facility.
  To request an amendment, your must submit a written request. You must also provide a reason that supports your request, Your request for an amendment may be denied if:
  1. Your request is not in writing or does not include a reason to support the request;
  2. The medical information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  3. The medical information is not part of the medical information kept by or for the facility;
  4. The medical information is not part of the information you would be permitted to inspect and copy; or
  5. The medical information is accurate and complete.
- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information for purposes other than treatment, payment and health care operations.

  To request this list or accounting of disclosures:
  1. You must submit your request in writing:
  2. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.
  3. Your request should indicate in what form you want the list (for example, on paper, electronically).

  The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions:** You have a right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member.

  To request restrictions, you must make your request in writing. In your request, you must tell us:
  1. What information you want to limit;
  2. Whether you want to limit our use, disclosure or both;
  3. To whom you want the limits to apply, for example, disclosures to your spouse.

  You also have a right to request that a health care item or service not be disclosed to your health plan for payment purposes or health care operations. We are required to honor your request if the health care item or service is paid out of pocket and in full. This restriction does not apply to use or disclosure of your health information related to your medical treatment.
- **Right to Request Confidential Communication:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
  For example: You can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice:** You have the right to a copy of this notice. You may ask us to give you a copy at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have received a copy of the RHC Notice of Privacy Practices.

_____
Signature

_____
Print Name

_____
Date

OFFICE USE ONLY

Unable to obtain patient's written acknowledgement because:

☐ Patient refused to sign

☐ Patient is incapacitated and no responsible party is available prior to discharge

☐ Other: _____

_____

NEW HOPE
cancer and research institute - a medical corporation
www.newhopecancerinstitute.com

Name:_____ **DOB:** _____

Assignment of Insurance Benefits.
I, the undersigned, assign any benefits payable due me under any terms of any insurance policy or policies that may cover professional and technical services rendered to, to be paid directly to New Hope Cancer and Research Institute.

Release of information.
I the undersigned, authorize release of any information, other than psychotherapy notes, needed to act on this request.

Financial Agreement.
The undersigned agrees, whether he/she signs as an agent or as a patient, that in consideration of the services to be rendered to the patient, he.she hereby individually obligated himself to pay the account of New hope cancer and research institute with the regular rates and terms of the mentioned, Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expenses in full. All delinquent accounts interest at the legal rate.

Payment of Medicare Benefits to Provider.
I request that payment of authorized medicare benefits be made either to me or on my behalf to New Hope Cancer And Research Institute. For any services furnished me by that physician/supplier, I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agent any information needed to determine these benefits or the benefits payable for related services.

Authorization to Assign Benefits, and Accept Financial Responsibility for my Account:
I assign and authorize insurance payments to New Hope Cancer and Research Institute. I understand my insurance carrier may not approve and reimburse my medical services in full due to unusual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessary. I understand i am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or state or federal law. A duplicate or faxed copy of this authorization is considered the same as original document.

THE UNDERSIGNED AGREES TO ALL OF THE ABOVE CONDITIONS.

Signature:_____ **Date:** _____