SUNCOAST CANCER INSTITUTE
THE POWER TO CARE

RECORDS REQUEST RELEASE FORM

☐I hereby authorize and request the unconditional release of my medical records ***to***:

Suncoast Cancer Institute, 1217 East Ave S. Suite 201, Sarasota, Florida 34239

 **Phone 941-200-1125** 

Fax 941-200-1126

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☐I hereby authorize and request the unconditional release of my medical records ***from***:

Suncoast Cancer Institute, 1217 East Ave S. Suite 201, Sarasota, Florida 34239

To:_____

Phone:_____ Fax:_____

I understand that my records may contain information regarding drug, alcohol, psychological, or psychiatric conditions and communicable diseases, which are protected by federal law and cannot be disclosed without written consent, unless otherwise approved in the federal regulations. I also understand that I may revoke this consent at any time and that in any event this consent expires automatically as described below. My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand.

_____ _____ _____

Last Name (printed) First (printed) Middle Initial

Birthdate: ____/____/_____ Social Security Number: _____-_____-_____

_____Date: _____

Patient's Signature (guardian/surrogate):

Physician Requesting Information: Penny Heinrich, MD
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SUNCOAST CANCER INSTITUTE
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NEW PATIENT INTAKE FORM

Patient Name: (First, Middle, Last)				Today's Date
Social Security Number	Date of Birth			Sex
Local Street Address	City	State	Zip	
Local Home Phone	Cell		Work/Other	
Other Street Address	City	State	Zip	
Email Address (*NOT* shared with anyone)				
Occupation	Employer			
City of Birth	State of Birth	Marital Status		
Preferred Pharmacy	Location		Phone	
Emergency Contact Person	Phone		Relationship to patient	

Primary Insurance	Secondary Insurance

How did you hear about our office?

- ☐ Physician Referral
- ☐ Insurance Provider
- ☐ Magazine/News/Media
- ☐ Internet (search engine/site?) _____
- ☐ Family or Friend (first & last name?) _____
- ☐ Other _____

Advance Directive / Living Will ☐ Has ☐ Does not have

Code Status / Do Not Resuscitate Order ☐ Full Code ☐ DNR ☐ Does Not Have

Medical Healthcare Surrogate / Durable Power of Attorney

☐ Has a Medical Healthcare Surrogate ☐ Does Not Have a Medical Healthcare Surrogate

Healthcare Surrogate's Name:_____

Name of referring physician:_____

Name of your Primary Care physician:_____

_____No primary physician ____Self-Referral ____Referred by family or friend ____Other

SUNCOAST CANCER INSTITUTE
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Patient Consent for Receipt and Transmittal of Protected Health Information

I give permission to SUNCOAST CANCER INSTITUTE to Share: (Please check yes or no)

1. The following information on your **HOME** - **CELL** - **WORK** voicemail:

• Appointment Information	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
• Billing Information	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
• Medical Information	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
• Prescription Refills	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
• Authorizations or Referrals	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

☐ *Check here to include ALL above*

2. I give permission to Suncoast Cancer Institute to share only **appointment and billing information** with the following people listed below:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

3. I give permission to Suncoast Cancer Institute to share only **medical information** with the following people listed below: ☐ *Check here to include ALL above*

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Patient Name (printed):_____

Patient Signature:_____ Date: _____

SUNCOAST CANCER INSTITUTE
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GENERAL CONSENT

1. I do hereby voluntarily consent to my care including examinations, tests, immunizations, vaccinations, regional or local anesthesia, routine procedures and other treatment by Suncoast Cancer Institute professionals and its assistants or consultants, as deemed necessary in their judgment.
2. I understand that blood may be taken from me for HIV testing without my further permission if a doctor, other professional, or an employee is exposed to my blood or bodily fluids.
3. If I do not understand any procedure or treatment or its risks or consequences, I have the right to question appropriate health care personnel.
4. I authorize the release to any party responsible for my care such information from my medical records as is required in order for Suncoast Cancer Institute and all entities providing services to obtain payment. This includes records of alcohol/drug abuse and or treatment records indicated testing, diagnosis or treatment for HIV infection or related problems, records of psychological or social services including communication made by the patient to the physician, social worker or a psychologist. This authorization shall be necessary only so long as to obtain payment or reimbursement and will end when payment or reimbursement is received.
5. I understand that Suncoast Cancer Institute is not liable for loss or damage to any personal property.
6. I understand the contents on this form and have read the form and my questions have been adequately answered prior to signing the form.

Patient Signature:_____

Today's Date:_____

FOR OFFICE USE ONLY: DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT:

Patient Name:_____

on _____ (date), Suncoast Cancer Institute office staff presented this acknowledgement of receipt of notice of privacy practices to above mentioned patient, who refused to provide a signature when requested.

Signature of office staff:_____

SUNCOAST CANCER INSTITUTE
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NEW PATIENT HEALTH HISTORY FORM

Name: (First, MI, Last)_____ M____ F____ DOB:_____

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: ☐ Retired ☐ Homemaker ☐ Working.

Current Medications:

Check Here ☐ if you brought a list of medications Rx/OTC that may be copied into your chart.

Name of Prescription Rx drug or OTC (over the counter) & Dosage and how often taken:

☐ Rx ☐ OTC 1._____ ☐ Rx ☐ OTC 5._____

☐ Rx ☐ OTC 2._____ ☐ Rx ☐ OTC 6._____

☐ Rx ☐ OTC 3._____ ☐ Rx ☐ OTC 7._____

☐ Rx ☐ OTC 4._____ ☐ Rx ☐ OTC 8._____

Allergies to Medications: ☐ **No Known Drug Allergies**

☐ Known Drug allergies: List drug and reaction. _____

☐ Penicillin ☐ Sulfa ☐ Other_____

Past Medical History:

☐ Abnormal Bleeding	☐ Diabetes	☐ IBS
☐ AIDS	☐ Epilepsy	☐ Kidney Disease
☐ Alcoholism	☐ Glaucoma	☐ Kidney Stones
☐ Anemia	☐ Gout	☐ Liver Disease
☐ Arthritis	☐ GERD	☐ Miscarriage
☐ Asthma	☐ H. pylori	☐ Osteoarthritis
☐ BPH	☐ Hearing Loss	☐ Pacemaker
☐ Breast Lump	☐ Hepatitis	☐ Pneumonia
☐ Bronchitis	☐ Herpes	☐ Rheumatoid Arthritis
☐ Cancer	☐ High Cholesterol	☐ Stroke
☐ Chemical Dependency	☐ HIV positive	☐ STD
☐ Cataracts	☐ Hypertension	☐ Tuberculosis
☐ CHF	☐ Hyperthyroidism	☐ Peptic Ulcer Disease
☐ Coronary Artery Dis	☐ Hypothyroidism	☐ Valvular heart disease

Hospital Admission/Surgeries & Date:

1._____

2._____

3._____

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Female Health History: (Males skip to Male Health History Section Below)

Menarche

☐ Age at Menarche_____ ☐ Last Menstrual Period_____ ☐ Frequency of periods_____

Use of Birth Control

☐ No Use ☐ Used birth control pills ☐ Length of use_____

Pregnancies

☐ No pregnancies ☐ Age at first pregnancy____ ☐ Number of pregnancies____

☐ Miscarriages_____ ☐ Breast feeding- yes ☐ Breast feeding- no

Children

☐ No children ☐ Boys___ ☐ Girls___

Menopause

☐ Age at menopause_____ ☐ Hormone replacement therapy ☐ Last used_____ ☐ No HRT

☐ Hysterectomy_____ Age at hysterectomy

Screening Tests

☐ Papsmear ☐ Last pelvic exam:_____ ☐ Papsmear results_____

☐ Mammogram ☐ Last Mammo Date:_____ ☐ Mammogram results:_____

☐ Frequency of mammograms_____ ☐ Location of mammogram_____

☐ Self-Breast Exam Date:_____

Family Breast Cancer History

☐ Negative ☐ Positive ☐ Self ☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Breast Cancer Family Syndrome

☐ Not asked ☐ None ☐ Suspicion of BRCA-1 ☐ Suspicion of BRCA-2 ☐ Suspicion of P53

Breast Biopsy

☐ Date Breast Biopsy_____☐ Done at_____ ☐ No biopsy

Family Ovarian Cancer History

☐ Negative ☐ Positive ☐ Mother ☐ Sister(s) ☐ Maternal Grandmother

☐ Paternal Grandmother

☐ Vaginal infections ☐ Vaginal dryness

Male Health History: (Females skip to General Health History Section Below)

Family Prostate Cancer History

☐ Negative ☐ Positive ☐ Father ☐ Brother(s) ☐ Maternal Grandfather

☐ Paternal Grandfather

☐ Testicular exam:_____

☐ PSA ☐ Last PSA Date:_____

☐ Erectile Dysfunction

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General Health History – ALL Patients Please Answer

Health Maintenance:

Maintenance/Screening Tests

☐ Colonoscopy ☐ Last Colonoscopy Date:_____

☐ Physical Exam Date: _____ ☐ Digital rectal exam Date:_____

☐ Bone Density ☐ Last Bone density Date:_____

☐ Stool for Guaiac ☐ Last stool Guaiac Test:_____

☐ Cardiac stress test Date:_____ ☐ Last chest x-ray_____

Vaccines

☐ Pneumonia Date: _____ ☐ Flu Date: _____ ☐ Shingles Date: _____

☐ Hepatitis Date: _____ ☐ Other _____

Personal Habits

Exercise

☐ No exercise ☐ Regular exercise ☐ Type of exercise_____ ☐ Frequency _____

Sun Exposure

☐ No exposure ☐ Frequent exposure ☐ Use of sunblock ☐ SPF:_____

Dietary History

☐ Vegetarian ☐ Vegan ☐Meat ☐ Fruit ☐Vegetables ☐ Salt use ☐ Fat

Sexual History

☐ Negative ☐ Positive

☐ Multiple Sexual partners ☐ Heterosexual ☐ Homosexual ☐ Bisexual

☐ Low libido

Past Surgical History

☐ Cholecystectomy ☐ Appendectomy ☐ Tonsillectomy ☐ Open Heart Bypass

☐ Hernia repair ☐ Other_____

Social History

Living arrangements

☐ With spouse/partner ☐ Alone ☐ With Children ☐ Skilled Nursing Facility ☐ Other_____

Tobacco Use

☐ Never ☐ Former ☐ Date stopped and packs year_____

☐ Current ☐ Packs year_____ ☐ Second Hand Smoke exposure

☐ E Cigarettes/Vaping ☐ Chew/Dip/Snuff: frequency _____

Alcohol Use

☐ Not asked ☐ Never ☐ Mild ☐ Heavy ☐ Moderate ☐ Former

Consumption: _____

Drug Use

☐ Negative ☐ Positive ☐ Marijuana ☐ Cocaine ☐ Heroine ☐ Other_____

Frequency _____

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Occupational Exposure

☐ No occupational exposure ☐ Type of occupational exposure_____

Family History

Father

☐ Father-alive Age _____ ☐ Father-deceased - Age _____

Father's health history_____

☐ Father's health history unknown

Mother

☐ Mother-alive Age _____ ☐ Mother-deceased - Age _____

Mother's health history_____

☐ Mother's health history unknown

Sister(s)

☐ _____Sister(s)-alive ☐ _____Sister(s)-deceased

Sister(s) health history_____

☐ Sister's health history unknown

Brother(s)

☐ _____Brother(s)-alive ☐ _____Brother(s)-deceased

Brother(s) health history_____

☐ Brother's health history unknown

Children

☐ No children

☐ _____Son(s) ☐ Son(s) health_____

☐ _____Daughter(s) ☐ Daughter(s) health_____

Ethnic Background

☐ Mother's ethnic background_____ ☐ Father's ethnic background_____

Family History of Bleeding Disorders

☐ Negative ☐ Positive _____

Other Family History of Significance

_____

_____

_____

Family Colon Cancer History

☐ Negative ☐ Positive ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Maternal Grandmother

☐ Maternal Grandfather ☐ Paternal Grandmother ☐ Paternal Grandfather

Other Family Cancer History

☐ Other_____ ☐ Mother_____ ☐ Father_____

☐ Sister(s)_____ ☐ Brother(s)_____

☐ Other Relatives_____

SUNCOAST CANCER INSTITUTE NOTICE OF HIPAA PRIVACY

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.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protecting Health Information for You

All parties listed above may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.
If you are being treated for a work-related injury, please note that the privacy practices outlined in this notice are superseded by Florida state law.

A. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription, to a laboratory to order or receive a blood test or to a cardiologist to receive an EKG. We may also disclose protected health information to physicians who may be treating you or consulting with this facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

C. Healthcare Operations. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of providing quality care to all patients. Healthcare operations include such activities as: quality assessment/ improvement activities; employee review activities; training programs including those in which students, trainees or practitioners in health care learn under supervision; accreditation, certification, licensing or credentialing activities; review and auditing, including: compliance reviews, medical reviews, legal services, legal services and maintaining compliance programs, and business management/ general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. **Other Uses and Disclosures.** As part of treatment, payment and health care operation, we may also use or disclose your protected health information for other purposes, such as to remind you of your appointment or to see how you are doing after surgery.

II. Uses and Disclosures Beyond Treatment, Payment, and Healthcare Operations Permitted Without Authorization or Opportunity to Object

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care. We may also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization, in writing, at any time except to the extent that we have taken action in reliance upon any authorization taken prior to your revocation or change.

V. Your Rights

You have the following rights regarding your health information:

A. **The Right to Inspect and Copy Your Protected Health Information**. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the facility uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action/proceeding or protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person or that it is likely to cause substantial harm to you or another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to our Medical Records Department. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. **The Right to Request a Restriction on Uses and Disclosures of Your Protected Health Information.** You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. **The Right to Request to Receive Confidential Communications From Us by Alternative Means or at an Alternative Location.** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests other than those accommodated by our general release form must be made in writing to our Privacy Officer.

D. **The Right to Request Amendments to Your Protected Health Information**. You may request an amendment of protected health information about you, including billing information, for as long as we maintain this information. We may require that such requests be put in writing, that a valid and legal reason be supplied and that such requests be directed to the Privacy Officer. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and we will provide you with a copy of any such rebuttal. Requests for amendments shall be handled in accordance with the timeliness guidelines outlined in the Privacy Act. All revisions or changes to a medical record must be done in consultation with the physician and in accordance with applicable state law on medical record amendments.

E. **The Right to Receive an Accounting of Disclosures**. You have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for: disclosures that you requested; disclosures that you agreed to by signing an authorization form; to friends or family members involved in your care or certain other disclosures we are permitted to make without your authorization. The request for an accounting of disclosures must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting of disclosures. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting of disclosures requests may not be made for periods of time in excess of six years. We will provide the first accounting for disclosures you request during any 12-month period without charge. Subsequent accounting for disclosures requests may be subject to a reasonable cost-based fee.

F. **The Right to Obtain a Paper Copy of this Notice**. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

Suncoast Cancer Institute is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time.

We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain.

VII.Complaints
You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally, in writing or via e-mail using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person
The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

Suncoast Cancer Institute
1217 East Ave S., Suite 201
Sarasota, FL 34239
ATTN: Privacy Officer

The Privacy Officer can be contacted by telephone at 941-200-1125 or via e-mail at inquiry@suncoastci.com

IX. Effective Date
This Notice is effective February 1, 2016

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required. We will disclose your protected health information when we are required to do so by any federal, state or local law.

B. When There Are Risks to Public Health. We may disclose your protected health information for the following public activities and purposes:
• To prevent or control disease, injury, or disability
• To report abuse or neglect
• To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance
• To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law
• To report to an employer information about an individual who is a member of the workforce as legally permitted or required

C. To Report Suspected Abuse. Neglect Or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including: audits; civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health

information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection With Judicial and Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person
- Under certain limited circumstances when you are the victim of a crime
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct
- In an emergency to report a crime

G. To Coroners, Funeral Directors and for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner/medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. For Research Purposes. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security/ intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions and law enforcement custodial situations.

K. For Worker's Compensation. The facility may release your health information to comply with worker's compensation laws or similar programs.

SUNCOAST
CANCER INSTITUTE
THE POWER TO CARE

Acknowledgment of Receipt of Privacy Notice

Suncoast Cancer Institute takes the rights and privacy of its patients and staff seriously and must comply with the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R. Parts 160 and 164, Subparts A and E and all state and federal confidentiality laws and regulations. This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA).

I acknowledge that I have received the attached Privacy Notice:

_____ _____

Patient's Name DOB

_____ _____

Signature Today's Date

Suncoast Cancer Institute Practice Policies

Thank you for choosing Suncoast Cancer Institute as your healthcare provider. We are committed to providing you with the highest quality and most affordable healthcare. Please read this Practice Policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Your health insurance policy is a contract between you and your insurance company; we are not party to that contract. *Your insurance company requires that we collect your co-payment*. We cannot waive any co-payments, co-insurance and/or deductible. Failure on our part to collect co-payments, co-insurance and deductibles from patients can be considered insurance fraud. Please help us in upholding the law by paying your co-payment at each visit.

Due to policy provisions in your contract with your insurance carrier, we are required to collect all patient responsibility balances. If your insurance policy has provisions such as deductibles, co-insurance, or co-payments, please note that these are provisions that have been agreed to between you and your insurance carrier. We cannot legally discount fees after their submission on your behalf to your insurance carrier.

If we are in your insurance carrier's network of providers, we have additional contractual obligations to collect the balances as outlined by your insurance carrier. Writing off patient responsibility balances could jeopardize our contract with your insurance carrier. If a portion of your fees are applied to an annual out of pocket maximum and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

For those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility for co-insurance, co-payment or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we are bound by all provisions of insurance policy and federal law. Please feel free to let us know if you have any questions or if you require assistance to fully understand these provisions.

Additionally, our practice policy requires that you notify us in person, by phone or mail any time you have a change in your insurance or billing information. **If you lose insurance coverage, we must be notified immediately so that our assistance process can be started before your balance rises.**

1. Health Insurance: We participate in most health insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If you are insured by a plan we are contracted with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.

If you are insured by a plan that we are not contracted with or are uninsured, payment in full is expected at each visit. Payment arrangements must be made prior to service. If you first saw the physician in the hospital, payment arrangements must be made immediately after hospital discharge.

2. Proof of insurance: All patients must complete our new patient information form before seeing the doctor. We must obtain a copy of your driver's license (or a gov't issued Photo I.D. Card) and current valid health insurance card to provide proof of insurance. If you fail to provide us with the correct and up to date insurance information, you will be responsible for payment of all services rendered at the time of service.

3. Coverage changes: If your health insurance changes, please notify us as soon as possible before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you with payment due upon receipt.

4. Co-payments, deductibles, & Time of Service Payments: All co-payments, co-insurance, deductibles, and time of service payments must be paid at the time service is rendered unless arrangements have been made in advance by you. We accept cash and checks. *Due to Credit Card processing fees, Credit Cards are only accepted for payments of $100 or less.*

5. Claims submission: As a service to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Should the service provided go beyond the amount covered by your insurance, we will need payment paid in full.

6. Missed appointments and cancellations: Missed appointments or cancellations with less than 24 hours' notice represents a cost to us and to other patients who could have been seen in the time that was scheduled for your visit. We request that you cancel or reschedule appointments at least ***24 hours*** prior to the appointment by telephoning our office. Our policy is to charge $50 for missed appointments or appointments not canceled within 24 hours. This charge will be your responsibility and will be billed directly to you, not your insurance company, and is *due at your next visit*. Please help us to serve you better by keeping your regularly scheduled appointments.

7. Prescription Refills: In order to continue to serve you best, the office staff will have 24 hours to fill all prescription refills. This time is very important as all medications; even refills must be reviewed and approved by a physician. The purpose of this policy is to make sure you are taking the correct medications in the correct doses. In addition, many prescriptions will require periodic blood work or even follow-up physician visit.

8. Non-covered services: Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. *You must pay for these services in full at the time of visit*. The following services are considered "Non-Covered Services" by most insurance companies. The fees listed below must be paid at the time of service

- Returned Checks: If your check is returned to us for any reason, you will be charged $35
- Missed Appointments: If you fail to notify us at least 24 hours in advance that you will not be able to make your appointment, we may charge you $50.
- Forms Completion: Disability, Work, Prior Authorizations, and other forms are not required by all insurance plans or employers. If you require a staff member/physician to complete these forms, there may be a $25 charge in addition to your office visit charge. This fee will be assessed on a case by case basis.
- Paper Records: We will provide to you, upon written request, a paper copy of your medical record. We charge a base fee of $20.00
- Phone Visits/Consults: If you request medical services via telephone instead of a visit to our office, the following fees apply. You must be an established patient to request this service. Phone visits are done only by prior physician approval and scheduling. If the phone visit results in an office visit within 24 hours, you will be refunded, per Federal insurance guidelines.

5-10 minutes: $30
11-20 minutes: $45
21-30 minutes: $60

9. Referrals and Pre-Certifications: Your insurance company may require a referral from a primary care physician (PCP) in order for you to see a specialist. Your insurance may also require pre-certification of office or outpatient services. As a courtesy, our office will make every reasonable effort to obtain these referrals and pre-certifications for you. If a referral or pre-certification cannot be obtained prior to the date of your visit, your appointment may have to be rescheduled. Referrals and/or pre-certifications are sometimes required for CT scans, X-rays and other diagnostic tests. Some managed care contracts specify the location for these services.

10. Nonpayment & Collection: If your account is over 30 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and notification to your insurance plan. This agreement is governed by and shall be construed in accordance with laws of the State of Florida. The courts of Sarasota County will have exclusive jurisdiction to adjudicate any dispute arising under or in connection with this agreement

Additionally, you may be discharged from this practice. If this should occur, you will be notified by regular Certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Any OTC medications supplied by Suncoast Cancer Institute prior to, or during your treatment, will incur a $1.00 charge per dose, for each medication administered, payable at time of service by the patient.

> Examples of common OTC medications are: Tylenol, Benadryl, Prilosec, Zantac, Compazine or Promethazine.

You may purchase and bring your own OTC medications with you on treatment day, however, you must bring the original OTC medication package or bottle with you for verification purposes. You must bring your own OTC medications for each treatment visit, as the office is not able to store your medications on site.

The reason for this additional charge is due to OTC medications *not being covered/reimbursed* by insurance companies. As a convenience to our patients, we are offering to provide common OTC medications at the lowest possible cost to our patients.

I have read and understand the payment policy and agree to abide by its guidelines. I hereby assign, transfer and set over to Suncoast Cancer Institute my assignment of benefits for reimbursement of services rendered.

This consent will remain in effect until revoked by me in writing. A copy of this assignment will be considered as valid as an original. I understand that I'm financially responsible for any charges not paid by my insurance carrier(s).

Patient Name (Print): _____

Patient Signature: _____

Date: _____

SUNCOAST CANCER INSTITUTE
THE POWER TO CARE

Patient Financial Responsibility and Assignment of Benefits

All professional services rendered are charged to the patient & are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. All unpaid balances will be considered delinquent 90 days from the date of service. Any delinquent accounts can be referred to a collection agency & will incur the cost of collection including reasonable attorney fees. This agreement is governed by and shall be construed in accordance with laws of the State of Florida. The courts of Sarasota County will have exclusive jurisdiction to adjudicate any dispute arising under or in connection with this agreement.

I, the undersigned, assign directly to Suncoast Cancer Institute all medical benefits to include all major medical benefits to which I am entitled, if any, otherwise payable to me for services rendered to myself and/or my dependents. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Suncoast Cancer Institute to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

I understand that medical treatment of an immediate nature is necessary & that such care, treatment and procedures will be provided during office hours only. I grant authorization & consent to treatment & certify that no guarantee or assurance has been made as to the results which may be obtained. I acknowledge that neither Suncoast Cancer Institute nor any of its owners, officers, directors or employees shall have any liability, whether direct or indirect, if I do not follow the prescribed course of treatment, including prescribed return visits or the failure to properly use prescribed medications and/or treatments.

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Suncoast Cancer Institute for any services furnished me by their physicians and staff. I authorize any holder of medical information about me to release to the Health Care Financing Administration & its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made & authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

Important Notice from the Government:

It is unlawful to routinely avoid paying your co-pay, deductible or co-insurance payments, even if your doctor allows it. Unless you complete a “Financial Hardship” form & qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as “professional courtesy” and “Take What Insurance Pays”. Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, and State Insurance Fraud Laws.

Late Policy “10 Minute Rule”

Being late by more than 10 minutes for your scheduled appointment without notice, will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. If you are being seen as a “walk-in” visit and want to see a particular provider, you will have to wait for an opening to see that provider instead of seeing the first available provider.

Printed Name:_____ **DOB:** _____

Signature:_____ **Date:** _____