ADVANCED ONCOLOGY SPECIALISTS

9165 Park Drive, Miami Shores, FL 33138
Phone 305.545.6685
Fax 305.545.6687

PATIENT REGISTRATION

(Please complete this form in its entirety)

Patient's Name _____
Last name *First name* *Middle initial*

Local Street Address_____ Apt #_____

City_____ State_____ Zip Code_____ Driver's License #_____

Home Phone _____ Other Phone _____ ◯mobile ◯work

May we leave messages: On an answering machine? ◯Yes ◯No With family? ◯Yes ◯No

Out of country Address (if any) _____

City_____ Country _____

Out of country Phone _____Other Phone _____

Sex:◯M ◯F Date of Birth _____ Age _____ Social Security # _____

Employer _____Occupation _____ Marital Status _____

Email Address _____

Pharmacy Name _____Pharmacy phone# _____

Referred by _____ Phone_____

Family physician _____ Phone _____

In case of emergency, contact _____ Relationship_____

INSURANCE INFORMATION

Do you have health insurance? ◯ No, I will pay in full for the services rendered ◯ Yes
Do you have an assigned case manager? ◯ Yes ◯ No
Case Manager Name _____ Phone _____
Primary Health Insurance_____
ID # _____ Group #_____
Subscriber's Name _____ Relationship to Patient _____
Secondary health insurance (if any) _____
ID#_____ Group#_____
*****Please give the receptionist your insurance card and a picture ID to be photocopied*****

Patient Signature _____ Date_____

Reviewed with patient by _____ time/date: _____

ADVANCED ONCOLOGY SPECIALISTS

9165 Park Drive, Miami Shores, FL 33138
Phone 305.545.6685
Fax 305.545.6687

AUTHORIZATION TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS OR OTHERS

I authorize disclosure of my protected health information for purposes of communicating results, finding, and care decisions to my family members and others as indicated below.

I acknowledge that no information regarding my health care can be communicated without my permission unless I become incapacitated. If I become incapacitated, health care providers will communicate to the individuals assigned in advance directives previously designated by me. If no advance directives have been designated, I acknowledge that health care providers will communicate with my nearest next of kin.

Name	**Relationship**	**Phone number**

_____ _____
Patient's Name (PRINT) Patient's Date of Birth

_____ _____
Signature of Patient Date and Time

_____ _____
Witness to Signature Date and Time

ADVANCED ONCOLOGY SPECIALISTS

9165 Park Drive, Miami Shores, FL 33138
Phone 305.545.6685
Fax 305.545.6687

RELEASE OF MEDICAL RECORDS

Patient's Name: _____

Date of Birth: _____

Social Security: _____

I, the above-named patient, request that the following medical information from my records be sent to the **Advanced Oncology Specialists, P.A.** I also grant permission for Advanced Oncology Specialists, P.A., to forward healthcare information on my behalf to my other healthcare providers.

Operative Reports ☐
Clinical Notes ☐
Pathology Reports ☐
Radiation Summary ☐
X-Ray Reports ☐
Other ☐

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical records as requested above.

_____ _____
Patient Signature Date

_____ _____
Witness Date

ADVANCED ONCOLOGY SPECIALISTS

9165 Park Drive, Miami Shores, FL 33138
Phone 305.545.6685
Fax 305.545.6687

PATIENT HEALTH HISTORY EVALUATION

Name: _____ Age: _____ Date: _____

Reason for Consultation: _____

Vitals: BP_____/_____ P_____ R _____ Temp _____

Have you ever had surgery or been hospitalized? (◯) Yes (◯) No

Date	Place	Biopsy / Surgery R/T Diagnosis

Current Medications Including ASA, Non-Rx, Vitamins and Herbs

Name	Dosage	Times per day

Allergies

Name of Medication	Type of Reaction

ADVANCED ONCOLOGY SPECIALISTS

9165 Park Drive, Miami Shores, FL 33138
Phone 305.545.6685
Fax 305.545.6687

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing **Advanced Oncology Specialists (AOS)** as your healthcare provider We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient is ultimately responsible for the payment for his/her treatment.
- We are pleased to assist you by billing our contracted insurers. However, the patient is required to provide us with the most current and up to date information about their insurance. You will be responsible for any charges incurred if the information provided is not correct or up to date.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, unless a prior payment agreement is set up. For your convenience, we accept cash, check, and most major credit cards at our office.
- Patients may incur and are responsible for the payment of additional charges at the discretion of AOS. These charges may include (but are not limited to):
    - Charge for returned checks and/or any balance due to termination of your insurance coverage due to non-payment of premium.
- Should AOS have to take action to collect you for its services, AOS will be entitled to all its fees, costs, and expenses incurred in any Court proceeding, including appellate costs and attorneys' fees.

Patient Authorizations

- By my signature below, I hereby authorize AOS to release medical and other information acquired during my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to AOS and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize AOS personnel to communicate by mail, answering machine messages, and/or email according to the information I have provided in my patient registration information.
- By my signature below, I authorize AOS to securely store my credit card information and only charge it should I have an outstanding balance or any leftover balance from a processed claim in the future. I am aware that the storage system used is fully compliant with the highest level of credit card storage security regulations. Once stored, I am aware that only the last 5 digits of my card are viewable by MCWHC personnel.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature of Patient or Guardian_____ Date _____

ADVANCED
ONCOLOGY SPECIALISTS

9165 Park Drive, Miami Shores, FL 33138
Phone 305.545.6685
Fax 305.545.6687

Dear Patient,

If you require a copy of your medical records, we will be happy to provide them for you. Please see below the options.

$1.00 per page

OR

$5.00 for CD

Or we can fax them directly to your physician office once we have your authorization.

Thank you in advance,

Advanced Oncology Specialists

ADVANCED ONCOLOGY SPECIALISTS

9165 Park Drive, Miami Shores, FL 33138
Phone 305.545.6685
Fax 305.545.6687

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

If you have any questions about this notice, please contact the Facility Privacy Official by dialing the main office number. Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test result, diagnosis, treatment a plan for future care or treatment and billing-related information. This notice applies to all of the records of your care generated by the medical office, whether made office personnel, agents of the medical office, or your provider. Your health insurance, hospitals and other treatment providers may have different policies or notices regarding the use and disclosure of your health information.

Our Responsibilities: We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.
Uses and Disclosures: How we may use and disclose Health Information about you.
The following categories describe examples of the way we use and disclose health information.
For Treatment: We may use health information about you to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or medical office personnel who are involved in taking care of you at the medical office. 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. Different departments of the medical office also may share health information about you to order and coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.
For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third-party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.
For Health Care Operations: Member of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and other like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may also combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and students for educational purposes. And we may combine health information we have with that of medical offices to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.
We may also use and disclose health information:

- To business associates we have contracted with to perform the agreed upon service and billing for it
- To remind you that you have an appointment for medical care.
- To assess your satisfaction with our services.
- To tell you about possible treatment alternatives.
- To tell you about health-related benefits or services.
- To contact you as part of fundraising efforts.
- To inform Funeral Directors consistently with applicable law.
- For population-based activities relating to improving health or reducing healthcare costs.
- For conducting training programs or reviewing competence of healthcare professionals, and

ADVANCED ONCOLOGY SPECIALISTS

9165 Park Drive, Miami Shores, FL 33138
Phone 305.545.6685
Fax 305.545.6687

- When disclosing information with primary appointment reminders and billing/collections efforts we may leave messages on your answering machine or voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates.
Examples include billing services, transcriptionists, and a copay service we use when making copies of your health record. When these services contract, 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, we require the business associate to appropriately safeguard your information.
Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
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 in which our facility is participating. As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
State Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing healthcare costs some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.
Your Health Information Rights: Although your record is the physical property of the healthcare practitioner or facility that compiled it, you have the Right to:
Inspect and Copy: You have the right to inspect and obtain a copy of the 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. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by the medical office will review your request and the denial. The person conducting the review will note the person who denied your request. We will comply with the outcome of the review.
Amend: If you feel that health 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 for as long as the information is kept by or for the medical office. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

ADVANCED ONCOLOGY SPECIALISTS

9165 Park Drive, Miami Shores, FL 33138
Phone 305.545.6685
Fax 305.545.6687

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment, a healthcare operation where an authorization was not required.
Request Restrictions: You have the right to request a restriction or limitation on the health 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 health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask if we do not use or disclose information about a surgery you had.
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 with emergency treatment.
Request Confidential Communications: 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 if we contact you at work instead of your home. The facility will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
A Paper Copy of This Notice: You have the right to copy a paper copy of this notice. You may ask us to give you a copy of this notice at the time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If the facility has a website, you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.
To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing
Changes to this notice: We reserve the right to change this notice, and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the medical office and include the effective date.
Complaints: If you believe your privacy rights have violated, you may file a complaint with the medical office by contacting the main number and asking for the Facility Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with the medical office, contact the Privacy Official. All complaints must be submitted in writing.
You will not be penalized for filing a complaint
OTHER USES OF HEALTH INFORMATION: Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose health information about you, you may revoke that permission, in writing at my time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back the disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided in you and documented in the doctor's office or clinic.

I hereby acknowledge that I have been given a copy of the above Privacy Notice:

_____ _____

Patient Signature Date