HOPE
CANCER CENTER
OF EAST TEXAS

Expertise. Experience. Compassion. HOPE.

Welcome to HOPE Cancer Center of East Texas, we have a tradition of caring. We are committed to providing our patients with the highest quality and compassionate care.

Appointment Date: __________ ***Appointment Time:*** __________ ***am/pm*** ***Physician:*** ________________________

Referred By: ________________________ ***Primary Care Physician:*** ________________________

Patient Information

Patient Name *(Last, First M.I.)*			Date of Birth / /		Marital Status S M D W	
Street Address			City	State	Zip	County
Home Telephone # ( )	Work Telephone # ( )		Cell Telephone # ( )		E-mail Address	
Sex M F	Social Security # - -		Language	Race	Ethnicity Hispanic/Latino Non-Hispanic	
How did you hear about our practice?			Occupation		Employed Y N	Student Full-time Part-time
Name of Employer / School			Employer's Street Address		City	State / Zip
Name of Spouse or Next of Kin		Relationship	Home Telephone # or Work #, if spouse ( )		Cell Telephone # ( )	
Name of Other Contact (Friend or Relative)		Relationship	Home Telephone # ( )		Cell Telephone # ( )	

***** Please complete form in its entirety*****

Insurance Information

Insurance (Primary)

Insurance Company *(Primary)*		Insured's Id. #		Policy Group #	Group / Employer Name		
Name of Insured	Date of Birth / /	Relationship	Insured's Street Address		City	State	Zip
Insured's Telephone #	Insured's Employer Telephone # ( )		Social Security # - -		Sex M F	Occupation	
Name of Employer			Employer Street Address		City	State	Zip

Insurance (Secondary)

Insurance Company *(Primary)*		Insured's Id. #		Policy Group #	Group / Employer Name		
Name of Insured	Date of Birth / /	Relationship	Insured's Street Address		City	State	Zip
Insured's Telephone #	Insured's Employer Telephone # ( )		Social Security # - -		Sex M F	Occupation	
Name of Employer			Employer Street Address		City	State	Zip

Please note: In order for our office to receive reimbursement from your insurance company according to the contractual terms set by your insurance plan, we request that you inform our office of any insurance changes immediately prior to or upon check-in for your visit and/or services. Failure to notify our office in a timely manner of the appropriate changes will result in the patient and/or guarantor assuming full responsibility of the balance.

Patient Name: ______________________________ Date of Birth: ____________________

MEDICAL CONSENT TO TREATMENT

I hereby voluntarily consent to receive medical services at HOPE Cancer Center of East Texas (HOPE) and give authorization and consent of any necessary medical treatment that is provided while under the care of one or more physicians at HOPE. I understand that such services may include examinations, diagnostic procedures, treatment, which may include chemotherapy, etc. Additional ancillary services may be ordered and performed in an effort of properly diagnosing and treating a medical condition and/or part of preventative care. I have the right to refuse specific treatments and/or procedures. I acknowledge that this agreement of "Medical Consent for Treatment" can be revoked by me at any time by written notification and is valid until revoked.

I understand that no warranty or guarantee has been made to me as to result or cure. I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

AUTHORIZATION TO RELEASE INFORMATION

I authorize my insurance carrier(s) to release information regarding my coverage to HOPE Cancer Center of East Texas (HOPE). I also authorize agents of any hospital, treatment center, physician, etc. to furnish HOPE copies of any records of my medical history, services and/or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to the review of my records for purposes of internal audits, research and quality assurance reviews within HOPE.

ASSIGNMENT OF BENEFITS

My right to payment for all procedures, tests, supplies and nursing/physician services including major medical benefits are hereby assigned to HOPE. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plan. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event payments are made directly to me or my representative, I will endorse such payments to HOPE.

FINANCIAL RESPONSIBILITY

I understand that I am responsible for all out-of-pocket amounts identified by my insurance carrier(s) that are due to HOPE, which includes, but not limited to deductible, co-payment and co-insurance amounts. I also understand that I am responsible for services not covered or reimbursed by my insurance carrier(s) or any other third party payer. Additionally, I understand that it is my responsibility to make sure insurance payments are processed and paid promptly. I understand that in order for HOPE to receive reimbursement from my insurance company according to the contractual terms set by my insurance plan, I am to inform HOPE of any demographic changes, i.e. address, telephone number(s), insurance carrier, etc. immediately prior to or upon check-in for my visit and/or services. Failure to notify HOPE in a timely manner of the appropriate changes may result in me and/or the responsible party assuming full responsibility of the balance. I agree that in the event that I do not have insurance or any other third party reimbursement program, that I am fully responsible for payment of services.

PATIENT RIGHTS & RESPONSIBILITIES

I acknowledge that I have received a copy of the Patient Rights & Responsibilities in addition to the Patient Policies "A Tradition of Caring", which includes payment & other financial obligations.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of this statement is considered the same as original.

______________________________________ ______________________
Patient Signature | Today's Date/Time AM or PM (*circle*)

______________________________________ ______________________
Responsible Party Signature | Relationship to patient | Today's Date/Time AM or PM (*circle*)

PHYSICIAN:		Acct #		LOC		EMPLOYEE INITIALS

Today's Date: ______________________
Name: ______________________
Date of Birth: ______________________
Age: ______________________

SEND REPORTS TO THE FOLLOWING PHYSICIANS:
Primary physician: ______________________
Surgeon: ______________________
Other Specialists: ______________________

What are your reasons for coming to see the doctor? ______________________

What tests have been done, where and by whom (include CT, MRI, bronchososcopy….etc.): ______________________

List any past surgery, date done and by whom: ______________________

List all past and present MEDICAL problems and HOSPITALIZATIONS unrelated to surgery (such as diabetes, heart disease, hypertension, emphysema) and date diagnosed:

List any problems you have had with ANESTHESIA in the past:

If you have ever been transfused with any BLOOD products, list when and why:

MEDICATIONS – Please list prescriptions, vitamins, herbals and supplements:

1 ______________________ 7 ______________________
2 ______________________ 8 ______________________
3 ______________________ 9 ______________________
4 ______________________ 10 ______________________
5 ______________________ 11 ______________________
6 ______________________ 12 ______________________

ALLERGIES to medicines: ______________________ Reaction medicine caused: ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

FAMILY HISTORY. Check if any family member has had the following and their age when diagnosed:

Breast Cancer ______	Melanoma ______	Colon Cancer ______	Brain Tumors ______
Ovarian Cancer ______	Sickle Cell Disease ______	Lung Cancer ______	Thalassemia ______
Lymphoma ______	Bleeding disorders ______	Leukemia ______	Hemophilia

Clotting disorders (include leg clots such as DVT, pulmonary embolus, strokes): ______________________

Other cancers ____

____

List ANY other medical problems with family members. If they have passed away, list their cause of death and at what age:

Mother: ______________________ Father: ______________________

Brothers: ______________________ Sisters: ______________________

Maternal grandmother: ______________________ Maternal grandfather: ______________________

Paternal grandmother: ______________________ Paternal grandfather: ______________________

SONS NAME(S)	AGE	PHONE NUMBER

DAUGHTERS NAME(S)	AGE	PHONE NUMBER

SOCIAL HISTORY

With whom do you live? ______________________ Marital status: ______________

How far did you go in school? ______________________

List present or past employer: ______________________ Retired? ___ **Yes** ___ **No**

Toxic exposures (Asbestos, Agent Orange, Benzene….etc): ______________________

Smoker, present or past? ____ Yes ____ No How many years did you smoke? ______________

When did you quit smoking? ______________ Use other tobacco products? ______________

Alcohol intake: ______________ If a former drinker, when did you quit? ______________

Have you or do you use other “street drugs” such as cocaine, heroin or IV drugs? ______________

Do you want to be screened for HIV by a lab test? ____ Yes ____ No

REVIEW OF SYSTEMS – Describe any significant or progressive symptoms over the past few months:

Fever: ______ Weight Change: ______ Night Sweats: ______
SKIN RASHES: ______ Moles changed: ______ Bruising: ______
LYMPH NODES enlarged or sore: ______ What areas? ______
THYROID nodules: ______ Over active (hyperthyroidism): ______ Under active (hypothyroidism): ______

HEAD, EYES, EARS THROAT, SINUSES

Headaches: ______ Visual change: ______
Hearing Loss: ______ Nose Bleeds: ______
Difficulty swallowing: ______ Mouth sores: ______
Dental problems: ______ Condition of teeth/dentures: ______

BREASTS

Mass/nodule: ______ Nipple drainage: ______ Pain: ______
Prior biopsies: ______ Last Mammogram: ______

LUNGS

Cough: ______ Sputum clear, discolored or bloody: ______
Chest pain: ______ Pleurisy: ______ Wheezing: ______ Short of breath: ______
PPD – last done? ______ PPD positive? ______

HEART

Chest heaviness or angina: ______ Murmur: ______
Palpitations: ______ Heart Failure: ______
Last cardiac catheterization and result: ______

GASTROINTESTINAL

Nausea/vomiting: ______ Blood seen: ______
Abdominal pain: ______ Indigestion: ______ Reflux: ______
Food catches when swallowing: ______ Jaundice: ______
Diarrhea: ______ Change in stool caliber: ______ Constipation: ______
Black or tarry stools: ______ Incontinence: ______
Last upper endoscopy: ______ By whom: ______
Last colonoscopy: ______ By whom: ______

GENITOURINARY

Painful urination: ___________ Strain to pass urine: _________ Frequent need to void: _________________
Nighttime voiding: ______________ Blood in urine: _______________ Incontinence: _________________
Sexually transmitted diseases (HIV/AIDS, Herpes, syphilis…etc): ____

MEN ONLY

Last digital rectal exam: _______________ Last PSA blood test and result: ___________________________
Impotence: ___________ Interest in medicines for erectile dysfunction? ___________________________

WOMEN ONLY

Could you be pregnant now? _________ Age of 1st menstrual period: _______________________________
Age of last menstrual period: __________ Excessively heavy menses now? _________________________
Postmenopausal bleeding? _________ Had hysterectomy? __________ Ovaries removed? ____________
Number of pregnancies: _____ Number of live births: _________ Age at 1st pregnancy: _________
Did you breast feed your children? ________ Have you ever taken postmenopausal estrogens? _________
If yes, name and for how long: _________________________________ Date stopped: _____________
Pain with sexual intercourse? ______________________ Vaginal dryness: _________________________
Hot flashes: ____________________ Date of last pelvic/PAP: ___________________________________

PSYCHIATRIC

Have you ever been hospitalized for a psychiatric problem? ____
If yes, please indicate diagnosis and dates: ____
Suicide attempt in the past? ____________ Depression: ______________ Panic attacks: _____________
Claustrophobia: _________________ Do you need sedation for an MRI? __________________________

NEUROLOGY

Weakness: _________________ All over? _______________ One side only? _________________________
Numbness or tingling: ___________ If yes, what area? ____________________ Confusion: ___________
Memory loss: ________________ Difficulty speaking: _____________________ Imbalance: ___________
Need assistance such as cane, walker, wheelchair? _________ Personality or behavior change? ___________
Fainting spells: _______________________ Dizziness related to standing up? __________________________
Seizures: _____ If yes, age of onset: ________ Tremors or any movement disorder? ________________

BONE AND JOINTS

Back pain: ______________ Joint pain: ____________ Muscle pain or weakness: ____________________
Last Bone density scan: _________________ Result? ____

VACCINATIONS (LIST ONLY MOST RECENT)

Pneumovax: _________ Zostavax: __________ Tetanus: _________ Flu: _________ Hepatitis B: ________

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Family History Questionnaire

Patient Name: ______________________________ **Date of Birth:** ____________________ **Age:** ___________

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then **indicate family relationship** AND **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

Example:	***3 or more Breast, Ovarian, or Pancreatic Cancers***	***Sister - breast @ 56***	***Aunt -breast @46 Cousin-ovarian @58***

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	**N**	**1 case** of Breast cancer ***at or under age 45***				
Y	**N**	**2 cases** of Breast cancer - ***one of which is at or under age 50*** *on the same side of the family*				
Y	**N**	Breast cancer in both breasts OR multiple primary breast cancers (***1ST diagnosis at or under age 50***)				
Y	**N**	Ovarian, peritoneal, or fallopian tube cancer ***at any age***				
Y	**N**	Male breast cancer ***at any age***				
Y	**N**	Breast Cancer diagnosis with Triple Negative Receptors: ER-, PR-, and HER2- ***at or under age 60***				
Y	**N**	**3 cases** of: Breast, Ovarian, or Pancreatic cancer at ANY AGE and IN ANY COMBINATION *on the same side of the family*				
Y	**N**	Colorectal cancer diagnosed **under age 50**				
Y	**N**	Endometrial cancer diagnosed **under age 50**				
Y	**N**	**2 cases** of Lynch syndrome related cancers*** *in one person*				
Y	**N**	**3 cases** of Lynch syndrome related cancers*** *on same side of the family*				
Y	**N**	**20 or more** total polyps in the colon *throughout life*				
Y	**N**	**Has anyone in your family had genetic testing for a hereditary cancer syndrome?**				

******Lynch syndrome related cancers – Colorectal, Endometrial, Gastric, Ovarian, Pancreas, Ureter, Renal Pelvis, Biliary Tract, Brain, and Small Intestinal Cancers.***

Patient's Signature:____ Date: __________

A TRADITION OF CARING

Our **GOAL** is to provide you with compassionate, individualized, and comprehensive health care. Good communication between you, your family, and our physicians and staff is vital to achieving this goal.

We have four clinic locations that specialize in the care and treatment of cancer and blood disorders. Many people are apprehensive when visiting a physician and we strive to reduce any anxiety you may have. The following information will aid you in understanding our services, but if you need further information, please do not hesitate to call the clinic nearest you. We appreciate the opportunity to participate in your healthcare needs.

OFFICE HOURS AND LOCATIONS

Athens	(903) 675-1322	8:00 AM – 5:00 PM	Monday thru Friday
Cedar Creek Lake	(903) 802-7799	8:00 AM – 5:00 PM	Tuesdays only
Henderson	(903) 392-8150	8:00 AM – 5:00 PM	Mondays and Wednesdays only
Jacksonville	(903) 589-1327	8:00 AM – 5:00 PM	Tuesdays and Thursdays only
Tyler	(903) 592-6152	8:00 AM – 5:00 PM	Monday thru Friday

(Note: Please contact our office for confirmation of days and hours as they are subject to change.)

PHYSICIANS

Our physicians are Board Certified and/or board eligible in Medical Oncology, Hematology, Internal Medicine, Hospice and Palliative Medicine. We have a physician "on call" 24 hours a day. If you have an after-hours emergency, please call the appropriate office number listed above and our answering service will contact the on call physician. If you feel you have a life threatening emergency, please call 911.

APPOINTMENTS

A scheduled appointment is required for all visits, including those with physicians, labs, and/or infusions. Patients who show up in a non-emergent situation will be asked to return for their scheduled appointment. If the patient's condition appears to be an emergency, a nurse will be called to assess their situation. If you are a new patient, you will be required to arrive 45 minutes **prior** to your scheduled appointment time. If you are an established patient and have an appointment to see the physician and or receive treatment, we request that you arrive 30 minutes **prior** to your appointment. Failure to arrive timely may result in your appointment being rescheduled.

DISABILITY FORMS

We will complete your Disability & Medical/Family Leave forms, but please allow us 10-15 working days to complete the forms. A $15 fee is payable at the time the forms are dropped off at our office.

HOSPITAL VISITS

As part of our services, our physicians care for patients at East Texas Medical Center (Athens, Henderson, Jacksonville, and Tyler), and Trinity Mother Frances Health System in Tyler. We try to see our hospitalized patients prior to office hours, however sometimes it is later in the evening before we can see everyone.

INFUSION SERVICES

We provide chemotherapy in our on-site infusion centers which are staffed with experienced registered nurses who follow careful ONS guidelines. We also work closely with the radiation oncologists at the ETMC Cancer Institute in Tyler, as well as the Athens Cancer Center.

LABORATORY

Our in-house laboratories meet the strict and detailed requirements for certification by the Clinical Laboratory Improvements Amendment (CLIA) under the authority of the Health Care Financing Administration. Our labs feature state-of-the-art equipment operated by caring, registered medical technologists. For your convenience, we also accept lab work performed at other laboratories.

OUTPATIENT TESTING

As a courtesy to our patients, we will schedule most outpatient testing for our patients. Every effort will be made to ensure that the facility is contracted with the patient's insurance company, however any outpatient amounts associated to deductible, co-insurance, co-payment, and any other out-of-pocket amounts (including out-of-network balances), will be the responsibility of the patient and/or responsible party. It is the responsibility of the patient to ensure the outpatient testing facility is considered in-network and/or contracted.

PATIENT COUNSELING

We have a counselor available to provide emotional and practical support to patients and their families. A wide variety of educational resources, along with individual and group counseling, is available at no cost to our patients.

PAYMENT & OTHER FINANCIAL POLICIES

We will discuss insurance coverage and benefits with you on your first office and/or treatment visit. We do expect to collect any co-payments, co-insurance, or deductible at the time of service. If we are a participating provider with your insurance plan, we will file a claim with your primary insurance. As a courtesy, we will also file secondary insurance claims. However, your policy is a contact between you and your insurance company and you are ultimately responsible for the entire balance on your account. It is also your responsibility to notify our office of any change in your insurance coverage. Our physicians are participating providers with Medicare, Medicaid and most other insurance plans. It is the patient's responsibility to ensure that our physician/practice is in-network with your insurance company. If our physician is considered out-of-network with your insurance company, we will file the claim for you; however, you will be responsible for all out of pocket amounts. For our convenience, we accept cash, personal check and most major credit cards. There is a $35.00 charge for all returned checks.

PRESCRIPTION REFILLS

Please allow 24 hours for prescription refills. We only refill medications which have been prescribed by our physicians. To speed up your request, please make sure you have the following when requesting a refill:

Name of medication, strength, frequency, and quantity
Number of refills requested
Name and telephone number of your preferred pharmacy

RESEARCH / CLINICAL TRIALS

Research is one of the most important weapons in the fight against cancer. Clinical trials test new medical approaches in cancer patients and are important in developing new treatments. Many of the standard treatments we have today were developed based on the results of previous clinical trials. As a patient, you may have the opportunity to receive newly developed cancer treatments or investigational drugs through participation in clinical trials.

Through these trials, patients can gain immediate access to new and promising treatment regimens for different types of cancer. All studies are reviewed and monitored for adherence to strict standards and protocol.

If you are interested in discussing these options, please talk with your oncologist. Participation in research and clinical trials is dependent upon numerous factors related to your health and upon the availability of the trials currently being offered.

TELEPHONE CALLS

Our professional nurses can answer many of your questions. They confer directly with our physicians and make every effort to call you back promptly. Calls received before 4:00 PM are returned before 5:30 PM the same day. Calls received after 4:00 PM are returned the next business day.

PATIENT RIGHTS & RESPONSIBILITIES

PURPOSE

This form is meant to inform the patient as well as their family that they have rights and responsibilities while undergoing medical care. If there are any questions regarding this matter, please notify any of our dedicated employees.

- **Access to Care** Individuals shall be accorded impartial access to treatment or accommodations as to his or her requests and needs for treatment or service that are within the clinic's capacity, availability, states mission and applicable law and regulation, regardless of race, creed, sex, national origin, religion, disability/handicap or source of payment for care/services.

- **Respect and Dignity** Every individual, whether adult, adolescent or newborn, has the right to considerate, respectful care/services at all times and under all circumstances, with recognition of his or her personal dignity and his or her psychosocial, spiritual and cultural variables that influence the perceptions of illness.

- **Privacy and Confidentiality** The patient or his or her parent or legally designated representative has the right, within the law, to personal and informational privacy, as manifested by the right to:

  a. Wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatment.
  b. Be interviewed and examined in surroundings designed to assure reasonable audiovisual privacy. This includes the right to have a person of one's own sex present during certain parts of a physical examination, treatment or procedure performed by a health professional of the opposite sex and the right to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.
  c. Expect that any discussion or consultation involving the patient's case-whether the patient is an adult, adolescent or newborn-will be conducted discreetly, and that individuals not directly involved in his or her care/services will not be present without his/her permission.
  d. Have the right to review his or her medical records and have the information explained, except when restricted by law.
  e. Have the medical records read only by individuals directly involved in the treatment or the monitoring of its quality and by other individuals only on the patient's or his or her parent or legal designated representative's written authorization.
  f. Expect all communications and other records pertaining to care/services of the individual, including the source of payment for treatment, to be treated as confidential.
  g. Request a transfer to another treatment room if another patient or visitor is unreasonably disturbing him or her.
  h. Be placed in protective privacy when considered necessary for personal safety.

- **Personal Safety** The patient, whether adult, adolescent or newborn, has the right to expect reasonable safety insofar as the clinic practices and environment are concerned.

- **Identity** The patient or his or her parent or legally designated representative has the right to know the identity and professional status of individuals providing service to the patient, and to know which physician or other practitioner is primarily responsible for his or her care/services. This includes the right to know of the existence of any professional relationship among individuals who are treating him or her, as well as the relationship of the clinic

to any other health care services or educational institution involved in his or her care/services. Participation by patients in clinical training programs or in the gathering of data for research purposes should be voluntary.

- **Information** The patient or his or her parent or legally designated representative has the right to obtain from the practitioner responsible for coordination of his or her care/services complete and current information concerning his or her diagnosis (to the degree known), treatment and any known prognosis. This information should be communicated in terms the patient or his or her parent or legally designated representative can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual.

- **Communication** The patient or his or her parent or legally designated representative has the right to access to people outside the clinic by means of visitors and by verbal and written communication. When the patient or his or her parent or legally designated representative does not speak or understand the predominant language of the community, he or she should have access to an interpreter. This is particularly true when language barriers are a continuing problem.

- **Consent** The patient or his or her parent or legally designated representative has the right to the information necessary to enable him or her, in collaboration with the health care practitioner, to make treatment decisions involving his or her health care services that reflect his or her wishes. To the degree possible, this should be based on a clear concise explanation of his or her condition and of all proposed technical side effects, problems related to recuperation, and probability of success. The patient should not be subjected to any procedure without voluntary, competent and understanding consent by the individual or by his or her parent or legally designated representative. When a medically significant need for care, services or treatment exists, the patient or his or her parent or legally designated representative shall be so informed.

    a. The patient or his or her parent or legally designated representative has the right to know who is responsible for authorizing and performing the procedures or treatment.
    b. The patient or his or her parent or legally designated representative shall be informed if the clinic proposes to engage in or perform human experimentation or other research/educational projects affecting his or her care, services or treatment, and the patient has the right to participate in any such activity. If the patient chooses not to take part, he or she shall receive the most effective care/services the clinic otherwise provides.

- **Consultation** The patient or his or her parent or legally designated representative has the right to accept medical care/services or to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal. When refusal of treatment by the patient or his or her parent or legally designated representative prevents the provision of appropriate care/services in accordance with ethical and professional standards, the relationship with the patient may be terminated upon reasonable notice.

- **Transfer and Continuity of Care** A patient has the right to expect that the clinic/facility will give necessary health services to the best of its ability. Treatment, referral or transfer may be recommended. If transfer is recommended or requested, the patient will be informed of risks, benefits and alternatives. The patient will not be transferred until the other institution agrees to accept such patient.

- **Charges** Regardless of the source of payment for the individual's care/services, the patient or his or her parent or legally designated representative has the right to request and receive an itemized and detailed explanation of his or her total bill for services rendered in the clinic. The patient has the right to timely notice prior to termination of his or her eligibility for reimbursement by any third-party payer for the cost of his or her care/services.

- **Delineation of Patient's Rights** The rights of the patient may be delineated on behalf of the patient, to the extent permitted by law, to the patient's guardian, next of kin or legally authorized responsible person if the patient

a. Has been adjudicated incompetent in accordance with the law.
b. Is found by his or her physician to be medically incapable of understanding the proposed treatment or procedure.
c. Is unable to communicate his or her wishes regarding treatment.
d. Is a minor.

- **Rules and Regulations** The patient or his or her parent or legally designated representative should be informed of the clinic rules and regulations applicable to his or her conduct as a patient. Patients are entitled to information about the mechanism for the initiation, review and resolution of patient complaints.

- **Keep Your Health Care Providers Accurately Informed** A patient or his or her parent or legally designated representative has the responsibility to provide, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health. He or she has the responsibility to report unexpected changes in his or her condition to the responsible practitioner. A patient or his or her parent or legally designated representative is responsible for making it known whether he or she comprehends a contemplated course of action and what is expected of him or her.

- **Follow Your Treatment Plan** A patient or his or her parent or legally designated representative is responsible for following the treatment plan recommended by the practitioner primarily responsible for the patient's care/services. This may include following the instructions of health care personnel as they carry out the coordinated plan of care/services and implement the responsible practitioner's orders and as they enforce the applicable clinic rules and regulations.

- **Keep Your Appointments** The patient is responsible for keeping appointments, and when unable to do so for any reason, they are to immediately notify the appropriate clinic location. There may be charge imposed for "missed appointments" and failing to notify our office..

- **Be Responsible For Any Decision You Make Not To Follow Your Treatment Plan, And Keep Your Health Care Practitioners Informed About Your Decision(s)** The patient or his or her parent or legally designated representative is responsible for his or her actions if he or she refuses treatment or does not follow the practitioner's instructions. If the patient cannot follow through with the treatment, he or she is responsible for informing the physician.

- **Be Responsible For Your Financial Obligations** The patient or his or her parent or legally designated representative is responsible for assuring the financial obligations of his or her health care services are fulfilled as promptly as possible. The patient is responsible for providing information for insurance.

- **Comply With The Rules Of This Facility Regarding Patient Care And The Conduct Of His Or Her Visitors** The patient or his or her parent or legally designated representative is responsible for following clinic rules and regulations affecting patient care/services and conduct.

- **Be Considerate Of Others** The patient or his or her parent or legally designated representative is responsible for being considerate of the rights of other patients and clinic personnel, and for assisting in the control of noise, and the number of visitors. The patient is responsible for being respectful of the staff and the property of other persons and of the clinic.

- **Be Responsible For Your Own Lifestyle Choices** A patient's health depends not just on his or her care/services but, in the long term, on the decisions he or she makes in daily life. He or she is responsible for recognizing the effect of lifestyle on his or her personal life.

- **Practice Rights** The practice reserves the right to terminate the relationship and treatment of any patient that does not comply with their responsibilities as described in this document. If this is necessary we will notify the patient and give them 30 days to find another physician outside of our group and will be happy to transfer all medical records when requested.

NOTICE OF PRIVACY PRACTICES

PURPOSE
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read this notice carefully. After reviewing this notice you will be asked to consent to the use of your information as described.

BACKGROUND
The Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or rally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

EFFECTIVE DATE
This notice takes effect on April 14, 2003 and remains in effect until we replace it.

OUR PLEDGE REGARDING MEDICAL INFORMATION:
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a records of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY
The Law requires us to:

* Keep your medical information private
* Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
* Follow the terms of the notice that is now in effect

We have the right to:

* Change our privacy practices and the terms of this notice at any time, provided the law permits the changes.
* Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the notice.

The office has policies and procedures in place to facilitate compliance with the law, as well as assure that this office consistently treats you with respect for you and your privacy and confidentiality. These policies and procedures are available for you to review. If you would like to read them, please notify the Privacy Officer or the Practice Administrator.

USE AND DISCLOSURE OF MEDICAL INFORMATION
We have a legal, ethical, and moral obligation to protect your confidentiality. All employees will hold any information about you and/or your family strictly confidential. No discussions about you outside of the patient care framework will be allowed, and any conversation between staff members that pertains to delivering you quality care will be held in a confidential and professional manner.

In order to provide quality care to you, as well as operate this office in an efficient manner, we will need to access your private health care information for purposes of treatment, payment, and operations (such as quality assurance). In using this information, this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and Security protections provided to you by the Health Insurance Portability and Accountability Act ("HIPAA").

Specifically, we will need to disclose your private information under the following circumstances:

SHARING INFORMATION FOR PURPOSES OF TREATMENT

We will share information with all members of your treatment team, both within this office and with other providers (personal and institutional) in order to provide you with quality care and the educational/wellness programs specified in your insurance plan. We also obtain the right to share information with the Cancer Registry and Tumor Board without patient consent for the purpose of making a treatment decision on behalf of the patient. We will share protected health information for preliminary research (Clinical Trials) for the purpose of developing hypotheses and recruiting research participants without prior patient authorization to determine good candidates for Clinic Trials. Once Clinical Trial candidates have been chosen, patients must sign an authorization from a privacy board of institutional review board allowing the researchers to follow patient progress.

SHARING OF INFORMATION FOR PURPOSES OF PAYMENT

We will share all necessary information with your insurer(s), Payor(s), governmental entities (such as Medicare, Medicaid, etc.), and their representatives (including but not limited to, benefit determination and utilization review) as well as our representatives involved in the billing process (including but not limited to, claims representatives, data warehouses, billing companies).

Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the office/Privacy Officer if you ever decide to revoke your consent.

Your specific authorization will be required for the release of any information not included above. Your authorization will need to be in writing and it will be specific to the disclosure requested. Incidences, which may require your authorization under HIPAA regulations, included (but are not limited to): some marketing purposes, the disclosure of any psychotherapy records in our possession and disclosures for fundraising by any entity.

This office will not release any information other than those incidents described above; unless, a disclosure is required by law, a court order, a warrant, a subpoena, a summons, a legal process, or government agencies.

YOUR RIGHT AS A PATIENT

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer:

* The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, closer personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

* The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

* The right to inspect and copy your protected health information.

* The right to amend your protected health information.

* The right to receive an accounting of disclosures of protected health information.

* The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.

* The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of Notice of Privacy Practices.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, please contact:

Compliance Officer
721-A Clinic Dr.
Tyler, TX 75701
Telephone: (903) 592-6152

For more information about HIPAA, or to file a complaint:

The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 20201
Telephone: (202) 619-0257
Toll Free: 1-877-696-6775

HOPE
CANCER CENTER
OF EAST TEXAS
Expertise. Experience. Compassion. HOPE.

NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement Form

I, ________________________________ hereby affirm that I have received a copy of the ***Notice of Privacy Practices*** from **HOPE Cancer Center of East Texas** Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name:________________________________ **Account Number:**____________________

____ ______________________________________
Signature of Patient or Personal Representative **Date**

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority (if applicable)

▼▼▼ FOR OFFICE USE ONLY ▼▼▼

Received by:	
Date Received:	**Time Received:**
Patient Declined ☐	
Staff Signature:	

Revised 06-16-16 per HIPAA guidelines, NB

PATIENT RECORD OF DISCLOSURE

I understand that it is the policy of HOPE Cancer Center of East Texas to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, and my insurance company/companies for payment of my claims, I would like the following person/people to have access to my Private Health Information.

CONTACT NAME	RELATIONSHIP	CONTACT TELEPHONE #	DATE OF BIRTH	ACCESS TO INFORMATION
1. *John / Jane Doe*	*Spouse*	*999-999-9999*	*01/01/1900*	○ All or ○ Restricted*
2.				○ All or ○ Restricted*
3.				○ All or ○ Restricted*
4.				○ All or ○ Restricted*
5.				○ All or ○ Restricted*

* Clinical Info Restricted – If you checked this box above, please specify what clinical information you **DO NOT** wish to share with the person(s) listed above:

○ Sexually Transmitted Disease(s)

○ Mental/Behavioral Health

○ Pregnancy

○ Other ___________________________

○ Terminal Illness

Communication:

You **MAY** or **MAY NOT** leave confidential clinical information on my answering machine. (Circle one)

______________________________ Patient Signature

______________________________ E-mail Address **(REQUIRED)**

______________________________ Patient Name (Printed)

______________________________ Date of Birth

______________________________ Witnessed By

______________________________ Date

State law permits both parents to have access to PHI unless we are provided a court order restricting this right.