SCRI Oncology Partners

Patient Registration Form

Legal Name: _____ **Preferred Name:** _____ **DOB:** _____
Last *First* *M.I.*

Home Phone: _____ **Cell Phone:** _____ **SSN#:** _____

Home Address: _____
Street *City* *State* *Zip*

Mailing Address: _____
Street *City* *State* *Zip*

Email Address: _____ **Preferred Contact Method:** ☐Cell Phone ☐Home Phone ☐Email

Sex at Birth: ☐M ☐F **Gender Identity:** _____

Marital Status: ☐Divorced ☐Domestic Partner ☐Married ☐Separated ☐Single ☐Widowed ☐Unspecified

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Hawaiian/Other Pacific Islander
☐White ☐Other: _____ ☐Decline to specify **Preferred Language:** _____

Employment Status: ☐Employed ☐Full-time Student ☐Part-time Student ☐Retired ☐Unemployed ☐Unspecified

Employer Name: _____ **Employer Address:** _____

Responsible Party: _____ _____
Name *Relationship* *Telephone*

Emergency Contact:
(Spouse/Next of Kin) _____ _____
Name *Relationship* *Telephone*

Referring Physician: _____ **Primary Care Physician:** _____

Primary Insurance: _____ **Telephone:** _____

Insured Name: _____ **DOB:** _____ **Group#:** _____ **Policy#:** _____

Secondary Insurance: _____ **Telephone:** _____

Insured Name: _____ **DOB:** _____ **Group#:** _____ **Policy#:** _____

How did you learn/hear about us?

☐ Doctor or Healthcare Provider
☐ Family/Friend
☐ Internet Search
☐ Social Media
☐ Radio
☐ Print Ad
☐ Event
☐ Online Review

SCRI Oncology Partners

SCRI Oncology Partners
Patient History

CancerCareSCRI.com

Name: _____ Today's Date: _____

Date of Birth: _____ ☐ Male ☐ Female

Reason for Today's Visit: _____

Personal Medical History: External Providers

	Provider Role	Name of Provider	Date Last Seen
1.	Referring Physician:		
2.	Primary Care Provider		
3.	OB/Gyn Physician:		
4.	Cardiologist:		
5.	Gastroenterologist:		
6.	Other specialty provider:		
7.	Other specialty provider:		

Personal Medical History: Please check all that apply and include date of diagnosis

☐	Anemia	
☐	Arthritis	
☐	Asthma	
☐	Bleeding Disorder	
☐	Cancer (please list type)	
	1.	
	2.	
	3.	
☐	Diabetes	
☐	Emphysema/COPD	
☐	Epilepsy	
☐	Exposure to Asbestos	
☐	Heart Disease (e.g. Heart Attack)	
☐	Hepatitis Type:	

☐	High Blood Pressure	
☐	High Cholesterol	
☐	Kidney Disease	
☐	Liver Disease	
☐	Mental Illness	
☐	Migraine Headaches	
☐	Pneumonia	
☐	Sexually Transmitted Disease	
☐	Sleep Apnea	
☐	Stroke	
☐	Thyroid Disease	
☐	Tuberculosis	
☐	Ulcer	
☐	Other:	

Hospitalizations/Surgeries: Please list all hospitalizations and surgeries

	Date	Reason for Hospitalization or Type of Surgery	Where	Doctor
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

SCRI Oncology Partners Patient History

Name: _____

Previous Treatment for Cancer (Radiation Therapy)

Have you previously received radiation therapy? ☐ **Yes** ☐ **No**

If yes, please describe:

	Date	Please describe previous radiation therapy	Where	Doctor
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Previous Treatment for Cancer (Chemotherapy)

Have you previously received chemotherapy? ☐ **Yes** ☐ **No**

If yes, please describe:

	Date	Please describe previous chemotherapy treatment(s)	Where	Doctor
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Previous Treatment for Cancer (Hormone Therapy)

Have you previously received hormone therapy? ☐ **Yes** ☐ **No**

If yes, please describe:

	Date	Please describe previous hormone therapy	Where	Doctor
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

SCRI Oncology Partners Patient History

Name: _____

Immunizations: Please check previous immunizations received and include date of last vaccine if known

Chickenpox ☐		Hepatitis B ☐		Polio ☐	
Flu ☐		Measles ☐		Smallpox ☐	
Hemophilus (HIB) ☐		Pneumococcal ☐		Tetanus ☐	
COVID-19: ☐		Other: ☐		Other: ☐	

Medications: Please list current prescriptions and over-the-counter medications, as well as herbals, supplements and vitamins.

	Medication	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

Allergies

Are you allergic to any medications? ☐ **Yes** ☐ **No**

If yes, please list the medications that you are allergic to and the type of reaction:

_____

_____

Are you allergic to:

Latex: ☐ **Yes** ☐ **No**

Tape: ☐ **Yes** ☐ **No** If yes, please list the type of tape: _____

Eggs: ☐ **Yes** ☐ **No**

Vaccines: ☐ **Yes** ☐ **No** If yes, please list the type of vaccine: _____

Other allergies: ☐ **Yes** ☐ **No**

If yes, please list other allergies:

_____

Blood Transfusions

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No**

If yes, did you have a reaction? ☐ **Yes** ☐ **No**

Date of last blood transfusion: _____

SCRI Oncology Partners Patient History

Name: _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Domestic partner ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how many children: _____

Occupation (previous if retired): _____ ☐ Retired

Have you served in the military? ☐ Yes ☐ No If yes, dates of service: _____

Do you have an Advance Directive? ☐ Yes ☐ No

If yes, continue below:

Do you have a Living Will? ☐ Yes ☐ No

Do you have a Power of Attorney for Healthcare? ☐ Yes ☐ No

Do you have a DNR Order? ☐ Yes ☐ No

Is there a person who you would like to be your primary contact regarding your healthcare? ☐ Yes ☐ No

If yes, Name: _____ Relationship: _____ Phone: _____

Do you currently use tobacco products: ☐ Yes ☐ No

If yes, use per day: ☐ Cigarettes: _____ ☐ Cigars: _____ ☐ Pipe: _____ ☐ Chewing tobacco: _____

For how many years have you used the above tobacco product? _____

If no, have you ever used tobacco products in the past? ☐ Yes ☐ No

If yes, use per day: ☐ Cigarettes: _____ ☐ Cigars: _____ ☐ Pipe: _____ ☐ Chewing tobacco: _____

When did you quit? _____ For how many years did you use the above tobacco product? _____

How many servings of wine, beer or other alcoholic beverage(s) do you drink per day? _____ Per week? _____

Do you have a history of alcoholism? ☐ Yes ☐ No

Do you use marijuana? ☐ Yes ☐ No

Have you used illegal drugs? ☐ Yes ☐ No

If yes, which ones? _____

What do you do for exercise? _____ How many times per week? _____

Family History: Please include age at diagnosis

Please list all first, second, and third degree family members with a history of cancer or colon polyps, either living or deceased.

First degree: Parents, siblings and children
Second degree: Grandparents, aunts/uncles, nieces/nephew, grandchildren and half siblings
Third degree: Great grandparents, great aunts/uncles, half aunts/uncles, first cousins and great grandchildren

Relationship to Patient	Maternal	Paternal	Cancer Type	Number of Polyps	Age at Diagnosis
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

☐ Adopted - Family history not known

☐ Ashkenazi Jewish Ancestry

Do you have a family history of blood clots or bleeding disorders?

☐ **Yes** ☐ **No**

If yes, please elaborate: _____

SCRI Oncology Partners Patient History

Name: _____

Male Prostate History

When was your last prostate exam? _____ When was your last PSA test? _____

Female OB/Gyn History

How many times have you been pregnant: _____ How many live births have you had: _____

Your age at the birth of your first child? _____

Any complications during pregnancy? ☐ Yes ☐ No Any history of miscarriages or abortions? _____

Did you breast feed? ☐ Yes ☐ No If yes, how long did you breast feed? _____

Are you sexually active? ☐ Yes ☐ No

Are you using birth control? ☐ Yes ☐ No If yes, please include type: _____

Do you wish to become pregnant? ☐ Yes ☐ No

How old were you when you began to menstruate: _____

Are you still having periods? ☐ Yes ☐ No

If yes, date of the first day of your last period: _____

Usual duration of flow: _____ Periods occur every _____ days

Are you experiencing any of the below symptoms:

☐ Menstrual pain ☐ Spotting between periods

☐ Bleeding between periods ☐ Excessive bleeding

If no, how old were you when you stopped having periods? _____

Are you experiencing bleeding after menopause: ☐ Yes ☐ No

Date of last PAP smear:_____ Date of last Mammogram:_____ Date of last Colonoscopy:_____

Have you had an abnormal PAP test? ☐ Yes ☐ No

If yes, please list date and type of any treatments(s) received: _____

Female Breast Cancer or Breast Surgery Patient

Do you have a history of breast cancer? ☐ Yes ☐ No At what age were you first diagnosed? _____

If yes, which side? ☐ Right ☐ Left

Were you treated with: ☐ Lumpectomy ☐ Chemotherapy

☐ Mastectomy ☐ Radiation therapy

Were your lymph nodes checked? ☐ Yes ☐ No ☐ Hormonal therapy

Do you have a lump in your breast? ☐ Yes ☐ No

If yes, which side? ☐ Right ☐ Left

Does the lump hurt? ☐ Yes ☐ No Is the pain related to your cycle? ☐ Yes ☐ No

Has the lump increased in size? ☐ Yes ☐ No Do you have nipple discharge? ☐ Yes ☐ No

Do you have any breast skin changes? ☐ Yes ☐ No Have you had a breast cyst drained? ☐ Yes ☐ No

Do you have lumps in your underarm? ☐ Yes ☐ No Have you had a breast biopsy? ☐ Yes ☐ No

Have you had prior breast surgery? ☐ Yes ☐ No Have you had breast plastic surgery? ☐ Yes ☐ No

Have you ever taken hormones? ☐ Yes ☐ No

If yes, ☐ Birth control pills ☐ Hormone replacement ☐ Fertility

Patient Pharmacy Information

Patient Name:_____ Acct #: _____

Date of Birth: _____ SS#: _____

Insurance Company: _____ ID#: _____

Pharmacy Name: _____

Address/Location: _____

Pharmacy#: _____ Alt#: _____

Drug Allergies:

_____

_____

_____

SCRI Oncology Partners

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SCRI Oncology Partners is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of SCRI Oncology Partners.

Printed Name: _____

Signature: _____

Date of Birth: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

SCRI ONCOLOGY PARTNERS OFFICE USE ONLY

Date acknowledgement received: _____ - OR –

Reason acknowledgement was not signed: _____

_____

_____

SCRI Oncology Partners Employee Printed Name: _____

SCRI Oncology Partners Employee Signature: _____

SCRI Oncology Partners
NOTICE OF PRIVACY PRACTICES

Effective Date: December 16, 2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

About Us
In this Notice, we use terms like "we," "us" or "our" to refer to SCRI Oncology Partners, its physicians, staff and other personnel. All of the sites and locations of SCRI Oncology Partners follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes as described in this Notice.

Purpose of this Notice
This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities
We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information
The following categories describe examples of the way we use and disclose health information:
For Treatment: We may use your health information to provide you with medical treatment or services. For example, your health information will be disclosed to the oncology nurses who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat you.
For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.
For Health Care Operations: We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities.
We may ask you to sign your name to a sign-in sheet at the registration desk and we may call your name in the waiting room when we call you for your appointment.
We may disclose your health information to a third party that performs services, such as billing and collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.
Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.
Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or e-mail you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.
Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a particular family member or friend, please notify our Privacy Officer.** We may also disclose your health information to disaster-relief organizations so that your family can be notified about your condition, status and location.
We are also allowed by law to use and disclose your health information without your authorization for the following purposes:
As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.
Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.
Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths; to report child abuse or neglect;
- To report adverse events, product defects or problems;
- To track FDA-regulated products; to notify people and enable product recalls; and
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition.
- To notify the State Cancer Registry

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat.
Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.
Workers' Compensation: We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when authorized by law.
Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.
National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.
Inmates: If you are an inmate of a correctional institution of under the custody of a law enforcement official to assist them in providing you healthcare, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.
Research: We may use and disclose your health information for certain limited research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project, assesses a number of specific issues, and determines that appropriate privacy safeguards are in place to allow the use of health information in the research project. We may, however, disclose your health information to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the practice.
Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information
You have the following rights regarding health information we maintain about you:
Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment, or healthcare operations. Under most situations we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to our Privacy Officer.
Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to our Privacy Officer. We will attempt to accommodate all reasonable requests.
Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to our Privacy Officer. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.
We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to our Privacy Officer. We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us.
Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we make of your health information. Please note that certain disclosures, such as those made for treatment, payment, or health care operations, need not be included in the accounting we provide to you. To request an accounting of disclosure, you must make your request in writing by filling out the appropriate form provided by us and submitting it to our Privacy Officer. Your request must state a time period which may not be longer than six years, and which may not include dates before December 16, 2023. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.
Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact our Privacy Officer. You may also print a copy of this Notice at our web site, www.cancercarescri.com

Right to Complain: If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to:

Privacy Officer
SCRI Oncology Partners
335 24TH Avenue N. Suite #200
Nashville, TN 37203

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing a complaint.

Changes to this Notice
We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the waiting room of each office. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our web site www.cancercarescri.com

SCRI
Oncology Partners

CancerCareSCRI.com

PROVIDING QUALITY AFFORDABLE CARE TO ALL OF OUR PATIENTS IS OUR MISSION

As cancer and hematology specialists, we know that modern cancer and hematology care may be expensive. We will work with you and your insurance company to provide the most effective treatment options at the minimal cost to you. The best outcomes are achieved when you and SCRI Oncology Partners work as a team to determine a financial plan.

***How SCRI Oncology Partners works with you**:*

SCRI Oncology Partners provides verification and review of your insurance benefits. Once your treatment plan is agreed on, one of our Financial Counselors can provide you an estimate of your financial responsibility.

If you feel your estimated cost is not affordable, we need to know immediately, so we can work with you to meet your medical and financial needs before treatment starts. Our Financial Counselors can give your information on financial assistance options that may be available from a wide variety of local and national resources. If you want to pursue any of the available options, you will need to complete all required paperwork and receive assistance approval prior to beginning treatment.

SCRI Oncology Partners will bill your primary insurance carrier. As a courtesy, we will also bill your secondary insurance carrier. After 60 days, any unpaid balances for secondary insurance will become patient responsibility.

You are responsible for ensuring SCRI Oncology Partners has your most current health insurance and billing information. We ask that you notify us either in person or via 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 the financial assistance process can be started before your balance rises.

- Please provide your current financial information when requested.
- Please bring your current health insurance identification card to all appointments.
- Please complete all required paperwork in a timely manner.
- Payments for co-pays, deductibles and balances not paid by your insurance company are your responsibility.

Co-payments are due at the time of service. We may also ask for payment on any outstanding patient balances at the practice site. Our billing office is available to help you with any billing or insurance questions you may have regarding your account. Please call our Business Office at 1-800-331-9194 Monday – Thursday 8:00AM – 4:00PM CST & Friday 8:00AM-2:00PM CST

You are responsible for assisting the practice in obtaining any referrals that may be required by your insurance plan prior to your appointment.

The Financial Counselors at SCRI Oncology Partners or your assigned Insurance Specialist at the Central Business Office are your contacts for any billing or insurance questions or concerns. A monthly patient statement is sent detailing any patient balance activity (new charges, adjustments, and payments from insurance, etc).

I understand the above policies and have had the opportunity to discuss any questions I may have.

Patient/Responsible Party Signature	MRN#	Date

Assignment of Benefits

Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made on my behalf to SCRI Oncology Partners (the "Provider") for any services furnished to me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian Signature: _____ Date: _____

Medigap (Medicare Supplemental Insurance) Assignment of Benefits

I request payment of authorized Medigap benefits be made to the Provider and authorize any holder of medical information about me to release to the Medigap insurer listed below any information needed to determine benefits payable for services from the Provider.

Medigap Insurance Name: _____

Patient/Guardian Signature: _____ Date: _____

General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature: _____ Date: _____

Receipt of HIPAA Patient Privacy Rights Notification

My signature below indicates that I have the HIPAA Patient Privacy Rights Notification and that I have been made aware of my privacy rights and how I may exercise those rights. I understand that all contact phone numbers listed on the Patient Registration Form may be used to contact me for treatment or payment purposes unless I submit a written request to restrict the use of any/all contact phone numbers listed.

Patient/Guardian Signature: _____ Date: _____

Authorization for Release of PHI to Others

(For individuals directly involved in the patient's care or payment for care)

_____, authorize the following persons(s) (spouse, partner, sibling, child, friend, etc.) access to my private health information (PHI).

Name (Printed) _____ Relationship _____ Date of Birth _____ Phone Number (____) _____
Name (Printed) _____ Relationship _____ Date of Birth _____ Phone Number (____) _____
Name (Printed) _____ Relationship _____ Date of Birth _____ Phone Number (____) _____

I understand that these persons are authorized to access my information until that authorization is revoked. Authorization can be revoked verbally or in writing at any time by me (patient) or an appointed Durable Health Care Power of Attorney.

Signature of Patient _____

Name (Printed) _____ Date _____

<u>Personal Representative</u> (Only fill out if there is one of the legal documents below)

I _____, attest that I can act on behalf of _____ (patient) for purposes of treatment authorization and or Use and Disclosure of the patient's PHI through rights afforded to me by the state. I will provide all legal documentation required to support the aboves statement. (Please attach legal documentation to this form).

Examples:

- Durable Power of Attorney for Health Care
- Health Care Proxy
- Court-Appointed Guardian
- Letters of Testamentary/Administration

Signature _____

Name (Printed) _____ Date _____

SCRI Oncology Partners

User Electronic Mail Authorization Form
Patient Portal: Navigating Care

CancerCareSCRI.com

Navigating Care, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password to access the Portal**. Please look for an email from Navigating Care promptly after submitting this form.** For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal; the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

_____ _____

Patient Name
(First Name, Middle Initial, Last Name)

Email Address of Patient/Authorized User

_____ _____

Date of Birth of Patient

SCRI Oncology Partners Physician's Name

Authorized User is:
☐ Patient
☐ Patient's Designee

_____ _____

Patient's Designee's Name (Printed)

Patient's Designee's Signature

_____

Patient's Medical Record Number

_____ _____

Patient's Signature Date

Date:

_____

Printed Name of Practice Staff
[confirming user's identity and authority]

_____ _____

Signature of Practice Staff

Date:

AUTHORIZATION AND ATTESTATION FOR FINANCIAL ASSISTANCE

At SCRI Oncology Partners, we are committed to alleviating the financial burden on our patients. Our dedicated team will diligently work to review and enroll eligible patients in various patient assistance programs. These programs are designed to provide financial relief by offering free or reduced-cost treatments. We strive to ensure that our patients have access to the necessary resources and support, allowing them to focus on their health and well-being without the added stress of financial concerns. Rest assured; we will explore all available options to assist you in managing your healthcare expenses.

I understand that SCRI Oncology Partners and its affiliates (*The US Oncology Network and Annexus Health*) are acting solely as agents to help me find and apply for appropriate financial assistance, either in the form of free or reduced-cost treatment.

I authorize SCRI Oncology Partners to use my personal health information to complete phone, electronic or hardcopy applications and to sign online applications on my behalf to determine my eligibility. I understand that my physician and SCRI Oncology Partners do not determine my eligibility for assistance. Eligibility for assistance is determined by the sponsors of the charitable foundations or product manufacturers ("Programs") and is contingent upon the eligibility criteria set forth by the program. I understand that the charitable foundations and product manufacturers ("Programs") may perform a "soft credit check" to obtain confirmation of household reported income.

By authorizing SCRI Oncology Partners to submit my application, I attest that I understand and agree to the below statements.

- I understand SCRI Oncology Partners and/or their affiliates may contact me to obtain any additional information needed to complete an application.
- I understand that the Program sponsor may request documentation to verify the accuracy of any information that I may provide for the application, including verification of my household income.
- If I do not provide documentation or information as requested by the Program, or if the Program determines I do not meet the Program eligibility requirements, my participation and all assistance may be terminated.
- SCRI Oncology Partners and the Assistance Program Sponsor(s) may obtain and discuss medical, treatment, therapy, financial and other information relating to my application with my providers, pharmacy, insurance company, and to other organizations working on my behalf to obtain eligible treatment.
- I understand that if I have applied for assistance elsewhere, I must disclose this to any other Foundation or Patient Assistance Program that approves me for funds or drug product.
- I understand that there is no fee or charge for this support service.
- I understand that the Program can at any time, and without notice, modify or discontinue all or any part of the Program and/or any assistance provided to me. The financial assistance or free product provided by any Program may not cover my entire liability for treatment. Some Programs limit assistance to the specific drugs that treat or cover only certain conditions. Should additional assistance be needed for continuity of treatment, I

Patient Initials_____

understand that SCRI Oncology Partners will complete and submit applications to secondary Programs or submit renewal applications on my behalf.

- I understand that this authorization is valid for 12 months. I may cancel this Authorization at any time by mailing a written request for such cancellation to SCRI Oncology Partners and the cancellation will not apply to any information already used or disclosed pursuant to this Authorization. I understand that I may request a copy of this Authorization once it has been signed.

PLEASE SIGN ONE OF THE SECTIONS BELOW

Patient Name: _____

Patient DOB: _____

I agree and certify that I have read, understood, and will abide by the above attestation and authorize SCRI Oncology Partners to proceed with applying for assistance on my behalf.

Signature of Patient/Legally Authorized Representative: _____

Relationship to Patient (if Patient is not siging): _____

I choose to decline and/or retract my authorization for SCRI Oncology Partners and the above listed affiliates to proceed with applying for assistance on my behalf.

Effective Date: _____

Signature of Patient/Legally Authorized Representative: _____

Relationship to Patient (if Patient is not siging): _____

SCRI
Oncology Partners

CancerCareSCRI.com

I hereby give my consent to be photographed:

Name: _____DOB:_____

☐ Yes ☐ No

I understand that my photograph is being taken for identification purposes only.

I understand that SCRI Oncology Partners will retain ownership rights to these photographs, and they will become a permanent part of my medical record for as long as that record exists.

Images that identify me will be released only upon written authorization from me or my legal representative.

_____Date: _____
Patient Signature

_____Date: _____
Witness Signature