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: **February 16, 2026**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION. YOU HAVE THE RIGHT TO REQUEST AN AMENDMENT TO YOUR MEDICAL INFORMATION FOR AS LONG AS IT IS MAINTAINED BY OR FOR US. PLEASE REVIEW IT CAREFULLY.

About Us

In this Notice, we use terms like "we," "us," "our" or "Practice" to refer to **SCRI Oncology Partners** its physicians, employees, 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 and for other 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 to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured 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 without your written authorization:

For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care.

For Payment: We may use and disclose your health information as needed to bill or obtain payment for the treatment and services provided. 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 also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. 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 also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

Individuals Involved in Your Care or Payment for Your Care and Notification: We will make the following uses and disclosures of your health information but will generally give you an opportunity to object before making these disclosures. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

We may use or disclose your information to notify or assist in notifying a family member, personal representative or any other person responsible for your care regarding your physical location within the Practice, general condition or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status and location.

We are also allowed to the extent permitted by applicable 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 in limited circumstances such as: to identify or locate suspects, fugitives, witnesses or victims of a crime, to report deaths from a crime, and to report crimes that occur on our premises.

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;
- Activities related to the quality, safety or effectiveness of FDA-regulated products;
- 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 as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

Serious Threat to Health or Safety: We may use or disclose your health information when necessary to prevent a serious and imminent threat to your health or safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help prevent the threat of harm.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation or banking of organs, eyes, or tissues.

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 as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that 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 required or authorized by law.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your medical information as required by military command

authorities or to the Department of Veterans Affairs. We may also disclose your medical information to authorized federal officials for intelligence and national security purposes to the extent authorized by law.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, 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 research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.

- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.

- Sale of Your Health Information: We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization. Note that there is a potential that information disclosed to third parties under an authorization may no longer be protected by HIPAA, and those third parties could re-disclose your information.

Fundraising Activities

We may use your demographic information (such as name, contact information, age, gender, and date of birth), the dates you received services from us, the department of your service, your treating physician, outcome information, and health insurance status to contact you in an effort to raise money for charitable purposes. We may also disclose this information to a foundation related to the Practice so that the foundation may contact you to raise money for the foundation. You have the right to opt out of receiving fundraising communications.

Your Rights Regarding Your Health Information

You have the following rights regarding the 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 health care operations. **In most circumstances, we are not required to agree to your request.** If we agree to a restriction, 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 **Dani Allen, Practice Administrator at 335 24th Ave N, Suite 200 Nashville, TN 37203**. We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes if the information applies solely to a healthcare item or service for which we have been paid out of pocket in full and such disclosure is not otherwise required by law.

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 **Dani Allen, Practice Administrator at 335 24th Ave N, Suite 200 Nashville, TN 37203.** We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy:

You have the right to inspect and/or obtain a copy of your health information maintained in a designated record set. If we maintain your health information electronically, you may obtain an electronic copy of the information or ask us to send it to a person or organization that you identify. To request to inspect and/or obtain a copy of your health information, you must submit a written request to **Dani Allen, Practice Administrator at 335 24th Ave N, Suite 200 Nashville, TN 37203.** If you request a copy (paper or electronic) of your health information, we may charge you a reasonable, cost-based fee.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **Dani Allen, Practice Administrator at 335 24th Ave N, Suite 200 Nashville, TN 37203.**

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we have made of your health information in the past six (6) years. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **Dani Allen, Practice Administrator at 335 24th Ave N, Suite 200 Nashville, TN 37203**. 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 **Dani Allen, Practice Administrator at 335 24th Ave N, Suite 200 Nashville, TN 37203.** You may also obtain a paper copy of this Notice at our website, **www.cancercarescri.com.**

Communications

We may reach out to you regarding your healthcare via the phone numbers and email addresses you've provided. This could include calls, texts, or emails, possibly through automated systems or pre-recorded messages. Some communications sent via text message may request an additional confirmation from you that you would like to receive the message. You'll always have the option to opt out of future communications like these.

Our messages might cover topics such as appointment reminders, your experience as a patient, discharge planning, billing, prescription updates, research opportunities, our products and services, treatment options, general health information, and regulatory notices. Please be aware that texts and emails are not encrypted, so there's a risk they could be accessed by others. To protect your privacy, we limit the sensitive health information in these messages. If you prefer not to receive texts or emails, please contact us, and we will remove you from such lists.

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 front waiting area of the practice.** Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, **www.cancercarescri.com.**

Complaints

If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: **Dani Allen, Practice Administrator 615-329-7640 or 335 24th Ave 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.**

Questions

If you have questions about this Notice, please contact **Dani Allen, Practice Administrator at 615-329-7640.**

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 1-800-331-9294 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

SCRI Oncology Partners

Docfluent

Disability/FMLA Intake and Authorization Form

Tell us about the request.

Request Date: ___/___/___ Document Type: ☒ FMLA ☒ Disability ☐ Other: _____

Requestor Name: _____ Relationship to patient: ☐ Self ☐ Other: _____

Purpose of Request: _____

Start Date: ___/___/___ Estimated Return Date: ___/___/___ Type: ☐ Intermittent ☐ Continuous

Restrictions: _____

Tell us about the patient.

Name: _____ DOB: ___/___/___ SSN: ___-___-___

Email: _____ Treating Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone #: (___) ___-_____ Type: ☐ Home ☐ Mobile ☐ Work Best Time to Call: ☐ AM ☐ PM

Send completed form(s) and/or records to:

Company Name: _____ Attention: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: (___) ___-_____ Fax: (___) ___-_____

Authorization and Attestation

I hereby authorize SCRI Oncology Partners and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, HIV, or STDs, unless otherwise noted. This authorization is valid for 12 months from the date of signature. I understand that I may cancel or revoke this authorization at any time in writing, but any information released prior to SCRI Oncology Partners receiving cancellation will not be affected. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

I understand the turnaround time for completion of this request is 10 business days. I further understand that SCRI Oncology Partners is not responsible for technical issues resulting in unsuccessful or delayed transmission of documentation. Upon request, a copy of completed forms and supportive documentation can be made available via secure email. If email is not an option, arrangements can be made for pick-up by the patient and/or authorized representative on file.

Requests for completed documentation can be made by contacting Docfluent by phone at 512.298.1843 or by email at fmla@docfluent.com

☐ Patient ☐ Documented Authorized Representative Printed Name: _____

Signature: _____ _____ _____

Date Time

Received by: _____ _____ _____

Date Time