



Patient Information

Date _____ Social Security Number _____
Patient Name (First) _____ (M.I.) _____ (Last) _____
Patient Address _____
Zip Code _____ City _____ State _____
Home Telephone _____
Employer _____ Work Telephone _____
Date of Birth _____ Sex _____ Marital Status _____
Nearest Relative (outside the home) _____
Relationship to patient _____ Phone _____

Insurance Holder Information *(If other than self)*

Patient Relation *(i.e. self, husband, wife, father, or mother)*
Name (First) _____ (M.I.) _____ (Last) _____
Social Security Number _____ DOB _____
Address _____
Zip Code _____ City _____ State _____
Home Telephone _____

Patient Medical History

Allergies _____

Current Medications _____

History of Cancer (location, type, year) _____

Previous Surgeries (location, physician, year) _____

Previous biopsies (location, physician, year) _____

Significant Medical History _____

Please list other physicians and caregivers that you would like to receive a copy of your report. _____



Authorization to Release Medical Records/Information

Physician to provide records: _____

Patient's name: _____

Social Security #: _____ DOB: _____

Person/Facility to receive records: _____ Outpatient Cytopathology Center

Address: _____ 2400 Susannah Street, Suite A

City, State, Zip: _____ Johnson City, Tennessee 37601

Phone #: _____ (423) 283-4734 FAX (423) 283-4736

(Please initial one line)

- | Release these records: | <u>Initials</u> |
|---|-----------------|
| 1. Only records generated by this facility (not including records received from other sources) | _____ |
| 2. Only some portion of records maintained at this facility (dates of treatment, etc., specify below) | _____ |
| 3. All medical records at this facility | _____ |

Expiration or revocation of authorization- I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. Use of copies- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print):

Person authorized to sign for patient (print):

Patient's signature

Signature
Relationship to patient

Date: _____

Date: _____



PAYMENT POLICY

Payment or partial payment is required on the day of visit.

I intend to pay today by cash _____, check _____, or credit card _____.

If you have insurance coverage, we ask that you pay the amount the insurance does not cover, such as the deductible and co-insurance. All accounts are to be paid in full within 90 days from date of service. Payment(s) can be made by cash, check, or MasterCard, Visa or Discover. If account is not paid, it will be placed with our collection agency. If a check is returned to us for any reason, a \$20.00 service charge will be added to your account.

INSURANCE

As a courtesy, our office will file your insurance. Your insurance policy is a contract between you and your insurance company. You are responsible for payment of all services rendered, whether or not your insurance company has paid. It is important to understand that your insurance company may not pay all of the charges and the difference between what they pay and your total charges is your responsibility. Our office can help you with problems which may arise with your claim, but our office does not accept the responsibility for negotiating a settlement on a disputed claim.

Sometimes, an insurance company sends checks directly to the patient for services rendered by Outpatient Cytopathology Center. Unless you have paid your charges in full, that check is the property of Outpatient Cytopathology Center.

Each month, you will receive a statement if your account has a balance due. If you have insurance, the amount paid by the insurance company will be posted immediately to your account.

I have read the above payment policy and understand that I am responsible for payment of my account. Assignment: I assign and request payment of medical benefits to physician for services.

Patient/Guardian Signature

Date

Witness Signature

Date



May the OCC staff contact you to provide you with appointment reminders or for the purpose of advancing medical education through clinical and surgical follow ups? Below is a list of persons with whom we have permission to speak to. Please circle all that apply.

- A. Home, we may speak with _____.
Relation: _____.
- B. Work. Number _____.
- C. Answering machine.
- D. Voicemail.
- E. I do not have a home telephone number, you may call _____ and speak with _____.
- F. Do not call me to confirm appointments or to obtain medical follow up information.

Patient/Guardian name: _____ Date: _____

Patient/Guardian Signature: _____

*This form is valid until further notice, until modified
or replaced at the patient's request.*

I have received a copy of the *Notice of Privacy Practices for Protected Health Information* brochure.

Patient/Guardian name: _____ Date: _____

Patient/Guardian Signature: _____



**Notice of Privacy Practices for
Protected Health Information**

**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!**

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of use of your health information for payment purposes:

- We submit requests for payment to your health insurance company. The health insurance company or business associate helping us obtain payment requests information from us regarding your medical care given before the claim can be processed. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such business associates as necessary to obtain these services

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office. You have the following rights with respect to your Protected Health Information

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office—we are not required to grant the request but we will comply with any request granted;
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
3. Right to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request; appeal a denial of access to your protected health information except in certain circumstances;
4. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
5. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;

6. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request; and,

If you want to exercise any of the above rights, please contact the Medical Director of the Outpatient Cytopathology Center in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the Medical Director of the Outpatient Cytopathology Center.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Medical Director of the Outpatient Cytopathology Center. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is

Tommy Thompson, Secretary of Health and Human Services
Address: **200 Independence Avenue Southwest, Washington D.C. 20201.** E-mail address: **Tommy.Thompson@HHS.gov.**

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule

Patient Contact

We may contact you to provide you with appointment reminders, with information about treatment alternatives, for the purpose of advancing medical education through clinical and surgical follow up or with information about other health-related benefits and services that may be of interest to you.

Notification – Opportunity to Agree or Object

Unless you object we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family - Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

We may use and disclose your protected health information to assist in disaster relief efforts.

Opportunity to Agree or Object Not Required

PUBLIC HEALTH ACTIVITIES

Controlling Disease - As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Child Abuse & Neglect - We may disclose protected health information to public authorities as allowed by law to report child abuse or neglect.

Food and Drug Administration (FDA) - We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Health care providers working for an Industry performing medical surveillance or evaluating whether the individual has a work related injury or illness may disclose PHI pertaining to the work related injury or illness to the employer if the employer needs the findings in order to comply with OSHA regulations.

VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE

We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victim.

OVERSIGHT AGENCIES

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations: inspections; licensures or disciplinary actions, and for similar reasons related to the administration of healthcare.

JUDICIAL/ADMINISTRATIVE PROCEEDINGS

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.

LAW ENFORCEMENT

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

ORGAN PROCUREMENT ORGANIZATIONS

Consistent with applicable law, we may disclose your protected health information to organ procurement

organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of donation and transplant.

RESEARCH

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

THREAT TO HEALTH AND SAFETY

To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

FOR SPECIALIZED GOVERNMENTAL FUNCTIONS

We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

CORRECTIONAL INSTITUTIONS

If you are an inmate of a correctional institution, we may disclose to the institution or it's agents the protected health information necessary for your health and the health and safety of other individuals.

WORKERS COMPENSATION

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Other Uses and Disclosures

- Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.