



Date: \_\_\_\_\_

Patient RT#: \_\_\_\_\_

**PATIENT INFORMATION**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
First Name MI Last Name Date of Birth Age

\_\_\_\_\_  
Address Apt# City State Zip

\_\_\_\_\_  
Home Phone Work Phone Cell or Message Phone

**Attention: We will use all phone numbers listed above to contact you as necessary for treatment and payment purposes unless you place a restriction on the use of these numbers in writing. Please only list phone numbers that you wish to be contacted at.**

Social Security # (optional): \_\_\_\_\_ Sex: **M F** Marital Status: **S M W D**

Retired: **N Y** \_\_\_\_\_ Disabled: **N Y** \_\_\_\_\_ From what company? \_\_\_\_\_  
Date Date

**Are you currently staying in a SNF, Convalescent Home or enrolled in Hospice? \_\_\_\_\_ Yes \_\_\_\_\_ No**

*NOTE: If NO, Patient or Caregiver must immediately notify staff if Patient is admitted to a hospital, SNF, Convalescent Home, or Hospice.*

\_\_\_\_\_  
Name of Facility Phone

\_\_\_\_\_  
Address City State Zip

**INSURANCE INFORMATION**

\_\_\_\_\_  
**Primary Insurance** Medical Group (HMO) ID# Group #

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name/Relation of Policy Holder Social Security # of Policyholder Date of Birth of Policyholder

\_\_\_\_\_  
**Secondary Insurance** Medical Group (HMO) ID# Group#

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name/Relation of Policy Holder Social Security # of Policyholder Date of Birth of Policyholder

\_\_\_\_\_  
Primary Care Physician Phone

\_\_\_\_\_  
Referring Physician Phone

**EMERGENCY CONTACT**

\_\_\_\_\_  
Name Phone Relationship

**Attention: Emergency Contact will only be contacted in the case of a true emergency unless this same phone number is listed above in which case it may be used to contact you for treatment or payment purposes.**

**PHARMACY INFORMATION**

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Patient/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**Inspections and Copies:** the right to inspect and obtain copies of the medical information that may be used to make decisions about you, including medical records, billing records, but not including psychotherapy notes. In order to inspect or obtain records, you must submit the request in writing to the address on the back of this brochure.

**Amendment:** the right to ask us to amend your medical information if you believe it is incorrect or incomplete, and you may request and amendment for as long as the information is kept by or for our organization. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request and the reason for your request to in writing to the address in on the back of this brochure. Also, we may deny the request if you ask us to amend information that is accurate and complete; not part of the information kept by our organization; not part of the information you are permitted to inspect and copy; not created by our organization, unless the individual or entity that created the information is not available to amend the information.

**Accounting of Disclosure:** the right to request an accounting of disclosures made of your medical information to entities with whom you do not have an established relationship. In order to obtain an accounting, you must submit your request in writing to the address on the back of this brochure. All requests may not be longer than 6 years and may not include dates prior to October 16, 2003. The first request in a 12 month period is free of charge. You may be charged for any additional lists requested in a 12 month period.

**Right to File a Complaint:** if you believe your rights have been violated, you may file a complaint with our organization or with the secretary of the Department of Health & Human Services. You will not be penalized for filing the complaint. All complaints must be submitted in writing at the address below.

**Right to Provide an Authorization of Other Uses and Disclosures:** our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or are not permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your medical information for reasons described on the authorization. Of course, we will not be able to take back any disclosures that we have already made with your permission.

**Right to Paper Copy of This Notice:** you are entitled to receive this paper copy of this notice. You will be asked to sign an acknowledgment proving this receipt of this Notice of Privacy Practices. A more detailed notice that contains examples is available upon request at the office listed below.

**Comprehensive Cancer Care**  
470 John Young Way, Suite 400  
Exton, PA 19341  
Phone (610) 524-5550  
Fax: (610) 524-5546

## HIPAA Patient Privacy Rights Notification



## How We May Use and Disclose Your

Medical Information: the following describe the different ways we may use and disclose your medical information.

1. Treatment: in order to treat you we may disclose information to others who are involved in your care or treatment.
2. Payment: in order to bill and collect payment for services you receive from us. We may use and disclose information to obtain payment from third parties that may be responsible for such costs such as family members. We may use your medical information in order to bill you directly for services and items.
3. Health Care Operations: to operate our business to ensure you receive quality care and to assure our organization is well run.
4. Appointment Reminders & Test Results: to remind you that you have an appointment or change an appointment we will use all daytime phone numbers supplied on the Patient Information form you completed.
5. Treatment Alternatives: to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.
6. Fundraising: in order to contact you as part of fundraising activity we may disclose your information to a business associate or to a foundation related to our organization to raise money for our organization. Name and address only will be used.
7. Marketing: to make a marketing communication to you that occurs in a face-to-face encounter with you; concerns, products or services of nominal value; or concerns of health-related products or services or those of another party, provided that we tell you that we are the party communicating with you and tell you if we have received or will receive directly or indirectly any money or other remuneration for making the communication to you.

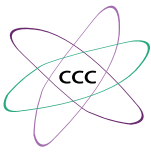
8. Required By Law: when required by applicable law regarding crime or criminal conduct; warrant, summons, subpoena or legal process. If served with a legal subpoena for records (contains a release or records signed by you or verbal authorization obtained from your or you're your attorney of record or proof of service from the requesting party) we must honor the request.
9. Public Health Activities: to control disease, injury or disability; maintain vital records such as birth or death; cancer reporting; child abuse or neglect; exposure to communicable disease; drug reactions or FDA warnings; recalled devices or medications. To notify appropriate government agencies and authorities regarding potential abuse or neglect of an adult patient including domestic abuse if the patient agrees or we are required by law to do so. Under limited circumstances to your employer for related workplace injury or illness or medical surveillance.
10. Coroners, Medical Examiners, Funeral Directors: as needed to carry out their duties required by law.
11. Organ and Tissue Donation: to organizations that handle organ and tissue procurement, banking or transplantation.
12. Research: subject to special approval process, information may be used on research projects or studies. The information will not leave our premises without your authorization.
13. Serious Threats to Health or Safety: to reduce or prevent a serious threat to your health and safety or that of another individual or the general public. We will only disclose to persons or organizations able to help prevent the threat.
14. Specialized Government Functions: if you are a member of the U.S. or foreign military forces (including veterans) and if required by appropriate military command authorities; or to federal officials for intelligence and national security.
15. Workers Compensation: our organization will release your medical information for workers' compensation and similar programs to all parties as required by state and federal law.

## Your Rights Regarding Your Medical Information:

You have the following rights regarding the medical information that we maintain about you. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when necessary to treat you. In order to request a restriction on the use or disclosure of your medical information, you must make your request in writing to the address on the back of this brochure.

Requesting Restrictions: the right to request a restriction on our use and disclosure of your medical information for treatment, payment, or healthcare operations. You have the right to limit our disclosure to individuals involved in your care or the payment for your care such as family members and friends. We will use all contact phone numbers and addresses list on the Patient Information form unless you place a restriction. The request for restriction must be submitted in writing and sent to the address on the back of this brochure.

Confidential Communications: the right to request our organization communicate with you about your health and related issues in a particular manner or certain locations without stating a reason for your request. We will use all contact phone numbers and addresses list on the Patient Information form unless you place a restriction. The request for restriction must be submitted in writing and sent to the address on the back of this brochure.



# Comprehensive Cancer Care

*A Vantage Oncology Affiliate*

Please list the names, addresses and phone numbers of physicians that you are seeing. If you do not have all the information with you at the time of your visit, please call us when you get home. This information is very important so that we can inform your physicians of your progress.

**Primary Physician:**

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**Phone:**

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**Referring Physician:**

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**Phone:**

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**Other Physician:**

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**Phone:**

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**Other Physician:**

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**Phone:**

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**Other Physician:**

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**Phone:**

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**Other Physician:**

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**Phone:**

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