FLORIDA CANCER AFFILIATES

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Phone: 850.763.0036 ▪ Fax: 850.763.0259

ASSIGNMENT OF BENEFITS
FINANCIAL RESPONSIBILITY

Date: _____

Patient Name: _____ DOB: _____

Age: _____ ☐ M ☐ F SS#: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Home Telephone: (_____) _____ Cell: (_____) _____

Physical Address: _____

Mailing Address: _____

Email: _____ Race*:_____

Ethnicity* Hispanic/Latino: ☐Yes ☐No Preferred Language*: _____

Preferred Contact Method: ☐ Cell Phone ☐ Home Phone ☐ Email ☐ Home Address Veterans Status: ☐ YES ☐ NO

Employer: _____ Phone(_____) _____
Address:_____

Responsible Party: _____ Phone(_____) _____
Emergency Contact: _____ Phone(_____)_____

Referring Physician: _____ Primary Care Physician: _____
Primary Ins: _____ Policy #:_____
Phone (_____) _____ Insured Name: _____
DOB:_____ Group #:_____

Secondary Ins: _____ Policy #:_____
Phone (_____)_____ Insured Name: _____
DOB:_____ Group #: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Florida Cancer Affiliates.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Florida Cancer Affiliates. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Florida Cancer Affiliates.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Florida Cancer Affiliates.

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

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

Patient signature: _____ Date/Time:_____
Responsible party signature: _____ Date/Time:_____
Responsible party relationship to patient: _____

FLORIDA CANCER AFFILIATES

HIPAA Release Form

Patient's Name: _____ DOB: _____

We may release your health information, including information about your condition, to a family member or friend who may be involved in your medical care or who helps pay for your care. As described in our Notice of Privacy Practices, you have the right to request that we do not release your health information to certain individuals.

Please use the form below to indicate with whom we may release your health information to notify or assist in the notification of a family member or friend who may be involved in your care.

Release of Information: I authorize the release of information including the diagnosis, records, examination rendered to me and claims information.

The information may be released to: (Please be specific with names.)

☐ Spouse _____

☐ Child(ren)_____

☐ Other _____

☐ Information is NOT to be released to anyone.

This HIPAA Release will remain in effect until terminated by me in writing.

When leaving messages:

Please call: ☐ my home ☐ my work ☐ my cell Phone: (_____) _____

If you are unable to reach me:

☐ You may leave a detailed message.

☐ Leave a message requesting me to return your call.

☐ Other: _____

Signed: _____ Date: _____/ _____/ _____

Witness: _____ Date: _____/ _____/ _____

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FLORIDA CANCER AFFILIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Florida Cancer Affiliates 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 organization 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 Florida Cancer Affiliates.

Name: _____

Signature: _____

Name of personal representative (if applicable): _____

Signature of personal representative (if appropriate): _____

Date: _____

FLORIDA CANCER AFFILIATES

PATIENT FINANCIAL POLICY

We understand that healthcare can be expensive. We would like to partner with you to make sure you understand your insurance coverage and out of pocket costs for your care. We will assist with establishing a financial plan in advance to avoid any misunderstandings or confusion regarding payment expectations. **PROVIDING QUALITY MEDICAL CARE TO OUR PATIENTS IS OUR PRIMARY CONCERN**. It is our privilege to provide high quality care to you, our patient; however, it is your responsibility to understand your insurance benefits and communicate directly with your insurance company for clarification of questions relating to your coverage. Payment for co-pays, deductibles, and balances not paid by your insurance company is your responsibility.

▪ All patients are responsible for ensuring our office has the most current insurance and billing information.

▪ All patients are responsible for assisting the practice in obtaining any referrals necessary prior to your appointment if required by your insurance plan.

▪ All patients are responsible for co-pays at the time of service. We may also ask for payment of any patient balances not covered by your insurance or agreed upon budget plan payments. A receipt will be provided for all payments made at the practice site; cash, check, money order, charge and debit cards are accepted.

▪ You will be assigned a designated Patient Benefit Representative at the office and an Insurance Specialist at the Central Business Office who will assist with any insurance or financial questions you may have.

▪ Your Patient Benefit Representative will meet with you on your first visit to the practice, at any time your insurance changes, and if you have specific questions.

▪ Your Patient Benefit Representative will meet with you when a treatment plan has been established by your physician; to review your benefits and provide you with the best possible out-of-pocket cost estimate of your financial responsibility.

▪ Your Patient Benefit Representative may be able to locate assistance if needed from a wide variety of sources. We encourage you to communicate financial needs you may have, so we can guide you to those resources. A monthly patient statement is sent detailing any patient balance activity. Our Central Business Office accepts check and credit card payments by phone, and you may also pay your bill or set up monthly recurring payments on our website: http://floridacancer.com/patients/payment/

▪ If your physician is not a provider with your insurance company, as a courtesy, we will file your claims for you if you assign benefits to your physician. If your insurance company does not pay within a reasonable time, you will be responsible for payment on your account.

▪ RETURNED CHECKS- The charge for a returned check is $30.00 payable by cash or money order. This will be applied to your balance, in addition to any additional insufficient funds we incur. You may be placed on a “Cash Only” basis following any returned check.

▪ MEDICAL RECORD COPIES & FMLA PAPERWORK- If you want a copy of your records, then you will be charged a $25.00 copying fee. There is a $15.00 fee for completion of FMLA paperwork.

Our goal is to assist you, with your cooperation, in receiving all the benefits offered to you by your insurance plan or patient assistance programs and allowing us to do what we do best – concentrating on delivering high quality medical care.

I understand these policies and have had opportunity to discuss any questions.

Patient/ Responsible party signature: _____ **Date**: _____

FLORIDA CANCER AFFILIATES

PATIENT ASSISTANCE

What is Patient Assistance?

"Patient Assistance" is a term used to describe a charitable organization dedicated to providing help to individuals with difficulty affording the high cost of healthcare associated with their specific illness. These foundations offer financial assistance to eligible patients for covering out-of-pocket healthcare costs. For instance, there are specific foundations established to help with coinsurance for certain cancer drugs or blood disorders. Specific patient guidelines must be met for acceptance into these programs. Some of these guidelines include household income, insurance coverage, diagnosis, specific chemotherapy drugs, and available funding.

How do we help you?

Once our billing specialist has determined that you may be a candidate for assistance, you will be referred to our Patient Assistance Coordinator. From here, we try to match your diagnosis and therapy plan with a foundation that may be able to assist with funds. If order to begin the process, you will be asked to provide proof of income and diagnosis. Once all proper documentation has been obtained, we will submit the application on your behalf. From there, the foundation will determine your eligibility. It is important to note that regardless of your eligibility with patient assistance and regardless of your status in these programs, you are still responsible for paying your co-payment. The assistance that you may or may not receive will help only with specific drugs and not your entire balance. Please remember, you alone are responsible for your balance. This service is not a guarantee of payment. It is simply to assist in trying to minimize your out-of-pocket expenses with our office. We encourage our patients to seek out other forms of assistance as well for making payments on your balance. If you do take outside assistance, please let someone in our insurance and billing department know of your status in these organizations.

If you have any questions, please do not hesitate to ask to speak to one of our Patient Assistance Coordinators.

I understand the above specifications and conditions of the patient assistance program and accept the guidelines listed above.

Patient/ Responsible party signature: _____ Date:_____

FLORIDA CANCER AFFILIATES

Agreement for Controlled Substances Prescriptions
1/2

Patient's Name: _____ DOB: _____

Controlled substance medications (i.e. pain, anti-anxiety, and stimulant medications) are very useful, but have a high potential for misuse and are therefore closely controlled by the federal, state, and local government. They are intended to relieve pain or to improve function and/or ability to work and not simply to feel good. Because my physician is prescribing such a medication for me to help manage my symptoms, I agree to the following conditions. Please initial each number when read.

1. _____ **I am responsible for my controlled substance medication.**

a) If the prescription of medication is lost, misplaced, stolen, of if I use it sooner than prescribed, then I understand it cannot be replaced.

b) I will use my medicine at a rate no greater than the prescribed rate and understand that use of my medicine at a greater rate will result in my being without medication for a period of time.

c) If rate of medicine prescribed is not relieving pain, I will contact physician's office to let the doctor/nurse know so the dosage can be adjusted and noted in record.

d) I will not share, sell, or trade my medication with anyone.

2. _____ **I will not request or accept controlled substance medications from any other physician** while I am receiving the same medication from my physician, as this may endanger my health. The only exception is when it is prescribed when I am admitted to the hospital.

3. _____ **Refills** of controlled substance medication:

a) Will be made only during regular business hours between the hours of 8am ad 5pm, Monday-Thursday and between 8am and 12pm on Friday once each month or during a scheduled office visit**. Refills will not be made after business hours (i.e., at night, on holidays, or weekends).**

b) Will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

c) Will not be made as an "emergency", such as a Friday afternoon, because I "suddenly realized I will run out tomorrow". I will notify the clinic staff at least 5-7 days in advance if I need assistance with a controlled substance medication prescription.

4. _____ While I am receiving controlled substance medication, it may be deemed necessary by my doctor for me to see a specialist in interventional pain, psychology, psychiatry, or other specialty with the goal of improving my symptoms. I understand if I do not attend this appointment that my medications may not be continued or refilled past a tapering dose to completion. I understand that if a specialist feels that I am at risk for psychological dependence (addiction) that my medications no longer will be refilled.

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FLORIDA CANCER AFFILIATES

Agreement for Controlled Substances Prescriptions
2/2

Patient's Name: _____ DOB: _____

5. _____ I understand that driving a vehicle may not be allowed at times while taking controlled substance medications, and that it is my responsibility to comply with the laws of this state while taking the controlled substance medication prescribed.

6. _____ I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment may be tapered immediately. If the violations involve the use of non-prescribed, illicit (illegal) drugs while I am receiving my controlled substance medication or involves obtaining controlled substances from another individual as described in section 2, then I may also be reported to my physician, medical facilities, and other appropriate agencies.

7. _____ I understand that the main treatment goal is to improve my ability to function, and/or work, and/or reduce pain. In consideration of that goal and the fact that I am given potent medication to help me reach that goal, I agree to help myself by the following better health habits: exercise, weight control, and avoiding the use of tobacco and alcohol. I must comply with the treatment plan as prescribed by my doctor. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

8. _____ I understand that the long-term advantages of chronic opioid use have yet to be scientifically determined and treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substance medications and that my physician will advise me as knowledge and training advances will make appropriate treatment changes.

I have been fully informed regarding psychological dependence (addiction) of a controlled substance medication, which I understand is rare. I know that some persons may develop a tolerance, which is the need to increase the dose of medication to achieve the desired effect. I also understand that I can become physically dependent on the medication if I am on the medication for several weeks, and that in order to stop the medication I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I have read this agreement and I understand the consequences of violating this agreement. If I have any questions, then I can ask the physician or staff regarding the use of controlled substances at any time.

I agree to use _____ Pharmacy, located at _____,
or in case of an emergency

I agree to use _____ Pharmacy, located at _____,
for filling prescriptions for all of my controlled substance prescriptions.

Patient signature: _____ Date: _____

Witness: _____ Date: _____

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ontadaHEALTH

Patient Communication Email Authorization Form
(Patient Portal)

I, _____, hereby authorize McKesson Specialty Health Technology Products, LLC (d/b/a "Ontada"), a third party acting on behalf of Florida Cancer Affiliates, to communicate with me via email for purposes related to my treatment, payment for health care, and/or healthcare operations. I understand and agree to the following terms:

▪*Email communications*:

I consent to receive electronic communications from Ontada at the email address provided below. These communications may include registration links, treatment updates, and other relevant healthcare information.

Email address: _____

▪*Communication frequency*:

I understand that the frequency of communications may vary depending on my treatment and healthcare needs.

▪*Updating contact information*:

I will promptly inform the practice in case of any changes to my contact information to ensure accurate and timely communications.

▪*Opting out*:

I retain the right to opt out of receiving emails from Ontada at any time. I can adjust my communication preferences in my Ontada account if I have registered for an account.

By signing this patient communication email authorization form, I confirm that I have read and understood the terms of this authorization and I voluntarily grant Ontada the permission to communicate with me via email for purposes related to my treatment, payment for care, or healthcare operations on behalf of the practice.

Patient signature: _____ Date: _____

Print name: _____

FLORIDA CANCER AFFILIATES

Notice of Privacy Practices

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

About Us

In this notice, we used terms like “we”, “us” or “our” to refer to Florida Cancer Affiliates, its physicians, employees, staff and other personnel. All the sites and locations of Florida Cancer Affiliates 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 meet certain legal requirements related to providing you care. We understand that 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 health care 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.

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 if your health information.

Appointment Reminders: We may use and disclose your health information in order to contact and remind you of an upcoming appointment for treatment or health care services.

Treatment Alternatives and Health-Related Benefits 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.

Fundraising Activities: We may use your demographic information, such as name, address and phone number, and the dates you received service from us, 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. *IF YOU DO NOT WANT THE PRACTICE OR FOUNDATION TO CONTACT YOU FOR FUNDRAISING ACTIVITIES, PLEASE NOTIFY OUR PRIVACY OFFICER AT (850) 763-0036 OR BY MAIL AT 2100 STATE AVE., PANAMA CITY, FL. 32405*

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 care. *IF YOU WOULD LIKE US TO REFRAIN FROM RELEASING YOUR HEALTH INFORMATION TO A FAMILY MEMBER OR FRIEND, PLEASE NOTIFY THE OFFICE MANAGER AT THIS OFFICE.* A form will be provided to you to list the individual(s). We may also disclose your health information to disaster-relief organizations so that your family can be notified about your condition, status and location.

FLORIDA CANCER AFFILIATES

We are also permitted 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 victims agreement;
- About a death we suspect may have resulted from criminal conduct;
- 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 or 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 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.

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 Examiner 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 to 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 illnesses.

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.

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 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 healthcare, protecting your 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, asses a number of specific issues, and determines that appropriate privacy safeguards are in place to allow for 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.

FLORIDA CANCER AFFILIATES

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 health care options. 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 restriction, you must make your request in writing and submit it to the Office Manager at this medical facility.

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 does 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 the Office Manager at this medical facility. If you request a copy of your health information, we may charge a fee for the cost 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 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 from provided by us and submitting it to the Office Manager at this medical facility.

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.

FLORIDA CANCER AFFILIATES

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 to be included in the accounting we provide.

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 your Privacy Officer at (850) 763-0036, or by mail at 2100 State Ave, Panama City, Fl 32405. Your request must state a time period which may not be longer than six (6) years. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the cost 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 the office manager at this medical facility. You may also obtain a paper copy of this Notice at our website.

Right to Complain: If you have questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to our Privacy Officer at (850) 763-0036, or by mail at 2100 State Ave., Panama City, Fl. 32405. 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 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.