



Beverly Hills Cancer Center
STATE OF THE ART MEDICINE - STATE OF MIND HEALING

Patient Information

Name: _____ Birth Date: _____
 Last First MI
 Address: _____
 Street City State Zip
 Home Phone #: _____ Cell Phone #: _____ Marital Status: _____ Sex: _____
 Social Security #: _____ Occupation: _____
 Employer: _____ Work Phone #: _____
 Employer Address: _____
 Street City State Zip

Emergency Information

Nearest Relative or Friend: _____ Relationship: _____
 Last First
 Address: _____
 Street City State Zip
 Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

In the event you are unavailable to be contacted by our office, please indicate any family member or friend that we can release any or all information relating to your medical condition.

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Assignment of Benefits and Waiver of Liability

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Beverly Hills Oncology Medical Group of any insurance benefits otherwise payable to or on behalf of the undersigned for Services rendered. It is understood by the undersigned that he/she is financially responsible for charges not covered over and above the insurance payment. This is to make you aware that your insurance company can deny payment for a multitude of reasons. Depending on your plan, your insurance can and may deny payment based on the coverage of your policy. We do not know until your insurance company is billed. Insurance Companies do not guarantee payment until they have received your claim. If your claim is denied, Beverly Hills Oncology Medical Group will resubmit the claim. After such resubmission, if the claim is still denied we will bill you for the procedure.

I agree to be personally and fully responsible for payment to Beverly Hills Oncology Medical Group.

Date: _____ Signature: _____

Relationship if other than patient: _____



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Patient Questionnaire

Date: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Primary Care Physician/ Referring Physician: _____

Reason for Today's Visit: _____

Past Medical History: (Please check all that apply and explain)

- | | |
|---|---|
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Cataracts _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Emphysema _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Blood Transfusions _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Heart Disease/Procedures _____ |
| <input type="checkbox"/> Ulcers _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Jaundice/Cirrhosis _____ |
| <input type="checkbox"/> Gall Bladder Disease _____ | <input type="checkbox"/> Diverticulitis _____ |
| <input type="checkbox"/> Hemorrhoids _____ | <input type="checkbox"/> Colon Polyps _____ |
| <input type="checkbox"/> Prostate Disease _____ | <input type="checkbox"/> Kidney _____ |
| <input type="checkbox"/> Inguinal Hernia _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Lupus _____ | <input type="checkbox"/> Scleroderma _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Blood Clots _____ |
| <input type="checkbox"/> Other: _____ | |

Have you previously been treated for cancer: Yes No

If so, please explain: _____

Past Surgical History/Hospitalizations:

Reason: _____	Date (month/year): _____	Hospital: _____

Present Medications:

Medication Name: _____	Dose: _____	How Often: _____

Allergies Yes No

(If YES, please list any allergies that you have, including medications and shellfish and type of reaction):



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Advanced Directives Questionnaire

Please answer the following questions if you are able to do so. The nursing staff will provided assistance if necessary.

Name: _____ Date: _____

1. Do you have a:

Durable Power of Attorney for Health Care? Yes _____ No _____
Living Will? Yes _____ No _____

2. If 'yes' to either of the above, please provide us with a copy for your chart

3. If 'no', would you like more information? Yes _____ No _____

Signature

FOR NURSING STAFF USE ONLY

1. Copy of Advanced Directive Requested _____
Date _____

Received _____
Date _____

2. Information given:

a. "Your Right to Make Decisions About Medical Treatment" Pamphlet _____
Date _____

b. DPAHC Form _____
Date _____

c. Living Will Form _____
Date _____

d. Referral to: _____
Date _____

Comments: _____

RN Signature

Date



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). PLEASE REVIEW IT CAREFULLY.

Our pledge to you.

We understand that medical information about you is personal. We are committed to protecting medical information about you. Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal physician.

As required by law, we will:

- keep medical information about you private;
- provide, or make available, as applicable, this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

Obtain a copy of this notice

You have the right to a current copy of this notice. You may obtain a copy of this notice any time in person or by written request

How we may use and disclose medical information about you

We will share medical information about you for purposes of treatment, such as sending medical information about you to your physician or specialist as part of a referral, to obtain payment for treatment, and to support health care operations.

We may use health information about you without prior authorization for several other reasons. Subject to applicable law to carry out their duties, we may give out medical information about you to other entities for:

- public health authorities that are authorized by law to collect the information (such as, births, deaths, public surveillance)
- abuse, neglect or domestic violence reporting when it is a threat to your safety and the safety of another individual or the public
- health oversight audits or inspections
- research studies
- workers' compensation purposes
- emergencies
- requests from law enforcement, or in response to valid judicial or administrative orders

Your rights regarding medical information about you

- You have the right to look at or get a copy of medical information that we use to make decision about your care. We will provide you with a form you can complete to make the request. If you request copies, however, we may charge a fee for copying, mailing and other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for review of that decision.
- You have the right to request us to amend your health information if you believe it is incorrect or missing. We will provide you a form which you can complete to make the request. We may deny your request to amend a record if the information was not created by us, if it is not part of medical information maintained by us, or if we determine that the record is accurate. If we deny your request to amend, you may submit a request to review that decision by us not to amend the record.
- You have the right to make a written request to us for a list of instances where we have disclosed medical information about you other than for treatment, payment, health care operations or where you specifically authorized disclosure.
- You have the right to request that medical information about you be communicated to you in a confidential manner.
- You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but our processes may not be able to accommodate it and we are not legally required to accept it. We will inform your of our decision on your request.

All written requests for review of denials should be submitted to our Facility Privacy Officer

Other uses of medical information

In any other situation not cover by this notice, we will ask for your written authorization before using or disclosing medical information about you. If we request and obtain your authorization to use or disclose your medical information, you can later revoke authorization by notifying us in writing.

Complaints

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Facility Privacy Office in writing. Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Under no circumstance will you be penalized or retaliated against for filing a complaint.

If you have any questions regarding this Notice of Privacy Practices please contact us at Beverly Hills Cancer Center, 8900 Wilshire Blvd, Beverly Hills, CA 90211, or call 310-432-8900.

Facility Privacy Officer



Patient HIPAA Statement

I understand as part of my healthcare, the Beverly Hills Cancer Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and health information for billing purposes;
- A means by which a third-party payer can verify that services billed were actually provided;
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge that I have read and understand Beverly Hills Cancer Center's *Notice of Privacy Practices*, which provides a more complete description of information uses and disclosures. I have the right to review this notice prior to signing this consent. I understand the organization reserves the right to change their notice and practices at any time and I may request a copy of any revised notice by contacting our Privacy Officer at (310) 432-8900.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this organization is not required to agree to the restrictions requested.

This acknowledgement is given freely with the understanding that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, excepted as authorized by law. A photocopy or fax of this consent is as valid as this original.

Print Patient's Name

Date

Patient's Signature (or personal representative)

Date