CENTRAL GEORGIA | CANCER CARE

Passion for innovation, compassion for your care.

Name_____ _____ _____ Is this your legal name? ☐ ☐
Last First Middle Yes No

Birth Date _____ Place of Birth_____ Social Security #_____

Marital Status ☐ ☐ ☐ ☐ ☐ Sexual Orientation ☐ ☐ ☐ ☐ ☐ ☐
Married Single Divorced Separated Widowed Heterosexual Homosexual Bisexual Other Unknown Decline to Answer

Email Address_____

Home # (_____)_____ Cell # (_____)_____Work# (_____)_____

Street Address/P.O. Box _____

_____ _____ _____
City State Zip code

Gender at Birth ☐ ☐ Gender Identity ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Male Female Male Female Gender Non-conforming Male to Female Transexual Female to Male Transexual Other Unknown Decline to Answer

Religion_____ Primary Language_____

Race ☐ ☐ ☐ ☐ ☐ ☐ _____ Ethnicity ☐ ☐ ☐ ☐
White African American Asian Native American Pacific Islander Other Hispanic or Latino Not Hispanic nor Latino Other Decline to Answer

Employer _____ Occupation_____

Employer Phone # (_____)_____ Employment Status ☐ ☐ _____
Active Retired Retirement Date

Employer Address _____

_____
City State Zip code

Insurance Information

Primary Insurance_____ Policy #_____ Group #_____

Subscriber's Name _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

Subscriber's Employer_____Employer Address_____

Occupation _____ Employer Phone _____

Patient's Relationship to Subscriber: ☐ ☐ ☐ ☐ ☐
Self Spouse Child Domestic Partner Other _____

Secondary Insurance_____ Policy #_____Group #_____

Subscriber's Name _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

Subscriber's Employer_____Employer Address_____

Occupation _____ Employer Phone _____

Patient's Relationship to Subscriber: ☐ ☐ ☐ ☐ ☐
Self Spouse Child Domestic Partner Other _____

_____ _____ _____
Signature Relationship to Patient Date

Central Georgia Cancer Care New Patient History

Name: _____ Date of Birth :_____

By what name do you prefer to be called: _____ Age ____

Reason for referral or visit to our practice: _____

- Who referred you to our office? _____
- Who is your family or primary care doctor? _____
- Do you see any other specialists? If so, who? _____

Social History

How long is your commute to our office? _____

Occupation/Job: _____ Are you currently working? **Yes or No**

Marital Status: _____ Name & ages of children: _____

Do you use tobacco? **Yes or No If yes how much? _____ When did you start? _____**

If no, did you ever use tobacco products? Yes or no When did you stop? _____

Do you use alcohol products? **Yes or no If yes: how much? _____ How often? _____**

Past Medical History

Do you have or have you ever had: (check box if yes)

☐ Heart Disease	☐ Congestive Heart Failure	☐ Lung Disease (Emphysema COPD) _____
☐ Diabetes	☐ Thyroid Problems	☐ Stomach Problems (Ulcer, Acid Reflux) _____
☐ High Blood Pressure	☐ Frequent Bladder Infections	☐ Bowel Problems _____
☐ Stoke or mini-stroke	☐ Kidney Failure or dialysis	☐ Hepatitis or cirrhosis: _____
☐ Epilepsy or seizures	☐ Enlarged Prostate	☐ Skin condition or rash _____
☐ Anemia	☐ Bleeding or Clotting Disorder	☐ Neurological Condition – (Parkinson's, etc._____
☐ Anxiety	☐ Blood Clot in Leg	☐ Eye Problems (Glaucoma, etc.) _____
☐ Endometriosis	☐ Blood Clot in Lung	☐ Previous Cancer_____

- Previous surgeries: _____
- Hospitalizations in last 10 years: _____
- Is there anything more you think we should know about you or your history?

_____

Check for Yes to the following questions:

- ❑ Do you spend more than half your day in bed or recliner?
- ❑ Do you require assistance with bathing, meal preparation, etc.?
- ❑ Do you take the flu shot every year? If so, when was your last flu shot? _____
- ❑ Have you ever had a colonoscopy? If so, when _____
- ❑ Have you had an echocardiogram before? If so, when _____
- ❑ Have you had a bone density test? If so, when? _____
- ❑ Do you have pain? If so, who manages your pain? Dr. _____
- ❑ For women only:
  - ➢ When was your last mammogram? _____
  - ➢ When was your last period? _____
  - ➢ Do you have hot flashes, vaginal dryness or menopausal symptoms? _____ When did they start? _____
  - ➢ Have you had a hysterectomy? _____ Do you still have your ovaries? _____
  - ➢ Do you take hormone replacement therapy? _____

Family History: Any history of the following diseases in your family? If yes, what is the relationship of the person to you?

- ❑ **Heart disease _____**
- ❑ **High blood pressure _____**
- ❑ **Cancer _____**
- ❑ **Genetic or chromosomal abnormalities _____**

Allergies:

Medication: _____ Describe Reaction_____Date of 1st reaction_____

Medication: _____ Describe Reaction_____Date of 1st reaction_____

Medication: _____ Describe Reaction_____Date of 1st reaction_____

Medication: _____ Describe Reaction_____Date of 1st reaction_____

Food allergies: _____

Are you allergic to iodine, seafood or shellfish? _____

Current Medications: Please fill out this form to include any medicines you are currently taking. Remember to include any over the counter drugs and herbal products that you may take on a regular basis:

Drug Example: Lipitor	Strength 40mg	Directions one at bedtime	Start Date April 2005	Prescribing Doctor Dr. John Jones

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date _____

Reviewed by Physician _____ Date _____

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E-Prescribing Information and Patient Consent

What is E-Prescribing and Why Does Central Georgia Cancer Care E-Prescribe?

E-Prescriptions, or Electronic Prescriptions, are computer generated prescriptions created by your provider and sent directly to your pharmacy. Central Georgia Cancer Care participates in E-Prescribing because we care about your health and wellbeing and E-Prescribing has multiple safety benefits.

How does E-Prescribing work?

Instead of writing out your prescription on a piece of paper, your doctor enters it directly into the computer. Your prescription travels from your doctor's computer to the pharmacy's computer. E-prescriptions are sent electronically through a private, secure and closed network, so your prescription information is not sent over the open internet or as email. Your E-Prescription arrives at the pharmacist's computer faster and may help you to save time. The E-Prescription can be sent to the pharmacy you choose. If you do not want your prescription sent electronically, or your pharmacy does not accept E-Prescriptions, your provider can print your prescriptions for you. **Please be aware that not all prescriptions may be legally E-Prescribed, such as controlled substances. These will have to be mailed or picked up in person.**

Privacy

The privacy of your personal health information contained in all your prescriptions, whether written or electronic, is protected by a federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that your personal health information be shared only for the purposes of providing you with clinical care. E-prescriptions meet this requirement.

Patient Consent for E-Prescribing

I agree that Central Georgia Cancer Care may E-Prescribe my prescriptions and may request and use my prescription medication history from other providers or third party pharmacy benefit payors for treatment purposes.

Pharmacy Name _____ **Pharmacy Phone Number** _____

_____ ___/___/_____ _____

Patient Name (Print) Date of Birth Account Number

_____ _____

Patient Signature Date

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Financial Responsibility and Assignment of Benefits

To provide timely and accurate payment to Central Georgia Cancer Care, PC for services rendered:

- I certify the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
- I hereby give lifetime authorization for payment of insurance benefits be made directly to Central Georgia Cancer Care, PC for services rendered.
- I request that payment of authorized benefits be made on my behalf to Central Georgia Cancer Care, PC for any/all services furnished to the patient listed below by the physician and healthcare providers for Central Georgia Cancer Care, PC.
- I authorize Central Georgia Cancer Care, PC to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to their services and care provided.
- If my health insurance plan will not direct payment to Central Georgia Cancer Care, PC, I agree to forward to Central Georgia Cancer Care, PC all health insurance payments which I receive for the services rendered by this practice and its health care providers.
- I authorize Central Georgia Cancer Care, PC to release to my Health Insurance Plan my private healthcare information as needed to determine these benefits or the benefits payable for related services.

I further acknowledge and agree:

- That I am responsible for all charges for services provided to the patient listed below which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- That I will pay all charges which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. (co-pays, deductibles, etc)
- That this financial form with assignment of benefits applies and extends to subsequent visits, appointments and treatments rendered by Central Georgia Cancer Care, PC.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction and that I agree with each statement above.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature or Person Legally Responsible Date

_____

Relationship to Patient

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Linda K. Hendricks, MD
Bradley T. Sumrall, MD
Harry F. Moore, Jr., MD
Marcus K. Weldon, MD

Amanda K. Hale, MPA, PA-C
Cayla Schnider, MMSc, PA-C
Rachel Youngblood, MPA, PA-C
Ashley H. Vinson, MSN, APRN, FNP-C
Amber Wilson, MSN, APRN, FNP-C
Morgan B. Adams, MSN, FNP-C
Catherine H. Braley, MSN, APRN, FNP-C
Staci T. Cox, FNP-C

Consent to Obtain Medical Records

I hereby authorize Central Georgia Cancer Care, P.C. to obtain any/all of my medical records from any physician, hospital, or medical institution.

Name: _____

SSN: _____

Date of birth: _____

Date signed: _____

Signature: _____

This signature/authorization shall be valid for 12 months unless revoked by patient in writing.

800 First Street, Suite 410
Macon, Georgia 31201
478.743.7068 tel
478.741.1354 fax

114 Sutherlin Drive, Suite C-1
Warner Robins, Georgia 31088
478.287.6144 tel
478.287.6958 fax

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Acknowledgement of Receipt of Notices of Privacy Practices & Consent for Disclosure of Health Information

Name _____ SSN_____ DOB_____

CGCC has permission to disclose my health information to the people listed below.
**You do not need to list your physicians on this form, we will send them the appropriate information.*

Name_____Relationship_____Phone # _____

Name_____Relationship_____Phone # _____

Name_____Relationship_____Phone # _____

In Case of Emergency Notify:

Name_____ Phone # _____

By signing this form, you grant Central Georgia Cancer Care, PC consent to disclose your protected health care information to the individuals listed above. Our Notice of Privacy Practices provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it as it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were taken in reliance upon this Consent. You are entitled to a copy of this Consent Form after you have signed.

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I received a copy of this office's Notice of Privacy Practices.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature or Legal Representative Date

_____
Relationship to Patient

Central Georgia Cancer Care, P.C.

Principal Office: 800 1st Street, Suite 410, Macon, GA 31201-8300
Website: https://www.centralgeorgiacancercare.com
Privacy Officer: Shelley Barrentine
478-743-7068
sbarrentine@centralgacancercare.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

In addition to the above, note:

We do not create or maintain a hospital directory.

We do not create or maintain psychotherapy notes at this practice.

We will never share any substance abuse treatment records without your written permission.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: February 15, 2019

This Notice of Privacy Practices applies to the following organizations.

The practice participates in the Central Georgia Health Exchange ("CGHE"). CGHE is a health information exchange and we may share information about you through CGHE to other participating providers of CGHE for treatment, payment, or healthcare operation purposes.

Privacy Officer: Shelley Barrentine
478-287-6924
sbarrentine@centralgacancercare.com