

Patient Information

Last Name:		First Name:		MI:	Salutation:
Date of Birth:		SSN:		Referring Physician:	
<u>Is this your legal name?</u> Y N	If not, what is your legal name?			Former Name:	
Marital Status:	Sex (select one) <small>at birth</small> : Male Female				
Street Address:		City:		State:	Zip:
PO Box: <i>(if applicable)</i>	Email Address:				
Home Phone:		Cell Phone:		Work Phone: <i>(or other number)</i>	
<u>Employment Status:</u> <i>(please circle)</i> Full-Time Part-Time Retired		Employer:		Occupation:	
<u>Preferred Contact Method:</u> <i>(please circle)</i> Home Phone Cell Phone Work Phone Email Text				Preferred Language:	

In Case of Emergency

Emergency Contact Name:	Relationship to Patient:
Phone Number:	Other Phone Number: <i>(please specify)</i>

If the Patient is not the Policyholder:

Policyholder Name:	DOB:	SSN:
Policyholder Signature:		

Advanced Care Planning

<u>Is the patient in possession of the following documents?</u> <i>(please circle)</i>				
Living Will	Power of Attorney	Healthcare Proxy	Advance Directive	N/A

Physician & Pharmacy Information

Primary Care Provider (PCP):	PCP Phone Number:		
Preferred Pharmacy:	Pharmacy Phone Number:		
Pharmacy Street Address:	City:	State:	Zip:

Please list ALL active treating physicians
 (e.g. Cardiologist, Internist, Pulmonologist, Oncologist, etc.)

Doctor's Name	Specialty

Demographic Data

<i>Collection of the following information is encouraged by federal health agencies. This information is used to monitor & improve the quality of care provided to all patients.</i>			
Race:	Asian	American-Indian or Alaska Native	
	Black or African-American	Native Hawaiian or Pacific Islander	
	White	Decline Response	Other: _____
Ethnicity:	Hispanic or Latino	Not Hispanic or Latino	Other: _____

How did you find us?

Family/Friend	Radio	Television	Referring Physician
Online Search	Billboard	Drive-by	Other: _____
Social Media	Print Ad	Community Event	

Patient Name: _____ DOB: _____

Reason For Visit: _____

Are you experiencing pain today? If so, please indicate below:

<i>no pain</i>						<i>unbearable pain</i>				
0	1	2	3	4	5	6	7	8	9	10

Cancer History (please mark all that apply)

Type	N/A	Self	Mother	Father	Sibling(s)	Grandparents		Other	Comments
						Maternal	Paternal		
Lung									
Breast									
Prostate									
Colorectal									
Head & Neck									
Skin									
Gynecological									
Other: _____									

Are you of Ashkenazi Jewish Descent? Y N

Surgical History/Major Hospitalizations

Procedure	Date (MM/YYYY)	Surgeon/Hospital	Reason/Complications

Social History

	Yes	No	Quit	Comments
Do you drink alcohol?				Drinks per week: _____
Do you smoke tobacco?				Years smoked: _____ Packs per day: _____
Do you use illegal drugs or controlled substances?				
Weekly exercise routine?				
Describe your typical diet:				

Medication List

Name	Dosage	# of times per day	Route (oral/injection?)

Exams & Vaccines
Please list the dates and results of any of the following that you may have had

Type	Approximate Date	Results (if applicable)
Physical Exam		
Colonoscopy		
Mammogram		
Pap Smear		
Flu Vaccine		
HPV Vaccine		
Pneumonia Vaccine		
Shingles Vaccine		
Covid-19 Vaccine		
Other: _____		

Allergies

Category	Type of Allergen	Reaction to Allergen
Food		
Medication		
Latex		
Contrast/IV Dye		
Other: _____		

Medical History	Current Symptoms
<i>Please circle all that apply</i>	<i>Please circle all that apply</i>
Gastrointestinal	
Constipation Gallbladder Disease GERD (Heartburn) Liver Disease	Diarrhea Ulcers Bowel Incontinence Vomiting Nausea Blood in Stool (Black or Tarry) Decreased Appetite Pain: Abdominal Rectal Other:
Genitourinary	
Urinary/Kidney Disorder	Sexual Function Concerns Pelvic Pain Urination: Blood Frequency Hesitancy Pain Weak Stream Incontinence Urgency Infections Frequent Urination at Night Other:
Womens' Health:	
Abnormal Pap Smear Past Pregnancies (#____) Past Deliveries (#____)	Hot Flashes / Night Sweats Pain/Bleeding During Sex Currently Pregnant Vaginal Discharge/Itching Significant Pain/Cramps with Menses Breast: Discharge Lumps Pain Nipple Inversion Other:
Mens' Health:	
	Erectile Concerns Testicle Lumps/Swelling Other:
Musculoskeletal	
Arthritis Fractures Osteoporosis	Joint Swelling Pain: Back Joint Limb Muscle Neck Bone Other:
Skin	
	Hives Itchy Skin Surgical Incision Masses Rashes Skin Changes Other:
Psychiatric	
Anxiety or Panic Disorder Depression PTSD (Post-Traumatic Stress Disorder)	Other:

Patient Name: _____ DOB: _____

Wellness Questionnaire

please mark your answers below

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over 50% of the days	Nearly every day
Little interest or pleasure in doing things?				
Feeling down, depressed, or hopeless?				

Are there any additional resources that you would like to discuss with Social Work?

please circle below

Support Groups	Lodging	Home Health
Transportation	Insurance	Other: _____

Patient Name: _____

DOB: _____

Medical Record Release

(Full Disclosure of Health Information for Treatment and Quality of Care)

I understand that my choice on whether to sign this form will not affect my ability to get medical treatment, payment for medical treatment, health insurance enrollment, or eligibility for benefits. By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

Of What: All my health information including any details regarding sensitive conditions (if any).
From Whom: All information sources.

To Whom: Ackerman Cancer Center | Medical Records Department
10881 San Jose Boulevard Phone: 904-880-5522
Jacksonville, FL 32223 Fax: 904-880-5533

Purpose: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

Effective Period: This form will remain in effect during my lifetime or until the day that I withdraw my permission.

Revoking My Permission: I can revoke my permission at any time by giving written notice to the Ackerman Cancer Center.

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be re-disclosed to other persons.
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

Patient/Representative Signature_____
Date_____
Representative Name if Applicable *(please print)*_____
Relationship to Patient

Patient Name: _____

DOB: _____

General Consents

Diagnostic Services

I consent to receive diagnostic services at Ackerman Cancer Center. These services may include, but are not limited to, CT scans, PET-CT scans, mammograms, diagnostic x-rays, MRIs, and ultrasounds.

Many of these diagnostic services are offered elsewhere in the community. Please check with our front desk to obtain an updated list of facilities that offer these services if you would like to obtain them elsewhere.

Digital Communication

I consent to receive digital communication, such as text or email, from Ackerman Cancer Center. This facility uses Telehealth/Virtual services. When Telehealth services are required, you will be alerted via phone call prior to your appointment. By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use of text messaging services.

Message and/or data rates may apply. To opt out any time, call 904-880-5522 and speak with an Ackerman Cancer Center representative. Text messages are not a substitute for professional or medical attention.

Medical Imaging

I consent to have medical imaging (photo, video, and/or audio) made of me or parts of my body with the consent of my physician. This imaging shall be used in my medical record only, unless my physician believes that this information could be beneficial for use in medical research, education, or science. I hereby relinquish any property rights in any photography, video, and/or audio taken and/or published. I understand that I will not receive payment from any party.

Contact Information Change

I consent that I am responsible for notifying Ackerman Cancer Center when my contact information changes.

Refusal to consent to any of the above will not affect the medical care I will receive in any way. *I have read and agree to the above consents.*

Patient/Representative Signature_____
Date_____
Representative Name if Applicable (*please print*)_____
Relationship to Patient

ACKERMAN CANCER CENTER

HIPAA Omnibus Notice of Privacy Practices



10881 SAN JOSE BLVD, JACKSONVILLE, FL 32223 | 904.880.5522

Effective as of April/14/2013

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

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 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/.

- **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Jennifer Zelaya, MHA

904-880-5522

jenniferz@ackermancancer.com

HIPAA Compliance Officer

phone

email

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

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.

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.

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.

Our Responsibilities

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

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.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgment of Receipt of the Notice of Privacy Practices

Name of patient or representative

Date

Patient Name: _____ **DOB:** _____

Notice of Privacy Practices | HIPAA

As stated in the Ackerman Cancer Center Notice of Privacy Practices, we may disclose your health information to a member of your family, a relative, a close friend, or and other person whom you identify. This form is effective for the lifetime of the patient or until permission is withdrawn via written notice to Ackerman Cancer Center.

Please print below the people/persons to whom you give authorization to disclose your health information.

Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have read and agree to the Notice of Privacy Practices.

Patient/Representative Signature _____
Date

Representative Name if Applicable (please print) _____
Relationship to Patient

Patient Name: _____ **DOB:** _____

Financial Responsibility Form

We are committed to providing our patients with the highest quality care. Please read and sign this form to acknowledge your understanding of our patient financial policies. This form is effective for the lifetime of the patient or until permission is withdrawn via written notice to Ackerman Cancer Center or Ackerman Urology.

I hereby authorize Ackerman Cancer Center, Ackerman Urology, and its associate healthcare entities to release any information necessary to insurance carriers regarding my health and treatments and process insurance claims generated in the course of examination or treatment on my behalf.

I hereby authorize assignment of financial benefits directly to Ackerman Cancer Center, Ackerman Urology, and its associate healthcare entities for medical services. I understand that if my insurance carrier denies or does not cover my claim for medical services provided to me, I acknowledge that I assume full financial responsibility for these services, given that I was notified of this prior to the services being rendered. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage. I understand that co-payments are due at time of service.

I understand that any services connected to an elective Total Body MRI scan at the Ackerman Cancer Center is not covered by insurance and I assume full financial responsibility for these services.

I have read and understand this Financial Responsibility Form described above. I agree to pay on time and in full amounts due to Ackerman Cancer Center and/or Ackerman Urology for all items and services.

Patient/Representative Signature

Date

Representative Name if Applicable (please print)

Relationship to Patient