CANCER CARE
OF WEST CENTRAL OHIO

David D. Powell, D.O.
2740 W. Market St.
Lima, OH 45805
P: 419.221.2273
F: 419.227.3737

We strive to give you the best in quality care. To reach that goal we are asking for your assistance by completing the following for your appointment:

- ☐ Please complete the enclosed personal forms and return them as soon as possible.
- ☐ Bring your current insurance or Medicaid/Medicare cards with you to this appointment as well as a current Medication List.
- ☐ Bring a Photo ID with you to your appointment. Patients without a Photo ID will NOT be seen!
- ☐ Please contact your insurance company to see if you require any precertification for your appointment.

Also, please note the following:

- ☐ First visits are consults only. Any procedure that may be needed will be scheduled at your first visit.
- ☐ Please arrive early for your appointment. We do enforce a late policy and will reschedule late comers.

If you have any questions regarding your appointment, please call the office at **(419) 221-2273**.

Patient Information Form

Updated: 1/16/2020

Demographics Information					
Patient Name:				Date of Birth	Gender
					□ Male □ Female
E-Mail Address:				Phone	
Street Address:				Home:	
City				Cell:	
State		Zip		Social Security Number	
Marital Status	Communication Preference:				
□ Single □ Married □ Divorced □ Widowed	□ By Phone & Voicemail □ By Phone, no Voicemail □ By Mail □ No Preferrence			Ethnicity:	
				□ Hispanic or Latino □ Not Hispanic or Latino	
Name of Spouse:				Spouse Phone:	
Race:					
□ Caucasian □ Hispanic	□ Black □ American Indian	□ Asian □ Native Hawaiian		□ Pacific Islander □ Other	
Referring Doctor:				Phone:	
Family Doctor:				Phone:	
Pharmacy:					
Street Address:				Phone:	
City:		State:		Zip:	
Emergency Contact Information (Not living at the same address)					
Contact Name:					
Relationship to Patient:				Phone:	

Authorization to Release Demographic Information

I hereby authorize release of information to any insurance company, hospital, physician, or corporation which may need this information in regard to care or liability for payment for services in relation to my treatment. I understand and agree that a copy fee may be charged to me for this service.

Patient Signature: **Date:**

Patient Information Form

Employer and Insurance Information

Employment Status:

□ Full-Time Employed	□ Full-Time Student	□ Retired
□ Part-Time Employed	□ Part-Time Student	□ Unemployed

Insurance Information

Primary Insurance Company:					
Policy Holder's Name:					
Date of Birth:		Social Security Number:			
Relationship to Patient		Effective Date		Co-Pay	
Employer's Name:					
Street Address:				Phone:	
City:		State:		Zip:	
Policy Identification Number:					
Policy Group Number:					
Prescription Drug Information:					
Secondary Insurance Company:					
Policy Holder's Name:					
Date of Birth:		Social Security Number:			
Relationship to Patient		Effective Date		Co-Pay	
Employer's Name:					
Street Address:				Phone:	
City:		State:		Zip:	
Policy Identification Number:					
Policy Group Number:					
Prescription Drug Information:					

Assignment of Benefits

I understand and agree that health insurance policies are an agreement between my insurance carrier and myself. This office will provide information necessary in assisting me in billing my insurance. I understand that I am responsible for all charges incurred. I hereby assign payments from my insurance companies (including health plans, private insurance, and government programs) for all services rendered by Cancer Care of West Central Ohio and authorize payment directly to Cancer Care of West Central Ohio.

Patient Signature: **Date:**

Financial Policy

- □ If your Insurance company requires you to have a referral from your primary care physician in order to be treated by a specialist, *it is your responsibility* to verify that the referral is in place. *If a referral is not in place, your appointment will have to be rescheduled or you will be responsible for any penalties charged by your insurance company.*

- □ Co-Pays must be paid at the time services are rendered, as required by your insurance company. We accept cash, check, and/or credit card. Bank fees for any returned checks will be forwarded to you.

- □ If you do not have insurance, you will be required to pay for services at the time they are rendered, unless other arrangements have been made with us.

- □ As a courtesy, we will file primary and secondary insurance claims for you. However, it is your responsibility to assure that we are provided with accurate information in order to process your claims. **Please inform us of any insurance changes.** You will be responsible for charges related to claim denials which occur as a result of your failure to provide us with accurate insurance information.

- □ I understand that Cancer Care of West Central Ohio will attempt to obtain a pre-certification as a courtesy for me. I understand that Cancer Care of West Central Ohio is not obligated to obtain pre-certification for me. It is my responsibility to obtain or verify any required pre-certification has been obtained for me prior to my treatment. I agree to advise and confirm with Cancer Care of West Central Ohio that a pre-certification has been obtained for me prior to treatment. I understand that in the event pre-certification is not obtained or verified, I will be responsible for any and all amounts not paid, reduced or denied by my insurance company.

- □ For our patients who are Medicare beneficiaries, we are "participating physicians". This means that we will accept Medicare's allowed amounts for the services rendered, and Medicare will send payment to us. You will be billed for 20% of the approved charge, plus any deductible. If your doctor recommends treatment that is not covered by Medicare, you will be asked to sign a form accepting the service and responsibility for payment of that service.

- □ We will process disability, Family Medical Leave Act forms or other forms at a charge of $10.00 each. We ask that you leave these forms with the receptionist at the front desk with payment. We will complete these for you and mail to you within 10 business days, or you may arrange to pick these up at the office.

- □ Concerning Medical Records, there will be no charge for copying records for a referral to another physician made by Cancer Care of West Central Ohio. Any other patient request for medical records will be payable by the patient at the rate recommended by the Ohio Revised Code.

- □ You will receive a statement from this office monthly. Please pay your bills promptly. If you are having difficulty in keeping your account current, please call our Billing Department immediately at 419-879-2000 or 419-879-2500. We may be able to set up a payment plan for you. Accounts that are 90 days past due will be subject to collection action. Any legal activity could cause a breach in the physician-patient relationship, possibly resulting in discharge from the practice.

- □ Maintaining regular appointments is essential to continue receiving medical care for your condition. Cancer Care of West Central Ohio asks all patients to provide at least twenty four (24) hours of notice for changes in appointment times. The fees for missing or rescheduling less than twenty four (24) hours prior to a scheduled appointment time are twenty five dollars ($25) for established patients and seventy five dollars ($75) for new patients or patients being seen after admission to and discharge from a hospital. When a patient has missed or rescheduled two (2) scheduled appointments, our office will send a letter of warning to remind you of the policy. After three (3) missed or rescheduled appointments we will send a letter of dismissal and it will be the patient's responsibility to find alternative care.

I have read, understand, and agree to the above Financial Policy of Cancer Care of West Central Ohio. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and coinsurances are my responsibility. I authorize my insurance benefits to be paid directly to Cancer Care of West Central Ohio.

_____ _____

Signature of Patient Date

Release of Protected Health Information

Federal and State Law direct when Cancer Care of West Central Ohio may disclose a patient's Protected Health Information to persons involved in a patient's care. This form allows a patient to designate family members, friends or other individuals to whom Cancer Care of West Central Ohio may release Protected Health Information.

I, _____, hereby agree that the following person(s) may receive Protected Health Information about me and/or my care. (Please list family members or friends you would give permission to know about your care if we are unable to speak with/contact you directly).

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

This form is not intended as a full authorization to release all of your Protected Health Information. The individuals listed above will only receive Protected Health Information directly relevant to such individual's involvement in your care or payment related to your care.

You may cancel or alter this designation at any time by informing Cancer Care of West Central Ohio in writing of such change or alteration. Any change or alteration can only apply to future disclosures and/or actions regarding your Protected Health Information and cannot change or alter actions taken or disclosures made while the designation was in effect.

Voicemail Authorization

Cancer Care of West Central Ohio will use phone calls to communicate pertinent health care information to you or your authorized family members/friends. If we contact you by phone, may we have your permission to leave a message with regards to your care, any lab results, and appointment information, if you are unavailable or do not answer the phone?

I authorize/request Cancer Care of West Central Ohio to (please select one box for each option):

Leave a message at Work: ☐ Yes ☐ No

Leave a message at Home: ☐ Yes ☐ No

_____ _____

Patient Signature Date

Cancer Care of West Central Ohio
2740 W. Market Street
Lima, OH 45805
P: (419) 221-2273
F: (419) 227-3737

Authorization for Release and Exchange of Information

I, _____, do hereby grant my permission for release and/or exchange of all information relating to my care to and from necessary parties, including, but not limited to other physicians, consulting physicians, medical testing facilities, laboratory services, insurance companies, insurance company affiliates, any other parties not specifically mentioned, including any requested form or precertification request, and any other parties deemed necessary by myself, the patient, or by Dr. David Powell and the staff of Cancer Care of West Central Ohio.

To assist in identification and location of my records, I am providing the following information:

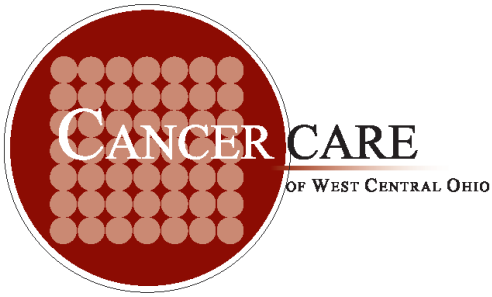
Name: _____ Date of Birth: _____

S.S. #_____ - _____ - _____

_____ _____
Patient Signature Date

I have been offered a copy of the Authorization Form: ☐ Accept ☐ Decline

Acknowledgement of Receipt of Notice of Privacy Practices



I,_____ , hereby acknowledge that I have reviewed and received a copy of this practice's Notice of Privacy Practices, which has been updated for the new Omnibus Rule and has an effective date of March 1, 2016.

The notice describes:

- the ways that the Privacy Rule allows our practice to use and disclose protected health information. How our practice will get your permission, or authorization, before using your health records for any other reason.
- the practice's duties to protect health information privacy.
- the patient's privacy rights, including the right to complain to HHS and to the covered entity if you believe your privacy rights have been violated.
- how to contact our practice for more information and to make a complaint.

I understand that the Notice of Privacy Practices may be revised from time to time and that I have a right to receive an updated copy upon request.

_____

Patient 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.

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

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

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

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 amend your medical record

- You can ask us to amend 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.

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 ensure the person has this authority before we take any action.

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

If you are not able to tell us your preference 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
- Most sharing of psychotherapy notes
- Sale of your information

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.

We can use your health information and share it with other professionals who are treating you.

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. Your information may be shared w/ other providers, labs and radiology groups through our EHR system as listed:

1) New Vision Medical Lab

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
- Preventing or reducing a serious threat to anyone's health or safety
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence
- Reporting adverse reactions to medications
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director.

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.

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 as military, national security, and presidential protective services
- Respond to lawsuits and legal actions

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.

You Have A Right To File A Complaint If You Feel Your Privacy Has Been Violated

- **If you feel your Privacy Rights have been violated, please ask our staff for a Privacy Complaint Form. Our Security Officer will review the form and promptly notifiy you of the actions our office will take.**
- or 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 http://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html
- We will not retaliate against you for filing a complaint.

Cancer Care of West Central Ohio
HIPAA Compliance Officer: Christopher L. Powell
Phone: 419-221-2273

This Notice of Privacy Practices is effective September 1, 2017