Assignment of Benefits/ Financial Responsibilities

Today's Date:______________________

Patient Name: ____**MRN:**______________
Last First M.I.

SS# ______________________**DOB**: ____________________ **Email:**____

Marital Status: □ Married □ Single □ Divorced □ Other ____

Religion:______________________________________ **Preferred Language**: _____________________________

Sex: □ Female □ Male

Ethnicity: □ Hispanic □ Non-Hispanic

Race: □ American Indian □ Asian □ Black/African American □ Native Hawaiian □ White □ Other ______________________

Telephone: ( ) ________________ □ **Primary** ( ) ________________ □ **Primary** ( ) ________________ □ **Primary**
Home Cell Work

Home Address: ____
Street City State Zip Code

Patient Employer: ____ ( ) ______________
Name Telephone Number

____ ____________________________
Address Occupation

Responsible Party: ____ ____________________ ( ) ______________
Name Relationship Telephone Number

Emergency Contact: ____ ____________________ ( ) ______________
Name Relationship Telephone Number

Referring Physician: ____ ( ) ______________
Name Address Telephone Number

Primary Care Physician: ____ ( ) ______________
Name Address Telephone Number

Primary Ins: ____ Subscriber: ____

Relationship to patient:_________________________ Subscriber Employer:______________________________________

Subscriber SS# _______________________ DOB: ______________ Group # ____________ Policy # _______________

Claims Address: ____ Telephone:( ) __________

Secondary Ins: ____ Subscriber: __________________________________

Relationship to patient: _________________________ Subscriber Employer:____________________________________

Subscriber SS# __________________ DOB: ______________ Group # _____________ Policy # _________________

Claims Address: ____ Telephone:( ) ______________

Turn over for page 2

Advanced Directives: This includes a Living Will, Medical Power of Attorney, and Out of Hospital Do Not Resuscitate order and allows you to state your choice for healthcare if you become unable to make decisions. Advanced directives are not required in order to receive proper medical treatment at this facility, but if you have executed advanced directives you must provide a copy to us to be put in your medical chart to ensure that your wishes are honored. If you are interested in learning more about advanced directives, ask your nursing professional for information.

Please check at least one box.

☐ I have a Durable Power of Attorney for Health Care.

☐ I have a Living Will (directive to physicians)

☐ I have an Out of Hospital **Do Not Resuscitate** directive. I understand I must wear an approved ID device or carry the original document in a visible manner in order for the document to be honored.

☐ At this time, I have not executed any of the above directives and understand that in an emergency situation the medical staff will be responsible for making decisions regarding my care.

HIPAA Consent for Treatment, Payment, and other Healthcare Operations

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 Austin Cancer Center. I also authorize agents of any hospital, treatment center, and/or previous physicians to furnish Austin Cancer Center copies of any records of my medical history, services, or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state, or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research, and quality assurance reviews within Austin Cancer Center.

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 Austin Cancer Center. 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 Austin Cancer Center.

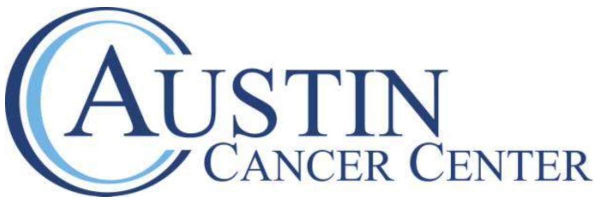
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with Austin Cancer Center.

5. I consent to the disclosure of my protected health information to any physician or facility that is currently or will be participating in my diagnosis, evaluation, treatment or follow-up care.

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.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNTIL SUPERCEDED BY AN UPDATED AOB BY ME IN WRITING.

Patient Signature	**Date**	**Time**	**AM or PM (circle one)**
Patient Representative Signature	**Date**	**Time**	**AM or PM (circle one)**
Austin Cancer Centers Representative Signature	**Date**	**Time**	**AM or PM (circle one)**



CONTACT PERMISSION

Patient: ______________________________ MRN: _______________________ Date: ________________

In the event that Austin Cancer Center needs to contact you about your medical care but is unable to reach you directly, we would like to know if we are allowed to attempt any of the following commonly requested alternatives. Before you check one or more of the options below, please be mindful that these messages may include information about your test results, medications, insurance coverage, billing information, appointment details, or other personal information regarding your care at our practice.

If unable to contact me directly, I authorize Austin Cancer Center to (**please check the boxes you wish to include):**

☐ **Leave a voicemail message at this phone number** – ____

☐ **Speak to my spouse or significant other (name and relationship)** – ________________________________

☐ **Speak to or leave a message with the individuals listed below.**

Name: ________________ Relationship to patient: ________________ Contact number: ( ) -

Name: ________________ Relationship to patient: ________________ Contact number: ( ) -

Name: ________________ Relationship to patient: ________________ Contact number: ( ) -

***I understand that if I should decide to no longer authorize Austin Cancer Center to share my information with any of the individuals listed above or leave a voicemail at the numbers indicated, that it will be my responsibility to notify the office in writing*.**

____ ________________

Print Patient Name Date of Birth

____ ________________

Signature of Patient or Patient Representative Date

____

Relationship to Patient

E-PRESCRIBING CONSENT FORM

Patient: ______________________________ **MRN:** _______________________ **Date:** ________________

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- ☐ **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.
- ☐ **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- ☐ **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Austin Cancer Center can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Austin Cancer Center to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

____ __________________

Print Patient Name Date of Birth

____ __________________

Signature of Patient or Patient Representative Date

____

Relationship to Patient

Pharmacy Name: __________________________________ **Phone**: __________________

Pharmacy Address: ____

Street **City** **State** **Zip**

AUSTIN CANCER CENTER

HISTORY AND PHYSICAL

Patient Name: ____ MRN: ___________ Date: _____________

DOB: ______________ Age: ________ Sex: ☐ Male ☐ Female

Primary Care Physician: _______________________ Surgeon: ____

Specialists/Other Physician(s):____

Medical History

Major Medical Problems (ie. Diabetes, heart problems, etc.)	Surgeries (please list approximate dates)	Hospitalizations (Please list approximate dates)

Drug Allergies: ☐ **Yes** ☐ **No**

Please List:

Pacemaker: ☐ **Yes** ☐ **No**

Current Medications

Include Vitamins and/or Herbal Products

Medication	Dose	Frequency

Treatment Options

Have you had past experience with cancer?

☐ No

☐ Yes, type of cancer: ______________________

When were you diagnosed? ______________

Have you had any prior radiation treatments?

☐ No

☐ Yes, in year(s) ________________

Where? ________________________________

Have you had any prior chemotherapy treatments?

☐ No

☐ Yes, in year(s) ________________

Where? ________________________________

Patient: ______________________________ **MRN:** _______________________ **Date:** ________________

Social History

Employment: ☐ No ☐ Yes ☐ Retired Occupation: __________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other: ___________________________________

Number of people in household:

Do you now or have you ever smoked? ☐ No ☐ Yes, I started at age ____, quit at age ________
Cigarettes, _______ packs per day
Other Tobacco, _________ packs per day

Do you want information on smoking cessation? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes, _________ drinks per week

Have you been treated for drug/alcohol abuse? ☐ No ☐ Yes

Have you been exposed to hazardous materials? ☐ No ☐ Yes

Family History

Is there a history of cancer in your family?
☐ No ☐ Yes, please list below

Relationship	Type of Cancer

Women's Health

Age at first period:

Age at birth of first child:

Did you breastfeed?

Age at Menopause?

Have you ever used Hormone Replacement Therapy?
☐ No ☐ Yes

Breast Patients:
Bra Cup Size _____

Most Recent Screenings

Type	Date	Results
Lipid (Cholesterol)		
PSA		
Stool test for occult blood		
Colonoscopy		
Mammogram		
Ever Abnormal?		
Pap Smear		
Ever Abnormal?		
Osteoporosis		

Most Recent Immunizations

Type	Date
Hepatitis A	
Hepatitis B	
Flu Shot	
Measles	
Pneumonia	
Rubella	
Tetanus	
Varicella/Chicken Pox	

Patient Signature ____ Date ________________________

Review of Systems

Patient Name:______________________________________MRN: _____________Date:__________________

Eyes	Y	N
Near-sighted		
Far-sighted		
Do you wear contacts?		
Glaucoma		
Cataracts		
Eye pain		
Double vision		
Floating lights		
Excessive tearing		
Matting		
Immunology	**Y**	**N**
Rheumatoid arthritis		
Lupus		
Scleroderma		
Gastrointestinal	**Y**	**N**
Chronic abdominal pain		
Persistent nausea/vomiting		
Heartburn		
Appetite loss		
Vomiting blood		
Diarrhea		
Blood/clay-colored stools		
Hemorrhoids		
Constipation		
Hepatitis		
Gall bladder disease		
Difficulty swallowing liquids		
Difficulty swallowing solids		
Genitourinary	**Y**	**N**
Excessive dribbling		
Burning upon urination		
Incontinence		
Frequent urination at night		
Blood in urine		
Kidney stones		
Reproductive – Male	**Y**	**N**
Discharge/sore penis		
Hernias		
Testicular pain or lumps		
History of venereal disease		
Type:		
Sexually active		
Endocrine	**Y**	**N**
Thyroid trouble		
Hot/cold intolerance		
Excessive thirst/hunger		
Diabetes		
If yes, do you take insulin?		
Musculoskeletal	**Y**	**N**
Numbness in arms or legs		
Tingling in arms or legs		
Problems walking		
Muscle jerking		
Paralysis		
Shaking/tremors		
Limited motion		
Muscle pain		
Psychiatric	**Y**	**N**
Depression		
Anxiety		
On psychiatric medicine?		

Pain Rating Scale© Mosby

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

None Mild Moderate Severe

0 NO HURT · 2 HURTS · 4 HURTS · 6 HURTS · 8 HURTS · 10 HURTS

ECOG Performance: _______

0 = normal
1 = symptoms fully ambulatory
2 = in bed less than 50%
3 = in bed greater than 50%
4 = in bed 100%

Nurse:

Date:

Ears/Nose/Throat/Mouth	Y	N
Hearing loss		
Ringing in ears		
Pain in ears		
Discharge from ear		
Chronic nose obstruction		
Repeated nosebleeds		
Persistent sore gums		
Dentures		
Prolonged hoarseness		
Dry mouth		
Respiratory	**Y**	**N**
Chronic cough		
Difficulty breathing		
Asthma		
Emphysema		
Bronchitis		
Sit up to breathe easier?		
Wheezing		
Tuberculosis		
Pneumonia		
Require oxygen? l/min		
Coughing up blood		
Skin	**Y**	**N**
Lumps or bumps?		
Color change in moles		
Hives or rashes		
Psoriasis/eczema		
Prior skin cancer		
Shingles		
Neurological	**Y**	**N**
Dizziness/fainting		
Memory loss		
Seizures		
Speech changes		
Sensory loss or changes		
Weakness in arms or legs		
Reproductive – Female	**Y**	**N**
Breast lumps		
Nipple discharge		
Hormone therapy		
Last menstrual period / /		
# of Pregnancies		
# of births		
Sexually active		
History of venereal disease		
Type:		
Cardiovascular	**Y**	**N**
High blood pressure		
Heart disease or defects		
Pacemaker		
Chest pain		
Hemo/lymphatic	**Y**	**N**
Anemia		
Bruising/bleeding		
Swollen lymph nodes		
HIV positive		
If yes, diagnosis date: / /		
Night sweats		
Frequent infections		
Allergies	**Y**	**N**
Hay fever		
Molds		

AUSTIN CANCER CENTER

Hereditary Cancer Intake Form

Patient: ___________________________________ **DOB:** _______________________ **Date:** ________________________

This form will help determine whether there is an increased risk for hereditary cancer in your family. Individuals with hereditary cancer are at increased risk to develop multiple cancers, and their family members are at increased risk for cancer. If you have a hereditary form of cancer, it may be managed differently. This form will be reviewed by a genetics specialist who may not be familiar with your medical history, so we kindly ask that you please fill it out entirely.

- Are you adopted and/or unaware of your family history? (circle one) **YES / NO**

	If diagnosed with cancer, what **kind(s)** of cancer (e.g. breast). If you are unsure of the type of cancer an individual has had, write 'unk'.	At what **age(s)** were they diagnosed (best guess)
You		
Your **sisters and brothers**		
Your **nieces and nephews**		
Your **mother**		
Your **mother's parents, sister(s) and/or brother(s)**		
Your **maternal 1st cousin(s)**		
Your **father**		
Your **father's parent(s), sister(s), and/or brother(s)**		
Your **paternal 1st cousin(s)**		
Your **child(ren)**		
Your **grandchild(ren)**		

- Has anyone in your family been diagnosed with more than one type of cancer? **YES / NO** If yes, please **circle** the cancers that this applies to in the chart above.
- Has anyone in your family been diagnosed with a hereditary cancer syndrome, such as a BRCA mutation or Lynch syndrome? **YES / NO** If yes, which hereditary cancer syndrome_________________
- Have any males in your family been diagnosed with breast cancer? **YES / NO**
- Are you of Jewish ancestry? **YES / NO** If yes, is your **mother**, **father**, or **both** of Jewish ancestry? ______________
- Have you or any of your family members had more than 20 colon polyps? **YES / NO**

Patient's initials________________ **Date**_______________

AUSTIN CANCER CENTER

ACCIDENTAL EXPOSURES

Patient: ___________________________________ **MRN:** ________________ **Date:** __________________

In the course of care and treatment, health care workers may be accidentally exposed to a patient's blood or body fluids. Communicable diseases, including the HIV virus that causes AIDS, are known to be transmitted through accidental exposures.

I understand that, in the event a health care worker is exposed to my blood or body fluids, my blood will be tested for the HIV antibody and other communicable diseases at no cost to me. My initials below signify that I understand the information and agree to your proposal.

On behalf of Austin Cancer Center, we thank you for your cooperation.

Patient Initials _________ **Date** ________________

Pregnancy

Female patients, please let us know if there is <u>any</u> possibility that you may be pregnant.

☐ **Yes** ☐ **No**

Patient Initials _________ **Date** ________________

NOTICE OF PRIVACY PRACTICES
Acknowledgment of Receipt

Patient Name: ____

Date of Birth: ____________________________________

MRN: ____

I acknowledge that Austin Cancer Center provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

____ ____________________

Patient Signature Date

____ ____________________

Personal Representative Signature (if applicable) Relationship to Patient

----

Austin Cancer Center Office Use Only

Date acknowledgement received: __________________________

_______________________________________ ________________________

Staff signature Date

AUSTIN CANCER CENTER

NOTICE OF PRIVACY PRACTICES

Effective Date: *10/21/13*
Last Updated: *03/29/2016*

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.

If you have any questions about this Notice, please contact:

Ashley St. John, HIPAA Privacy Officer at *(512) 334-2623*.

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at Austin Cancer Center, a record of the care and services you receive is made. Typically, this record contains your treatment plan, office visit note, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.
Austin Cancer Center shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Austin Cancer Center will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run Austin Cancer Center in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, we may provide a written or telephone reminder that your next appointment with Austin Cancer Center is coming up.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval

process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:
  - To prevent or control disease, injury, or disability;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

  All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order or subpoena; or
  - If Austin Cancer Center determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.,* to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosures will be made only upon your individual written authorization. This includes, but is not limited to, uses and disclosures for marketing purposes. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the HIPAA Privacy Officer of Austin Cancer Center. If you request a copy of the information, Austin Cancer Center may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

  Austin Cancer Center may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Austin Cancer Center will review your request and denial. The person conducting the review will not be the person who denied your request. Austin Cancer Center will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask Austin Cancer Center to amend the information. You have the right to request an amendment for as long as the information is kept by Austin Cancer Centers.

  To request an amendment, your request must be made in writing and submitted to the Austin Cancer Center HIPAA Privacy Officer. In addition, you must provide a reason that supports your request.

  Austin Cancer Center may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by Austin Cancer Center, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by Austin Cancer Center;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

  To request this list you must submit your request in writing to the *Austin Cancer Center HIPAA Privacy Officer*. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, paper or electronic copy). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Austin Cancer Center will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information Austin Cancer Center uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information Austin Cancer Center discloses about you to someone who is involved in your care or the payment for your care.

  Austin Cancer Center is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which Austin Cancer Center has been paid out of pocket in full. Should Austin Cancer Center agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions you must make your request in writing to the Austin Cancer Center HIPAA Privacy Officer. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit Austin Cancer Center's use and/or disclosure; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have the right to request that Austin Cancer Center communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only at work or by mail.

  To request that Austin Cancer Center communicate in a certain manner, you must make your request in writing to the HIPAA Privacy Officer. You do not have to state a reason for your request. Austin Cancer Center will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all medical information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the HIPAA Privacy Officer.

HIPAA PRIVACY OFFICER CONTACT INFORMATION:

AUSTIN CANCER CENTER
ATTN: ASHLEY ST. JOHN, PRIVACY OFFICER
9715 BURNET RD.
BLDG 7, SUITE 200
AUSTIN, TX 78758
PH: (512) 334-2623
FAX: (512) 334-2702

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with Austin Cancer Center or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with Austin Cancer Center, contact the Privacy Officer at the address listed above. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint