

Patient Name: _____ Date of Birth: _____

Why are you seeing the doctor? _____

Breast Review of Systems – Check symptoms you currently have or have had in the past year

Breast:

- ___ Breast Cancer
- ___ Right Breast Mass
- ___ Left Breast Mass
- ___ Right Breast Pain
- ___ Left Breast Pain
- ___ Breast Swelling
- ___ Right Nipple Discharge
- ___ Left Nipple Discharge
- ___ Nipple Pain
- ___ Skin Changes

General:

- ___ Chills
- ___ Fatigue
- ___ Fever
- ___ Night Sweats
- ___ Weight Gain > 10lbs.
- ___ Weight Loss > 10lbs.

Skin:

- ___ Bruising
- ___ Rash
- ___ Skin Color Changes

HEENT

- ___ Blurred Vision
- ___ Headache
- ___ Neck Mass
- ___ Swollen Glands

Respiratory:

- ___ Chronic Cough
- ___ Difficulty Breathing
- ___ Tuberculosis

Cardiovascular:

- ___ Chest Pain
- ___ Difficulty Breathing On Exertion
- ___ Irregular Heart Beat
- ___ Elevated Blood Pressure
- ___ Difficulty Breathing Lying Down
- ___ Rapid Heart Rate
- ___ Shortness of Breath
- ___ Swelling of Extremities
- ___ Pacemaker

Gastrointestinal:

- ___ Abdominal Pain
- ___ Black, Tarry Stool
- ___ Bloody Stool
- ___ Change in Bowel Habits
- ___ Constipation
- ___ Diarrhea
- ___ Nausea and Vomiting
- ___ Hepatitis A, B, or C

Female Genitourinary:

- Date of Last Menstrual Period: _____
- Date of Last Pap Smear: _____
- Form of Birth Control: (Circle)
 - Medication
 - Vasectomy
 - Tubal Ligation
 - Hysterectomy
- Are you currently pregnant? Yes No
- Are you currently breast feeding? Yes No
- Number of Pregnancies: _____
- Number of Living Children: _____
- ___ Complications with Menstrual Cycle
- ___ Complications with Urination
- ___ Pelvic Pain
- ___ Vaginal Bleeding
- ___ Herpes
- ___ Sexually Transmitted Diseases
- ___ Vaginal Infections

Male Genitourinary:

- ___ Lump in Testicles
- ___ Penis Discharge
- ___ Prostate Conditions
- ___ Other: _____

Musculoskeletal:

- ___ Muscle Pain
- ___ Bone Pain
- ___ Lymphedema

Neurological:

- ___ Headaches
- ___ Weakness In Extremities

Psychiatric:

- ___ Anxiety
- ___ Depression
- ___ Insomnia
- ___ Panic Attacks
- ___ Suicidal Attempts or Ideations

Endocrine:

- ___ Cold Intolerance
- ___ Hair Changes
- ___ Heat Intolerance
- ___ Hot flashes
- ___ Libido Change
- ___ Thyroid Problems

Hematology:

- ___ Abnormal Bleeding
- ___ Easy Bruising
- ___ Enlarged Lymph Nodes
- ___ Nose Bleed
- ___ Prolonged Bleeding
- ___ Anemia
- ___ HIV or AIDS

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

Allergies – List all allergies to medications/foods/substances

Medications – List all medications/vitamins/supplements you are currently taking

Operations and Hospitalizations – List all operations and hospitalizations, if applicable

Family History

Breast Cancer: Yes No

Ovarian Cancer: Yes No

List all blood relatives of the patient who have or have had breast and/or ovarian cancer(s).

Type of Cancer

Relation to Patient

List any other relevant family history (i.e. hypertension, diabetes, heart disease, etc.)

Social History – Check which substances you use and describe how often you use them per day

___ Caffeine: _____
___ Tobacco: _____
___ Alcohol: _____
___ Illicit Drugs: _____

Pharmacy Name: _____ **Phone Number:** _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Today's Date: _____



Assignment of Benefits and Financial Responsibilities

Patient Name: _____
Last First M.I. Date of Birth Age

Home Phone: () Cell: () Work: ()

Home Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

Email Address: _____

Gender: Male Female Widowed
Marital Status: Married Single Divorced

Home Health / Hospice (Name): _____

The Texas Cancer Incident Reporting Act requires cancer incidence reporting to the Texas Cancer Registry (TCR) mandatory. Primary racial origin captures information used in research and cancer control activities.

Race: Caucasian African American Hispanic Asian/Indian/Pakistani/Sri Lankan Chamorran Chinese Fiji Islander Filipino Guananian NOS Hawaiian Hmong Japanese Kampuchean/Cambodian Korean Laotian Melanesian NOS Micronesian NOS Native American New Guinean Other Asian including Asian NOS and Oriental NOS Pacific Islander NOS Polynesian NOS Samoan Tahitian Thai Tongan Vietnamese Other

Employer: _____
Name Address City State Zip

Responsible Party: _____
Name Relationship Telephone

Emergency Contact Spouse/Next of Kin: _____
Name Relationship Telephone

Alternate Emergency Contact: _____
Name Relationship Telephone

Referring Physician: _____ Primary Care Physician: _____

Primary Insurance: _____ Telephone: ()

Subscribers Name: _____ DO B: _____ Employer: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____ Telephone: ()

Subscribers Name: _____ DO B: _____ Employer: _____

Policy Number: _____ Group Number: _____

Tertiary Insurance: _____ Telephone: ()

Subscribers Name: _____ DO B: _____ Employer: _____

Policy Number: _____ Group Number: _____

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 Texas Oncology P.A.

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 Texas Oncology P.A. 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 Texas Oncology P.A.

4. I understand that I have the right to request and receive a Notice of Privacy Practices from Texas Oncology P.A.

Notice to Patients: By submitting your check for payment, you are authorizing Texas Oncology, PA, or its agent, upon receipt of your check to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to your account, in accordance with the same terms and conditions as your check.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

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 original.

Patient Signature Date/Time AM or PM (circle one)

Responsible Party Signature Relationship Date/Time AM or PM (circle one)

Patient Name: _____

Please Print

Account # _____

TXO will Complete

Why are we asking these questions? In 2009 Congress passed the HITECH Act to create uniformity among electronic health records. Asking for your language ensures you and your healthcare providers will be able to communicate clearly. We will be asking about race & ethnicity because some groups are at a higher risk of developing certain diseases. This information will be updated in your medical record and will remain confidential.

Circle Preferred Language

AMERICAN SIGN LANGUAGE	FRENCH CANADIAN	LAO	SWAHILI
ARABIC	GERMAN	MAORI	SWEDISH
ARMENIAN	GREEK	MIEN	TAGALOG
BRAZILIAN PORTUGUESE	GUJARATI	NAVAJO	THAI
CHINESE	HEBREW	NORWEGIAN	TIGRINYA
CHINESE (CANTON)	HINDI	OROMO	TURKISH
CHINESE MANDARIN	HMONG	OTHER	UNDEFINED
CROATIAN	HUNGARIAN	PERSIAN	URDU
DANISH	INDIAN	POLISH	VIETNAMESE
ENGLISH	INDONESIAN	PORTUGUESE	VISAYAN
FARSI	ITALIAN	RUSSIAN	YIDDISH
FILIPINO	JAPANESE	SLOVAK	
FINNISH	KHMER	SOMALI	
FRENCH	KOREAN	SPANISH	

Circle Ethnicity HISPANIC OR LATINO NOT HISPANIC OR LATINO

Circle Preferred Method of Contact Home phone Cell phone Work phone
Email Mail Home Address

Phone number not previous provided _____ H C W (circle type)

Email address: _____

CIRCLE RACE

AFRICAN AMERICAN	HMONG	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS
ASIAN INDIAN PAKISTANI SRI LANKAN	JAPANESE	PACIFIC ISLANDER NOS
CAUCASIAN	KAMPUCHEAN CAMBODIAN	POLYNESIAN NOS
CHAMORRAN	KOREAN	SAMOAN
CHINESE	LAOTIAN	TAHITIAN
FIJI ISLANDER	MELANESIAN NOS	THAI
FILIPINO	MICRONESIAN NOS	TONGAN
GUAMANIAN NOS	NATIVE AMERICAN	VIETNAMESE
HAWAIIAN	NEW GUINEAN	UNKNOWN
HISPANIC	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS	OTHER



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Breast Surgeons is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. **Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.**

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Oncology.

Name: _____

Signature: _____

Name of Personal Representative (if appropriate):

Signature of Personal Representative (if appropriate):

Date: _____

Texas Breast Surgeons
Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:



TEXAS BREAST SURGEONS

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

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.

About Us

In this Notice, we use terms like “we,” “us” or “our” to refer to Texas Oncology its physicians, employees, staff and other personnel. All of the sites and locations of Texas Oncology follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information:



For Treatment: ~~We may use your health information to provide you with medical treatment or services.~~ For example, your health information will be disclosed to the oncology nurses who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

We may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities.

We may ask you to sign your name to a sign-in sheet at the registration desk and we may call your name in the waiting room when we call you for your appointment.

We may disclose your health information to a third party that performs services, such as billing and collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a family member or friend, please notify the Medical Records Department.** We may also disclose your health information to disaster-relief organizations so that your family can be notified about your condition, status and location.

We are also allowed by law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement : We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- To report adverse events, product defects or problems;
- To track FDA-regulated products;
- To notify people and enable product recalls; and
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain limited research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project, assesses a number of specific issues, and determines that appropriate privacy safeguards are in place to allow the use of health information in the research project. We may, however, disclose your health information to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the practice.

Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **We are not required to agree to your request.** If we do agree, 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 and submit it to the *Privacy Official at your local Texas Oncology office.*

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to the *Privacy Official at your local Texas Oncology office.* We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the Medical Records Department. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.

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

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the Privacy Official at your local Texas Oncology office.

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we make of your health information. Please note that certain disclosures, such as those made for treatment, payment or health care operations, need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the Medical Records Manager. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact our Business Office.

Right to Complain: If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: Texas Oncology at 1 800-758-7608 and ask for the Privacy Officer. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the Reception Area. Each version of the Notice will have an effective date listed on the first page. Updates are also available at our website, www.texasoncology.com.



Texas Breast Surgeons

CONSENT/AUTHORIZATION FOR RELEASE OF INFORMATION

1 I hereby authorize :

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ FAX: _____

To release the following information from the health record (s) of

Patient's Name: _____ Phone: _____

Birth date: _____

Covering the period (s) of treatment: From _____ To: _____

2. Information to be released:

- Progress Note
 - Radiology
 - Lab
 - Billing Records
 - X-ray Films
 - Complete Medical Record (includes information regarding insurance, demographic, referral documents and records.)
- Mail Copies: _____
Patient Pick-Up _____
FAXED _____

3. Information is to be released to:

Name _____ Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ FAX: _____

4. Purpose of disclosure (circle one): **Treatment** **Payment** **Health Care Operations** **Other (Specify Below)**

5. I understand that I may revoke this consent/authorization at any time by notifying Texas Oncology® in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.

6. This authorization will remain in effect until revoked by me in writing, or on this date: _____

7. The facility, its employees and officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Texas Oncology will not be affected if I refuse to sign this authorization.

Signature: _____ Date: _____
Patient or Legal Representative

Witness: _____ Relationship _____