Regional One Health
CANCER CENTER
A WEST CANCER CENTER & RESEARCH INSTITUTE AFFILIATION

Patient Information

Welcome to Regional One Health Cancer Center, a hospital-based clinic site of Regional One Health, with professional services provided by West Cancer Center & Research Institute Affiliation. We want to provide excellent service. In order to help us contact you and properly handle your insurance and billing, please fill out the information below.

General Patient Information:

Patient Name: _____ Date of Birth: _____

SSN: _____ ☐ Male ☐ Female

Patient Mailing Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Spouse (Next of Kin): _____ Relationship:_____ Phone: _____

Employer: _____ Work Phone: _____

The below information will be used to contact you. Please do not provide information for any method you prefer Regional One Health Cancer Center not use for contact (e.g., work phone, mobile phone).

Email Address:_____ Home Phone:_____

Work Phone:_____ Mobile Phone (voice and text):_____

Contact Preference: Home / Work / Mobile/ Email

Insurance Information:

Primary Pharmacy:_____ Phone: _____

Pharmacy Cross Streets or Address: _____

Primary Insurance: _____ Policy Holder: _____ Policy Holder DOB: _____

Secondary Insurance: _____ Policy Holder: _____ Policy Holder DOB:_____

**Please provide a copy of your insurance card upon arrival.*

Information Required by Federal Government:

Race: ☐ Caucasian/White ☐ African American/Black ☐ American Indian ☐ Asian

☐ Other _____

Ethnic Background: ☐ Hispanic ☐ Non-Hispanic

Preferred Language:_____

Do you need language translation assistance? ☐ Yes ☐ No

Do you need interpreter aids or assistance? ☐ Vision ☐ Hearing ☐ Other

Do you require a physical accommodation? ☐ Yes ☐ No

If Yes, please let us know what type of accommodation is required.

Advanced Directive for Medical Care (Living Will):

Do you have a Living Will? ☐ Yes ☐ No

Did you bring a copy with you? ☐ Yes ☐ No

I acknowledge that if I have a Living Will or any form of Advanced Directives I should inform Regional One Health and West Cancer Center and present a copy even if one is created after my initiation of care.

Patient Representative Identification

By law, the HIPAA Privacy Rule Prohibits Regional One Health Cancer Center and West Cancer Center from disclosing your Protected Health Information (PHI) to anyone without your authorization, except for treatment, payment, and health care operations. Persons involved in your care or payment for care, such as a family member or caretaker may have access to your health information related to their involvement unless you indicate otherwise. In addition, your legal representative may access or receive your health information on your behalf.

Please list ALL PERSONS you wish to have access to your Protected Health Information (PHI): (i.e. those making appointments or checking on test results)

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Please list those with whom we can discuss your bill:

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

Please list your Emergency Contact:

Name:_____ Phone:_____ Relationship: _____

NOTE: In an Emergency, HIPAA permits release of PHI as necessary for informing your Emergency Contact of your location and condition.

If applicable, please list your Legal Representative:

Name:_____ Phone:_____ Relationship: _____

By what authority is this person your Legal Representative? (Please check one)

☐ Next of Kin ☐ Guardian ☐ General Power of Attorney ☐ Health Care Power of Attorney

PLEASE NOTE: In order for us to disclose your Private Health Information, the above representatives must be able to provide up to two (2) patient identifiers and documentation of legal representation.

Patient/Patient Representative Signature: _____ Date: _____

Clinical History

Chief Complaint: (Reason for your visit) _____

Referring Physician:_____

Primary Care Physician: _____

Past/Present Illness:

	Yes	How long?		Yes	How long?
Heart and Blood Vessels			**Kidney/Bladder**		
Anemia			Kidney Disease		
Angina			Kidney Stones		
Heart Attack			Urinary Tract		
Heart Disease/Failure			**Blood Disorders**		
High Blood Pressure			Bleeding with tooth		
Irregular Heartbeat			Blood Clots/Clotting		
Peripheral Vascular Disease			Easy bruising		
Stent Placement			**Immune System**		
Stroke/TIA			Other Collagen		
Brain and Nerves			Human Immune		
Glaucoma			Lupus		
Migraines			**Joint/Skelton**		
Multiple Sclerosis			Arthritis		
Parkinson's Disease			Rheumatoid		
Seizures or Epilepsy			**Endocrine**		
Lungs			Diabetes or Sugar		
Chronic Bronchitis			Thyroid Disease or		
Emphysema/COPD			**Psychological**		
Pneumonia			Anxiety		
Sleep Apnea			Depression		
Tuberculosis (TB)			Psychiatric		
Stomach/Intestines			**Other**		
Colitis			GYN Problems		
Crohn's Disease			Hepatitis/Liver		
Diverticular Disease			Sinusitis		
Gall Bladder Disease			Vision Problems		
Pancreatitis			Other:		
Ulcers of Stomach or			Other:		
Skin			Other:		
Psoriasis			Other:		
Skin Condition(s)			Other:		
	Yes	How long?		Yes	How long?

Personal Cancer History:

Please complete the following regarding the treatment of your prior cancer(s):

Cancer Type		Yes/No	Date Treated	Treating Physician	Where?
	Did you receive chemotherapy?				
	Did you have surgery?				
	Did you have radiation?				
	Did you receive chemotherapy?				
	Did you have surgery?				
	Did you have radiation?				
	Did you receive chemotherapy?				
	Did you have surgery?				
	Did you have radiation?				

Past Surgeries

None: (please check box if none) ☐

	Surgery Type	**Date**	**Hospital Performed**	**Surgeon Name**
Surgery 1				
Surgery 2				
Surgery 3				
Surgery 4				

Are you under the care of a cardiologist? ☐ Yes ☐ No Doctor Name: _____

Do you have any surgical hardware (please check yes for all that apply)?

☐ Hip Valve(s) ☐ Pacemaker ☐ Defibrillator ☐ Aneurysm Clip

☐ Mechanical Stimulating Device (Neuro Stimulator, Infusion Pump, etc) ☐ Other _____

Have you ever had a colonoscopy? ☐ Yes ☐ No If yes, when? _____ Where? _____

Have you ever had polyps? ☐ Yes ☐ No If yes, when? _____

Please list any other physicians you currently see:

Physician Name	Specialty

Allergies and Reactions:

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to contrast IV? ☐ Yes ☐ No

Have you had any vaccinations? ☐ Yes ☐ No

If yes which?_____

Please list any allergies and reactions:

Allergy	Type of Reaction

Social History:

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Lives with:_____

Do you have your own transportation? ☐ Yes ☐ No

Highest Education Level:_____

Do you smoke? ☐ Yes ☐ No

If yes, estimate how many packs a day:_____ If yes, how many years?_____

Are you a former smoker? ☐ Yes ☐ No

If yes, how many years did you smoke?_____ If yes, when did you quit smoking? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you have a history of recreational drug use? ☐ Yes ☐ No If yes, what type? _____

Gender Information:

For Clinical Use Only (please answer if applicable).

What sex were you assigned at birth or what is your legal sex?

☐ Female ☐ Male

What is your current gender identity?

☐ Female ☐ Male ☐ Trans female to male ☐ Trans male to female ☐ Questioning/Unsure

☐ Decline to state ☐ Other _____

What is your sexual orientation (or do you think of yourself as)?

☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual ☐ Pansexual

☐ Questioning/Unsure ☐ Something else ☐ Decline to state

Other:

If you are a female under 45 years old, how important is fertility maintenance to you?

☐ Not ☐ Somewhat ☐ Very

If you are a male under 50 years old, how important is fertility maintenance to you?

☐ Not ☐ Somewhat ☐ Very

Do you have any other health information you would like to add?

_____

_____

_____

_____

Family Medical History

Patient Name:_____

What is your ancestry: (English, German, African, etc.)_____

Are you of Eastern European Jewish Ancestry/Ashkenazi? ☐ Yes ☐ No

Do you have any relatives with cancer? ☐ Yes ☐ No

Would you be interested in speaking with someone about your history of cancer? ☐ Yes ☐ No

Family Member	Chronic Disease or Conditions	Cancer Site (ex. breast, colon)	Age Detected	Living (L) or Deceased (D)	Current Age or Age at Death
Mother					
Father					
Sisters					
Brothers					
Children					

Family Member	Maternal	Paternal	Chronic Disease or Conditions	Cancer Site	Age Detected	Living (L) or Deceased (D)	Current Age or Age at Death
Grandfathers							
Grandmothers							
Aunts							
Uncles							
First Cousins							

Have anyone in your family undergone genetic testing for hereditary syndrome cancer? ☐ Yes ☐ No

If yes, please list family members: _____

Breast and Reproductive History

(For Female Patients Only)

Do you have: check all that apply):

☐ Yes ☐ No	Abnormal Mammogram	If yes,	☐Left Breast	☐Right Breast
☐ Yes ☐ No	Lumps	If yes,	☐Left Breast	☐Right Breast
☐ Yes ☐ No	Breast Pain/Tenderness	If yes,	☐Left Breast	☐Right Breast
☐ Yes ☐ No	Nipple Discharge	If yes,	☐Left Breast	☐Right Breast
☐ Yes ☐ No	Skin Changes	If yes,	☐Left Breast	☐Right Breast

Other:_____

Breast History:

Have you ever had a mammogram? ☐ Yes ☐ No
If Yes, When was your last mammogram?_____ Where?_____

Have you ever had a breast ultrasound? ☐ Yes ☐ No
If Yes, When was your last ultrasound? _____ Where?_____

Have you ever had breast implants? ☐ Yes ☐ No
Do you perform monthly breast self-examinations?_____☐ Yes☐ No

Have you ever had a breast biopsy (removal of a piece of breast tissue)? ☐ Yes ☐ No
If yes, when?_____ If yes, were your results abnormal?_____☐ Yes ☐ No

Gynecologic History:

At what age did you have your first period?_____
Are you pregnant now, or is there a possibility that you could be? ☐Yes ☐No
How many times have you been pregnant? _____ How many children have you given birth to?_____
How old were you when you gave birth to your first child? ___ Are you post-menopausal? ☐Yes ☐No
What is the date of your last pap smear?_____
If you are post-menopausal, how old were you when you stopped having periods?_____
Have you had your uterus removed? ☐Yes ☐No
Have you had your ovaries removed? ☐Yes ☐No
Have you ever taken oral contraceptives for birth control? ☐Yes ☐No If yes, for how long?_____
Are you currently still taking oral contraceptives? ☐Yes ☐No
Have you ever taken hormone replacement therapy (estrogen or progesterone)? ☐Yes ☐No
Are you still taking them? ☐Yes ☐No If not, how long have you been off?_____
Do you currently have hot flashes or night sweats? ☐Yes ☐No
Are they ☐Mild ☐Moderate ☐Severe

Your Medicine Guide

Your doctor needs to know all of the medicine you take. This covers medicines you buy from a pharmacy or buy off the shelf at a store.

Your doctor will probably order medicine for you. But, some drugs do not work well with others. When some drugs are mixed, they may have side effects that make you sick.

To keep you safe, it is important that you make a list of all your medicine and keep it up-to-date.

BEFORE YOUR DOCTOR VISIT:

1. **Make a list of <u>all</u> your medicines.** Please use the form on the next page. If it is easier, you may bring your medicines with you. We are happy to write the list for you.

2. **Bring this list to all of your appointments**.

We will update your Medicine list at every doctor visit. We will give you a new copy

Most pharmacies now have apps that will list your drugs for you if you have a Smart Phone.

Talk to the pharmacist to help you keep track of your medicines.

If you have questions, please call Regional One Health Cancer Center at 901- 300-1562 to speak with a nurse.

Patient Name:_____

Date of Birth:_____

Name of Medicine	Dose (strength/ milligrams)	Frequency (How often do you take this medicine)	Why do you take this medicine?	Start Date (When did you start taking this medicine?)	Do you have any problems with this medicine? Yes or No	Prescribing Doctor

Patient Name:_____

Date of Birth:_____

Name of Medicine	Dose (strength/milligrams)	Frequency (How often do you take this medicine)	Why do you take this medicine?	Start Date (When did you start taking this medicine?)	Do you have any problems with this medicine? Yes or No	Prescribing Doctor

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that Regional One Health has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically.

If your first date of service with Regional One Health was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

☐ Regional One Health's privacy practices have been explained to me.

☐ I was given a copy of the Notices of Privacy Practices.

☐ Regional One Health has given me the chance to discuss my concerns and questions about the privacy of my health information and to request certain restrictions.

_____ _____

Patient's Signature Date of Acknowledgement

_____ _____

Alternate Signature (Next of Kin or other person responsible for patient) Relationship

Registration staff to complete if Acknowledgement Form is **not** signed:

1. Does patient have a copy of the Privacy Notice?
   - ☐ Yes
   - ☐ No
   - ☐ Yes, Acknowledgement Form on file from previous visit.

2. Please explain why the patient was unable to sign an Acknowledgement Form and Regional One Health's efforts in trying to obtain the patient's signature:
   - ☐ Patient physically unable to sign/no alternate responsible person available
   - ☐ Patient refused to sign. Give reason below:

_____

_____

Affix Patient Label

General Conditions of Admission

General Consent to Treatment and Test: I hereby give my authorization and consent to the medical staff, Regional One Health, and its employees and others involved in my care to provide such treatment, testing or care in ways they judge beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent. I consent to examinations, x-rays, blood tests, (including blood tests for communicable diseases such as hepatitis and AIDS to include testing where health care personnel have been exposed to my blood and body fluids), laboratory procedures, medications, infusions, anesthesia, radiation therapy and other services or treatments rendered or ordered by my physician, consulting physicians and their associates and assistants, or rendered by Regional One Health's employees under the instructions, orders or direction of such physician(s). I understand that State Law requires reporting of certain positive test results, such as hepatitis and the antibody for the AIDS virus, to the Health Department.

Who Are My Doctors and Other Health Care Providers: I understand that the doctors and some other health care providers who provide care and services to me (including resident physicians, medical students, pathologists, anesthesiologists, radiologists, emergency room physicians, certain nurses, etc.) are NOT employees or agents of Regional One Health. They practice their professions on behalf of themselves and/or groups of corporations unrelated to Regional One Health, including but not limited to UT Medical Group, Inc., the University of Tennessee, Semmes-Murphy Clinic, P.C., and Campbell Clinic, P.C. They are not employees or agents of Regional One Health. I also understand that Regional One Health permits the University of Tennessee and other schools/universities to train medical students, resident physicians, and other health care professionals at Regional One Health. I consent to the observation and participation of all such personnel in my care. I understand and acknowledge that while these personnel practice on Regional One Health's premises, use Regional One Health's equipment, and are subject to Regional One Health's administrative rules and protocols, they are NOT employees or agents of Regional One Health. Regional One Health is not responsible for their acts or omissions, and I will not attempt to hold Regional One Health responsible for their acts or omissions. If I want to know the employment status/affiliation of any health care provider, I will ask questions to satisfy myself of their status sufficient to make informed decisions regarding or based on the employment status/affiliations of the various health providers.

Facility Based Physician: I understand that I may receive treatment from a non-participating facility based physician and may receive a separate bill from the physician for the amount unpaid by my insurer. A non-participating facility based physician is someone that has privileges at Regional One Health, but does not have a current contract with your insurer.

Medication Reconciliation: I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component to my care. I authorize my provider to query and review my medication fill history, including drug, dose, form, strength, prescribing provider, and pharmacy using medication management software.

Medical Information Received: The patient, if in a condition to receive it and if not, the undersigned representative of the patient, acknowledges that he/she has been informed concerning the need for hospital or clinic services, the purpose of the patient entering the hospital/clinic, and the planned examinations, procedures, and treatment. It is understood that the practice of medicine is not an exact science and no guarantee can be given by anyone as to the results that will be attained.

Release of Information: I agree that if my case is handled by or under any carrier, agency responsible for follow-up health care, workers' compensation act, hospitalization or medical or accident insurance policy, self-insured organization, mutual hospital association, Medicare, or Medicaid, that the agency or insurance consent to the release of medical information during or after my hospital stay to physicians or representatives of agencies which may be involved in my follow-up care after discharge or to hospitals or facilities to which I may be transferred. Regional One Health may disclose at any time all or any part of my medical record to any person or organization which is or may be liable for or responsible for payment of all or part of the hospital or clinic charges, including but not limited to, insurance companies, medical or hospital service companies, workers compensation carriers, employers and welfare funds. I further agree that a copy of this Release shall be as binding and effective as an original.

This is a two-page document, please complete backside of form

General Conditions of Admission

Assignment: I hereby authorize direct payment to Regional One Health of all health insurance benefits/hospitalization benefits and further assign and transfer all other insurance benefits that I am entitled to from any source or are otherwise due or payable to me or my estate. I assign and transfer all benefits for claims for payment that I am entitled to or are otherwise due or payable to me or my estate from any additional source for hospitalization and/or other clinical expenses. I understand that I am financially responsible to Regional One Health for all charges and grant a lien to said Regional One Health on any recovery, chose in action and/or cause of action, proceeds of my cause of action, judgment, payment, or settlement which may be obtained by me or on behalf of my estate. Payments made on my behalf will not discharge the debt of the person causing my hospitalization and care. Until the debt of the party causing my injuries has been discharged, Regional One Health may maintain its authorized lien.

Financial Agreement: The undersigned SEVERALLY agree, that in consideration of the services rendered to patient, payment of the account is guaranteed by the undersigned in accordance with the regular rates and terms of Regional One Health, which are set in the charge master located in the office of finance at the hospital. Although payments related to the hospital account may be hereby assigned to and payable directly to the hospital, the undersigned remains responsible for the balance of the account not so paid. Regional One Health may still maintain its lien for any obligation of those causing my injuries for the full amount of Regional One Health's charges regardless of payments made on my behalf. I understand that Regional One Health will return any payments made on my behalf if Regional One Health recovers funds in excess of those payments from those causing my injuries.

Responsibility For Valuables: I agree that Regional One Health will not be liable or held responsible for the loss or damage of personal items, including cash, dentures, eyeglasses, contacts, and other items of personal property retained by me, my relatives and/or visitors. Items of value may be held by Security. I also agree that Regional One Health will not be liable for items that are not properly secured with security.

Advance Directives: I hereby confirm that I have been asked about the existence of advance directives for me or my relative such as a living will or durable power of attorney for healthcare. If a living will or durable power of attorney for healthcare exists, I will deliver a copy or, if necessary, the original to Regional One Health.

Responsible Party: I hereby affirm the correctness of the foregoing statements given by me as a patient or the party responsible for the above-named patient and assume full responsibility for payment of all charges in connection with the services rendered to me or the above named patient. I understand that a final bill will be rendered to me for which payment will be made. In case of default of payment and if these accounts should be placed in the hands of a collection agency or an attorney for collection, all collection fees, attorney's fees (which shall equal one third of any balance due), costs and other expenses will be paid by the undersigned. Notice of dishonor, demand and protest is waived.

Medical Education and Teaching: I consent to recordings, films, or other images for current or future use by Regional One Health and its academic affiliates for the purpose of advancing medical education and teaching. I understand I have the right to rescind this consent.

Term/Duration of Agreement: I agree that the terms of this agreement shall apply to all subsequent and future services rendered to me by Regional One Health unless this agreement is revoked by written notice sent certified mail prior to the subsequent date of admission.

_____ _____

Signature of Responsible Party (Patient, Relative, or Designated Next of Kin) Date

_____

Relationship, if not Patient

_____ _____/_____

Electronic/Signature of Witness/Title Date Time

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.

Please read it carefully.

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

Regional One Health
Compliance and Privacy Officer
901-545-6554 or privacy@regionalonehealth.org

For operator or appointment scheduling, please call: 901-545-7100

This Notice covers the privacy practices of Regional One Health, our affiliated sites, and physicians or other professional healthcare providers, when they see or treat you in one of our facilities, including our Primary Care Network and Outpatient Center sites. If you visit a provider in his or her private office, you may be asked to read and acknowledge the provider's Notice of Privacy Practices.

Notice of Privacy Practice

Summary

A. Introduction

At Regional One Health our greatest concerns are your health and privacy. We are committed to using and disclosing your health information responsibly. This Notice of Privacy Practices describes how Regional One Health may collect, use, and disclose information, along with your patient rights regarding your protected health information.

Protected health information, or "PHI", is information about you, including demographic information, that can reasonably be used to identify you and which relates to your past, present, or future physical or mental health or condition, the provision of healthcare to your or the payment for that care. For purposes of this notice, PHI means any information, whether verbal, paper, or electronic, created or received by Regional One Health relating to your health, or the provision or payment for your healthcare.

1. Our Responsibilities:

In addition to the responsibilities set forth in this Notice, we are required by law to:

- Maintain the privacy and security of your PHI;
- Provide you with notification if we discover a breach of unsecured PHI unless there is a demonstration, based on a risk assessment, that there is a low probability that the PHI has been compromised.
- Obtain your written authorization before we use or disclose your psychotherapy notes, except for: use by the originator of the psychotherapy notes for treatment; or use or disclosure by Regional One Health to defend itself in a legal action or other proceeding brought by the individual;
- Provide you with a notice as to our legal duties and privacy practices with respect to PHI we maintain about you;
- Ensure all healthcare professionals, employees, students, and other healthcare personnel abide by the terms of the Regional One Health Notice of Privacy Practices currently in effect.

We reserve the right to change our practices and to make changes effective for all PHI we maintain, including information created or received before the change. Should our privacy practices change, we are not required to notify you, but we may post the revised notice at each facility, and you may request copies of the revised notice in person at Regional One Health or website: www.regionalonehealth.org

B. We May Use and Disclose Your PHI Without Your Authorization in the Following Circumstances:

Generally, we may not use or disclose your PHI without your written authorization. However, in certain circumstances, we are permitted to use your PHI without authorization. This Notice describes different ways that we may use and disclose your PHI without your written authorization. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose your PHI without your written authorization should fall within one of these categories.

1. Healthcare Treatment

Your PHI may be used and disclosed to provide or manage your healthcare and related services. This may include communicating with other healthcare providers, including physicians, nurses, and technicians or other medical personnel about treatment, as well as coordinating and managing your healthcare with others. We may use and disclose PHI when you need a prescription, lab work, an x-ray, or other healthcare services. In addition, we may disclose PHI about you when referring you to another healthcare provider.

2. Payment of Services

Your PHI may be used and disclosed so 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 give information to your insurance carrier about surgery you received so your health plan will pay us in accordance with your benefits. We may also tell your insurance carrier about an outpatient treatment to obtain prior approval or to determine whether your plan will cover the treatment. We may need to share your demographic information with another provider who also rendered care to you so that they can bill for their services.

3. Healthcare Operations

Your PHI may be used and disclosed in performing business activities, which we call "healthcare operations". These healthcare operations allow us to improve the quality of care we provide and reduce healthcare costs. The following are examples:

- To review and improve the quality, efficiency, and cost of care provided to you and other patients;
- To improve healthcare and lower costs for people who have similar health problems to help manage and coordinate their care. We may use PHI to identify groups of people with similar health problems to give them information about treatment alternatives, classes, or new procedures;
- To provide training programs for students, trainees, healthcare providers, or non-health professionals;
- To cooperate with outside organizations that assesses the quality of the care provided. Such organizations might include government agencies, licensing boards, or accrediting bodies;
- To assist individuals reviewing our healthcare operations. For example, your PHI may be viewed by doctors reviewing the services provided to you, as well as accountants, lawyers, and others who assist us in complying with applicable laws;
- To plan for the organization's future operations and fundraising to benefit our organization;
- To conduct business management and general administrative activities related to services we provide;
- To review activities and the use or disclosure of PHI in the event the organization is sold or control of our business and/or property is given to someone else.

4. Other Circumstances Without Your Authorization

In some cases, we may disclose your PHI for circumstances in which you do not have to consent, give authorization, or otherwise have an opportunity to agree or object. The following are ways we may be required to disclose your PHI without authorization. If you request a list of your PHI disclosures, most of these disclosures will be reported to you.

- Disclosures required by federal, state, or local law or other judicial or administrative proceedings;
- Disclosures necessary for public health activities;
- Disclosures related to victims of abuse, neglect, or domestic violence;
- Disclosures for health oversight activities;
- Disclosures for law enforcement purposes;
- Disclosures for non-regulatory tracking and statistical analysis of the incidence of certain diseases or conditions;

4. Other Circumstances Without Your Authorization (Continued)

- Disclosures related to decedents. We may disclose PHI to a coroner, medical examiner, or funeral director, for example, to identify the deceased or to determine cause of death;
- Disclosures to organizations involved in organ, eye, or tissue transplant or donation banks;
- Under certain circumstances, disclosure of limited PHI about your for medical research purposes;
- Disclosures to prevent a serious threat to health or safety;
- Disclosures related to specialized government functions. For example, we may disclose your PHI if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State;
- Disclosures related to correctional institutions and in other law enforcement custodial situations;
- Disclosures related to Workers Compensation claims.

5. Patient Contacts

Your PHI may be used to contact you to provide a reminder about an appointment you have for treatment or medical care.

6. Treatment, Services, Products, or Healthcare Provider Information

Your PHI may be used and/or disclosed to manage or coordinate your healthcare. This may include telling you about treatments, services, products, and/or other healthcare providers.

7. Fundraising Activities

Your demographic information may be shared with the Regional One Health Foundation to contact you to raise money for the hospital and its operations. We would only release contact information and the dates you received treatment or services at the hospital. If you do not want to be contacted in this way, you may submit a request in writing to the Privacy Officer.

8. Patient Objections

Unless you object, we may use or disclose your PHI in the following circumstances:

- If you are an inpatient, we may share your name, room and telephone numbers, and condition in our patient listing with people who ask for you by name. We may also share your religious affiliation with clergy;
- We may share with a family member, relative, or other person identified by you, PHI that is directly related to that person's involvement in your care or payment for your care. We may share with a family member or other person responsible for your care PHI necessary to notify them of your location, general condition, or death;

If you object to our use or disclosure of PHI in any of the circumstances listed above, please notify your caregiver, a Patient Advocate, or our Privacy Officer.

Any Other Use or Disclosure of Your PHI Requires Your Written Authorization

Other uses and disclosures of medical information not covered by this notice or by the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke you permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the care that we provided to you.

C. You Have Several Rights Regarding Your PHI:

1. To Request Restrictions on the Use and Disclosure of Your PHI

You have the right to request that we restrict specific uses and disclosures of your PHI. We are not required to agree to your requested restrictions; however, if we agree to your request, in certain situations, your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in Section B, Paragraph 4 of this Notice.

If you pay for services you received at Regional One Health out of pocket and in full, you can request that we not disclose information about that service to your insurance company.

You may request a restriction during your visit by contacting our Patient Advocate, who is available to all patients. Others may contact our Privacy Officer.

2. To See and Request a Copy of Your PHI

You have the right to see and request to receive a copy of your health information contained in clinical, billing, and other records used to make decisions about you. Your request must be in writing and we may charge you related fees. We can substitute a summary or explanation of your health record, if you agree in advance to the form and costs of the summary explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. To request to see and receive a copy of your health information, contact the Health Information Management Department at 901-545-7581.

3. To Request Changes or Corrections of Your PHI

You have the right to request we make changes or corrections to clinical, billing, or other records used to make decisions about you. Your request must be in writing and must explain your reason(s) for the change or correction. We may deny your request if:

- The information was not created by us (unless you prove the creator of the information is no longer available to amend the record);
- The information is not part of the records used to make decisions about you;
- We believe the information we have is correct and complete.

If we deny the request, we will tell you in writing the reason(s) for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we

will attach the corrected information, identified as an amendment, to the record, along with the original information. We will make reasonable efforts to inform others of the amendment, including people you name who have received your PHI and need the amendment. To request an amendment, contact the Health Information Management Department at 901-545-7581.

4. To Request a Listing of PHI Disclosures that Have Been Made

If you make a request in writing, you may receive a written list of certain disclosures of your PHI. You may ask for disclosures made up to 6 years before your request (not including disclosures made prior to April 14, 2003). We are required to provide a listing of all disclosures except the following:

- For your treatment;
- For billing and collection of payment for your treatment;
- For our healthcare operations;
- Made to or requested by you or that you authorized;
- Occurring as a by-product of permitted uses and disclosures;
- Made to individuals involved in your care, for directory or notification purposes, or for other purposes described;
- Allowed as part of a limited set of information, which does not contain information that would directly identify you.

The list will include the date of the disclosure, the name (and address, if applicable) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If, under permitted circumstances, your PHI has been disclosed for certain types of research projects, the list may include different or additional information. If you request a list of disclosures more than once every 12 months, you may be charged a fee.

To request a listing of disclosures, submit a request in writing to the Health Information Management Department.

5. To Request to Be Notified of a Breach of Your PHI

A breach is the unauthorized use or disclosure of your PHI. If a breach occurs and it poses a significant risk of financial reputation, or other harm, Regional One Health is required to notify you.

6. To Request Confidential Communication by an Alternative Method

You have the right to request how and where we contact you about PHI. For example, you may request that we contact you at your work phone number or by email. To request a different communication method, please contact the Health Information Management Department at 901-545-7581. Regional One Health will accommodate all reasonable requests for confidential communication.

7. To Request a Copy of This Notice

You have the right to request a paper copy of this Notice at any time during your visit by asking any caregiver. At any other time, you may send a written request to the Privacy Officer or you can read and download a copy from our website: www.regionalonehealth.org.

D. You May File a Complaint About Our Privacy Practices:

If you think your privacy rights have been violated or you want to file a complaint about our privacy practices, please call any of the following numbers:

- Patient Advocate (available 24/7 to inpatients): 901-545-7123;
- Regional One Health Primary Care Network: 901-545-4526;
- Regional One Health Privacy Officer: 901-545-6554.

You may also send a written complaint to the Secretary of the United States Department of Health and Human Services or file a complaint online at: http://www.hhs.gov/ocr/hipaa.

If you file a complaint, we will not take action against you or change your treatment in any way.

E. Effective Date of This Notice:

Effective Date: January 1, 2007
Revised: September 12, 2016

F. Important Contact Information:

For questions regarding any use or disclosure of PHI, contact:

Regional One Health
Attn: Privacy Officer
877 Jefferson Avenue
Memphis, TN 38103
901-545-6554

To request a release of PHI or request restrictions, amendments, or receive a listing of disclosures, contact:

Regional One Health
Attn: Health Information Management Department
877 Jefferson Avenue
Memphis, TN 38103
901-545-7581

For questions regarding Regional One Health Primary Care Network, contact:

Regional One Health Primary Care Network
Attn: Medical Records Manager
877 Jefferson Avenue
Memphis, TN 38103
901-545-4526

Patient's Rights

Within our capacity and scope of our mission and services, Regional One Health respects and supports the patient's rights to impartial access to treatment and services that are consistent with relevant laws and regulations and medically indicated regardless of race, creed, sex or sexual orientation, national origin, age, disability, diagnosis or sources of payment.

As part of our teaching mission, resident and students may participate in your care along with your attending physician, registered nurses and other caregivers. Please speak with your nurse or doctor if you have any concerns.

We respect each patient's rights, dignity, values, and spiritual, cultural, and personal needs. Because you are a partner in your healthcare, we want you to know your rights as well as your responsibilities during your hospital stay. We encourage you to join us an active member of your care team.

You, the patient, have the right to:

- Respectful care in a safe environment.
- An environment that is free from all forms of abuse, neglect, or mistreatment. If you have any concerns, please call (844) 260-0009.
- Receive appropriate pain management.
- Obtain full information in layman's terms concerning your diagnosis, treatment, and progress.
- Communication you can understand. Interpreter services and TDD phones are provided at no cost to you.
- Be informed of unexpected or unanticipated events.
- Know the identity of and professional status of individuals, doctors and other health care providers, involved in your care, and to know which physician or other practitioner is primarily responsible for your care.
- To be treated with consideration, respect, and recognition of your individuality, including the need for privacy in treatment. This includes the right to request the facility provide a person of one's own gender to be present during certain parts of physical examinations, treatments or procedures performed by a health professional of the opposite sex, except in emergencies, and the right not to remain undressed any longer than is required for accomplishing the medical purpose for which the patient was asked to undress.
- Wear appropriate personal clothing or religious, cultural or other symbolic items that do not interfere with recommended treatment or procedures. You will receive respectful consideration of your beliefs in regard to these items.
- Be accompanied by a service animal per guidelines set forth in the organization's Service Animal policy and the Americans with Disabilities Act (ADA).
- Help plan your care and do your part of the plan.
- Have a surrogate decision maker take part in medical decisions.
- Choose visitors, even if they are not legal family members. You can withdraw consent or deny visitors at any time.
- Have access to a support person of your choosing at any time.
- To make decisions concerning your care, including advance medical directive such as a living will, durable power of attorney for health care, advance care plan or refusal of care. Should you be unable to make these decisions, you may appoint a surrogate to act on your behalf.

Continued on the next page

You, the patient, have the right to (continued):

- To express personal, spiritual and cultural beliefs and have your religious or other spiritual needs accommodated provided they do not interfere with others or the facility operations.
- Be free from restraints or seclusion that is not medically required.
- Respect for your privacy. You may give or refuse consent for recordings, photographs, films or other images used for internal or external purposes. Consents for recordings, photographs, films or other images may be withdrawn at any time.
- Have your medical records and discussions regarding your care kept private unless you tell us to share information regarding your condition and treatment.
- Receive detailed information about facility and physician charges.
- Look at your written medical record with a doctor.
- Access to your protected health information. We offer our patients access to their PHI through a patient portal, which allows you to securely view some of your clinical information online.
- Agree or refuse to participate in research studies. You may withdraw from a study at any time.
- Voice your concerns about your care to a doctor, nurse manager, patient relations, or any staff or contact:
    - Patient Relations representative by calling (901) 545-7123;
    - The Joint Commission by calling (800) 994-6610; via email at: complaint@jointcommission.org or by mail to: One Renaissance Boulevard, Oakbrook Terrace, IL 60181;
    - State of Tennessee Department of Health Complaint Line at (800) 852-2187; or
    - Medicare beneficiaries can contact 1-800-MEDICARE with a concern about the quality of care received.

You, the patient, have the responsibility to:

- To provide, to the best of your knowledge, accurate and complete past health information.
- Ask questions if you do not understand something that about your condition or treatment plan.
- Tell us when you see changes in your health condition.
- Provide a copy of your advance medical directive.
- To speak and act in a respectful manner. Using discriminatory or culturally insensitive language or behaviors is not acceptable. Yelling, verbal threats or physical harm to other patients, staff, visitors or property is not acceptable. Requests for changes of a provider or other staff based on the provider or staff's race, ethnicity, religion, sexual orientation or gender identity will not be honored.
- To maintain the confidentiality of staff, visitors and other patients by not taking cell phone pictures or audio/video recordings of staff, visitors and other patients.
- Tell us if you feel unsafe or you are not happy with your care.
- Respect the rights and privacy of other patients, families, and staff.
- Let us know if you have any personal, cultural, spiritual or other needs.
- Follow the hospital rules.
- Pay your bill on time.

Tobacco-free Environment: In order to give you the healthiest possible environment during your stay, we have joined a city-wide initiative for tobacco-free hospitals. Individuals may not use any tobacco products anywhere on our campuses. That includes hospitals, clinics, parking lots/decks, sidewalks, and in cars on hospital property.

Patient Privacy Notice Acknowledgement:

I acknowledge that **West Cancer Center's Notice of Privacy Practices** has been made available to me.

This packet is available on the West Cancer Center website, westcancercenter.org,

and available for print at all front desk locations by request.

Patient or Patient Representative Signature:_____

Date: _____

Patient Financial Responsibilities

Financial Policy

Thank you for choosing West Cancer Center as your health care provider. We are committed to your visit being successful on all levels. Because healthcare reimbursement is a complex and sometimes complicated system, we would like to work with you to ensure insurance benefits and financial assistance are maximized.

If you have health insurance:

West Cancer Center accepts assignment of insurance benefits for Medicare, Medicaid, TennCare, MS CAN, Worker's Compensation, and many Commercial health insurance plans. Your insurance policy is a contract between you and your insurance company. Please inform us of all health insurance carriers and if you have more than one, indicate which one is primary and secondary. If your insurance coverage changes, please inform our office as soon as possible so we can file your claims properly.

West Cancer Center will file a claim with your health insurance company for services you receive. The patient balance as determined by your policy is your responsibility and will be requested at the time of service. If your insurance company has not paid within 120 days of the date of service, the balance will be transferred to you.

If you do not have insurance:

If you do not have insurance coverage, payment for services will be requested at the time services are rendered. Our policy is to reduce the usual and customary rates charged to uninsured patients to approximate the payment rates allowed by private insurance companies in the market. Please contact our Patient Representatives at (901) 683-0055 X68151 prior to your visit to discuss payment options.

I acknowledge receipt of The West Clinic Financial Policy and authorize The West Clinic, PLLC d/b/a West Cancer Center to release to my health insurance company or organizations that provide financial assistance, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original.

I also request that payment of authorized benefits be made on my behalf of The West Clinic, PLLC d/b/a West Cancer Center.

Patient or Patient Representative Signature:_____ Date:_____