

Maryland Oncology Hematology, P.A.
10710 Charter Drive
Suite G020
Columbia, MD 21044
phone (410) 964-2212
fax (410) 964-0380
web www.mdonc.com



**MARYLAND
ONCOLOGY
HEMATOLOGY P.A.**

Jon K. Minford, M.D.
Nicholas W. Koutrelakos, M.D.
Clement B. Knight, M.D.
Edward J. Lee, M.D.
Tejaswi R. Sastry, M.D.
Adam Schmuckler, P.A.-C.

Dear Patient:

Thank you for choosing Maryland Oncology Hematology, P.A. As a new patient to our practice, we encourage you to read through the literature provided in this packet to familiarize yourself with your physician and the practice.

At your first appointment, you will be asked to return a completed copy of the included forms,

- 1. Assignment of Benefits**
- 2. Medical History**
- 3. HIPAA Practices and Release**
- 4. Routine Disclosure Release**

Please also bring with you,

- 1. All medical insurance cards**
- 2. Insurance Referral from your Primary Care Physician**
- 3. A copy of your medical records (The records we are looking for include: most recent labs, physician notes, radiology, and pathology reports pertinent to your diagnosis.)**

Again, thank you for choosing Maryland Oncology Hematology for your care and we look forward to meeting and serving you. Should you have any questions regarding this appointment or about us, please feel free to contact us at (410) 964-2212.

Sincerely,

Maryland Oncology Hematology

Maryland Oncology Hematology, P.A.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____

Patient Name: _____ () _____
Last First M.I. Home Telephone

Home Address: _____ Mailing Address: _____
Street Street

City State Zip City State Zip

DOB: _____ Age _____ M F SS# _____ Married Single Divorced Widowed Other
Sex Check Marital Status

Employer: _____ () _____
Name Telephone

Address Occupation

Responsible Party: _____ () _____
Name Relationship Telephone

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

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone:() _____

Insured Name: _____ DOB _____ Group # _____ Policy # _____

Secondary Ins: _____ Telephone:() _____

Insured Name: _____ DOB _____ Group #: _____ Policy # _____

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 **Maryland Oncology Hematology, P.A. (MOHPA)**.
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 **(MOHPA)**. 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 **(MOHPA)**.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from **(MOHPA)**.

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*)

PHYSICIAN: _____	EMPLOYEE INITIALS _____
ACCT NBR: _____ LOC: _____	
FOR OFFICE USE ONLY	

Maryland Oncology Hematology, P.A.

Patient Survey:

Name:	DOB:	Age:
Address:	City:	State:
Home:	Referring Physician:	
Oncologic History:	HEIGHT:	WEIGHT:
Past Medical and Surgical History:		
Medications:		
Allergies:		
Family History:		
Social History:		
Married:	Number of Children:	

Do you smoke?	How much?	How many years?
Do you drink?	How much?	How many years?
Do you work?	Where?	At what?

Review of Systems:

Headache	Cough	Difficulty urinating
Dizziness	Shortness of Breath	Blood in urine
Visual Disturbances	Chest Pain	Pain
Speech Disturbances	Nausea	Anxiety
Stiff Neck	Diarrhea	Depression
Fever	Constipation	
Chills	Blood in Stool	
Night Sweats		
Weigh Loss		

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 Maryland Oncology Hematology, P.A., its physicians, employees, staff and other personnel. All of the sites and locations of Maryland Oncology Hematology, P.A. 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.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or e-mail you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

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 “Privacy Official” in writing at Maryland Oncology Hematology, P.A., 10710 Charter Dr., Suite G020, Columbia, Maryland 21044.** 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 "Privacy Official" Maryland Oncology Hematology, P.A., 10710 Charter Dr., Suite G020, Columbia, Maryland 21044.

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 "Privacy Official" Maryland Oncology Hematology, P.A., 10710 Charter Dr., Suite G020, Columbia, Maryland 21044. 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 "Privacy Official" Maryland Oncology Hematology, P.A., 10710 Charter Dr., Suite G020, Columbia, Maryland 21044. 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 "Privacy Official" Maryland Oncology Hematology, P.A., 10710 Charter Dr., Suite G020, Columbia, Maryland 21044.

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 "Privacy Official" Maryland Oncology Hematology, P.A., 10710 Charter Dr., Suite G020, Columbia, Maryland 21044. 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 "Privacy Official" Maryland Oncology Hematology, P.A., 10710 Charter Dr., Suite G020, Columbia, Maryland 21044. You may also obtain a paper copy of this Notice at our web site, www.mdonc.com

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: "Privacy Official" Maryland Oncology Hematology, P.A., 10710 Charter Dr., Suite G020, Columbia, Maryland 21044. 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 waiting room at 10710 Charter Dr., Suite G020, Columbia, Maryland 21044. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our web site, www.mdonc.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Maryland Oncology Hematology, P.A. 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 Maryland Oncology Hematology, P.A.

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

(Practice Name) Use Only _____

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

MARYLAND ONCOLOGY HEMATOLOGY, P.A.
10710 CHARTER DR., SUITE G020
COLUMBIA, MD 21044
410-964-2212
410-964-0380 FAX

ROUTINE DISCLOSURE OF HEALTH INFORMATION

I, _____, hereby authorize Maryland Oncology Hematology, P.A. to release routine results of lab tests, scans or other diagnostic tests to me or to my designated personal representative as requested.

I authorize Maryland Oncology Hematology, P.A. to release medical information and/or reports regarding my treatment to any federal, state or accreditation agency or any physician or insurance carrier as needed.

I authorize agents of any hospital, treatment center or previous physicians to furnish Maryland Oncology Hematology, P.A. copies of any records of my medical history, services or treatments.

I understand that this release will expire one year from the date of my signature and can be revoked at any time prior to that date at my written request.

Name of Patient

Social Security Number

Signature of Patient

Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

Name of Personal Representative

Relationship to Patient

