

ST. LOUIS CANCER CARE, L.L.P

PATIENT _____ DATE _____

ADDRESS _____ MAIDEN NAME _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ CELL _____ BIRTHDATE _____

SOCIAL SECURITY # _____ EMAIL ADDR _____

PLACE OF BIRTH: CITY _____ STATE _____ COUNTRY _____

RACE: CAUCASIAN/WHITE _____ AFRICAN AMERICAN/BLACK _____ ASIAN _____

AMERICAN INDIAN _____ NATIVE HAWAIIAN _____ OTHER _____

ETHNICITY: HISPANIC LATINO _____ NOT HISPANIC LATINO _____

PREFERRED LANGUAGE: ENGLISH _____ SPANISH _____ OTHER _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

OCCUPATION _____ EMPLOYER _____

MARITAL STATUS: S__ M__ W__ D__ IF MARRIED SPOUSE'S NAME _____

SPOUSE'S DOB _____ SPOUSE'S SOCIAL SECURITY # _____

SPOUSE'S EMPLOYER _____ PHONE # _____

NUMBER OF CHILDREN _____ AGES _____

IF UNMARRIED, NEAREST RELATIVE _____

RELATIONSHIP _____ PHONE# _____

DO YOU HAVE A DURABLE MEDICAL POWER OF ATTORNEY? __ Y __ N. IF YES CAN YOU PROVIDE US WITH A COPY

BILLING INFORMATION: PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS YOU ARE INSURED BY AN INSURANCE COMPANY THAT WE ARE CONTRACTED WITH PLEASE PRESENT YOUR CARD TO BE COPIED FOR VERIFICATION. THEY CONTAIN POLICY, GROUP AND TELEPHONE NUMBERS WHICH ARE VERY IMPORTANT FOR PRECERTIFICAION AND ADMISSION REQUIREMENTS. ALL COPAYS ARE DUE BEFORE SEEING THE PHYSICIAN.

PRIMARY INSURANCE _____

SECONDAY INSURANCE _____

I AUTHORIZE THE INSURANCE COMPANIES NAMED ABOVE TO MAKE PAYMENTS DIRECTLY TO ST.LOUIS CANCER CARE, L.L.P., FOR THE MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR THEIR SERVICES.

I AUTHORIZE ST.LOUIS CANCER CARE, L.L.P. TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO THE ABOVE NAMED INSURANCE CO. OR PHYSICIANS PARTCIPATING IN MY CARE.

DATE

PATIENT'S SIGNATURE

I AGREE TO UPDATE ST.LOUIS CANCER CARE,L.L.P. OF ANY CHANGES IN INSURANCE IMMEDIATELY UPON THE CHANGE. MY FAILURE TO PROVIDE CORRECT INSURANCE INFORMATION WILL RESULT IN ME BEING PERSONALLY RESPONSIBLE FOR THE BILL.

DATE

PATIENT'S SIGNATURE

ST. LOUIS CANCER CARE, LLP

MEDICATIONS: LIST CURRENT PRESCRIPTION MEDICATIONS AND DOSES IF KNOWN.

PREFERRED PHARMACY: _____ LOCATION: _____
PHARMACY ZIP CODE: _____

LIST ANY OVER THE COUNTER MEDICATIONS: (ASPIRIN, VITAMINS, LAXATIVES)

LIST ANY ALLERGIES TO MEDICATIONS AND ADVERSE REACTIONS:

PAST MEDICAL HISTORY: LIST ALL MEDICAL CONDITIONS (HYPERTENSION, DIABETES, ARTHRITIS, STROKE, HEART ATTACK, ETC.) AND DATES OF ONSET.

SURGERIES: LIST ALL SURGERIES AND DATES OF SURGERY.

TOBACCO USE:

NEVER SMOKER CURRENT EVERYDAY SMOKER
 CURRENT SOME DAY SMOKER FORMER SMOKER

IF A **FORMER** OR **CURRENT** SMOKER:

YEAR DISCONTINUED: _____ NUMBER OF YEARS: _____

PACKS PER DAY: _____

ALCOHOL USE:

NONE OCCASIONAL/SOCIAL EXCESSIVE

TYPE (BEER, WINE, SPIRITS): _____ DRINKS PER DAY: _____

RECREATIONAL DRUG USE:

NONE OCCASIONAL EXCESSIVE

PATIENT SIGNATURE: _____ DATE: _____

ST. LOUIS CANCER CARE, LLP

FAMILY HISTORY

MOTHER:

LIVING AGE: _____

DECEASED AGE AT DEATH: _____ CAUSE: _____

HEALTH ISSUES INCLUDE:

CANCER/TYPE: _____ DIABETES

THYROID DISEASE HYPERTENSION/HEART ATTACK/HEART DISEASE

RESPIRATORY DISEASE (EMPHYSEMA, COPD, ASTHMA, ETC.) STROKE

LIVER DISEASE KIDNEY DISEASE ARTHRITIS

OTHER (PLEASE LIST): _____

FATHER:

LIVING AGE: _____

DECEASED AGE AT DEATH: _____ CAUSE: _____

HEALTH ISSUES INCLUDE:

CANCER/TYPE: _____ DIABETES

THYROID DISEASE HYPERTENSION/HEART ATTACK/HEART DISEASE

RESPIRATORY DISEASE (EMPHYSEMA, COPD, ASTHMA, ETC.) STROKE

LIVER DISEASE KIDNEY DISEASE ARTHRITIS

OTHER (PLEASE LIST): _____

GRANDPARENTS:

HEALTH ISSUES INCLUDE:

CANCER/TYPE: _____ DIABETES

THYROID DISEASE HYPERTENSION/HEART ATTACK/HEART DISEASE

RESPIRATORY DISEASE (EMPHYSEMA, COPD, ASTHMA, ETC.) STROKE

LIVER DISEASE KIDNEY DISEASE ARTHRITIS

OTHER (PLEASE LIST): _____

SIBLINGS:

HEALTH ISSUES INCLUDE (PLEASE LIST): _____

CHILDREN:

HEALTH ISSUES INCLUDE (PLEASE LIST): _____

ST. LOUIS CANCER CARE, LLP

MENSTRUAL HISTORY

AGE AT FIRST MENSTRUATION: _____ AGE AT MENOPAUSE: _____

REGULAR MENSES IRREGULAR MENSES

LIGHT FLOW NORMAL FLOW HEAVY FLOW

LAST MENSTRUAL PERIOD: _____

MATERNITY

NUMBER OF PREGNANCIES: _____ NUMBER OF BIRTHS: _____

AGE AT FIRST FULL TERM: _____

BREASTFED: YES NO

HYSTERECTOMY:

NO YES, YEAR: _____

WITH SINGLE OOPHORECTOMY WITH BILATERAL OOPHORECTOMY

HORMONE EXPOSURE:

NONE

ORAL CONTRACEPTIVE PILLS/YEARS TAKEN: _____ TYPE: _____

YEAR STOPPED: _____

HORMONE REPLACEMENT THERAPY/YEARS TAKEN: _____

TYPE: _____ YEAR STOPPED: _____

MAMMOGRAM:

NEVER DATE OF LAST: _____

MONTHLY SELF BREAST EXAMS:

YES SPORADIC NO

PAP SMEAR:

NEVER DATE OF LAST: _____

COLONOSCOPY:

NEVER DATE OF LAST: _____

BONE DENSITY SCAN:

NEVER DATE OF LAST: _____

PSA (PROSTATE-SPECIFIC ANTIGEN) SCREENING:

NEVER DATE OF LAST: _____

ST. LOUIS CANCER CARE, LLP

HEREDITARY CANCER SYNDROMES

BREAST CANCER:

NO FAMILY HISTORY

SELF/AGE: ___ OTHER FAMILY MEMBERS (PLEASE LIST): _____

BILATERAL BREAST CANCER:

NO FAMILY HISTORY

SELF/AGE: ___ OTHER FAMILY MEMEBERS (PLEASE LIST): _____

OVARIAN CANCER:

NO FAMILY HISTORY

SELF/AGE: ___ OTHER FAMILY MEMBERS (PLEASE LIST): _____

UTERINE/ENDOMETRIAL/CERVICAL CANCER (**PLEASE LIST TYPE**):

NO FAMILY HISTORY

SELF/AGE: ___ OTHER FAMILY MEMBERS (PLEASE LIST): _____

PANCREATIC CANCER:

NO FAMILY HISTORY

SELF/AGE: ___ OTHER FAMILY MEMBERS (PLEASE LIST): _____

COLORECTAL CANCER:

NO FAMILY HISTORY

SELF/AGE: ___ OTHER FAMILY MEMBERS (PLEASE LIST): _____

TESTICULAR CANCER:

NO FAMILY HISTORY

SELF/AGE: ___ OTHER FAMILY MEMBERS (PLEASE LIST): _____

10 OR MORE COLON POLYPS:

NO FAMILY HISTORY

SELF OTHER FAMILY MEMBERS (PLEASE LIST): _____

MALE BREAST CANCER:

NO FAMILY HISTORY

SELF/AGE: ___ OTHER FAMILY MEMBERS (PLEASE LIST): _____

GASTROINTESTINAL- ESOPHAGUS, STOMACH, SMALL BOWEL, NON-COLORECTAL
CANCER (**PLEASE LIST TYPE**):

NO FAMILY HISTORY

SELF/AGE: ___ OTHER FAMILY MEMBERS (PLEASE LIST): _____

GENITOURINARY- KIDNEY, BLADDER, PROSTATE CANCER (**PLEASE LIST TYPE**):

NO FAMILY HISTORY

SELF/AGE: ___ OTHER FAMILY MEMBERS (PLEASE LIST): _____

ST. LOUIS CANCER CARE, LLP

BRAIN CANCER:

NO FAMILY HISTORY

SELF/AGE:_____ OTHER FAMILY MEMBERS (PLEASE LIST):_____

THYROID CANCER:

NO FAMILY HISTORY

SELF/AGE:_____ OTHER FAMILY MEMBERS (PLEASE LIST):_____

MELANOMA:

NO FAMILY HISTORY

SELF/AGE:_____ OTHER FAMILY MEMBERS (PLEASE LIST):_____

MULTIPLE MYELOMA, LYMPHOMA, LEUKEMIA (**PLEASE LIST TYPE**):

NO FAMILY HISTORY

SELF/AGE:_____ OTHER FAMILY MEMBERS (PLEASE LIST):_____

ARE YOU OF ASHKENAZI JEWISH DESCENT?

NO YES

HAVE YOU OR A FAMILY MEMBER EVER HAD GENETIC TESTING?

NO YES

Authorization for Verbal Communication and/or to Leave Voice Mail Messages Regarding My Personal Health Information

Patient Information

Name- Last, First, MI	Date of Birth:
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Information to be disclosed: verbal communication only regarding patient's care-no copies of medical records provided

Please Provide your current telephone numbers

Home Phone	Cell Phone
Work Phone	Other Phone

We normally contact our patients between 8 a.m. and 5 p.m. Monday through Thursday and 8 a.m. to 3 p.m. on Friday. Please **check below** where you would prefer to be contacted during these hours.

Home Phone _____ Cell Phone _____ Work Phone _____ Other Phone _____

If we need to reach you after hours, please **check below** where you prefer to be called:

Home Phone _____ Cell Phone _____ Work Phone _____ Other Phone _____

Your Protected Health Information Designees:

If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information). This person (designee) will also be able to call the office on your behalf.

Please print the name and relationship to you/patient of each designee below: _____

Designee Name:	Phone number:	Relationship to Patient:
Designee Name:	Phone number:	Relationship to Patient:
Designee Name:	Phone number:	Relationship to Patient:
Designee Name:	Phone number:	Relationship to Patient:

_____ Check here if you **do not want** your health care information discussed with anyone other than yourself.

Confidential Voice Mail:

Please **check below** where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) blank if you **do not wish** to receive voice mails.

Home Phone _____ Cell Phone _____ Work Phone _____ Other Phone _____

Email Address: _____

Your signature **below** confirms your approval of these updated HIPPA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE SIGNED

Verbal Communication Only. This authorization allows for verbal communication {both in person and on the telephone between and the designated person(s) on this form. It does not allow for copies of medical records to be released.

Voice Mail Messages : Providers and their staff recognize confidentiality as a very important part of your relationship with them. To protect your confidentiality, they will not routinely leave messages on your personal messaging system (voice mail or answering machine or with your spouse, family members or any other individual) unless you specifically give your permission to do so. This authorization may be used to share this information in the manner that you specify.

ST. LOUIS CANCER CARE, L.P.P
Authorization for Release of Healthcare Information

Please fill out the starred areas only. This is to request records from other Providers.

*Patient Name: _____ MRN: _____
*Social Security Number: _____ *DOB: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Name: _____

Address: _____

3. The type and amount of information to be used or disclosed is as follow:

Complete Medical Record List of Allergies Radiology Reports

Physician Progress Note Problem List EKG's

Immunization Record Lab Reports Medication List

Other (please specify) _____

Dates of Treatment: _____

4. Unless otherwise provided by law, records and information concerning the following types of diagnoses, care and treatment will be released only if I indicate my specific consent by checking the appropriate box:

Alcohol Abuse Mental Health Notes Drug and Substance Abuse

Testing for presence of HIV-Antibodies and /or treatment of AIDS

5. This information may be released to an used by the individual or organization:

Name: _____

Address: _____

For the purpose of: _____

6. I understand that I have the right to cancel this authoriaztion at any time. I understand that if I wish to withdraw this authorization I must do so in writing. I must present my written cancellation to the health information management department. I understand that the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

7. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I don't have to sign this form to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager. I understand that there may be charge for costs associated with copying my health information.

*Signature of Patient / Legal Representative (specify Relationship to Patient)

Date

FINANCIAL POLICY FOR ST LOUIS CANCER CARE, L.L.P.

MISSED NEW PATIENT APPOINTMENTS:

St. Louis Cancer Care, L.L.P. will assess a \$30.00 no show fee for any missed new patient appointments. If you are unable to keep your appointment please notify our office.

COPAYS:

All copays are **expected at the time of service**. Copays include office copayments charged for specialist or MD visits (on your insurance card) copays charged for chemotherapy or lab draws, and % of bill not paid by your insurance. **Our office accepts cash, check, Visa, Mastercard or Discover.**

FORMS AND REGISTRATION

All patients will fill out the necessary paperwork to ensure prompt payment by the insurance company. These forms include but are not limited to the following:

- SIGN IN SHEET
- COPY OF CURRENT INSURANCE
- PATIENT INFORMATION SHEET
- ASSIGNMENT OF BENEFIT FORMS
- PRIVACY NOTICE

When any information changes, **the patient will notify our office immediately of the change.** All information will be updated yearly.

VERIFICATION OF BENEFITS:

All benefits will be verified before any treatment is given. This is performed by calling the patient's insurance and verifying coverage. An insurance pre-certification form will be filled out on all patients receiving treatment.

POSTING OF CHARGES:

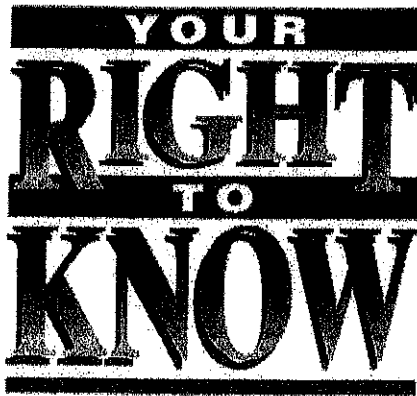
All daily transactions are posted by our billing office on a daily basis. Their phone number is 314-628-1423.

FILING OF INSURANCE:

All insurance claims will be filed on timely basis to all insurance companies. Insurance claims are filed daily. We accept assignment on all claims, which enables insurance checks to be sent directly to our office. All insurance is filed electronically. We file secondary insurances as a courtesy to our patients.

SIGNATURE: _____

St. Louis Cancer Care, LLP



10004 Kennerly Road
Suite 137A
St. Louis, MO
314-842-7301
www.stlouiscancercare.com

**Your Information.
Your Rights.
Our Responsibilities.**

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.**

Effective Date: April 13, 2003
Last Updated: June 01, 2018

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- If for any reason we deny your request to get access to your medical record you have the right to appeal this denial.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
 - Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days. The reasons we may deny your request are:
 - We didn't create the PHI.
 - The amendment would not be part of normal record keeping of PHI for the covered entity.
 - If the amendment would never be included for inspection by any other group or party.
- We will NOT require an explanation for the request from the patient as a condition of agreeing to follow it.

YOUR RIGHTS

Request confidential communications

- You can ask us to contact you in a specific way (for example: home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. We will request the above details in writing by using our

Method of communication form. We have the option to condition the agreement for above communications with assurance that payment of special fees required will be handled.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
 - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for an accounting of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise our rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Service Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint

YOUR CHOICE

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Contact you for fundraising efforts.
- You may also at any time revoke or change these authorizations by notifying us and completed the method of communication form.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
 - Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
 - Example: We can use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
 - Example: We give information about you to your health insurance plan so it will pay for your service.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing diseases
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Service if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can share health information about you:
 - For workers compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law

- For special government functions such as military, national security, and presidential protective service

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/notiPatientpp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This Notice of Privacy Practices applies to the following organizations:

St. Louis Cancer Care, LLP

- North County / Bridgeton
- West County / Chesterfield
- South County
- Midtown / Clayton

Privacy and Security Officer:

Carol Riley
10004 Kennerly Road
Suite 137A
St. Louis, MO
314-842-7301
CRiley@stlouiscancercare.com

Stephen P. Allen, M.D.
J. Daniel Cuevas, M.D.
Craig R. Hildreth, M.D.
Giancarlo A. Pillot, M.D.



10004 Kennerly Road Suite 137 A
St. Louis, MO 63128
Office: (314) 842-7301
Fax: 314-842-7308

Privacy Notice

Effective date: This notice is effective 4/13/03.
Updated 6-1-18

I acknowledge receipt of this notice:

Signature: _____

Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

NORTH COUNTY
3440 Depaul Lane Suite 201
Bridgeton, MO 63044
314-291-3312

SOUTH COUNTY
10004 Kennerly Road Suite 137 A
St. Louis, MO 63128
314-842-7301

WEST COUNTY
226 S Woods Mill Rd Suite 45 W
Chesterfield, MO 63017
314-579-0051

MIDTOWN/CLAYTON
1031 Bellevue Ave Suite 300
St. Louis, MO 63117
314-579-0051

Patient Portal Authorization Agreement



Name: _____

Email: _____

Purpose of this Form

St. Louis Cancer Care, L.L.P. offers secure electronic access to your medical record and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks we have imposed some terms and conditions of participation. Your signature on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log into the Portal site. Using the connection channel between your computer and the Web site, you can read, view, or send information on or from your computer. It is automatically encrypted in transmission between the Web site and your computer.

How to Participate

You may compose and reply to secure messages or view information sent to you through the Patient Portal. Once you have reviewed, agreed to, and signed our policies and procedures regarding use of the Patient Portal, and given us a valid personal email address we will email you the registration instructions to your personal email address (or that of your caregiver or adult child).

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes. Protect your login information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information.

If you believe someone has learned your password, you should immediately go to the Web site and change it. You agree not to share your username and password with unauthorized persons and to maintain that your login information is in a secure place at all times. Access to the Patient Portal is a free

service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential. Please read our Notice of Privacy Practices for additional information on uses and disclosures.

Conditions of Participating in the Patient Portal

Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service, we will notify you as promptly as we reasonably can. You agree to not hold St. Louis Cancer Care, L.L.P. or any of its staff or physicians liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this agreement and do not request access to the patient portal.

If you have questions we will gladly provide more information.

Patient Acknowledgement

Signature: _____

Date: _____

For Office Use Only	
I have authenticated the identity of the person named on this authorization form:	
___ Picture ID	___ Person known to me
_____	_____
Employee Signature	Date

What is CareSpace?

CareSpace is a secure, online patient portal that provides you with access to your health information and care team. Through CareSpace, you can:

- Access your health information. CareSpace is easily accessible on your personal computer, tablet, or mobile device, so you have 24/7 access to your medical information.
- Communicate with your care team. CareSpace provides you a place to send and receive messages with your care team at our practice, and have your questions answered seamlessly.
- Keep friends, family, and caregivers informed. By inviting friends and family to your CareSpace account, your support team can easily access your health information.
- Download and securely send your health information. From CareSpace you can securely send your health information to providers outside of our practice, like your primary care doctor.

How do I get a CareSpace account?

To get a CareSpace account, you just need to provide our practice with your email address. We will send you an invitation to CareSpace which includes instructions on how to complete the simple registration process.

Where do I login for CareSpace?

You can always access CareSpace by visiting <https://carespaceportal.com> from a browser on your computer, tablet or mobile device.

Where does the information in CareSpace come from?

The information in CareSpace comes from your medical records at our practice.

Who can see my account?

Only you will be able to determine who can see your account. If you invite someone to your CareSpace account, they can see all the information in your portal, but they cannot send messages to your practice. At this time, you cannot limit their access, however you can revoke someone's access once you've invited them.

Is the information in CareSpace private and secure?

Yes, CareSpace uses the latest security standards and your information will stay private and secure. CareSpace is HIPAA compliant, and ONC 2015 certified. CareSpace access is only permitted to authorized users who have been given access privileges and verified through a registration process.

How can I access and see my medical record?

You can view, download, and transmit your health information via CareSpace today. Simply go to the "Download" button in the upper-right hand corner of the Health page. From there, you can view or download your medical record.

Can I change the email associated with my CareSpace account?

Right now, you cannot change the email address associated with your CareSpace account.

Are there Patient Resources specific to my diagnosis in CareSpace?

At this time, CareSpace includes links to the leading patient education resources for oncology: NCI, American Cancer, and CancerCare.

I can't remember my password. How do I get back into my account?

You can reset your own password from the CareSpace login page, <https://carespaceportal.com> by clicking "Forgot Password."

When will I be able to see new lab results in CareSpace?

Per new regulatory guidelines from CMS, all health information (including lab results) must be released to a patient within 4 business days of when the results were available to clinicians. As such, lab results will be released to CareSpace after your doctor signs them, or after 4 business days.

When can I expect to get a response if I send the practice a message?

You can expect a response from our practice **within 48 hours**.

What happened to SeeYourChart, the old patient portal?

The SeeYourChart patient portal is being fully retired over the course of the year, and replaced with CareSpace. In a continued effort to support high quality patient care, we are excited to announce this upgrade. CareSpace offers a more user-friendly experience, and it is accessible on computer, tablet and mobile devices.

Will I lose information from SeeYourChart when I transition to CareSpace?

Today in CareSpace, you will have access to historical Care Plans, Patient Education Materials, and any historical document types that our practices has set to continue to flow to the CareSpace portal. You will also see historical lab results, messages, and have the ability to generate your medical record from the "Download" button in the upper-right hand corner of the Health page.

Where are my appointments?

The CareSpace team is working on this feature in the upcoming months and hopes to release the Appointment Calendar to CareSpace in the third quarter of 2019!

Do the authorized users (e.g. friends, family or caregivers) that had access to my SeeYourChart account have access to my CareSpace account?

You will need to re-invite friends, family and caregivers to your new portal. Inviting someone is easy. From the [Sharing](#) page, just enter your invitees email address and birthday (as a security measure), and they will be sent registration instructions.