ST. LOUIS CANCER CARE – PATIENT INFORMATION FORM

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

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Maiden Name: _____ **Email Address** _____

Home Phone: _____ **Cell Phone:** _____

Social Security #: _____ **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: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Children :_____ **Ages:** _____

If married, spouse's Name: _____ **DOB:** _____

Spouse SSN: _____ **Employer:** _____**Spouse Phone:** _____

If unmarried, nearest relative: _____ **Relationship:** _____**Phone:** _____

Do you have a Durable Medical Power of Attorney? ☐ Yes ☐ No If yes, can you provide us with a copy?

Billing Information:

Payment is expected at the time of service unless you are insured by an insurance company with which St. Louis Cancer Care, L.L.P. participates. Please present your current policy group and identification numbers at each visit. Verify any referrals, preauthorization, and admission requirements. All copays are due before seeing the physician.

Primary Insurance: _____
Secondary Insurance: _____

Insurance Authorization:

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 company or physicians participating in my care.

Patient's Signature: _____ **Date:** _____

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.

Patient's Signature: _____ **Date:** _____

Personal and Family Medical History

Current Prescription Medications (Please include name, dose, and how often you take it.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Over-the-Counter Medications (Include aspirin, vitamins, laxatives, supplements, etc.)

_____
_____

List any Allergies to Medications and Adverse Reactions

_____

Preferred Pharmacy: _____**Location:** _____
ZIP Code _____**Phone Number**:_____

Past Medical History

Condition	Y/N?	Condition	Y/N?
High Blood Pressure		Thyroid Disorder	
Diabetes		Depression / Anxiety	
Heart Disease		High Cholesterol	
Stroke		Blood Clots	
Asthma / COPD		Kidney Disease	
Other:			

Past Cancer History

Type	Age of Diagnosis	Notes / Ongoing Issues

Surgical History

Surgery	Date

Cancer Screening History			
Mammogram (Date of Last and Location)		**Colonoscopy (Date of Last and Location)**	
Pap Smear (Date of Last and Location)		**Prostate (PSA) (Date of Last and Location)**	
Skin (Date of Last and Location)		**Lung screening CT scans (Date of Last and Location)**	
Bone Density (Date of Last and Location)		**Genetic Testing (Date and Results of Last and Location)**	

Smoking Use/ Drug Use					
Smoker ☐	Number of years?		Number of Packs/Day		**Nonsmoker** ☐
If Smoker Type	Cigarettes ☐	Vape ☐	Pipe ☐	Chews Tobacco ☐	E-Cigarette ☐ Cannabis ☐
If Smoker and quit, year stopped					
Recreational Drugs?	Yes ☐		No ☐		

Alcohol Use				
Social ☐	**Former** ☐	Year stopped		**Current** ☐
If Drinker Type (wine, beer, spirits)				
Number of drinks?		Frequency?		

Menstrual History			
Age at first menstruation		**Age at menopause**	
Last menstrual period		Regular Menses ☐	Irregular Menses☐
Light flow ☐	Normal flow ☐	Heavy flow☐	

Maternity History			
Number of Pregnancies		**Number of births**	
Age at first full term		**Breast fed**	Yes ☐ No☐

Hormonal Exposure						
None ☐						
Oral Contraceptive pills ☐	Years taken?		Oral Contraceptive Type			
Hormonal replacement therapy☐	Years taken?		Type?		Year stopped?	

Vaccine Status		
Name	**Y/N**	**Date Taken**
Flu Vaccine		
Shingles Vaccine		
Pneumonia Vaccine		
Tetanus Vaccine		

Family Medical History	
Condition	**Family Member (s)**
High Blood Pressure	
Diabetes	
Heart Disease	
Stroke	
Asthma / COPD	
Thyroid Disorder	
Depression / Anxiety	
High Cholesterol	
Blood Clots	
Kidney Disease	
Other:	

Family History of Cancer					
Relative	Maternal vs Paternal side	Type of Cancer	Age of Diagnosis	Age of death	Multiple Cancers?

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

Patient Information

Name – Last, First, M	Date Of Birth

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 Patient's between 8am and 5 pm Monday through Thursday and 8 am to 3 pm Friday.
Please ***check below*** where you would prefer to be contracted 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 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:	Relafionship to Patient:
Designee Name:	Phone number:	R01atlonship 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 boxes unchecked if you do not wish to receive voice mails.

Home Phone ☐ Cell Phone ☐ Work Phone ☐ Other Phone ☐

Email Address; _____

Your signature ***be/ow*** 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. Typing your name in the signature fields below will be considered your signature.

Patient's Signature: _____ Date: _____

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 Mall 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 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 authorization 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.Typing your name in the signature fields below will be considered your signature.

_____ _____
Signature of Patient / Legal Representative (specify) Date

*FINANCIAL POLICY FOR ST LOUIS CANCER CARE, LL*P

COPAYS:
ALL COPAYS ARE EXPECTED AT THE TIME OF SERVICE. COPAYS RE IN THE AMOUNT ON CURRENT INSURANCE CARD AND % OF INVOICE NOT PAID BY YOUR INSURANCE OUR OFFICE ACCEPTS CASH, CHECKS, MASTERCARD OR VISA CARDS.

FORMS AND REGISTRATION:
ALL PATIENTS WILL FILL OUT THE NECESSARY PAPERWORK TO ENSURE PROMPT PAYMENT BY THE INSURANCE COMPANY. THESE FORMS INCLUDE:

SIGN IN SHEET
COPY OF INSURANCE CARD
PATIENT INFORMATION SHEET
ASSIGNMENT OF BENEFITS FORMS
PRIVACY NOTICE

IF ANY INFORMATION CHANGES, THE PATIENT WILL NOTIFY OUR OFFICE IMMEDIATELY OF THE CHANGE.

VERIFICATION OF BENEFITS:
ALL BENEFITS WILL BE VERIFIED BEFORE ANY TREATMENT IS GIVEN. THIS IS PERFOMED BY CALLING THE PATIENTS INSURANCE AND VERIFYING COVERAGE. AN INSURANCE PRECERT FORM WILL BE FILLED OUT ON ALL PATIENTS.

FILING OF INSURANCE
ALL INSURANCE CLAIMS WILL BE FILED ON A 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

Typing your name in the signature fields below will be considered your signature.

SIGNATURE_____

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: April 13, 2003 **LAST REVISION DATE: May 1, 2003**

THIS NOTICE OF PRIVACY PRACTICES ("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 THIS NOTICE

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and our Business Associates' subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

"Protected Health Information" is information about you, including demographic Information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPM") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health Information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for treatment or a hospital stay may require that your relevant protected health information be dlsclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health Information in order to support the business activities of our physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization, These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military aclivity and national security, workers' compensation, Inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request.

The HIPAA law requires us to also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object, unless required by law. Without your authorization, we are expressly prohibited from using or disclosing your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health Information.

We will not use or disclose 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. You may revoke the authorization, al any lime, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure Indicated In the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information - Pursuant to your written request, you have the right to inspect or copy your protected health Information whether in paper or electronic format. 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 we deny access to the requested Information, you can appeal the denial.

Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or Information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information - This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved In your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications - You have the right to request confidential communication from us by alternative means or at alternative locations. We will comply with all reasonable requests, but we reserve the right to request the details in writing. We will not require an explanation for the request as a condition of agreeing to follow it. We also have the option to condition the agreement for alternate confidential communications with assurance that payment of special fees required will be handled.

You have the right to request an amendment to your protected health Information - You have the right to request an amendment lo health information about you if you think is incorrect or incomplete. We may deny your request if we did not create the protected health information, if the amendment would not be part of our normal record keeping of protected health information, if the amendment would never be included for inspection by any other group or party or If we believe the record is accurate and complete without the amendment. We will not require an explanation for the request for amendment from you as a condition of agreeing to follow it.

If we deny your request for amendment, we'll tell you why in writing within 60 days. You have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of It.

You have the right to receive an accounting of certain disclosures - You have the right to receive an accounting of disclosures, in paper or electronic form, except for disclosures that are pursuant to an authorization, for purposes of treatment, payment, healthcare operations as defined here, required by specific law, or six years prior to the date of the request.

You have the right to obtain a paper copy of this notice from us even If you have agreed to receive the notice electronically. We will also make available copies of our Notice, if you wish to obtain one.

We reserve the right to 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.

COMPLAINTS

You may complain to us If you believe your privacy rights have been violated by us. You may reach out to our Compliance Officer by calling our office at 314-842-7301 or sending a letter to our office at 10004 Kennerly Rd, Ste 137A, St Louis, MO 63128. We will not retaliate against you in any way for filing a complaint.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, or calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 314-842-7301.

Please sign the "ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES". By signing

this form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practice

ST. LOUIS CANCER CARE, L.L.P.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of SLCC's "Notice of Privacy Practices" for protected health information on the date set forth below. Typing your name in the signature fields below will be considered your signature.

Date of Receipt	Patient Date of Birth
Patient Name	Authorized Personal Representative
Patient Signature	Signature of Authorized Personal Representative

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FOR USEBY SLCC PERSONNEL ONLY
Complete if patient acknowledgement is not obtained.

An Acknowledgment of Receipt of Notice of Privacy Practices was not received because:

- ☐ Patient refused to sign Acknowledgment
- ☐ Unable to gain signed Acknowledgment due to communication/ language or other barrier
- ☐ Patient was unable to sign Acknowledgment due to emergency treatment situation
- ☐ Other (please indicate reason):

Signature of SLCC Representative	Date

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, pick up, 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 give you instructions on how to use the portal and your login information will be emailed 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 username and password 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 username and password 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. Typing your name in the signature fields below will be considered your signature.

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.

ST. LOUIS CANCER CARE CONSENT FORM

PATIENT CONSENT FORM- CONFIDENTIAL

Patient Name: _____

Patient DOB: _____

- **Consent to Treatment:** I hereby authorize the employees, agents and staff of St. Louis Cancer Care to perform, and hereby consent to such medical treatment and examinations as may in the opinion of the patients' physician be necessary. This also includes any services related to nutrition support/counseling and activity level and temperature monitoring.
- **Consent to Navigation Services:** I consent to receive principle navigation services provided by St. Louis Cancer Care employees. Such navigation services may include, but are not limited to, providing informational assistance, financial assistance, and/or social and support services. By signing this agreement, I understand and agree to these services.
- **Principal Care Management (PCM):** PCM services are available to patients with one serious chronic condition. Medicare defines a serious chronic condition as one that is expected to last for at least 3 months, is the focus of ongoing medical care, and places the patient at significant risk of hospitalization, functional decline, or death. Benefits of PCM Services include:
    - 24/7 access to a care provider familiar with your chronic condition.
    - A personalized care plan focused specifically on managing your principal chronic condition, available in print or electronically.
    - Regular check-ins and follow-up to support treatment goals and symptom management.
    - Coordination with specialists, pharmacists, and community-based services involved in your care.
    - Transition support after hospital or skilled nursing facility discharges related to your chronic condition.
    - Medication management and oversight specific to your chronic illness.
    - Should you desire to receive these services through your provider, he/she agrees to only bill your insurance for services once per 30-day billing cycle. The standard Medicare Part B cost-sharing (copayment or deductible) may apply to these services.You have the right to withdraw your consent at any time, and such withdrawal will not affect your ability to receive care from your providers.
- **Mental Health Consent:** We have a behavioral health integration ("BHI") program designed to support patients experiencing challenges with their mental health. A behavioral health care manager and consulting psychiatrist works collaboratively with our physicians to help patients learn coping skills and make recommendations about medications if they might be useful. Your participation in the program is entirely voluntary. You have the right to withdraw your consent at any time, and such withdrawal will not affect your ability to receive care from your providers. Cost sharing (such as copayments, deductibles and co-insurance) may apply to both face-to-face and

non-face-to-face services provided, even if cost sharing is covered by supplemental insurers.By signing this form, you acknowledge that you understand the nature of BHI and provide your consent to participate and for your health information to be shared among your care team.

- **Remote Patient Monitoring (RPM) Consent:** We offer Remote Patient Monitoring ("RPM") services to help manage your chronic condition between office visits. RPM involves the regular collection and transmission of your health data (such as weight, blood pressure, blood glucose, or oxygen levels) from a device in your home to your care team. These readings are monitored daily, and your provider or a member of your care team may contact you if results fall outside of a set range or to support your treatment goals. RPM can improve early intervention, reduce hospitalizations, and help maintain your quality of life. Should you choose to receive RPM services, your provider agrees to only bill your insurance once per 30-day billing cycle. Standard Medicare Part B cost-sharing (copayment or deductible) may apply.
- **AI Scribing in the Office:** To support accurate documentation and help your provider focus more on you, our office may utilize a secure, HIPAA-compliant AI technology to assist with medical notes. A temporary recording and transcript of your visit are used to generate a draft, which your provider reviews and edits. Transcripts are stored securely for a limited time. Your privacy remains a top priority at every step.

Should you have questions about this consent please ask one of our staff or contact us at 314-842-7301

I have read this form, I understand what it says, and any questions of mine have been answered. I am signing this form voluntarily. Typing your name in the signature fields below will be considered your signature.

Print Patient Name _____

Patient Signature: _____ Date: _____