

**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 PRECERTIFICATION AND ADMISSION REQUIREMENTS. ALL COPAYS ARE DUE BEFORE SEEING THE PHYSICIAN.

PRIMARY INSURANCE \_\_\_\_\_

SECONDARY 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 PARTICIPATING 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:** \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: April 13, 2003

LAST REVISION DATE: May 1, 2023

**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 ("HIPAA") 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 disclosed 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 activity 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, at any time, 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 to 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/](http://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 Practices.



**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.

\_\_\_\_\_  
Date of Receipt

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Authorized Personal Representative

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Signature of Authorized Personal Representative

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**FOR USE BY 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 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.