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 PHYSCIANS 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 MEDICL 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 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 SELF EXAMS:
☐YES ☐SPORATIC ☐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 DECENT?
☐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:

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.

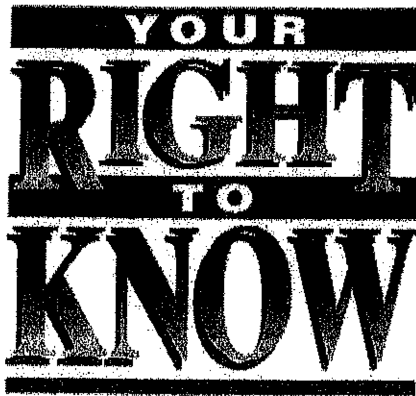
VERIFCIATION OF BENEFITS:
All benefits will be verified before any treatment is given. This is performed by calling the patient's insurance and verifying coverage. An insurance pre-certification form will be filled out on all patients receiving treatment.

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: ______________________________

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.

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

Patient Portal Authorization

In the event of an emergency dial 911.
Do not use the Patient Portal.

What is the Patient Portal?
The Patient Portal is a web-based system that allows for secure communication and transfer of information between St. Louis Cancer Care, L.L.P. and the patient. When a patient logs into the Portal, current data is pulled directly from the clinic's database and is displayed on the web page. Patient information is NOT stored on the Patient Portal server.

Explanation of and Guidelines for Use of the Patient Portal
Due to patient privacy laws, we do not accept electronic patient communications through traditional email. Our Patient Portal provides a secure method of messaging to ensure your privacy is in compliance with Federal and State regulations.

After logging in to the Portal a patient can:

- Use the messaging function to communicate with clinic staff
- View results of lab and other diagnostic tests
- View upcoming appointments
- Share data with specified family and caregivers
- Be knowledgeable when making treatment decisions
- Request a referral or medication refill (in near future)
- View health summary information
- Print or save an electronic copy of health summary

Response Time
Please do not use the Patient Portal for **urgent** messages. We will normally respond to non-urgent inquires within 24 hours but no later than 3 business days after receipt. If you have not heard from us within 3 business days, please call your respective office (DePaul – (314)291-3312, Lukes – (314)579-0051, Sunset Hills – (314)842-7301) to check the status of your request.

General Guidelines for Communication
Please be as concise as possible. If your communication contains too many issues or complex issues we will ask you to come in for an appointment to discuss your concerns and questions you may have. Remember that all communications will be part of your medical record.

Include an appropriate subject line such as "Question - Nurse", "Question - Doctor, "Refill", etc.

The Patient Portal is not designed to replace the face-to-face encounter. Rather, it is designed to supplement those encounters.

Portal eligibility

Current patients who are at least 18 years of age are eligible to access the Patient Portal. We will provide instructions to patients on how to access the patient portal once they have signed our Patient Portal Authorization Agreement.

Privacy and Security

All messages sent to you will be encrypted. Your email address is confidential and protected information. We will protect this information as we do all of your medical and other personal information. We will not purposefully share this information with a third party unless authorized by you or required by law.

Similar to phone communications, messages may be read and addressed by staff other than the physician staff. When your physician is out of the office your emails may be addressed by a covering physician. Access to our internal network and electronic medical records (EMR) is password protected. Use of the Patient Portal is extended as a courtesy to allow enhanced communication between our patients and their doctor. Abuse of this courtesy will result in our discontinuing electronic communication with you.

Getting Started

Read and sign the Patient Portal Authorization Agreement. By signing the agreement you are indicating that you have read and agree to all the policies and procedures contained in this document. Once we have received the signed Patient Portal Authorization Agreement from you and have authenticated your identity, and have a valid personal email address we will hand you instructions on how to access the portal and your login information will be emailed to you.