CENTRAL ALABAMA
RADIATION ONCOLOGY

Your visit is located at this location:

□ 4143 Carmichael Road
Montgomery, AL 36106
(334)395-2200

□ 585 Jasmine Trail
Prattville, AL 36066
(334)395-2250

With:
□ Dr. Robert L. Franklin
□ Dr. Michael L. Ingram
□ Dr. Alexander C. Whitley
□ Dr. John S. Jarboe

Dear Patient,

Thank you for choosing Central Alabama Radiation Oncology, LLC for your radiation oncology services. Central Alabama Radiation Oncology, LLC is committed to providing the highest level of coordinated, compassionate care. We would like to make your visit with us as pleasant as possible.

To facilitate your first visit with Central Alabama Radiation Oncology, LLC, we have included a new patient registration packet that contains information on our registration process. **Please bring completed forms with you 15 minutes prior to your scheduled appointment and present it to the receptionist upon arrival. You will save a significant amount of time at your visit by completing the forms prior to your arrival. If you prefer to complete paperwork at our office, you will need to arrive 45 minutes prior to your scheduled appointment time. We reserve the right to reschedule your appointment if you do not arrive on time.**

A current photo ID is required at the time of registration. If you do not have a photo ID with you when you arrive for your appointment, your appointment will be rescheduled so that you may obtain your ID.

Patients without insurance will be required to pay $200 on the day of their initial consult visit.

Patients with insurance will be required to pay any co-pay or deductible at the time of service.

In the event your insurance policy requires you to have an authorization and/or referral to see the Physicians at Central Alabama Radiation Oncology, LLC, please be sure to obtain it prior to the day of your visit. If you are unsure if you need a referral, please contact your insurance company. We must have the referral prior to your being seen. If the referral is not available on the day of your appointment, your appointment will be rescheduled until after the referral if obtained. If you need help or have questions about obtaining the referral, please contact our business office prior to your appointment day.

Again, thank you for choosing Central Alabama Radiation Oncology, LLC for your radiation oncology services.

CENTRAL ALABAMA RADIATION ONCOLOGY

Directions to Central Alabama Radiation Oncology:
585 Jasmine Trail
Prattville, AL 36066

From Selma:

- Start out going southeast on Summerfield Rd toward Highland Ave/Black Belt Nature and Heritage Trail/US-80 E/US-80 W/AL-14/AL-8.
- Take the 1st left onto Highland Ave/Black Belt Nature and Heritage Trail/US-80 E/AL-14/AL-8. Continue to follow AL-14.
- Turn left onto Old Autaugaville Rd/County Hwy-29. Continue to follow County Hwy-29.
- Turn right onto W 4th St/AL-206. Continue to follow W 4th St.
- Turn left onto N Washington St.
- Take the 1st right onto Wetumpka St/County Hwy-2.
- Turn left onto N Memorial Dr/US-31 N/AL-3/AL-14.
- Turn slight right onto Fairview Ave/AL-14.
- Turn right onto Jasmine Trl.
- 585 Jasmine Trl, Prattville, AL 36066-3657, 585 JASMINE TRL is on the right.

From Cobbs Ford Road:

- Start out going northwest on Cobbs Ford Rd/County Hwy-2 toward S Edgewood Rd.
- Merge onto I-65 N toward Birmingham.
- Take the AL-14 exit, EXIT 181, toward Prattville/Wetumpka.
- Keep left to take the ramp toward Prattville.
- Turn left onto Highway 14/AL-14. Continue to follow AL-14.
- Stay straight to go onto Fairview Ave/AL-14.
- Take the 1st left onto Jasmine Trl.
- 585 Jasmine Trl, Prattville, AL 36066-3657, 585 JASMINE TRL is on the right.

From Clanton:

- Merge onto I-65 S toward Montgomery.
- Take the AL-14 exit, EXIT 181, toward Prattville/Wetumpka.
- Merge onto AL-14 toward Prattville.
- Stay straight to go onto Fairview Ave/AL-14.
- Take the 1st left onto Jasmine Trl.
- 585 Jasmine Trl, Prattville, AL 36066-3657, 585 JASMINE TRL is on the right.

CENTRAL ALABAMA RADIATION ONCOLOGY

Patient Name:		Birth date: Height:	Race:
Address:		City/State/Zip:	☐Male ☐Female
Marital Status:	# Of Children:	Preferred Contact Number (Please Check): ____Home ____Cell Home Phone #: Cell Phone #:	
EMAIL:			
Primary Caregiver Name: (Not your primary MD)		Do you have a living will? □Yes □No (If yes, please provide a copy.) Do you have a Durable Power of Attorney? □Yes □No (If yes, please provide a copy.)	

SSN: Are you a citizen of a European Union member country? ☐Yes ☐No

INSURANCE INFORMATION:

Primary: ______________________________________ Member ID:_________________________ Group: ___________

Secondary:____________________________________ Member ID:__________________________ Group:__________

Spouse Name:____ Spouse DOB:______________________________

Spouse Employer:____ Phone:_____________________________________

Referring Physician :___________________________________Primary Care Physician: ___________________________

Additional Physicians: ____

Reason for your visit today:

Do you have a PORT/VASCULAR DEVICE? ☐Yes ☐No

Do you have an Implanted Pacemaker or Defibrillator? □ Yes □No (If yes, please show the Nurse your card.)

Do you have an implanted device? □ Yes □No Functional? □ Yes □No Type:___________________________

Have you received radiation in the past? ☐Yes ☐No Area: Year: Where:

Have you or are you currently receiving Chemotherapy? ☐Yes ☐ No Year: Chemo Doctor:

Problems/Illnesses (Circle all that apply to you.)

AIDS/HIV	Alzheimer's/Dementia	Arthritis	Asthma	Cardiac Disease/Heart Problems
Diabetes	Emphysema or COPD	GERD (reflux/heartburn)	Hepatitis	High Cholesterol
High Blood Pressure	Hypothyroid (low) or Hyperthyroid (high)		Kidney Disease/Dialysis	Stroke or TIA's

Other (please describe): ____

(Female only) Date of last mammogram: Date of last Pap smear:

Last Menstrual Period: Menopause: ☐ Yes ☐No

SURGERIES (Provide approximate dates): Colonoscopy: ☐ Yes ☐No Date:

Drug Allergies - Medication	Reaction

Have you ever received intravenous contrast? ☐ Yes ☐No Any reaction to contrast? ☐Yes ☐No

Do you have any seafood allergies? ☐Yes ☐No

PREFERRED PHARMACY: LOCATION: PHONE:

MEDICATION HISTORY: List Medications Below or Attach List			
Name of Medication	Strength	Frequency	Reason for taking

FAMILY HISTORY

Father ☐ Living ☐ Deceased Age_____ | Mother ☐ Living ☐ Deceased Age_____

Check all that apply:	Father	Mother	Brother	Sister
Hypertension	☐	☐	☐	☐
Heart Disease/Attack	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Cancer (describe below)	☐	☐	☐	☐
Other (describe below)	☐	☐	☐	☐

SOCIAL HISTORY

Tobacco use at present? ☐Yes ☐No Type:☐Cigarettes ☐Cigars ☐Pipe ☐Oral Tobacco Daily Amount: Years:

Tobacco use in the past? ☐Yes ☐No When did you quit?

Do you drink alcoholic beverages? ☐Yes ☐No Type of alcohol: How much and how often:

Any illegal "street" drug use: Present:☐Yes ☐No Type: Past:☐Yes ☐No Type:

Education: Highest-grade completed-____________________ Retired: ☐Yes ☐No Are you employed? ☐Yes ☐No

Occupation: ________________________________Employer: ____

Employer Phone:________________________________ City, St.:____

Any exposure to chemicals or hazardous materials? ☐Yes ☐No Type: _____________________________________

REVIEW OF SYSTEMS (symptoms within last two weeks) (circle all that apply)

Poor Appetite	Hair Loss	Bloody Vomit	Muscle Weakness
Fatigue	Increased Skin Sensitivity to Sun	Rectal Bleeding	Range of Motion
Fever	Hives/Itching/Rash	Hemorrhoids	Describe ____________________
Night Sweats	Breast Masses	Black Tarry Stools	Disorientation/Confusion
Weight Change	Nipple Discharge	Nausea	Dizziness
Blurred vision	Nipple Inversion	Abdominal Pain/Cramping	Difficulty Walking
Double Vision	Breast Pain	Vomiting	Headaches
Visual Difficulties	Heart Racing	Burning in Urination	Nerve Pain/Neuropathy
Difficulty Swallowing	Chest Pain	Frequent Urination	Seizure
Impaired Hearing	Swelling to feet and legs	Blood in Urine	Anxiety
Hoarseness	Cough	Impaired Sex Function/Impotent	Hallucinations
Mouth Dryness	Shortness of Breath	Loss of Bladder/Bowel	Depression
Oral Bleeding	Coughing up Blood	Waking at Night to Urinate	Diabetes
Mouth Sores	Chest Pain upon Breathing	Urine Urgency	Hot Flashes
Neck Pain	Wheezing	Vaginal Discharge/Bleeding	Thyroid Disease
Swelling in Neck	Constipation	Bone Pain	Easy Bruising
Blisters on Skin	Diarrhea	Joint Pain	Swollen Lymph Nodes
Other: ______________________			

I attest that all of the information in this document is true, correct to the best of my knowledge, and understand that my physician will base his opinions and judgements on the same.

____ ___________________________

Patient Signature **Date**

CENTRAL ALABAMA RADIATION ONCOLOGY

As our patient, we care about you and want to help you understand our billing process. Please take a moment to become familiar with the services provided by the Business Office staff at the Central Alabama Radiation Oncology, LLC. Representatives are available Monday – Friday from 8:00am – 5:00pm to facilitate inquiries.

Health Insurance

Central Alabama Radiation Oncology, LLC participates with most major insurance companies, such as Medicare and Medicaid. Prior to your visit, check with your employer or insurance company to see if you have access to health care services at Central Alabama Radiation Oncology, LLC, otherwise you may be responsible for all or a large portion of your health care services. Bring all of your health insurance information when you register. This includes your insurance cards which will provide the name of your insurance company, group number, and plan number. We will bill the primary insurance carrier for your healthcare services, and if applicable, your secondary insurance company as a courtesy. It is important to remember that health insurance coverage varies and some services may not be covered. If you have questions regarding your health insurance coverage, please call ***your insurance carrier*** to better understand how ***your policy*** works prior to receiving care at Central Alabama Radiation Oncology, LLC.

Information Update

It is ***your responsibility*** to inform us of any insurance or personal data change. Incorrect information can cause payment delays or denials that may ultimately leave you responsible for payment.

Co-Payments & Deductibles

Co-payments and other balances are due ***on the day you receive services***. If your insurance carrier requires it, you will need to pay for estimated coinsurance or deductibles related to the services provided. If you have any questions regarding co-payments or deductibles, please call your insurance carrier for policy guidelines.

Non-Covered Services

If your insurance carrier disagrees with our Provider that the service provided was not medically necessary, is a pre-existing condition, or is a non-covered service, you may be asked to sign a notice that makes you financially responsible for the services provided and you will be asked to pay at the time of service.

Patient Statements

In the event your insurance carrier does not pay the entire bill, we will send you a statement to notify you of any remaining unpaid balances. This statement will usually arrive within 45 days of receiving services at Central Alabama Radiation Oncology, LLC unless there is a delay in your insurance carrier's payment. Your insurance company may be billed for services covered by another physician in our facility if your doctor was not available for your treatment. For your convenience, we accept cash, checks, and all major credit cards including Visa, Master Card, and Discover. ***Payment is due 15 days after you receive a statement***. Please tell us if you are unable to pay your bill in full. We are available to assist you with monthly payment plans.

Collection Process

Central Alabama Radiation Oncology, LLC will use the services of ***Holloway Credit Solutions*** in collection of all outstanding debt. Accounts which are not paid within 90 days, and for which NO special arrangements have been made, will be subject to placement with ***Holloway Credit Solution.*** If your account is placed for collection, you agree to be responsible for paying all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

Consent to contact patient

You agree, in order for us to service your account or collect monies you may owe, Central Alabama Radiation Oncology, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that Central Alabama Radiation Oncology, LLC, its employees and/or agents may contact me/us as described above.

____ ____________________

Patient Signature **Date**

CENTRAL ALABAMA
RADIATION ONCOLOGY

Insurance claims are completed without charge as a courtesy to our patients. We reserve the right to accept insurance assignment based on your services and/or treatment. If we accept assignment, we will allow up to 45 days for payment from your insurance carrier. Your Insurance policy is a contract between you and the insurance company. Assignment of benefits does not relieve you of your obligation to assist in the collection of said insurance benefits and pay any uncollected balance due for the services rendered to you. Additional information regarding our financial policy will be provided by you. A counselor from our Business Office will review your insurance coverage and estimate your portion of the bill. The patient balance is due at the time of service.

For assigned benefits, I request that my payment under my insurance plans be made to Central Alabama Radiation Oncology for any medical services and treatment rendered to me. I also request that Central Alabama Radiation Oncology submit a claim to my insurance carrier(s) for payment and authorize payment directly to Central Alabama Radiation Oncology. I hereby authorize release to my insurers all billing and medical information regarding services and treatment rendered for the purpose of determining eligibility for and payment of charges for services and treatment rendered. Should an insurance payment be received that is less than the physician's actual charges for services provided, I (we), as a responsible party understand that l, (we), owe the difference.

I (we) further understand that Central Alabama Radiation Oncology may utilize the services of a collection agency to expedite collection of any balance due. If such action becomes necessary, I (we) agree to pay all collection cost incurred by Central Alabama Radiation Oncology, including my attorney fees.

____ ____________________

Patient Signature **Date**

FOR MEDICARE PATIENT ONLY

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER

(EXTENDED PAYMENT REQUEST FOR PHYSICIAN SERVICES APPLICABLE TO CURRENT AND FUTURE TREATMENTS)

Patient Name:______________________________ **Medicare Number:** __________________________

I certify that all information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Central Alabama Radiation Oncology.

I authorize Central Alabama Radiation Oncology and any holder of medical and billing information about me to release to the Health Care Financing Administration and its agents, any information needed to determine benefits payable for services rendered or the benefits payable for related services. I recognize that this authorization will permit Central Alabama Radiation Oncology to submit any Medicare claim without obtaining any additional signature from me, and will remain in the files of Central Alabama Radiation Oncology for inspection by the Medicare Carrier, and will continue in full force and effect unless cancelled by my written request.

____ ____________________

Patient Signature **Date**

CENTRAL ALABAMA RADIATION ONCOLOGY

Financial Policy

It is the policy of ***Central Alabama Radiation Oncology, LLC*** that all fees including co-pays, deductibles and non-covered services are *due and payable on the date of service unless other payment arrangements have been made in advance*.

Insurance coverage is considered by ***Central Alabama Radiation Oncology, LLC*** as an agreement between the patient, the insurance company and the employer, where applicable. ***Central Alabama Radiation Oncology, LLC*** is not a party to that agreement and as a result is not bound by any of the covenants, limitations, or restrictions of that policy.

As a *service to our patients*, we will file insurance claims for the services provided. Itemized bills will be provided to you for those services upon request. The filing of insurance does ***NOT*** release the patient from responsibility for charges for services which have been provided.

Charges for services ***not covered by insurance*** are due when a patient statement is received unless specific arrangements have been made for an extension of time. If you have special needs, contact our Billing Office for assistance. ***You are responsible*** for payment of services not paid in whole or in part by your insurance.

Statements showing the status of your account are mailed monthly. ***Central Alabama Radiation Oncology, LLC*** is prepared to counsel any patient experiencing difficulty in meeting payment obligations. If you are unable to make payment when due, please contact our office as soon as you receive our statement.

Central Alabama Radiation Oncology, LLC will use the services of an outside collection company in the collection of all debt accounts which are not paid within 90 days and for which no special arrangements have been made. You will be responsible for any fee(s) charged in collection of the lawful debt to include; collection agency fee(s), (33.33%), attorney fees, and/or court costs, if such is necessary.

Having read and understood ***Central Alabama Radiation Oncology, LLC Financial Policy***, I agree to the terms set forth.

_______________________________________ _______________________________________

Patient Signature Date

CENTRAL ALABAMA
RADIATION ONCOLOGY

ACKNOWLEDGEMENT OF PHOTOGRAPH
CONSENT TO EMAIL AND VOICE MESSAGES

Patient Name:	**Date of Birth**:

I, ________________________________ understand that as part of my treatment for safety and identification purposes my
(Print Name)
picture will be taken for placement in my medical record. I understand that ownership of this photograph will be retained by Central Alabama Radiation Oncology, LLC. Images that identify me will be released to outside agencies only if a written authorization is signed by me or my legal representative.

________ **(initial)** I hereby acknowledge that my picture will be taken on my initial visit and as deemed necessary by my attending physician and/ or his associates.

________ **(initial)** I authorize Central Alabama Radiation Oncology, LLC to communicate via email to me regarding missed appointments, reminders, education material etc…

________ **(initial)** I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, for me by voice mail at the numbers listed on my HIPAA Privacy Form and/or Registration Form. I understand that it is my responsibility to keep the practice informed of any changes to this information. This authorization is in effect until cancelled in writing by me.

Email Address: ____

____________________________________ ____________________________
Patient's Signature **Date**

CENTRAL ALABAMA
RADIATION ONCOLOGY

Patient Name:	Date of Birth:

I hereby authorize **Central Alabama Radiation Oncology** to use, disclose and/or obtain my health information for continuation of medical care.

By providing this Authorization, I understand as follows:

(1) I understand that I will receive a copy of the authorization form after I sign it.
(2) I understand that the health information may be subject to re-disclosure by the recipient of the health information. In the case of re-disclosure, such health information may no longer be protected by HIPAA privacy rules.
(3) I understand that if I refuse to sign this authorization my treatment and/ or payment obligations do not change. While signing this authorization is voluntary, refusal to do so may slow the disclosure of records with any appropriate health or payment institution that requires a signed authorization through internal requirements.
(4) I understand that revocation of this authorization may be done by me at any time in writing by notifying the Compliance Officer at Central Alabama Radiation Oncology, LLC, 4143 Carmichael Road, Montgomery, AL, 36106. Should I do so, I understand this will not have any effect on uses or disclosures prior to the receipt of the revocation.

Medical Records use only:

Specific description of the health information to be used/disclosed/obtained:

____

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____

____ ____________________

Patient Signature **Date**

CENTRAL ALABAMA RADIATION ONCOLOGY

HIPAA PRIVACY FORM

Patient Name:	Date of Birth:	Social Security #:

By signing this form, I hereby acknowledge receipt of the "Notice of Privacy Practices".

I understand it is the policy of this healthcare facility to protect the privacy of my healthcare information.

As a necessary condition of treatment, I consent to release of my protected health information to other physicians and third party payers for the purpose of my treatment, payment for my treatment, and general operation of the healthcare facility. Otherwise, healthcare staff will only disclose information about me with my permission.

If I expect a family member to telephone or pick up test results or films on my behalf, healthcare staff will only disclose information to persons designated by me. Similarly, if I expect a family member or friend to routinely be involved in my healthcare and I would like the healthcare staff to be able to share that information with him or her, I need to list their name below.

Persons Permitted by Patient to Receive Patient's Healthcare Information if you don't want to give permission please write NONE.

Date	Name of Person	Release all information or specify	Relationship to the Patient	Telephone #	Your Initials
				( )	
				( )	
				( )	
				( )	

I understand this release of information will remain in effect until terminated by me in writing.

______________________________________ ____________________

Patient Signature **Date**

CENTRAL ALABAMA
RADIATION ONCOLOGY

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements To Include Nondiscrimination Statement:

Discrimination is Against the Law

CENTRAL ALABAMA RADIATION ONCOLOGY, LLC (CARO) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CARO does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CENTRAL ALABAMA RADIATION ONCOLOGY, LLC (CARO):

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

○ Qualified sign language interpreters

○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

○ Qualified interpreters

○ Information written in other languages

If you need these services, contact the COMPLIANCE OFFICER

If you believe that CENTRAL ALABAMA RADIATION ONCOLOGY, LLC (CARO) has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: COMPLIANCE OFFICER, 4143 Carmichael Road, Montgomery, AL 36106, (334) 395-2200, [TTY number—if covered entity has one], Fax (334) 395-2201. You can file a grievance in person or by telephone, mail, or fax. If you need help filing a grievance, the COMPLIANCE OFFICER is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call (334) 395-2200.

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (334) 395-2200.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (334) 395-2200번으로 전화해 주십시오.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電(334) 395-2200。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (334) 395-2200.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم x 395-2200 (334)
(رقم هاتف الصم والبكم: 395-2200 (334).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (334) 395-2200.

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (334) 395-2200.

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (334) 395-2200.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (334) 395-2200.

Hindi

ध्यान दें: यदि आप □□□□□ बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (334) 395-2200 पर कॉल करें।

Laotian

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (334) 395-2200.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (334) 395-2200.

Portugese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (334) 395-2200.

Turkish

DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. (334) 395-2200 irtibat numaralarını arayın.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(334) 395-2200 まで、お電話にてご連絡ください。

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

"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 August 30, 2013)

Central Alabama Radiation Oncology, LLC ("Provider") is dedicated to protecting your health information. Provider is required by law to maintain the privacy of protected health information, to provide you adequate notice of your rights and our legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. 45 CFR § 164.520. "Protected Health Information" is defined at 45 CFR § 164.501 and includes past, present and future information created or received by Provider. It also includes demographic information that may identify you and that relates to your past, present or future medical condition (physical or mental), the providing of health care to you, or payment for the health care treatment. We will use or disclose Protected Health Information in a manner that is consistent with this notice.

WHAT IS THIS NOTICE?

Provider maintains a record (paper/electronic file) of the information we receive and collect about you and of the care we provide to you. This record includes, without limitation, physicians' orders, assessments, medication lists, clinical progress notes and billing information. This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights regarding your Protected Health Information.

As required by law, Provider maintains policies and procedures about our work practices, including how we coordinate care and services provided to our patients. These policies and procedures include how we create, receive, access, transmit, maintain and protect the confidentiality of all health information in our workforce and with contracted business associates and/or subcontractors; security of Provider's building and electronic files; and how we educated staff on privacy of patient information.

PERMITTED AND REQUIRED USES AND DISCLOSURES.

As our patient, information about you must be used and disclosed to other parties for purposes of **treatment, payment and health care operations**. Examples of information that must be disclosed:

1. **Treatment:** Providing, coordinating or managing health care and related services, consultation between health care providers relating to a patient or referral of a patient for health care from one provider to another. For example, we may need to give information to doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you both in and outside of Provider's office.
2. **Payment:** Billing and collecting for services provided, determining plan eligibility and coverage, utilization review (UR), precertification, and medical necessity review. For example, we may need to give information to your health plan about treatment you received so that your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.
3. **Health Care Operations:** General agency administrative and business functions, quality assurance/improvement activities; medical review; auditing functions; developing clinical guidelines; determining the competence or qualifications of health care professionals; evaluating agency performance; conducting training programs with students or new employees; licensing, survey, certification, accreditation and credentialing activities; internal auditing; and certain fundraising activities, if applicable, and with your authorization, marketing activities. For example, we may disclose medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. The medical information we have may be combined with medical information from other sources in order to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so that others may use it to study health care and health care delivery without learning who the specific patients are.

The following uses and disclosures do not require your consent, and include, but are not limited to, a release of information contained in financial records and/or medical records, including information concerning communicable diseases such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), drug/alcohol abuse, psychiatric diagnosis and treatment records and/or laboratory test results, if applicable, medical history, treatment progress and/or any other related information as permitted by state law to:

1. Your insurance company, self-funded or third-party health plan, Medicare, Medicaid or any other person or entity that may be responsible for paying or processing for payment any portion of your bill for services;

2. Any person or entity affiliated with or representing us for purposes of administration, billing and quality and risk management;
3. Any hospital, nursing home or other health care facility to which you may be admitted;
4. Any assisted living or personal care facility of which you are a resident;
5. Any physician providing you care;
6. Licensing and accrediting bodies, including the information contained in the OASIS Data Set to the state agency acting as a representative of the Medicare/Medicaid program;
7. Contact you to raise funds for Provider; you will be given the right to opt out of receiving such communications, if applicable;
8. Any business associate or institutionally related foundation for the purpose of raising funds for the agency (information may include: demographics – name, address, contact information, age, gender, date of birth; dates of health care provided; department of services; treating physician; outcome information; and health insurance status), if applicable. You will be given the right to opt out;
9. Refill reminders for drugs, biologicals and/or drug delivery systems that have already been prescribed to you;
10. Marketing communications promoting health products, services and information programs or communications if the communication is made face to face with you or the only financial gain consists of a promotional gift of nominal value provided by Provider; and
11. Other health care providers to initiate treatment.

We are permitted to use or disclose information about you without consent or authorization in the following circumstances:

1. In **emergency treatment situations**, if we attempt to obtain consent as soon as practicable after treatment;
2. Where **substantial barriers to communicating with you** exist and we determine that the consent is clearly inferred from the circumstances;
3. Where we are **required by law** to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure of medical information about you **is required by federal, state or local law**;
5. To provide information **to state or federal public health authorities**, as required by law to: prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify persons of recalls of products they may be using; notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence (if you agree or when required or authorized by law);
6. **Health care oversight activities** such as audits, investigations, inspections and licensure by a government health oversight agency as authorized by law to monitor the health care system, government programs and compliance with civil rights laws;
7. **To business associates** regulated under HIPAA that work on our behalf under a contract that requires appropriate safeguards of Protected Health Information;
8. **Certain judicial administrative proceedings** if you are involved in a lawsuit or a dispute. We may disclose medical information about you in response to a court or administrative order, a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested;
9. **Certain law enforcement purposes** such as helping to identify or locate a suspect, fugitive, material witness or missing person, or to comply with a court order or subpoena and other law enforcement purposes;
10. **To coroners, medical examiners and funeral directors**, in certain circumstances, for example, to identify a deceased person, determine the cause of death or to assist in carrying out their duties;
11. **For cadaveric organ, eye or tissue donation purposes** to communicate to organizations involved in procuring, banking or transplanting organs and tissues (if you are an organ donor);
12. **For certain research purposes** under very select circumstances. We may use your health information for research. Before we disclose any of your health information for such research purposes, the project will be subject to an extensive approval process. We may also request your written authorization before granting access to your individually identifiable health information but are not required to do so;
13. **To avert a serious threat to health and safety**: To prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public, such as when a person admits to participation in a violent crime or serious harm to a victim or is an escaped convict. Any disclosure, however, would only be to someone able to help prevent or lessen the threat;

14. **For specialized government functions**, including military and veterans' activities, national security and intelligence activities, protective services for the President, foreign heads of state and others, medical suitability determinations, correctional institution and custodial situations; and
15. **For Workers' Compensation purposes**: Workers' compensation or similar programs provide benefits for work-related injuries or illness.

We are permitted to use or disclose information about you provided you are informed in advance and given the opportunity to individually agree to, prohibit, or restrict the use or disclosure in the following circumstances:

1. Use or disclosure of a directory (including name, location, condition described in general terms and/or religious affiliation) of individuals served by Provider;
2. Provide proof of immunization to a school that is required by state or other law to have such proof with agreement to disclosure by parent, guardian or other person acting in loco parentis of the individual, if the individual is an unemancipated minor; and
3. Provide a family member, relative, friend, or other identified person, prior to, or after your death, the information relevant to such person's involvement in your care or payment for care; to notify a family member, relative, friend, or other identified person of your location, general condition or death.

Other uses and disclosures not covered in this notice will be made only with your written authorization. Authorization is required and may be revoked, in writing, at any time, <u>except in limited situations</u>, for the following disclosures:

1. Marketing of products or services or treatment alternatives, including any subsidized treatment communications, that may be of benefit to you when we receive direct payment from a third party for making such communications, other than as set forth above with regard to face-to-face communications and promotional gifts of nominal value;
2. Psychotherapy notes under most circumstances, if applicable; and
3. Any sale of Protected Health Information resulting in financial gain by Provider unless an exception is met.

YOUR RIGHTS.

You have the right, subject to certain conditions, to:

1. **Request restrictions on uses and disclosures of your Protected Health Information** for treatment, payment or health care operations. However, we are not required to agree to any requested restriction. Restrictions to which we agree will be documented. Agreements for further restrictions may, however be terminated under applicable circumstances (e.g., emergency treatment).

   We must agree to your request to restrict disclosure of Protected Health Information about you to a health plan if: 1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and 2) the Protected Health Information pertains solely to a health care item or service for which you or someone on your behalf paid the covered entity in full. (164.522 Rights to request privacy protection for Protected Health Information).
2. **Confidential communication of Protected Health Information.** We will arrange for you to receive Protected Health Information by reasonable alternative means or at alternative locations. Your request must be in writing. We do not require an explanation for the request as a condition of providing communications on a confidential basis and will attempt to honor reasonable requests for confidential communications.

   If you request your Protected Health Information to be transmitted directly to another person designated by you, your written request must be signed and clearly identify the designated person and where the copy of Protected Health Information is to be sent.
3. **Inspect and obtain copies of Protected Health Information** that is maintained in a designated record set, except for psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or Protected Health Information that may not be disclosed under the Clinical Laboratory Improvements Amendments of 1988 [42 USC § 263a and 45 CFR 493 § (a)(2)]. If you request a copy of your health information, we will charge a reasonable, cost-based fee, that includes only the cost of labor for copying, supplies, postage, if applicable, and preparing an explanation or summary of the projected health information if agreed to, in accordance with applicable state and federal regulations. If the requested Protected Health Information is maintained electronically and you request an electronic copy, we will provide access in an electronic format you request, if readily producible, or if not, in a readable electronic form and format mutually agreed upon. IF YOU REQUEST AN ELECTRONIC COPY, PROVIDER HEREBY EXPRESSLY DISCLAIMS ALL DUTIES AND RESPONSIBILITY FOR THE SECURITY AND PROTECTION OF SUCH INFORMATION ONCE TRANSMITTED TO YOU AND HAS NO CONTROL OVER ACCESS TO THAT INFORMATION

AFTER THE TRANSMISSION TO YOU THEREOF. ALL SUCH INFORMATION MAINTAINED BY PROVIDER WILL CONTINUE TO BE SECURED AND PROTECTED AS REQUIRED BY APPLICABLE LAW.

If we deny access to Protected Health Information, you will receive a timely, written denial in plain language that explains the basis for the denial, your review rights and an explanation of how to exercise those rights. If we do not maintain the medical record, we will tell you where to request the Protected Health Information if we have knowledge thereof.

4. **Request to amend Protected Health Information** for as long as the Protected Health Information is maintained in the designated record set. A request to amend your record must be in writing and must include a reason to support the requested amendment. We will act on your request within sixty (60) days of receipt of the request. We may extend the time for such action by up to thirty (30) days, if within the initial sixty (60) days we provide you with a written explanation of the reasons for the delay and the date by which we will complete action on the request.

   We may deny the request for amendment if the information contained in the record was not created by us, unless you provide a reasonable basis for believing the originator of the information is no longer available to act on the requested amendment; is not part of the designated medical record set; would not be available for inspection under applicable laws and regulations; or the record is accurate and complete. If we deny your request for amendment, you will receive a timely, written denial in plain language that explains the basis for the denial, your rights to submit a statement disagreeing with the denial and an explanation of how to submit that statement.

5. **Receive an accounting of disclosures of Protected Health Information** made by Provider for up to six (6) years prior to the date on which the accounting is requested for any reason other than for treatment, payment or health operations and other applicable exceptions. The written accounting includes the date of each disclosure, the name of the entity or person who received the Protected Health Information and, if known, the address, a brief description of the information disclosed and a brief statement of the purpose of the disclosure or a copy of the written request for disclosure. We will provide the accountings within sixty (60) days of receipt of a written request. However, we may extend the time period for providing the accounting by thirty (30) days if within the initial sixty (60) days we provide you with a written statement of the reasons for the delay and the date by which you will receive the information. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests within the applicable 12-month period may be subject to a reasonable cost-based fee, which fee information will be provided to you in advance of fulfilling your request; you will also have an opportunity upon receipt of fee information to withdraw or modify your request for the accounting in order to avoid or reduce the applicable fee.

6. **Receive notification of any breach in the acquisition, access, use or disclosure** of unsecured Protected Health Information by Provider, its business associates and/or subcontractors.

7. **Obtain a paper copy of this notice from us upon request,** even if you had previously agreed to receive this notice electronically. We reserve the right to amend this notice of privacy practices at any time.

COMPLAINTS.

If you believe that your privacy rights have been violated, you may complain to Provider or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation against you for filing a complaint. The complaint should be filed in writing, and should state the specific incident(s) in terms of subject, date and other relevant matters. A complaint to the Secretary must be filed in writing within 180 days of when the act or omission complained of occurred, and must describe the acts or omissions believed to be in violation of applicable requirements. 45 CFR § 160.306.

EFFECTIVE DATE.

This notice is effective: August 30, 2013. We are required to abide by the terms of the notice currently in effect, but we reserve the right to change these terms as necessary for all Protected Health Information that we maintain. If we change the terms of this notice (while you are receiving service), we will promptly revise and distribute a revised notice to you as soon as practicable by mail, e-mail (if you have agreed to electronic notice) or hand delivery.

If you require further information about matters covered by this notice, please contact:

Privacy Officer
Central Alabama Radiation Oncology, LLC
4143 Carmichael Road
Montgomery, AL 36106
(334) 395-2291

I HAVE RECEIVED AND HAD AN OPPORTUNITY TO ASK QUESTIONS CONCERNING THIS NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

____________________________________ ____________________

Patient Signature **Date**