Verity
LIFE SAVING THERAPY

AUTHORIZED FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____

To Release To: Verity Radiation Therapy
6957 West Plano Pkwy Suite 1300
Plano, TX 75093

Telephone Number: 972-820-1400 Fax Number: 972-820-1020

The following information from the medical record of:
Patient Name: _____ Date of Birth: _____
Date of Treatment: _____ Social Security Number: _____

Information to be released:

_____ Consultation Reports	_____ Physical Therapy Records
_____ Discharge Summary	_____ Progress Note
_____ History & Physical	_____ X Ray Reports
_____ Itemized Bill	_____ X Ray Films/Images
_____ Other (specify) _____	

The information specified above is to be released for the following purpose:

_____ Treatment/Consultation	_____ Patient Request	_____ Billing or Claims
_____ Attorney	_____ Social Security	_____ Other (specify) _____

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC AND/OR HIV/AIDS RECORDS RELEASE:

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release
Check one _____ Yes _____ No _____ Initials

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address. This authorization will automatically expire 180 days from the date of my signature or unless revoked prior to that time or unless otherwise specified as follows:

_____

Re-disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released form any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative:
I authorize **Verity Radiation Therapy** to use and disclose the protected health information as specified above.
I further understand that a reasonable copy fee may be charged for medical record copies.

_____ _____
Signature of Patient or Legal Representative Date

Authority to sign if not Patient (documentation of authority required) _____

Identity or Requestor Verified via: _____ Photo ID _____ Matching Signature verified by: _____

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CONSENT TO DISCUSS HEALTH CARE INFORMATION

I understand that "**Directory Information**" such as my presence in the facility, as described in the **Verity Radiation Therapy** Notice of Privacy Practices, may be released to all who ask for me by name, unless I object by specifically requesting to be a "No Information" patient as described below.

_____ **STANDARD DISCLOSURE**: I authorize this facility and medical staff members to discuss my medical history, diagnosis, treatment and prognosis with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse.

_____ Spouse _____ Children

_____ Other Family Members (Parents, In-Laws, Grandparents, etc)

_____ Other: _____

_____ **NO INFORMATION** - I do not authorize the release of any information concerning my treatment. I understand that this includes Directory Information. I choose to be a "No Information" patient.

_____ _____ _____

Signature of Patient or Legally Authorized Representative | Relationship | Date

_____

Witness

* For purposes of this form only. A "legally authorized representative" is: 1) a legal guardian 2) an agent authorized in a medical power of attorney or directive to physicians 3) an attorney appointed by the court 4) an attorney retained by the patient or the patient's legally authorized representative or 5) a parent or legal guardian of a minor.

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Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

MEDICAL PHOTOGRAPHY CONSENT

I consent to medical images and / or video being made of me or my child / dependant. I agree that duplicates may be made for the referring doctor.

I agree that the images and results of my investigative tests may be:
(please tick below to show consent)

	Yes	No
…placed in my medical record for future treatment		
…electronically emailed to my treating health professional		
…used by health professionals for education and training		
…used in paper or electronic health publications		

PATIENT SIGNATURE: _____ **DATE:** _____

_____ **DATE:** _____
Signature of Parent or other Legally Responsible Person

TREATMENT OBSERVATION CONSENT

Verity Radiation Therapy is an official Varian Reference Site. Periodically, we host visitors from other centers who wish to learn about our equipment. These are Radiation Oncology clinical personnel and administrators, and Varian representatives. A Verity Radiation Therapy staff member will ask your approval each time there is an outside observer present during your treatment. All patient information will be kept strictly confidential.

I ☐ DO ☐ DO NOT consent to periodic observers during my treatment
(Check one)

PATIENT SIGNATURE: _____ **DATE:** _____

_____ **DATE:** _____
Signature of Parent or other Legally Responsible Person

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CONSENT FOR TREAT

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services at Verity Radiation Therapy, provided by physicians, employees and such associates, assistants and other health care providers, as my physicians deem necessary. I understand that such services (such as lab and x-rays), examinations and treatment that may include chemotherapy and/or radiation therapy.

RELEASE OF INFORMATION: I authorize Verity Radiation Therapy/Pro Physicians Clinic, P.A. to disclose my health information for the purpose of continued care, claims processing or other related needs. Any other use of this information without the written consent of the patient is prohibited.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance. Medicare, Medicaid or other third-party payer benefits for medical or health care services otherwise payable to me to Verity Radiation Therapy/ Pro Physicians Clinic P.A.. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to the Verity Radiation Therapy/Pro Physicians Clinic, P.A.. **I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-payer** and agree to make payment as requested by Verity Radiation Therapy/Pro Physicians Clinic, P.A.

I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct and that it is my responsibility to notify Verity Radiation Therapy/Pro Physicians Clinic, P.A. of changes to my address, telephone number, primary care physician or insurance carrier _____ (Patient's Initials)

I (**do**) (**do not**) consent to the use of blood and blood products as deemed necessary.

I understand that no warranty or guarantee has been made to me as to result or cure. I certify that this form has been fully explained to me, that I have read it or had it read to me* and that I understand its contents.

ADVANCE DIRECTIVE: I have signed an Advance Directive. _____ Yes _____ No (Patient's Initials)
If yes, is it still in effect? _____ Yes _____ No
I have provided a signed copy to Verity Radiation Therapy _____ Yes _____ No

NOTICE OF PRIVACY PRACTICES: I have received a copy of the Verity Radiation Therapy/Pro Physicians Clinic, P.A. Notice of Privacy Practices.
_____ (Patient's Initials)

_____ Date

_____ Time

_____ Patient / Other Legally Authorized Person

_____ Witness / Translator*

_____ Print Name and Relationship to Patient

_____ Print Witness Name and Translated Language

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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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of [name of practice]. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Research
Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you would like this office to communicate your health information to you in a confidential manner, please indicate your wishes on the '*Acknowledgement of Receipt of HIPAA Notice of Privacy Practices*' form.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information;
- The right to receive confidential communications concerning your medical condition and treatment;
- The right to inspect and copy your protected health information;
- The right to amend or submit corrections to your protected health information;
- The right to receive an accounting of how and to whom your protected health information has been disclosed; &
- The right to receive a printed copy of this notice.

Practice Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this "Notice of Privacy Practices".

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter or placing a call outlining your concerns to:

HIPAA Privacy Officer
Verity Radiation Therapy
6957 West Plano Pkwy
Suite 1300
Plano, TX 75093
(972) 820-1400

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit complaints to the Secretary of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.

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NEW PATIENT INTAKE **DATE: _____ TIME: _____**

Attending Physician (circle one): Lubbe Nichols

Patient Name: _____

Patient Phones | Primary: _____ Alternate: _____

Date of Birth: _____ SS#: _____

Patient's Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ Emp. Phone: _____

Primary Insurance: _____ Insurance Phone: _____

Insurance ID#: _____ Group #: _____

Policy Holder: _____ DOB: _____ SS#: _____

Secondary Insurance: _____ Insurance Phone: _____

Insurance ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ SS#: _____

Medical Oncologist: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Doctor: _____ Phone: _____ UPIN# _____

Other Doctors: _____ Phone: _____

Emergency Contact 1: _____ Relationship: _____ Phone: _____

Emergency Contact 2: _____ Relationship: _____ Phone: _____

Race: _____ E-mail: _____ Appt. Reminder

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MEDICARE SECONDARY PAYER QUESTIONNAIRE **DATE: _____ TIME: _____**

Patient Name: _____

Are you receiving Black Lung benefits? **□ Yes □ No**

Are Services to be paid by a government program such as a research grant? **□ Yes □ No**

Has the Department of Veterans Affairs agreed to pay for care at this facility? **□ Yes □ No**

Are you here based on a work related illness? **□ Yes □ No**

Are you eligible for Medicare based on: (Check One)
□ Age
□ Disability
□ ESRD

Are you currently employed? **□ Yes □ No**
If no, date of retirement: _____
If yes, place of employment: _____

If married, is your spouse currently employed? **□ Yes □ No**
If no, date of retirement: _____
If yes, place of employment: _____

Do you have General Health Plan (GHP) Coverage based on your spouse's current employment? **□ Yes □ No**

Does your employer with <u>your</u> General Health Plan Coverage employ 20 or more employees? **□ Yes □ No**

Are you covered by any secondary Health Insurance Plan? **□ Yes □ No**
If yes, name of insurance company: _____

_____ _____
Patient Signature ***Date***

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BILLING INFORMATION | ASSIGNMENT OF BENEFITS **DATE: _____ TIME: _____**

Patient Name: _____

Facility:
□ Verity Radiation Therapy

Physician:
□ Timothy D. Nichols, M.D., Board Certified Radiation Oncology
□ Wilhelm J. Lubbe, M.D. Ph.D., Board Certified Radiation Oncology

The staff at this facility appreciates the opportunity to participate in your care. We will do our best to see that you receive the best possible care.

When your radiation treatments have been completed, you will receive TWO statements. You will receive *one bill from the Facility checked above and a second bill from your physician's billing office.* The latter will be the physician's professional fee for planning and directing your treatment.After you register, the Facility will provide the physicians with most of the information we will need to file your insurance claim for you. If, at any time, you have questions or concerns regarding the billing process, please do not hesitate to call and discuss them with the appropriate billing office.

Facility Billing Office:
Verity Radiation Therapy via RCBilling | Austin, Texas. Phone: 512.583.0205

Please assist us in filing your insurance by signing this authorization for assignment of benefits that will be submitted with your claim.

"I authorize the release of any medical information necessary to process this claim and request payment of insurance proceeds, including major medical benefits to _____. This will also serve as authorization for his office to obtain insurance information regarding any claims submitted in my behalf."
A copy of this signature is a valid as the original.

_____ _____
Patient Signature ***Date***

Patient Printed Name: _____

Verity Witness: _____ Date: _____