Southern Cancer Center

PATIENT REGISTRATION PROFILE **Patient ID:**_____

Patient Name: _____ **Sex:** ☐ M ☐ F
First Middle Last

Mailing Address: _____
Street City State Zip

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

Date of Birth: _____ **Social Security #:** _____ **Marital Status:** _____

Emergency Contact: _____
Name Relationship Phone

SCC MD: _____ **Referring MD:** _____
(First & Last Name)

Primary Insurance: _____ **ID:** _____ **Group Number:** _____

Policy Holder Name: _____ **Birthdate:** _____ **Sex:** ☐ M ☐ F

Relationship: _____

Secondary Insurance: _____ **ID:** _____ **Group Number:** _____

Policy Holder Name: _____ **Birthdate:** _____ **Sex:** ☐ M ☐ F

Relationship: _____

Please provide your email address which will allow you to view your medical records online from Southern Cancer Center.

Email Address: _____

Do you have a Health Care Durable Power of Attorney? Yes ___ No___
If Yes, who is your Health Care Durable Power of Attorney? _____

Do you have a Living Will? Yes___ No___

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:
- ☐ American Indian or Alaskan Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White

Patient Signature: _____ **Date:** _____

Authorized Representative if Patient unable to sign: _____ Date: _____

Relationship to Patient: _____

☐ **I do** ☐ **I do not** Authorize the release of information, including, if applicable, specific laboratory tests of HIV Infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.

Releasor, its agents and employees, are hereby authorized to obtain, inspect, and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information in accordance with this Authorization. This Authorization will expire one (1) year from the date of my signature.

I understand that I have the right to revoke this Authorization, if the revocation is in writing except if (i) Releasor has taken action in reliance upon this Authorization or (ii) if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

I understand that I may revoke this Authorization by providing a written revocation to the provider from which records are requested in the box above.

I understand that my Protected Health Information that is used or disclosed under this authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by law.

(A) RELEASE OF INFORMATION
I acknowledge that records concerning the patient are the property of Southern Cancer Center and are maintained for the use and benefit of Southern Cancer Center and its staff in providing care and treatment to the patient. I hereby authorize Southern Cancer Center to disclose all or any part of my patient record to my admitting physician, consulting physician(s), or hospital based physicians. I further authorize Southern Cancer Center and providing physicians to disclose all or any part of my patient record to any person or corporation that is or may be liable under contract to Southern Cancer Center or to me or a family member of mine, for all or part of Southern Cancer Center's charges, including, but not limited to, hospitals or medical service companies, insurance companies, Worker's Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations.

(B) ASSIGNMENT OF BENEFITS
I assign payment of all insurance benefits, basic and major medical for this period of medical treatment to be made directly to Southern Cancer Center.

(C) FINANCIAL AGREEMENT
For and in consideration of services rendered, each of the undersigned agrees to pay Southern Cancer Center, P.C. for all charges not covered by insurance payments as statements are rendered. Each of the undersigned also agrees to pay all costs of collection, securing, or attempting to collect or secure, including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise.

(D) STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS, AND PATIENT
I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Southern Cancer Center. I authorize any holder of medical or other information about me to release any information needed to the Health Care Financing Administration determine these benefits or the benefits payable for related services.

(E) STATEMENT TO PERMIT PAYMENT OF MEDIGAP BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT
I request that payment of authorized Medigap benefits be made either to me or on my behalf to Southern Cancer Center for any services furnished to me. I authorize any holder of medical information about me to release to my Medigap insurance carrier any information needed to determine these benefits payable for related services.

(F) AUTHORIZATION FOR MEDICAL CARE, TREATMENT AND CLINICAL PHOTOGRAPHY
1. I recognize that a condition exists that requires medical care and I voluntarily consent to such medical care and treatment, diagnostic procedure by Southern Cancer Center and its medical and professional staffs, associates, and agents as deemed necessary.
2. I hereby authorize my physician, as provided by law to furnish medical treatment, diagnostic procedures, x-ray diagnosis, clinical photography or therapy as he/she considers necessary and proper in the treatment of the patient.
3. I am aware that the practice of medicine and surgery, and the administration of medical care, are not exact sciences and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, treatments, examinations or care undertaken with Southern Cancer Center.

(G) ACKNOWLEDGEMENT OF HEALTH INFORMATION PRACTICES
Southern Cancer Center's Notice of Health Information provides information about how health information about patients may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand the terms of this Notice may change and that a copy of the revised Notice will be posted in all Southern Cancer Center facilities. By signing this form, I acknowledge that I have been offered and/or received the Southern Cancer Center's Notice of Health Information Practices.

1. The contents of this form have been fully explained to me and I have been given the opportunity to ask questions. Any questions I asked have been answered to my satisfaction. I certify that I understand the contents of this form.

2. Termination of care may result from failure to cooperate and/or compliance with Southern Cancer Center's Medical Group Policy and Procedure.

Patient Signature: _____ **Date:** _____

Authorized Representative if Patient unable to sign: _____ Date: _____

Relationship to Patient: _____

Reviewed with Patient (employee signature) _____ **Date:** _____

Southern Cancer Center

HEALTHCARE PROVIDER RELEASE OF MEDICAL INFORMATION

Patient's Name: _____
Last First Middle

Current Address: _____

Patient's DOB: SS#: Phone #:

I hereby authorize and request release of records by:	To release to: **Southern Cancer Center**
Name (Hospital, Clinic, Physician) Releasor	Releasee: **Attn: Medical Records**
Address	Address:
City State Zip	City: State: Zip:
Phone #: Fax #:	Phone#: **251-625-6896** Fax #:

A copy of the medical records of the above-named patient pertaining to: (Check appropriate box and list the date)

- ☐ Emergency Care Date: _____
- ☐ Hospitalization Date: _____ to _____, _____ to _____
- ☐ Outpatient Care Date:

Check appropriate box (s) as needed:

- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Occupational Therapy Notes
- ☐ Physical Therapy Notes
- ☐ Labs
- ☐ Pathology
- ☐ X-Rays
- ☐ Abstract (H&P, discharge summary, consult, OP report)
- ☐ Other

REQUIRED ***The purpose of the request for the Medical Record is:***

☐ at the request of the patient ☐ for diagnosis/treatment purposes ☐ Other (explain)

REQUIRED

☐ **I do** ☐ **I do not** Authorize the release of information, including, if applicable, specific laboratory tests of HIV Infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.

Releasor, its agents and employees, are hereby authorized to obtain, inspect, and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information in accordance with this Authorization.

This Authorization will expire one (1) year from the date of my signature.

I understand that I have the right to revoke this Authorization, if the revocation is in writing except if (i) Releasor has taken action in reliance upon this Authorization, or (ii) if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

I understand that I may revoke this Authorization by providing a written revocation to the provider from which records are requested in the box above.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by law.

Patient Signature: _____ **Date:** _____

Authorized Representative if Patient unable to sign: _____ Date: _____

Relationship to Patient: _____

Southern Cancer Center

Patient Name: _____ MRN: _____

RELEASE OF MEDICAL INFORMATION

Before we can discuss your medical condition with anyone (spouse, children, significant other, etc.), we **MUST** have the following authorization on file. The physicians of Southern Cancer Center and their staff have my permission to discuss my medical condition, treatment, etc., and to release all information they have available to those listed below:

NOTE: *This list can be modified by the Patient, Parent or Legal Guardian in writing only.*

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

_____ Relationship _____ Phone _____

ADDITIONAL PHYSICIANS PARTICIPATING IN YOUR CARE

In order to obtain your medical records and to coordinate your care with your current providers, please list the physicians that are participating in your care. Please include the **physician's full name** and the city and state in which you are seen. Thank you.

_____ City, ST _____

_____ City, ST _____

_____ City, ST _____

_____ City, ST _____

_____ City, ST _____

_____ _____

Signature of Patient, Parent or Guardian **Date**

Clinical Photography

1. **Purpose**

This policy sets forth guidelines that SCC clinical staff, and other employees must follow when photographing patient at any SCC clinic site.

2. **Definitions**

Photography/photography – any videotaping, filming, still photography, images, digital or other means of recording and reproducing images
Consent – Permission granted by the patient (or legal representative) agreeing to allow the production of photographic images of the patient.
Publication – any method of displaying or distributing photographs, including simple showing or sending the photographs to a limited number of individuals.
Treatment - purposes of identification, diagnosis, evaluation, management and/or treatment of a patient. Treatment includes diagnostic or therapeutic procedures when obtaining the non-textual data is part of the procedure using specialized equipment, clinical communications and documentation to support reimbursement for services rendered to the patient.
Payment – health information disclosed to commercial or federal insurance companies or the Department of Social Services for claims processing, insurance review, or to determine benefits.
Health care Operations – clinical functions internal to or within SCC clinic or departments. Examples may include peer review, quality improvement, and risk management activities; certification, licensing and credentialing; business planning and management.

3**. Policy**

1. The purpose of this policy is to protect patient privacy and confidentiality, and to ensure the security of patient identifiable information in the accordance with federal and state laws, regulations and SCC policies regarding the security of protected health information (PHI).

2. Clinical photography of patients may be appropriate and necessary for the identification, diagnosis, evaluation, management and/or treatment of medical conditions. Photographs of patients may be used for payment or healthcare operations purposes.

3. The general consent for treatment provided by a patient's consent to take medical photographs for treatment purposes. The photographs may be used for treatment, payment and healthcare operations purposes without additional consent authorization.

4. Patient photographs taken for treatment purposes must be permanently stored in the patient's electronic health records. As soon as possible after inclusion in the medical record, the image must be deleted from the device on which it was produced.

5. Any employee taking or storing medical photography on any electronic storage or mobile device is required to follow SCC HIPAA security policies and procedures.

6. If a mobile device is used to take clinical photographs, an appropriate application must be used to take and transmit the clinical photographs directly into the medical record.

7. Any other use of identifiable patient photographs – education, media, publication, and research – requires that the patient execute a separate SCC HIPAA Authorization form.

4. **Procedure**

1. Consent for Clinical Photography

2. Patients who complete the appropriate consent for treatment also provide permission to use patient information, including photographs, for treatment, payment and healthcare operations. The general consent includes the provision of medical treatment or diagnostic procedures including clinical photographs, deemed necessary.

3. If clinical photographs are used/disclosed for treatment, payment, or operations, they may be shared internally or externally. Use or disclosures external to SCC related to payment or operations may require the execution of a HIPAA Business Associate Agreement.

5. **Authorization for Clinical Photography for Other Purposes**

1. If patient photography is used and/or disclosed (internal or external to SCC) for any purposes other than treatment, payment or healthcare operations.

2. HIPAA patient authorization of protected health information (PHI) must be completed by the patient or legal representative; or the patient photography must be de-identified.

3. Patient photography might be used and/or disclosed for: education, research, media and publication purposes.

6. **De-identified Photography**

1. Patient photography that is de-identified appropriately does not require a patient consent or authorization for use/disclosure.

2. Such uses requiring authorization might include: patient photography of the patient or body part may be sufficient unique or recognizable to make it patient-identifiable; therefore, use/disclosure of the photograph may require a HIPAA patient authorization for Protected health information (PHI)