PATIENT REGISTRATION PROFILE

Patient ID:

Patient Name: _____ **Sex:** ☐ M ☐ F ☐ Other
First Middle Last Preferred Pronoun (specify):

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 ☐ Other

Relationship: _____

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

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

Relationship: _____

Please provide your email address for viewing your medical records online from Southern Cancer Center.

Email Address: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other
- ☐ Prefer not to answer

Race:
- ☐ American Indian or Alaskan Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Prefer not to answer
- ☐ Asian
- ☐ White
- ☐ Other

Do you have a Living Will? Yes___ No____

Do you have a Health Care Durable Power of Attorney? Yes___ No____

If Yes, who is your Health Care Durable Power of Attorney? _____
Name, phone # & relationship to patient

If No, would you like to discuss this with a Nurse Practitioner? Yes___ No____

Please designate a person who can make medical decisions for you in case you are unable to speak for yourself:

_____ (_____)_____ _____
First & Last Name Phone # Relationship to Patient

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 all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia. If applicable, it also includes 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.

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, public health registry reporting 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 AND TREATMENT
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 or therapy as he 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: _____

Employee Signature: **(Reviewed with Patient)** _____ **Date:** _____

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**
Releasor: Name (Hospital, Clinic, Physician)	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 all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia. If applicable, it also includes 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.

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: _____

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**

PATIENT AUTHORIZATION AND PLAN OF SERVICE

Patient Name:_____ID_____

I hereby agree that Coastal Pharmacy or any of its affiliates may contact me, or my authorized caregiver, by telephone at my place of residence.

Insurance payment authorization: I request that Medicare and/or any other insurance plan that I have to make payments of authorized benefits on my behalf directly to Coastal Pharmacy for pharmaceuticals that were furnished to me for which they bill Medicare and/or any other insurance plan on my behalf.

Release of insurance information: I request my medical insurance plan(s) to release to Coastal Pharmacy, any and all information which will assist in processing my claims for pharmaceuticals that I am receiving from Coastal Pharmacy even after service to me is discontinued. I also authorized any holder of hospital or medical information about me to release to the health care financing administration, its agents, my insurance company or Coastal Pharmacy any information needed to determine the benefits that are payable for related services.

I understand if my insurance plan(s) makes payment(s) to me for pharmaceuticals that I have received, rather than directly to Coastal Pharmacy, I agree to endorse those checks and send them immediately to Coastal Pharmacy

I also understand that I am responsible for the payment of any deductible, co-insurance or other portion of my charges not paid by my insurance plan(s). I also understand that I may be eligible for a partial or complete waiver of any unpaid co-insurance charges only, under Coastal Pharmacy financial hardship program.

I understand that prescribed pharmaceuticals cannot be re-dispensed. Therefore, these items cannot be returned for credit. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service.

_____**(Initials) I acknowledge that in the event I am unable to afford my prescription copays, the staff of Coastal Pharmacy have my permission to act on my behalf solely as agents to help me find and apply for appropriate financial assistance. I authorize Coastal Pharmacy to use my information to complete phone, electronic, or hardcopy applications and to sign those applications on my behalf to determine my eligibility.**

I have reviewed and understand the information above. Once my treatment plan has been decided by my SCC provider, I will be given the option of filling with Coastal Pharmacy. A pharmacist will contact me to be sure I have been instructed on and understand the use of the products provided. I will receive a copy of a patient handout that contains, patient rights and responsibilities, privacy standards, emergency planning, making decisions about your health care, grievance/complaint information and drug information. I will also receive monograph/instructions for medications received. I will receive pharmacy marketing material and information on the pharmacy's scope of services which will also contain instructions on how to follow up with Coastal Pharmacy

Identified needs/problems: The patient may be unfamiliar with use of the pharmaceuticals provided. Expected outcomes: The patient will be provided the pharmaceuticals to comply with the physician's prescription. The patient will use the pharmaceuticals as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: X_____ DATE:____/____/____

PATIENT/RESPONSIBLE PARTY PRINT NAME: _____

WITNESS SIGNATURE / RELATIONSHIP:_____

REASON PATIENT UNABLE TO SIGN:_____

urac ACCREDITED
Specialty Pharmacy
Expires 01/01/2023

ACHC ACCREDITED

Behavioral Expectations for Treatment at Southern Cancer Center

Our goal is to provide the best possible care to everyone who comes into Southern Cancer Center. To provide the best coordinated care we wish to make the following expectations clear:

Southern Cancer Center employees will:

1. Act as a team and to behave in a professional manner.
2. Respect your goals for treatment and care.
3. Treat every patient with equality and respect.
4. Facilitate your care by scheduling appointments as close to requested times as possible.

Southern Cancer Center expects patients and their caregivers to:

1. Be respectful of the staff, other patients and their caregivers in all areas of the clinic.
2. Do not utilize derogatory statements, profanity, or threats with staff, patients or their caregivers.
3. Do not raise your voice when talking with staff, patients or their caregivers.
4. Do not make demands on staff members that disregard Southern Cancer Center rules and guidelines.
5. Keep your scheduled appointment time. If you are unable to make your appointment, please notify the clinic 24 hours in advance.

We realize that coping with the effects of cancer and blood disorders and their treatment can be challenging at times. If you are having difficulty coping, please contact the social worker, Stephanie Andrews.

If you have concerns about interactions with staff, we welcome you to share those concerns with Regena Price RN/BSN/OCN, Director of Clinical Services.

I have read and understand the above-listed behavioral expectations. I understand that failure to meet these expectations may result in immediate termination of the relationship between me and this provider/organization.

Patient signature: _____ Date: _____

Notice of Health Information Practices

The notice describes how this practice may use and disclose your medical information and your rights to access this information. Please review it carefully

The HIPAA Privacy Rule permits this practice to disclose your protected health information to carry out Treatment, Payment, or other Healthcare Operations. We may also disclose your health information for purposes required by law. HIPAA also grants you rights to access and control your protected health information. We must abide by the information outlined in the Notice of Privacy Practices. As HIPAA evolves, we reserve the right to update our Notice of Privacy Practices at any time. You also have the right to request a copy of our current Notice of Privacy Practices at any time.

USES AND DISCLOSURES

Your protected health information may be used and disclosed by your physician, our office staff and others who are involved in your care andtreatment for treatment, payment, or other healthcare operations.

The following are common types of uses and disclosures your physician'soffice is authorized to make. While not a complete list of allowable disclosures, these examples will provide you with an understanding of acceptable disclosures made by this practice.

Treatment: Our practice will use and disclose your protected health information to provide, coordinate, or manage your health care. This includes the coordination or management of your health care with another provider. We will disclose protected health information to any other physicians who may be treating you. We may also disclose your protected health informationto another physician or health care provider, such as a laboratory, who becomes involved in your treatment.

Health Care Operations: Our practice will use and disclose your protectedhealth information in order to support our practice's business activities.
Examples of health care operations include, but are not limited to, quality assessment, employee reviews, medical student training, licensing, fundraising, and conducting or arranging for other business activities. We mayalso provide you with information about treatment alternatives or other services that may be of interest to you. Please contact our Privacy Officer if you would prefer these materials not be sent to you.

We may use or disclose your demographic information and the dates that youreceived treatment from your physician, in order to contact you for fundraising activities supported by our practice. Please contact our practice Privacy Officer if you do not wish to receive these materials.

Payment: Our practice will use and disclose your protected health information, to obtain payment for your services performed by us or by another provider. This may include disclosures to health insurance plans, insurance providers, and collection agencies. We strongly encourage you to be in contact with your insurance agency to determine the level of coverage your plan provides, as well as having an understanding of the financial figures you will be responsible for.

Business Associates: We will share your protected health information with third party "business associates" that perform various activities on our behalf.Examples of a Business Associate include, billing services, transcription services, and legal services. Prior to disclosing any protected health information with a business associate, we will establish a written contract thatcontains the terms that will protect the privacy of your information. Business Associates and their subcontractors must also comply with HIPAA Privacy and Security Regulations. We verify their understanding and responsibility.

HIPAA Permits and Requires Additional Uses and Disclosures That May BeMade Without Your Authorization or Opportunity to Agree or Object. Thesesituations include:

Disclosures Required By Law & Workers Compensation: We are permitted to use or disclose your protected health information to the extent that law requires the use or disclosure. We will maintain compliance with the law and will limit the disclosure to the minimum necessary. If required, you will be notified of any disclosure. We are permitted to disclose your protectedhealth information as authorized to comply with workers' compensation lawsand other similar legally established programs.

Abuse or Neglect: We believe abuse or neglect to be a serious issue. We maydisclose your protected health information to a public health authority authorized to receive reports of child abuse or neglect. We may also disclose your information if, in our best judgment, we believe you have been a victim of abuse, neglect or domestic violence. When disclosing protected health information in cases of abuse or neglect, we will follow applicable state and federal laws.

Public Health & Communicable Diseases: We are permitted to disclose your protected health information for public health purposes or to a public health authority that is permitted by law to collect or receive the information. Examples may include disclosure to prevent or controlling disease, or injury. We are permitted to disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease. We may disclose your information if said person may be at risk of contractingor spreading the disease or condition.

Research & Health Oversight: We are permitted to disclose your protectedhealth information to researchers when an institutional review board that hasreviewed the research proposal, as well as established protocols to ensure theprivacy of your information has approved their research. We are permitted todisclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Legal Proceedings: We are permitted to disclose protected health information in connection with any judicial or administrative proceeding,subpoena, or in responding to a court order or tribunal.

Law Enforcement: We may also disclose protected health information, under lawful conditions to law enforcement. Permitted law enforcement purposes include (1) legal processes and otherwise required by law,
(2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premisesof our practice, and (6) medical emergency associated with a crime.

Organ Donation, Coroners, & Funeral Directors: We are permitted to disclose protected health information to a coroner or medical examiner foridentification purposes, determining cause of death or for the coroner or medical examiner to perform other duties. Disclose may be made in reasonable anticipation of death. Protected health information may be usedand disclosed for cadaveric organ, eye or tissue donation purposes.

Military Activity and National Security: We are permitted to use or disclose protected health information of individuals who are Armed Forces personnel under the following circumstances: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We are also permitted to disclose your information to authorized federal officials for conducting national security and intelligenceactivities, including for the provision of protective services to the President orothers legally authorized.

Written Authorization

Unless required by law, your written authorization will be required for all other uses and disclosures of your protected health information. You may revoke authorization at any time, by written request. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Note: Weare unable to undo any disclosures previously made with your authorization.

Opportunity to Agree or Object

The following are examples of instances where we may use and disclose yourprotected health information; however, you have the opportunity to agree or object to the use or disclosure of all or part of the disclosure. If you are not present or able to agree or object to the use or disclosure, then we may, usingprofessional judgment, determine whether the disclosure is in your best interest.

- Unless you object, we may disclose to a member of your family, a relative, or a close friend, your protected health information that directlyrelates to that person's involvement in your health care. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your information to an authorized publicor private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

- Unless you object, we will use and disclose in our facility directory yourname, the location at which you are receiving care, your general condition, and your religious affiliation. This information, except religious affiliation, will be disclosed to individuals who ask for you byname. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

- Should we chose to participate in Marketing or Fundraising Efforts we will first provide you with an opportunity to Opt-Out of such Marketing or Fundraising Materials. You will be made aware if our Marketing or Fundraising Efforts will include our practice receiving financial remuneration. You will have the opportunity to opt-our of our current marketing or fundraising efforts, or to opt-out of all future marketing or fundraising efforts. Because we may receive financial remuneration, youwill be provided with a separate form to authorize or opt-out of our efforts.

Patient Rights

You have the right to inspect and copy your protected health information. As long as we are maintaining your protected health information, you may inspect and obtain a copy of your protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician uses for health care decisions. As permitted by federal or state law, we may charge you a "*reasonable copy fee*" for a copyof your records.

However, federal law prohibits you from inspecting or copying: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratoryresults that are subject to law that prohibits access. You may have the right to appeal the denial. Please contact our Privacy Officer if you have questions.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information 1) for the purposes of treatment, healthcare operations, or payment 2) to family members or friends who may be involved in your care or 3) for notification purposes as described in this Notice of Privacy Practices. Your written request must state the specific restriction requested and to whom you want the restriction to apply. We are NOT required to agree to a restriction that you may request, unless your account has been paid in full. However, if your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction other than emergency treatment situations.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We strive to accommodate all reasonable requests. As a condition, we may ask for additional information, such as payment, alternative address, or additional contact information. We will not request an explanation for the request. Notifyour Privacy Officer in writing for all requests.

You have the right to receive an accounting of certain disclosures made. This right applies to disclosures for purposes other than treatment, payment orhealth care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You may request an amendment of your protected health information ina designated record set for so long as we maintain this information. We may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement and we may provide you with a copy of any rebuttal. Please contact our Privacy Officer if you have questions.

If we maintain an electronic copy of your Medical Records then you havethe right to receive an electronic copy of your Medical Records.

You have the right to obtain a hard copy of this Notice of PrivacyPractices.

Complaints

Should you believe your privacy rights have been violated, and you wish to file a complaint, you may complain to us or to the Secretary of Health and Human Services.

To file a Complaint with us, you may contact our Privacy Officer. Protectingyour private health information is essential to us, and we will not retaliate against you should you file a complaint. Phone Number: 251-625-6896

Privacy Lead: Meredith Jones
Compliance Lead: Lindsey Hild
Executive Director: Lauren Pettis

Complaints filed with the Secretary of Health and Human Services should bedirected to your regional office. A directory of regional offices can be found by visiting the following website:
https://www.hhs.gov/about/agencies/regional-offices/index.html