ILLINOIS CANCERCARE, P.C.

Specializing in Cancer and Blood Disorders

PATIENT REGISTRATION FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Today's Date: _____

PATIENT INFORMATION

Patient's Name Last:	*First:*	*Middle:*

Maiden Name:	*Date of Birth:*	*Age:*

Social Security Number:	*Gender:* ❑ M ❑ F	*Marital Status:* ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

ETHNICITY AND RACE

This information helps aid your physician in diagnosis and research of your condition.

Preferred Language:
❑ English ❑ Spanish ❑ Decline to answer ❑ Other _____

Ethnicity:
❑ Hispanic ❑ Non-Hispanic ❑ Decline to answer

Race: *(Please mark all that apply)*
❑ White ❑ African American ❑ American Indian or Alaska Native ❑ Asian ❑ Hispanic or Latino ❑ Native Hawaiian or Other Pacific Islander
❑ Decline to answer

PREFERRED CONTACT NUMBER

❑ Home _____ ❑ Work _____ ❑ Mobile_____

PHYSICIAN INFORMATION

Family Physician:	*Referring Physician/Other Physician:*
1.	*1.*
2.	*2.*
3.	*3.*

PATIENT DEMOGRAPHICS

Home Street Address:	*City:*	*State:*	*Zip Code:*

Home Phone #:	*Mobile Phone #:*	*Email:*

Occupation:	*Employer:*	*Employer's Phone # :*

Employer's Address:

Retired: ❑ Yes ❑ No	*If yes, retired from:*

SPOUSE'S INFORMATION

Spouse's Name Last:	*First:*	*Middle:*
Date of Birth:	*Social Security Number:*	
Occupation:	*Employer:*	*Employer's Phone #:*
Employer's Address:		
Retired: ❑ Yes ❑ No	*If yes, retired from:*	

EMERGENCY CONTACT INFORMATION

First Name:	*Last Name:*	*Relationship:*	*Home Phone #:*	*Mobile Phone #:*
1.				
2.				
3.				

INSURANCE INFORMATION

Primary Insurance

Name:	*Address:*	*Phone #:*
Referral Required: ❑ Yes ❑ No	*Prescription Card:* ❑ Yes ❑ No	
Policy Holder Name:	*Patient's Name:*	
Policy Number:	*Group #:*	*Approved Hospital:*
Co-Pay Amount:	*Relationship to Policy Holder:*	*Phone #:*

Secondary Insurance

Name:	*Address:*	*Phone #:*
Referral Required: ❑ Yes ❑ No	*Prescription Card:* ❑ Yes ❑ No	
Policy Holder Name:	*Patient's Name:*	
Policy Number:	*Group #:*	*Approved Hospital:*
Co-Pay Amount:	*Relationship to Policy Holder:*	*Phone #:*

MEDICAL HISTORY

Please write down the reason why you came to the doctor this time:

Normal Weight:	*Present Weight:*		
Weight Loss Amount:	*Duration of Loss:*	*Weight Gain Amount:*	*Duration of Gain:*

SURGERIES

Year:	*Surgery Performed:*	*Hospital:*
1.		
2.		
3.		
4.		
5.		
6.		

Have you ever had a blood transfusion? ❑ Yes ❑ No

If so, have you ever had a reaction? *(If yes, please explain.)*

PAST ILLNESSES

Have you ever had any of the following:

❑ Hearing Loss
❑ Visual Loss
❑ Glaucoma
❑ Migraine Headaches
❑ Epilepsy
❑ Stroke or Paralysis *(explain below)*
❑ Thyroid Disease
❑ Hearing Loss
❑ Arthritis or Rheumatism
❑ Liver Disease/Hepatitis/Jaundice
❑ Other/Explanations:

❑ High/Low Blood Pressure
❑ Heart Disease *(explain below)*
❑ Conjestive Heart Failure
❑ Rheumatic Failure
❑ Pneumonia
❑ Tuberculosis
❑ Asthma
❑ High/Low Blood Pressure
❑ Gallbladder Disease

❑ Stomach Disease/Ulcer *(explain below)*
❑ Kidney Disease
❑ Nervous/Mood Disorder *(receiving counseling?)*
❑ Bleeding Disorder
❑ Clotting Disorder
❑ Chronic Infections *(explain below)*
❑ Prior Cancer *(explain below)*
❑ Stomach Disease/Ulcer *(explain below)*
❑ Diabetes (❑ Type 1 or ❑ Type 2)

_____

_____

_____

MEDICINES

If you brought a list of medications with you, you don't have to fill this out.

Name of Drug:	*Strength/Dosage:*	*Frequency Taken:*

ALLERGIES TO MEDICATION

Name of Drug:	*Reaction you had:*
1.	
2.	
3.	
4.	

Are you allergic to Iodine (IVP Dye, Arteriogram Dye, Shell Fish)? ❑ Yes ❑ No

If yes, please explain:

SOCIAL HISTORY

All questions on this questionnaire will be kept strictly confidential.

Diet	*Are you on a special kind of diet?* ❑ Yes ❑ No Explain: _____		
Caffeine	❑ None ❑ Coffee ❑ Tea ❑ Cola		
Alcohol	*Do you drink alcohol?* ❑ Yes ❑ No	*Did you drink in the past?* ❑ Yes ❑ No	
Tobacco	*Do you use tobacco?* ❑ Yes ❑ No	*How many years?* _____	*Year that you quit?*_____
Drugs	*Do you currently use recreational or street drugs?* ❑ Yes ❑ No		

FAMILY HISTORY

Has any blood relative ever had any of the following:

❑ Anemia	❑ Cancer	❑ Diabetes	❑ Inherited Kidney Disease
❑ Bleeding Problems	❑ High Blood Pressure	❑ Stroke	❑ Mood Disorder
❑ Blood Clots	❑ Heart Disease	❑ Tuberculosis	❑ Other

Please explain: _____

_____

_____

If Living Age/Health	**If Deceased** Age/Cause of Death	**If Living** Age/Health	**If Deceased** Age/Cause of Death
Father:		Spouse:	
Mother:		Son/Daughter:	
Brother/Sister:			

FEMALES ONLY

Date of Last Period:	❑ Regular ❑ Irregular
Number of Pregnancies? _____	*Number of Miscarriages?* _____
Prior/current use of oral contraceptives?	
Prior/current use of hormones?	

ADDITIONAL INFORMATION

Please provide any additional information that you feel would be helpful to the doctor:

_____

_____

_____

_____

_____

_____

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E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in a ePrescribe program. These include:

Formulary and benefit transactions—Gives the prescriber information about which drugs arecovered by the drug benefit plan

Medication history transactions—Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

Fill status notification—Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent from you are agreeing that Illinois CancerCare can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above I hereby provide informed consent to Illinois CancerCare to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Date _____

Print patient name _____ **DOB** _____

Guardian _____

Relationship to patient _____

ILLINOIS CANCERCARE, P.C.
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ASSIGNMENT OF INTEREST AND FINANCIAL AGREEMENT

FINANCIAL AGREEMENT. In consideration of the services to be rendered to Patient, Patient individually promises to pay the Patient's account at Illinois CancerCare at the charged rates as reduced by any applicable third-party contract.

RELEASE OF INFORMATION FOR BILLING. Patient authorizes release to insurance companies or their administering entities, governmental agencies or their intermediaries, and third party payors providing benefits to Patient, copies of all medical records or other information necessary to determine available benefits and to obtain payment for the service rendered to Patient by Illinois CancerCare. Patient understands that: (a) Patient's medical records may contain information relating to mental health, developmental disabilities, alcohol and/or drug abuse diagnosis and/or treatment, HIV/Aids test results and genetic information, and Patient authorizes release of such medical records for purposes of billing and collection; (b) Patient has the right to inspect and to obtain a copy of the information disclosed; (c) this authorization is valid with respect to mental health records until the date one year following today's date; (d) Patient has the right to revoke this authorization at any time, except to the extent that actions were taken in reliance thereon; and (e) if Patient refuses to sign or revoke this authorization, Illinois CancerCare may not be able to release medical information which is necessary to process claims for insurance benefits and Patient will be billed directly for these services.

ASSIGNMENT OF BENEFITS. Patient hereby irrevocably assigns to Illinois CancerCare any and all rights which the undersigned and Patient have against any insurance companies or their administering agencies, government agencies or their intermediaries, or other third party payor for payment of the Patient's bill to Illinois CancerCare. The Patient authorizes the application of any overpayment to any unpaid bill at Illinois CancerCare for which the Patient is responsible that has not been paid in full at the time of the overpayment.

FOR MEDICARE/MEDICAID BENEFICIARIES ONLY. Patient ce1tifies that the information given by Patient in applying for payment under Titles XVIII & XIX under the Social Security Act is correct. Patient requests that payment of authorized benefits be made on Patient's behalf for any services furnished Patient by Illinois CancerCare. Patient authorizes any holder of medical or other information about Patient to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information necessary to determine these benefits or related services.

Patient: _____ **Date:** _____
Please print full name

Signature: _____

Date of Birth: _____

If signed by an authorized representative of the Patient, please indicate relationship to Patient (e.g. spouse):

Relationship: _____ **Witnessed by:** _____

This authorization shall be in force until revoked by me in writing or a new one is signed, a photocopy of this authorization shall be as valid as the original.

ILLINOIS CANCERCARE, P.C.
Specializing in Cancer and Blood Disorders

HIPAA RIGHT OF ACCESS
AUTHORIZATION FOR FAMILY/FRIEND

Patient Name: _____ **Date of Birth:** _____

I hereby authorize Illinois CancerCare, P.C. ("ILCC") to release to the following individual(s):

NAME	RELATIONSHIP	PHONE NUMBER

all medical related information contained in my patient record, excluding any information not initialed below, at my request and for the purpose of assisting me with my treatment at ILCC. If you have **NOT** listed a person on this form our staff **WILL NOT DISCUSS ANY INFORMATION** with that person either by phone or in person.

By initialing any of the lines below, I am specifically authorizing ILCC to use and/or disclose the category of confidential Information indicated next to the line, if applicable to this authorization.

_____ Genetic Testing (ex: BRCA, PTEN, MSH2, etc)
_____ Drug Abuse Treatment Records
_____ HIV/Acquired Immune Deficiency Syndrome
_____ Alcoholism Treatment Records
_____ Mental Health Treatment Records

NOTICE

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that ILCC may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to ILCC of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where ILCC has already relied on it to use or disclose my health information. Written revocation must be sent to ILCC at the following address: **8940 N Wood Sage Rd, Peoria, IL 61615, Attn: Privacy Officer.**

Absent such written revocation, this **Authorization for Release of Confidential Heath Information** will terminate at the termination of my patient relationship with ILCC.

Signed: _____ **Dated:** _____

If you are not the patient, please state the basis for your authority to act on behalf of the patient: _____

Representative Name: _____

Representative Address: _____

Representative Phone / Email: _____

NOTE: This Authorization was revoked on (DATE)_____ Signature Of Staff _____

NOTICE TO RECIPIENT OF PROTECTED HEALTH INFORMATION: No records or information from such records which are within the provisions of (1) the Illinois Mental Health and Developmental Disabilities Confidentiality Act, (2) the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, (3) the Illinois AIDS Confidentiality Act, (4) the Illinois Genetic Confidentiality Act, or (5) other similar laws, may be further disclosed unless the person who executed the Authorization specifically consents, in writing, to such re-disclosure. A general authorization for release of medical or other information is not sufficient for this purpose. 519-6

ILLINOIS CANCERCARE, P.C.
Specializing in Cancer and Blood Disorders

AUTHORIZATION FOR RELEASE
MEDICAL RECORDS

I, _____ , authorize all entities that share in my medical treatment to furnish Illinois CancerCare with all personal health information and medical records, including those related to mental health, developmental disability, substance abuse, HIV/AIDS, sexually transmitted diseases, sexual assault, child abuse and neglect, abuse of an adult with a disability, and genetic testing.

I also authorize Illinois CancerCare to release any personal health information and medical records about me to other health care providers, insurance companies, or other third party payors necessary for Illinois CancerCare to provide treatment, payment, or health care operations related to my care, including those records related to mental health, developmental disability, substance abuse, HIV/AIDs, sexually transmitted diseases, sexual assault, child abuse and neglect, abuse of an adult with a disability, and genetic testing.

I understand that this authorization shall be in force until revoked by me in writing or a new one signed. A photocopy of this authorization shall be as valid as the original. I understand that to revoke this authorization I must provide written notice to Illinois CancerCare, Attention Chief Privacy Officer at 8940 N Wood Sage Rd, Peoria, IL 61615.

Date of Birth: _____ **SS#:** _____

Signature: _____ **Date:** _____

If signed by an authorized representative of the patient, please indicate relationship to patient (e.g. spouse):

Relationship: _____ **Witnessed by:** _____

512-002

ILLINOIS CANCERCARE, P.C.
Specializing in Cancer and Blood Disorders

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

Patient Name: _____ **Date of Birth:** _____

Illinois CancerCare is required to provide you with a copy of its Notice of Privacy Practices. This Notice of Privacy Practices provides information about how Illinois CancerCare may use and disclose your protected information. We encourage you to read it in full. Please sign this form to acknowledge receipt of the Notice.

This Notice of Privacy Practices is subject to change. A copy of the current Notice of Privacy Practices is available at each of our offices. A copy can also be found on our website: www.illinoiscancercare.com.

_____ _____
Signature Of Patient or Personal Representative **Date**

_____ _____
Name of Patient/Patient Representative (please print) **Relationship to Patient**

FOR ILLINOIS CANCERCARE USE ONLY
IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM THE PATIENT

On _____, I made a good faith effort to obtain written acknowledgement of receipt of our Privacy Practices, but

☐ **Patient/Representative Declined to Sign**

☐ **Emergency Situation Prevented Acknowledgement**

☐ **Other (Please Specify):** _____

_____

_____

_____ _____
Employee Signature **Date:**

Your RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Your USES AND DISCLOSURES

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Our RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date 05/01/2019

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FOR MORE INFORMATION

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

We may make your protected health information available electronically through an electronic health information exchange to other health care providers that request your information for their treatment and payment purposes. Participation in an electronic health information exchange also lets us see their information about you for our treatment and payment purposes.

Illinois and federal law provide additional protection for certain types of medical information. No records or information from records which are within the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Federal Act of July 1, 1975 (Confidentiality of Alcohol and Drug Abuse Patient Records), the Illinois AIDS Confidentiality Act, or the Illinois Genetic Confidentiality Act may be disclosed unless you specifically consent, in writing, to such disclosure. Illinois law also provides additional protection for individuals when law enforcement officials seek medical information for use in a criminal prosecution. These and other laws may further limit whether and how we may disclose medical information about you to others.

Illinois CancerCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-309-243-3000.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-309-243-3000.

Have a question?

PRIVACY OFFICIAL:

Janelle Hamilton
309-243-3456
jhamilton@illinoiscancercare.com

Your INFORMATION. Your RIGHTS. OUR Responsibilities.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ILLINOIS CANCERCARE, P.C.

Specializing in Cancer and Blood Disorders

Your RIGHTS

When it comes to your health information, you have certain rights.

GET AN ELECTRONIC OR PAPER COPY OF YOUR MEDICAL RECORD

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain to the Privacy Official if you feel we have violated your rights by contacting us using the information on the back of this brochure.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your CHOICES

For certain health information, you can tell us your choices about what we share.

IN THESE CASES, YOU HAVE BOTH THE RIGHT AND CHOICE TO TELL US TO:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

IN THESE CASES WE NEVER SHARE YOUR INFORMATION UNLESS YOU GIVE US WRITTEN PERMISSION:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

IN THE CASE OF FUNDRAISING:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.
- We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Our USES AND DISCLOSURES

How do we typically use or share your health information?

TREAT YOU

- We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.

BILL FOR YOUR SERVICES

- We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

- We can use or share your information for health research.

COMPLY WITH THE LAW

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

- We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.