Pledge to Our Patients

CONTRA COSTA ONCOLOGY

The physicians and staff of Contra Costa Oncology take very seriously the trust our patients place in us to meet or exceed all federal regulations with regard to transmitting, using, and storing personal health information. We will comply with HIPAA's requirements and will update our systems and operations as appropriate to assure adherence to all applicable sections of the law.

The physicians and staff of Contra Costa Oncology are dedicated to complying with the Health Insurance Portability and Accountability Act by the deadlines specified in each final rule. Of HIPAA's four parts, two have been published in final form – the Transactions and Code sets and Privacy rules. The purpose of this Policy and Procedure Manual is to implement practices to assure our current and future patients that we believe standardized electronic transactions simplify communications between providers, payers, clearinghouses and their business associates; to reaffirm our position that we will be prepared to send and receive the applicable HIPAA – mandated transactions by the requisite compliance date; and to ensure that our approach to handling patients' confidential health information meets the standards set forth under HIPAA.

We strongly support the Final Privacy Rule that requires all entities within the health care industry to take the necessary steps to protect patients' private health information. The physicians and staff of Contra Costa Oncology have always treated confidential information with the utmost care to prevent unintended or inappropriate use or disclosure. We will continue to do so, and we have adopted this Privacy Policy and Procedure Manual as evidence of our understanding of the privacy and confidentiality principles of HIPAA.

Patient Registration

Patient Last Name	First	Preferred	Middle

Date of Birth	Gender	Social Security Number
	Male Female	

Physical Address (Number, Street, Apt#)	City	State	Zip Code

Mail will be sent to address above unless patient indicates a different address below (leave blank if same as above)

Mailing Address (Number, Street, Apt#)	City	State	Zip Code

Marital Status (circle one)	Preferred Language	Email : allows access to online chart and message portal
Single / Married / Divorced / Widow / Partner		

Race (circle one) - Needed For American Reinvestment & Recovery Act (ARRA)	Ethnicity (circle one) - Needed for ARRA
American Indian or Alaska Native / African American - Black / Asian / Native Hawaiian or Other Pacifica Islander / Caucasian - White / Other_____	Hispanic or Latino Not Hispanic or Latino

Advanced Directives:	Living Will No____ Yes___	Durable Power of Attorney No___ Yes___	DNR No___ Yes___

Are you new to our Practice?	Who referred you to our Practice?	Who is your Primary Care Physician?

Phone Numbers		Okay to leave a detailed message?	Call in this order (circle 1-3)
Home	( )	No___ Yes___ Reminder only___	1st 2nd 3rd choice
Work	( )	No___ Yes___ Reminder only___	1st 2nd 3rd choice
Cell	( )	No___ Yes___ Reminder only___	1st 2nd 3rd choice

Confidentiality Communication Preference (HIPAA)

List any other person(s) you authorize to receive relevant information about your care/treatment					
Full Name		Relationship		Phone H/M	( )
Full Name		Relationship		Phone H/M	( )
Full Name		Relationship		Phone H/M	( )

Emergency Contact

List the name of the person(s) you would like us to contact in case of an emergency					
Full Name		Relationship		Phone H/M	( )
Full Name		Relationship		Phone H/M	( )
Full Name		Relationship		Phone H/M	( )

Insurance Information

Subscriber (Insurance Holder) Name	Subscriber Date of Birth	Subscriber Relationship to Patient	Subscriber Phone Number
			( )

Provide Copy of All Cards	Primary Health Plan	Secondary/Supplemental Health Plan	Prescription Benefits
Health Plan Name			
Health Plan Address			
Health Plan Phone #			
Subscribe Number / ID			
Group Number			

Patient Signature _____ Date _____

Contra Costa Oncology
500 Lennon Lane, Walnut Creek, CA 94598
Phone - 925.939.9610 Fax - 925.939.9630 | Danville - Concord - Rossmoor - Walnut Creek

Contra Costa Oncology

Please list all your other Physicians below.

REFERRING PHYSICIAN	Specialty	City	Phone Number
PRIMARY CARE PHYSICIAN	Specialty	City	Phone Number
Physician Name	Specialty	City	Phone Number
Physician Name	Specialty	City	Phone Number
Physician Name	Specialty	City	Phone Number
Physician Name	Specialty	City	Phone Number
Physician Name	Specialty	City	Phone Number
Physician Name	Specialty	City	Phone Number
Physician Name	Specialty	City	Phone Number

Print Name:_____ **Signature:**_____ **Date:**_____

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Name: _____ **FAMILY HISTORY** **Today's Date: _____**

DOB: _____

				Mothers Side Relatives (Maternal)			Fathers Side Relatives (Paternal)		
Type of Cancer	M=Mother F=Father Si=Sister B=Brother So=Son D=Daughter H=Husband W=Wife	AGE at Diagnosis	AGE L=Living or D=Deceased (Note both AGE & L or D)	A=Aunt U=Uncle C=Cousin GM=Gr-Mother GF=GrFather Ni=Niece Ne=Nephew	AGE at Diagnosis	AGE L=Living or D=Deceased (Note both AGE & L or D)	A=Aunt U=Uncle C=Cousin GM=Gr-Mother GF=GrFather Ni=Niece Ne=Nephew	AGE at Diagnosis	AGE L=Living or D=Deceased (Note both AGE & L or D)
EXAMPLE	W	56	L - 58	U	63	D - 78	GF	44	D - 61
Bladder 188.9									
Bone 198.5									
Brain 191.9									
Breast 174.9									
Colon/Rectal 153.9									
Endometrial 182.0									
Esophagus 150.9									
Head/Neck 195.0									
Intestinal 159.0									
Kidney 189.0									
Leukemia 204.00									
Lung 162.9									
Melenoma 172.9									
MultMyeloma 203.00									
Ovarian 183.0									
Pancreatic 157.9									
Prostate 185									
Spine 170.2									
Stomach 151.9									
Throat 195.0									
Uterine 182.0									
Unknown 199.1									
Other Cancers Not Listed									
Diabetes 250.00									
Heart Disease 429.9									
HIGH BP 401.1									
Others Not Listed									

Date_____

Medications List

Patient Name_____

DOB_____

Medication Allergies:

Medication	Reaction	Medication	Reaction

Prescription Medications

Name	Dosage	How Often	Name	Dosage	How Often

Non-Prescription Medications

Name	Dosage	How Often	Name	Dosage	How Often

Pharmacy Name/Address: _____

Tobacco Use (Circle One): **Never** **Former** **Current** **(if current everyday or someday?)**

Contra Costa Oncology

Print Name _____ Date _____
(Last, First, Middle)

Notice of Privacy Practices (NOPP) Acknowledgment

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it and the complete office Policies and Procedures which comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) final privacy rule.

Signature_____
Date_____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment to be made directly to _____, and any assisting physician for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I understand that if I cannot keep a scheduled appointment and fail to cancel within 24 hours, I may be charged a cancelation fee.

I further agree that a photocopy of this agreement shall be valid as the original.

Signature_____ Date_____

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Walnut Creek, CA 94598
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Danville – San Ramon – Concord – Rossmoor – Walnut Creek

CONTRA COSTA ONCOLOGY

FINANCIAL POLICY

Insurance/Cash Patients

Patients are financially responsible for services provided and are therefore expected to pay at the time of service. We will bill your insurance company as a courtesy; however, you will need to provide complete billing information at the time of your visit. A copy of your charges, if requested, will be supplied to you so that you may personally follow up with your insurance company.

HMO/PPO Patients

If you are a member of an HMO/PPO, you may be required to make a copayment at the time of your visit. As a contracted provider we cannot waive copayments; they will be collected at the time of service. Additionally, non-covered charges must be paid at the time of service. Payments not collected at the time of service will be subject to an additional $20 fee per occurrence.

Medicare

We are participating providers in Medicare, which means that we accept Medicare assignment as payment in full, once your deductibles and copayments have been made. You must provide valid cards from Medicare and other insurance. Without these, we are unable to bill your insurance and will require payment from you at the time of your visit.

Cancellations/No-Shows

If you are unable to keep a scheduled appointment, please contact our office as soon as possible so that we may offer your time to another patient. Cancelling appointments with less than 24 hours notice may result in charges consistent with the time allotted for the visit. Failure to show up for an appointment creates gaps in our schedule, resulting in our inability to provide appropriate care to all patients. Subsequent no-shows will result in a minimum $35.00 charge or maximum of $250.00, depending on the appointment type. Patients with continual no-shows may be dismissed from the practice.

Preparation of Forms/Photocopying of Medical Records

Preparation of various forms will be charged as follows: *Under 25 pages: $25.00. 26-75 pages: $35.00. 75 pages or more: $50.00*

IT IS YOUR RESPONSIBILITY TO NOTIFY OUR OFFICE OF ANY CHANGES TO YOUR INSURANCE PRIOR TO SERVICES BEING RENDERED. YOU COULD BE HELD FINANCIALLY RESPONSIBLE FOR ANY SERVICES RENDERED TO YOU IF PROPER NOTIFICATION IS NOT GIVEN.

I acknowledge I have read the above financial policy.

Print Full Name: _____

Signature: _____

Date: _____

Contra Costa Oncology

500 Lennon Lane
Walnut Creek, CA 94598

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

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.

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Your Rights *continued*

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 if you feel we have violated your rights by contacting us using the information on page 1. • 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. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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 • Contact you for fundraising efforts *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.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

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.*

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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.**

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.

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.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

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 10-1-2016

This Notice of Privacy Practices applies to the following organizations.

Contra Costa Oncology.

For more information, please contact our Practice Manager at (925) 939-9610.