BEACON
Cancer Care

# NEW PATIENT INTAKE FORM

| Patient Demographics Details | | | | |
|---|---|---|---|---|
| Name: | | DOB: | | SSN: |
| Home Phone: | Mobile Phone: | Email: | | |
| Address: | | City: | State: | Zip Code: |
| Primary Care Provider: | Practice: | Phone: | | |
| Referring Provider: | Practice: | Phone: | | |
| Pharmacy: | | Phone: | | |
| Mail-Order Pharmacy: | | Phone: | | |

## Acknowledgement of Receipt of Notice of Privacy Policies

I hereby acknowledge that I have received a copy of Beacon Cancer Care's Notice of Privacy Practices and have had an opportunity to read and ask questions about the same.

_____ Date: _____

Signature of Patient/Legally Authorized Representative

_____ Relationship: _____

Printed Name of Patient/Legally Authorized Representative

Please note: You may refuse to sign this Acknowledgment.

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Policies, but acknowledgment could not be obtained because:

☐ Communication barriers prohibited obtaining the acknowledgment

☐ Individual refused to sign

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other: _____

_____ Date: _____

Signature of Staff Member

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# NOTICE OF PRIVACY POLICIES

## 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

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

## OUR 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

# 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.

**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 RIGHTS

**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

*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.*

**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*

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# HIPAA RELEASE FORM

I, _____ , hereby authorize the use and disclosure of my protected health information, as more particularly described below, to:

Name: _____ Relationship: _____

Contact Information: _____

Health information to be disclosed upon the request of the person named above -- (check either A or B):

☐ A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions); OR

☐ B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):

- ☐ Substance abuse
- ☐ Psychiatric (mental health)
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Genetic testing
- ☐ Other (please specify): _____

Form of Disclosure (check one or both):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

Purpose for Use or Disclosure: _____

_____

Unless I revoke it, this authorization shall be effective until (check one):

- ☐ All past, present and future periods; OR
- ☐ Date or event:

I understand that I may revoke the authorization at any time by submitting a written request to: Beacon Cancer Care, 980 W. Ironwood Drive, Ste. 207, Coeur d'Alene, ID 83814. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____

Signature of Patient/Legally Authorized Representative

_____ Relationship: _____

Printed Name of Patient/Legally Authorized Representative

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# PATIENT HEALTH HISTORY FORM

Name of Patient: _____ DOB: _____

| **Personal Cancer History** | | |
|---|---|---|
| Type of Cancer: | Year Diagnosed: | Treatment Received: |
| 1. | | |
| 2. | | |
| Chronic Medical Conditions | Year Diagnosed: | Managing Physician: |
| 1. | | |
| 2. | | |
| 3. | | |

| Current Medications | Dosage: | Frequency: |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

| Allergies | Reaction: |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

| **Social History** | |
|---|---|
| Marital Status: | With whom do you live? |
| Do you have a history of smoking tobacco | Do you drink alcohol? |
| (this includes smokeless tobacco)? | If yes, how many drinks a week? |
| How many packs did/do you smoke per | If you used to drink, when did you stop? |
| day? | Do you use drugs? |
| Date you quit: | If yes, what drugs do you use and how often? |
| Total years you smoked: | |

| **Family Cancer History** | | | |
|---|---|---|---|
| Type of Cancer | Relationship to You: | Age at Diagnosis: | Current Age/ Age at Death: |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**Additional Information**

Date of last flu shot: _____ Date of last mammogram: _____

Date of last colonoscopy: _____ Date of last PET/CT Scan, MRI or other imaging: _____

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# MEDICATION REFILL POLICY

## Please Use These Guidelines For Planning Your Next Medication Refill:

- If you fill your prescription through a **local pharmacy**, please call and leave a message for the appropriate medical assistant (see below) at least **five (5) days** before your medication is due to run out.

  - If you are a patient of Dr. Samuels or Noelle Beierle, please call Shelli at (208) 755-2804 ext. 204.
  - If you are a patient of Dr. Bartels, please call Vickie at (208) 755-2804 ext. 206.

- If you fill your prescription through a **mail-order pharmacy**, please call and leave a message for Nicole at (208) 755-2804 ext. 207 at least **fourteen (14) days** before your medication is due to run out.

- If you need an urgent refill request (within 24 hours), please call the front desk at (208) 755-2804 ext. 0 to expedite the refill process. Please allow the medical assistant to get back to you by the end of the business day.

*Thank you for your cooperation. Please let us know if you have any questions.*

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# GRANT / CO-PAY ASSISTANCE

At Beacon Cancer Care, we make it a priority to provide any available financial assistance to our patients. If you would like to provide your personal information below, we will look for available grants and/or co-pay assistance opportunities related to your diagnosis. We keep this information confidential and will only share it with the grant issuer and/or co-pay assistance organization.

***By signing below, I hereby authorize Beacon Cancer Care to apply for financial assistance opportunities on my behalf without any further notification or permission required.***

Name: _____ DOB: _____ SSN: _____

Household Size: _____ Annual Income: _____

_____ Today's Date: _____

Signature of Patient/Legally Authorized Representative

# FOUNDATIONS

There are numerous grant and co-pay assistance opportunities available for many oncology and hematology diagnoses. Here is a non-exhaustive list of foundations we consider for potential opportunities:

**Patient Access Network Foundation**
www.panfoundation.org
1-866-316-7263

**Patient Advocate Foundation Copay Relief**
www.copays.org
1-866-512-3861

**Healthwell Foundation**
www.healthwellfoundation.org
1-800-675-8416

**CancerCare**
www.cancercarecopay.org
1-866-552-6729

**Lymphoma & Leukemia Society**
www.lls.org
1-877-557-2672

**The Assistance Fund**
www.tafcares.org
1-855-845-3663

**Patient Services Inc.**
www.patientservicesinc.org
1-800-744-9388

**Good Days**
www.mygooddays.org
1-877-968-7233

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# FINANCIAL POLICY AND CONSENT FOR BILLING

Name of Patient: _____ DOB: _____

We ask that you read through this financial policy and sign the bottom prior to treatment.

## Financial Policy:

I understand my insurance company will be billed on my behalf, and I am responsible for all fees, deductibles, co-payments and any unpaid portion of my bill. Payment in full is due at time of service, including full payment for self-pay patients, unless other arrangements have been made. We accept cash, credit card or check. There will be a service charge of the lesser of $20.00 or the face amount of the check on any returned check.

*Note: Please provide your insurance card and, if applicable, your pharmacy card upon check-in. Patients who do not supply accurate insurance information will be considered self-pay.*

We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. Please understand that you have the ultimate responsibility of verifying the coverage with your insurance. You acknowledge that we may be an out-of-network provider with your insurance. If your plan requires a referral from your primary care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to lack of referral, you understand you may be responsible for the charges. You must inform our office of any changes in your insurance, as you are the policyholder and it is ultimately your responsibility.

If you are unable to keep your appointment you must notify the office at least 24 hours prior to your scheduled appointment as a courtesy to the providers, staff and other patients. If you cancel or “no-show” without sufficient notice, you may be subject to a fee, payable by you, not your insurance company.

## Authorization and Release:

I authorize and request my insurance company to pay directly to Beacon Cancer Care, PLLC any insurance benefits otherwise payable to me.

I understand that my insurance carrier may deny or pay less than the actual bill for services, and I agree to be responsible for any remaining balance.

_____ Date: _____

Signature of Patient/Legally Authorized Representative

_____ Relationship: _____

Printed Name of Patient/Legally Authorized Representative