



Millennium Physicians Radiation Oncology

PATIENT HISTORY

Date: _____ Patient Name: _____ DOB: _____

Reason for Consultation: _____

Requesting MD: _____ Primary MD: _____

Names of doctors who have treated you for this condition: _____

Names of hospitals where you have been a patient for this illness: _____

Presenting Symptoms: _____

Have you ever had Radiation Therapy? NO YES Date(s) _____

If YES, reason and area irradiated: _____

Where? _____

Have you ever had Chemotherapy? NO YES When/Where? _____

ALLERGIES: Drug, Food, Latex or other – Please List: _____

CURRENT MEDICATIONS: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY:

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergy Immune System |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Blood Lymph System Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Breast / Last Mammo _____ |
| <input type="checkbox"/> Other: _____ | | |

Serious Injuries? Please describe: _____

Surgeries? Please list, include date/year: _____



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PATIENT HISTORY CONT'D

FAMILY HISTORY

Father: Living Deceased Age and cause of death: _____

Mother: Living Deceased Age and cause of death: _____

Siblings or children, cancer history: _____

Other family members, cancer history: _____

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed

Use of Tobacco: No Yes If Yes, how many packs per day? _____ How many years? _____

What type? Cigarettes Cigars Chewing Tobacco Quit? _____ When? _____

Use of Alcohol: No Yes If Yes, how many drinks per day/week? _____

Exercise: No Yes If Yes, how often? _____

Family: Lives with _____ Live Alone Have Assistance? _____

Number of children and their ages: _____

Education Level Completed: _____ Employer: _____ Occupation: _____

Exposure to Asbestos or other Hazardous Materials? No Yes When/Where? _____

NOTIFY IN AN EMERGENCY

Name: _____ Relation: _____

Home: _____ Cell: _____ Work: _____

Is there anything else that we need to know about you to provide better care for you? _____

Thank You. This ends your portion of the patient history questionnaire.



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PATIENT INFORMATION

Patient Name: _____

Last Name

First Name

Middle Initial

Address: _____

Street

Apt #

City

State

Zip

Phone Number(s): _____

Cell

Home

Work

Social Security Number

Birthdate

E-mail address

Married Single Widowed Divorced Female Male

Employer: _____ Occupation: _____

Referring Doctor: _____

Primary Doctor: _____

Other Doctor's: _____

Pharmacy Name & #: _____

INSURANCE

Primary Coverage list name

Card Holder Name

Subscriber ID #

Group #

Secondary Coverage Yes/No

List Name & ID # above

Card Holder Name



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PATIENT INFORMATION CONT'D

I, _____, give my authorization to release my protected Health information including results of my laboratory test, x-ray, and/or other test results to the following designated representative(s):

____ My Spouse (Name) _____

____ My Child (Name) _____

____ My Child (Name) _____

____ Other (Name) _____

____ Other (Name) _____

____ May be left on my answering machine at home/work.

____ May not be given to anyone other than myself.

Patient Initials: _____

Patient Signature: _____

Date: _____

Witness: _____



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RELEASE OF INFORMATION

I authorize _____ to release: _____ or receive from:
Millennium Physicians Radiation Oncology, 22730 Profession Dr., Kingwood, TX. 77339

Office #

Fax (if applicable)

Date of Birth

Social Security Number

History & Physical

Lab Work

Consultation

Pathology Report

Radiology Reports

Other: _____

This information is being released for the following purposes:

Continued Care

Attorney/Litigation

Insurance

Disability Services

Other: _____

TO THE PARTY RECEIVING THE INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent to the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or **for patients records applicable under federal law 42 CFR Part 2.**

Printed Name of Patient

Signature of Patient or Representative

Date



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ASSIGNMENT OF BENEFITS

Authorization / Consent for Health Care

I hereby authorize the physicians of GHPMA Radiation Department and affiliated or other providers to release and information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be release may include, but is not limited to history, diagnosis and/ or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorized direct payment to be made to the physicians or GHPMA Radiation Oncology or other providers for any and all medical or surgical services rendered. I understand that if any service or charges are not covered, or if GHPMA Radiation Oncology, is unable to verify eligibility, that I am responsible for all charged incurred for services rendered.

I hereby voluntarily consent to such healthcare encompassing diagnostic procedure and treatment by my physicians, and my physician's associated, assistants, and other healthcare providers, as may be necessary in my physician's judgment. I have relied on my physicians for information in this regard and acknowledge that no warranty or guarantee has been made to me as to result or cure. This form has been fully explained to, and I certify that I understand its contents.

- ✓ I authorize use of this form on all my insurance submissions.
- ✓ I authorize release of information to all my Insurance Companies.
- ✓ I understand that I am responsible for my bill.
- ✓ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
- ✓ I authorize payment direct to my doctor.
- ✓ I permit a copy of this authorization to be used in place of the original.

Date: _____

Medicare # (if applicable): _____

Printed Name of Patient: _____

Signature of Patient, Guardian, or Guarantor: _____



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.

Continued next page

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.*

continued next page

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 must 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.

- **For Treatment.** We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other Facility personnel who are involved in taking care of you at a Facility. Different departments of a Facility also may share health information about you in order to coordinate your care and provide you medication, lab work and x-rays. We may also disclose health information about you to people outside the Facility who may be involved in your medical care after you leave a Facility, such as through a referral.
- **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at a Facility may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations.** We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all patients receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine health information about many patients to help determine what additional services should offer, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by our corporate office for business development and planning, cost management analyses, insurance claims management, compliance/risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of the Facility including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of the Facility. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of patients.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates.** There are some services provided in our Facility through contracts with business associates. Examples include medical directors; outside attorneys and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Providers.** Many services provided to you, as part of your care at our Facility, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g., MD, etc.), therapists (e.g., Radiation Therapists, etc.), portable radiology units, clinical labs, hospice caregivers, pharmacies, financial counselor's), etc.
- **Treatment Alternatives.** We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services and Reminders.** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **As Required by Law.** We will disclose health information about you when required to do so by federal, state or local law and obtain the proper authorizations to use and disclose information.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
- **Organ and Tissue Donation.** If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- **Research.** Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave a Facility.
- **Workers' Compensation.** We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Reporting.** Federal and state laws may require or permit the Facility to disclose certain health information related to the following:
 - *Public Health Risks.* We may disclose health information about you for public health purposes, including:
 - Prevention or control of disease, injury or disability
 - Reporting births and deaths;
 - Reporting child abuse or neglect;
 - Reporting reactions to medications or problems with products;
 - Notifying people of recalls of products;
 - Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
 - Notifying the appropriate government authority if we believe a resident has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
 - *Health Oversight Activities.* We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
 - *Judicial and Administrative Proceedings:* If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
 - *Reporting Abuse, Neglect or Domestic Violence:* Notifying the appropriate government agency if we believe a resident has been the victim of abuse, neglect or domestic violence.
- **Law Enforcement.** We may disclose health information when requested by a law enforcement official:
 - In response to a court order, subpoena, warrant, summons or similar process;
 - To identify or locate a suspect, fugitive, material witness, or missing person;

- About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
 - About a death we believe may be the result of criminal conduct;
 - About criminal conduct at the Facility; and
 - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors.** We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.
 - **National Security and Intelligence Activities.** We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Correctional Institution.** Should you be an inmate of a correctional institution; we may disclose to the institution or its agent's health information necessary for your health and the health and safety of others.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information and give you a copy of it.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- 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 THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Facility and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the facility. This Notice of Privacy Practices applies to the following organizations: Millennium Physicians Associations, PLLC, Millennium Oncology, Millennium Radiation, Millennium PET/CT, Millennium Primary Care, Millennium Pulmonary Care, and any other service within Millennium Physicians.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility or with the Secretary of the Department of Health and Human Services. To file a formal grievance/complaint against a nurse or physician, please contact the following agencies (**Nurse**): Texas Board of Nursing, 333 Guadalupe Street, Suite 3-460, Austin, Texas 78701, (512) 305-6838. (**Physician**): Texas Medical Board, PO Box 2018, Austin, Texas 78768-2018, (800) 201-0353. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Millennium Physicians Chief Compliance Officer Tomeshia S. Beckett - contact: (281) 359-9935 ext. 2128.



Millennium Physicians Radiation Oncology

NOTICE OF PRIVACY PRACTICES

Signature below is only acknowledgement that you have received this **Notice of our Privacy Practices**

Print Patient Name: _____

Signature: _____

Date: _____