

**Please retain
for your records!**



Notice of Privacy Practices

This notice is to inform you about our company's policy regarding the use and disclosure of your protected health information and how you gain access to your information.

Please read carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) directs healthcare providers, payers and other healthcare entities to develop policies and procedures that assure the privacy, security and authenticity of health information. An employee from the clinic is required by federal law to provide you with a copy of our privacy policy.

Our Commitment to your Privacy

As a provider of healthcare, we may use your confidential information to create records regarding your health information in order to provide quality healthcare. However, we promise to remain in the boundaries of federal and state privacy act laws. Occasionally, we may need to also disclose health information to carry out your treatment, payment or healthcare operations to other clinics or offices within our organization. This notice applies only to records of your care maintained or created in this or an associate's facility. We are required by law to give you a copy of our Privacy Policies and to make sure that your health information is kept private.

How we may use or disclose personal information without authorization

The following describes different circumstances in which we may disclose or use your health information without your authorization.

1. When required by law
2. Organ and tissue donation information
3. To avert serious threat to health and safety to another person or the public
4. To military authorities or if you are a member of the armed forces
5. Workers Compensation
6. By court order for lawsuits or disputes
7. By court order, subpoena, warrant, summons or request by law enforcement officials to identify as suspect, fugitive, witness or missing person
8. Coroners, funeral directors and medical directors
9. Intelligence or National Security
10. If you are an inmate of a correctional institution under the custody of law enforcement officials and it is necessary to carry out proper healthcare
11. In case of emergency, lack of physical or mental awareness

Instances in which we may use and disclose your health information

In efforts to provide care for you, it may be necessary that your health information is available for healthcare providers who are involved in your treatment, care and billing. We will have to communicate with your insurance company about your care in order to obtain prior approval or to determine if your insurance company will pay for your treatment or care.

Your rights regarding your healthcare information

1. You have the right to revoke your consent or authorization to use and disclosure of your personal information by a written notice to the appropriate personnel at the clinic in which you are being treated. Please realize that we will not be responsible for any information that has already been disclosed or obtained by our office. We also are still required to retain any records of the care we provided for you at our clinics.
2. You have the right to copy and inspect your medical or billing records. To do so you must contact the personnel delegated as the Privacy Officer at the facility in which you are being treated and to fill out the appropriate form. The clinic will inform you of the fees for the cost of copying, mailing, or other supplies associated with your request. You also have the right to request that certain information be amended or changed. This must also be done in writing with the appropriate form. We may deny your request to inspect or copy your records because of certain circumstances. In this instance, it will be discussed with you and you will also have a right to review the denial with the Privacy Officer of that facility.
3. You have the right to request that your information be communicated within the specific guidelines. You may also request with the appropriate form, to restrict or limit our communication with you. For example, not calling your work or leaving messages on your answering machine.

Complaints

If you believe that any of your privacy rights have been violated, you may file a written complaint with our Privacy Officer at the facility in which you are being treated. The Privacy Officer will then investigate the complaint and follow up with you in an appropriate time frame.

Patient consent for use and Disclosure of Protected Health Insurance

I hereby give my consent for American Professional Associates (APA) to use and disclose protected health insurance information (PHI) about me to carry out treatment and healthcare operation (TPO). (APA's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. American Professional Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the American Professional Associates, Privacy Officer at: 3330 Preston Ridge Road, Ste 300, Alpharetta, GA 30005.

With this consent, APA may mail to my home or other alternative locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, APA may mail to my home or alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that APA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

By signing this form, I am consenting to APA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, APA may decline treatment to me.

Signature of Patient or Legal Guardian

Date

Print Patient Name

Print name of legal guardian (if applicable)

American Professional Associates

~Please complete the entire form~

Facility: _____ Account #: _____

Patient Name: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone Number (with area code): _____ Cell #: _____

Date of Birth: _____ Race: _____ SS#: _____ Sex: _____

Employer: _____ Phone Number (with area code): _____

Spouse's Name: _____ SS#: _____ DOB: _____

Spouse's
Employer: _____ Phone Number (with area code): _____

Emergency Contact (other than spouse): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number (with area code): _____ Relationship: _____

Referring Doctor: _____ Phone Number (with area code): _____

Primary Care Physician: _____ Phone Number (with area code): _____

Primary Insurance Company: _____

Card Holder Name: _____ SS#: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Is Patient a resident of: Skilled Nursing Facility? _____ Hospice? _____ Assisted Living Facility? _____

Address: _____ Phone Number (with area code): _____

All of the above information is true and factual to the best of my knowledge.

Signature of Patient _____

Date _____

How did you hear about us?? Please check ALL that apply

____ Physician ____ Friend/Family member ____ Newspaper Ad/Radio Ad

____ Other resource _____

Authorization for Release of Information

Please sign only! We will fill in the information if needed at a later time.

1. I hereby authorize _____ to release information including, if any psychiatric or psychological information, infectious or contagious disease information (including AIDS confidential information, and/or information about drug or alcohol abuse or treatment of the same) for the health records of:

Covering the periods from: _____ to: _____

Date of Birth: _____ SSN#: _____

2. Information to be released:

- Copy of Radiation Oncology Records
- Pathology
- History & Physical
- Diagnostic Reports
- Port Films
- Other _____

3. Information to be released to: (Please include name and address):

4. Purpose or disclosure _____

5. I have read and understand the Consent for Release of Radiation Oncology Records, and have voluntarily and knowingly signed such consent.

Signature of Patient or Representative

Date

Assignment of Benefits

Rosa of Georgia
d/b/a _____ American Professional Associates _____ (FACILITY)

Patient Name: _____
Patient Address: _____

I hereby assign to FACILITY all healthcare and medical benefits payable for care provided to the Patient named above under coverage existing at the time FACILITY provides treatment, which benefits are provided to me by any Payer whatsoever (including, but not limited to, commercial insurance coverage, ERISA-governed benefit plans, governmental health benefits plans, Medicare, Medicaid, and any other source of welfare coverage or insurance) and related rights existing under such coverage. This assignment applies to both past and future medical services provided by FACILITY to the Patient named above. I understand that *this assignment is irrevocable*. I hereby certify that the Payer information I have supplied FACILITY is true and accurate as of the date of service. I am fully aware that having healthcare coverage does not absolve me of my responsibility to ensure that my medical bill is paid in full. I understand different Payers have different requirements for payment including, but not limited to, pre-certifications, authorizations or that the services be medically necessary. I understand that it is my obligation to know my Payer's requirements and ensure that they have been fulfilled. I also understand that my Payer may not pay 100% of the amount of the medical claim and that I may be responsible for any and all amounts not paid by the identified Payer. I agree to notify FACILITY if any of the information I have supplied changes at any time during my treatment.

I hereby authorize FACILITY to submit claims on my behalf to the Payer listed on the copy of the current benefits card I have supplied FACILITY. I hereby instruct and direct my Payer to pay FACILITY directly. If my current coverage prohibits direct payment or assignment to FACILITY for services, I hereby instruct and direct my Payer to make the check payable to me, but to mail it directly to FACILITY for the professional or medical expense benefits allowable that are payable to me under my current coverage under Payer's policy for payment towards the total charges for medical services rendered. Upon receipt of any such check, I authorize FACILITY to deposit to FACILITY's account such check received if such check is made payable to me.

I am hereby making a direct and express assignment of all my rights and benefits (including, but not limited to, payment) under existing coverage to the fullest extent of the law. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of medical service charges over and above this payment (certain regulations and exceptions apply for Medicare and Medicaid Beneficiaries). I hereby acknowledge and give my express permission for FACILITY or its legal representative to release any of my patient health information, including privileged information (*i.e.*, mental health, alcohol/drug abuse or HIV/AIDS) for payment purposes. Furthermore, I authorize FACILITY or its legal representative to obtain information concerning my medical benefits directly from Payer (including, but not limited to, the policy or plan governing my benefits).

In the event that my coverage prohibits assignment of certain rights (such as right to file appeals or to file suit in state or federal court) I expressly authorize FACILITY, in its sole discretion, to be my personal representative such that FACILITY may: (1) submit any and all appeals if my Payer denies benefits in whole or part to which I may be entitled; (2) submit any and all requests for benefit information from my Payer; and (3) initiate formal or informal complaints to any State or Federal agency that has jurisdiction over my benefits; this includes express permission for the FACILITY or its legal representative to file suit against Payer for healthcare and medical benefits to which I may be entitled. I also agree that any fines, interest, attorney's fees, or other awarded damages that may be levied against my Payer will be paid to FACILITY for acting as my personal representative.

A photocopy of this Assignment shall be considered effective and valid as the original.

Signature of Patient/Policy Holder

Date

Signature of Policy Holder if not Patient

Date

Witness

Date



Patient Financial Policy

Thank you for entrusting us with your care. We at **American Professional Associates** realize that this may be a stressful period of your life and we want to make your experience with us as pleasant as possible.

We are committed to the success of your treatment. Part of that success is making sure that you have a clear understanding of our financial policy and payment guidelines.

- 1) **CO-PAYMENTS, DEDUCTIBLES, AND FEES** – All co-payments, insurance deductibles, and fees for services not covered by your insurance policy are due at the time service is rendered. We accept cash, check, or credit cards (VISA, MasterCard, and American Express, Discover).
- 2) **Medicare Patients:** The physicians of **American Professional Associates** are proud to be "Participating Providers" of medical services under the Medicare Part B program. As Participating Providers, we agree to accept an amount of payment equal to the Medicare "allowable" for covered services. Medicare pays 80% of the allowable, and the patient, or the patient's secondary insurance, is responsible for paying the remaining 20% of the allowable and any deductibles.
- 3) Insurance is a contract between you and **your insurance** company. We will file claims with your insurance company as a courtesy to you. In order to properly bill your carrier we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.
- 4) Within the first week of treatment, you will be scheduled for an appointment to meet with one of our financial counselors. As a convenience this appointment may be scheduled adjacent to your treatment appointment. At this time we will discuss insurance coverage and what out of pocket cost you will be expected to pay towards your care. The benefits quoted to you are based on the information that APA received from your insurance carrier at the time of insurance verification, APA should not be held responsible for inaccurate information received. Out of pocket cost is just an estimate provided to you as a courtesy and is not a guarantee of benefits. We will also take the opportunity to provide you with a statement of your current charges to ensure that you do not have any questions and are comfortable on how to interpret the statement. During this appointment feel free to discuss any concerns that you may have with the counselor. It is our expectation that your total out of pocket cost be paid in full by the end of your course of treatment, if paying the entire balance will be a hardship we will make every effort to accommodate you by offering reasonable budget arrangements. We also offer a Charity and Indigent program for those patients who may qualify.
- 5) APA files claims with your insurance carrier on a daily basis. Keep in mind that the balance on your statements may change, this is due to subsequent payments being made by your carrier and

additional monies being transferred to patient responsibility. Remember although you may not receive a statement initially you are considered to be liable for the bill at the time service is rendered.

- 6) **Cancer Policies-** APA will provide information necessary for you to file any cancer policy claims. This information will be made available to you at the completion of your course of therapy and once your APA account has been paid in full
- 7) If you have questions about your insurance or your statement feel free to contact our Central Billing Office at (770) 350-0126 or toll-free at 1-888-350-0126, we are available Monday through Friday 8:00 am to 4:30 pm.

Patient Financial Agreement

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I will notify you of any changes in my health insurance coverage.

A copy of this agreement may be used in place of the original.

Signature of Patient

Date

Printed Name: _____

Patient Pharmacy Information

Patient Name: _____ Acct #: _____

Date of Birth: _____ SS #: _____

Insurance: _____ ID #: _____

Pharmacy Name: _____

Address/Location: _____

Pharmacy #: _____ Alt #: _____

Drug Allergies:

Dr. Henry Cline

**3330 Preston Ridge Road
Suite 100
Alpharetta, Georgia 30005
770-255-7500**

Please take a few minutes to give us this necessary information. We understand the frustration of multiple forms, but this information will help us in obtaining your medical history. This form will be part of your medical record, and the contents are confidential.

YOUR NAME: _____ DATE OF BIRTH ___/___/___
(Last) (First) (MI)

REFERRING PHYSICIAN: _____

OTHER PHYSICIANS: _____

MEDICAL ILLNESS: Please list below any illnesses which have required hospitalization in the past.

SURGICAL PROCEDURES: Please list any surgical procedures you have undergone in the past.

INJURIES: Please list.

PRIOR HOSPITALIZATION (NOT LISTED ABOVE):

ALLERGIES: Please list.

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

CURRENT MEDICATIONS:

FEMALE MEDICAL HISTORY:

Approximate age at onset of menstruation: _____

Date of last period: _____

Approximate age of menopause (if applicable): _____

Please list any current or past birth control pill or hormonal agents (estrogen/progesterone):

PRIOR RADIATION:

Have you ever had radiation treatments in the past: Y N

If you have had radiation treatments, what area(s) of the body were treated?

At what facility did you receive these treatments?

CHEMOTHERAPY AGENTS (TAKEN NOW OR IN THE PAST. PLEASE INCLUDE HORMONE AGENTS, I.E. TAMOXIFEN, NOLVADEX, DES, MEGACE, LUPRON, FLUTAMIDE, ETC.):

FAMILY HISTORY: Have any of the following relatives had cancer? If so, what type?

Mother _____ Father _____

Brothers or Sisters _____

Grandparents _____

Name: _____ Date of Birth: _____

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING:

Diabetes _____	Heart Disease _____
High Blood Pressure _____	Arthritis _____
Anemia _____	Kidney Disease _____
Stroke _____	Headaches _____

OTHER FACTORS:

Have you ever been exposed to toxic materials through your job or other contact?
(ex. Toxic chemicals, work in textile mills, exposure to asbestos) Please list.

SOCIAL HABITS:

Do you smoke? Please circle one. In the past In the present Never

If you smoked in the past, when did you quit? _____

If yes to any of the above, do you smoke:

Cigarettes	Y	N	packs per day _____
			number of years _____
Cigars	Y	N	packs per day _____
			number of years _____
Pipe	Y	N	packs per day _____
			number of years _____

Do you use smokeless tobacco products? Y N

Have you used them in the past? Y N

If yes to either, please list: _____

DO YOU DRINK ALCOHOL?: Y N

Beer	Y	N	number of drinks per week _____
Wine	Y	N	glasses per week _____
Mixed Drinks	Y	N	glasses per week _____

OCCUPATION: _____ RETIRED? Y N

Have you received Flu vaccine for this season? Y N

Have you received the PneumoVax in the past 5 years? Y N

NAME _____ DATE _____ Date of Birth _____

PLEASE CIRCLE BELOW IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS

CONSTITUTIONAL

Weight Loss

Fatigue

Fevers

Chills

HEENT

Headaches

Congestion

Visual Changes

Sore Throat

Ear Pain

Nasal Bleeding/Discharge

CARDIAC

High Blood Pressure

Shortness of Breath on
Exertion

Swelling of Legs

RESPIRATORY

Cough

Coughing Up Blood

Tuberculosis

Chronic Lung Disease

Reactive Airway Disorders

GI

Trouble Swallowing

Nausea

Vomiting

Diarrhea

Rectal Bleeding

Jaundice

Nutritional Deficiencies
(i.e. pernicious anemia)

URINARY

Frequent Urination

Painful Urination

Blood in Urine

Difficulty Starting/Stopping Stream

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

MUSCULOSKELETAL

Bone Pain **Arthritis**
Detaching Fingernail

NEUROLOGICAL

Fainting **Weakness**
Seizures **Numbness**
Tingling

SKIN

Rash **Itching**
Jaundice

IMMUNE

Scleroderma **Lupus**
HIV/Immunocompromised Disease
Recurrent Infections
Other Collagen-Vascular Disease

HEMATOLOGIC

Easy Bruising **Anemia**
Excessive Bleeding **Thrombotic Disease**

ENDOCRINE

Excessive Thirst/Urination
Heat/Cold Intolerance

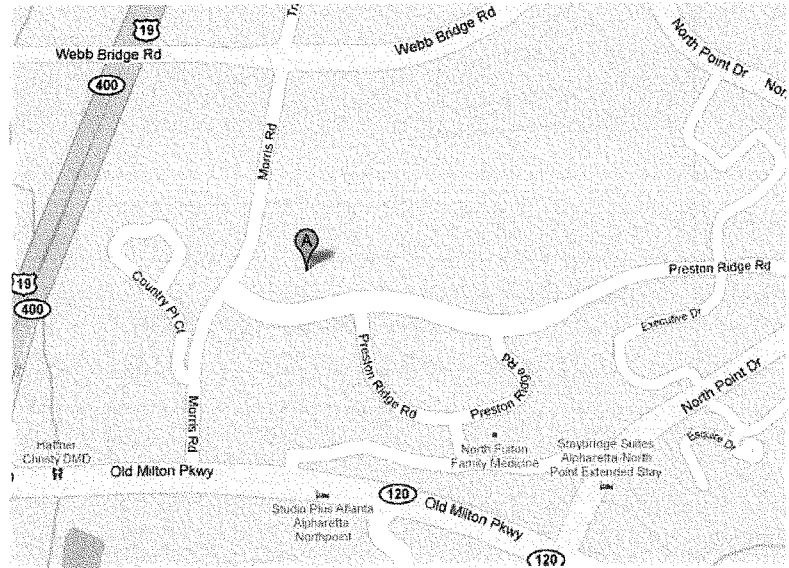
Georgia Center for Total Cancer Care at Preston Ridge

3330 Preston Ridge Road

Suite 100

Alpharetta, GA 30005

770/255-7500



From GA 400 Traveling North:

Take GA 400 North to Exit 10-Old Milton Parkway

Remain in center lane off exit ramp

Turn right on Old Milton Parkway

Stay in far left lane on Old Milton Parkway

Turn left at the first traffic light onto Morris Road

Turn right on the first road, Preston Ridge Road

Turn left into the first building on the left

From GA 400 Traveling South:

Take GA 400 South to Exit 10-Old Milton Parkway

Turn left onto Old Milton Parkway

After you cross over the bridge, get into the far left lane

Turn left at the first traffic light onto Morris Road

Turn right onto the first road, Preston Ridge Road

Turn left into the first building on your left

Parking:

You can use the deck or the parking lot behind the building. The entrance is also on the backside of the building. Suite 100 is on the walk-in level and is the first door on the left.