A Division of University Cancer & Blood Center, LLC

DATE: ____________________________
UHA GI PROVIDER: ________________
UHA MRN: ________________________

Patient Information Form

Name of Patient: ______________________________________ Date of Birth: ___________ Age: _____

Home Address: ____County:__________________

City, State, Zip: ____

Mailing Address (if different):____

Home Phone: (___)_________________ Cell:(___)___________________Work:(___)________________

Email Address: ____

Social Security Number: _________________________

Sex(Assigned at Birth): ☐ Male ☐ Female ☐ Other ☐Unknown

Gender Identity: ☐ Male ☐ Female ☐ Other ☐ Patient Declined

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Other ☐ Patient Declined

Race: ☐ African American or Black ☐ Asian ☐ Hispanic ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or other PAacific Islander ☐ Unspecified ☐ Patient Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unspecified ☐ Patient Declined

Preferred Language: __________________________ Religious preference: _________________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐Active Military ☐ Retired Military ☐Self Employed ☐ Disabled ☐ Unknown ☐Retired Date of Retirement: _________________________

Employer: __________________________________Occupation:__________________________________

Employer Address: ____

Emergency Contact

Name: ____Relationship:______________________________

Address: ____

Home Phone: (___)_______________ Cell Phone:(___)_____________Work Phone:(___)______________

Spouse Information:

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed

Preferred Pharmacy: ________________________________ **Phone #** _____________________________

MRN:____________________________

Patient Name: ________________________________

Name(s) of Physicians you are currently seeing

Date of Birth:___________________________

Patient doctors	Name	Phone Number	Location
Referring Physician			
Primary Care Physician			
Cardiology			
Pulmonology			
Gastroenterology			
Dermatology			
Surgeon(s)			
Surgeon(s)			
Urology			
OB/GYN			
Nephrology			
ENT			
Neurology			
Other Physicians			

UHA
UNIVERSITY HEALTH ALLIANCE
GASTROENTEROLOGY
A Division of University Cancer & Blood Center, LLC

MRN:______________________________

HIPAA RELEASE FOR ALTERNATIVE COMMUNICATION

Patient Name: ____ **DOB:** ___________________________

I consent to the following forms of communications: (check all that apply)

Home Phone/Cell Phone:

- ❑ Leave detailed message
- ❑ Leave call back number only

Work Phone:

- ❑ Leave detailed message
- ❑ Leave call back number only

Written Communication:

- ❑ Mail documents & correspondence to my home address
- ❑ Mail documentation & correspondence to the following alternate address:______________________________

____

Email Communication:

- ❑ Send encrypted email to the following email address: ____

Communication with Family and Others about Your Care:

List family members or others you want to be involved with coordinating your care or payment for care at University Cancer & Blood Center (UCBC). Be sure to check the box to show which type of information may be shared with each person. **Please note that if you choose not to list anyone below then our staff will only communicate with you, the patient, regarding your care.**

1. Name:	Phone:
Relationship to patient:	Expiration Date:

This person has permission to:

- ❑ Communicate with my health care providers
- ❑ Obtain billing, insurance, and other information regarding my financial account
- ❑ Receive information about my appointments with UCBC including appointment information, scheduling and rescheduling of patient appointments

2.	Name:	Phone:
Relationship to patient:		Expiration Date:

This person has permission to:

- ❑ Communicate with my health care providers
- ❑ Obtain billing, insurance, and other information regarding my financial account
- ❑ Receive information about my appointments with UCBC including appointment information, scheduling and rescheduling of patient appointments

By signing below, you understand and acknowledge the following:

- UCBC is authorized to engage in discussion about your health care with individuals listed on this form.
- This form does not restrict a healthcare provider from discussing your health information with individuals not listed on this form if such discussion is permitted by law.
- This form does not allow the individuals listed above to obtain copies of your medical records.
- This form is entirely voluntary and optional. Refusing to sign this form will not impact your care provided at this practice. Refusing to sign this form means that we will only communicate with you.
- You may modify or revoke any part of this HIPAA Release for Alternative Communication at any time. Changes to this form must be made by the patient in writing and in person by the patient.

Signature of Patient: ____ Date __________________________

UCBC/UHA Witness: ____ Date __________________________

Living Will & Power of Attorney

Do you have a living will?

- ❑ Yes
- ❑ No

Medical Power of Attorney to make medical decisions on your behalf?

- ❑ Yes
- ❑ No

Name: ____ Relationship: ____________________

Telephone: ____

(Please provide a copy of this document to our office to keep on file)

MRN:______________________________

Insurance Information

I request that payment of authorized Medicare, Medigap, or other insurance benefits be made on my behalf to University Cancer & Blood Center, LLC for services provided.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, my Medigap insurer or any other insurance company about which I have provided billing information, any information needed to determine benefits payable.

Patient Signature______________________________ Date: ______________

Patient Name: ________________________________ Date of Birth: _______________________

INSURANCE INFORMATION
(We will need a copy of your insurance cards, including Rx card. Please list Medicare and Medicaid if you have either.)

	Primary Insurance	**Secondary Insurance**
Insurance Company		
Insurance Phone Number		
Policy/Group Number		
Policyholder's Name		
Policyholder's Date of Birth		

Do you have prescription drug coverage? Yes☐ No☐
If yes, through what program?___________________________

Are you a resident of a skilled nursing facility? Yes☐ No☐
Name of Facility:____

Facility Address:___________________________________ Telephone: (___)_________________

ADDITIONAL INFORMATION NEEDED FOR PROCESSING OF INSURANCE:

Are you still working? Yes☐ No☐

Do you have employer group health coverage? Yes☐ No☐ Number of employees: ______

Is your spouse still working? Yes☐ No☐ Retirement Date: __________

Are you covered through your spouse's insurance? Yes☐ No☐ Number of employees: _____

Do you have a cancer or individual Policy you wish us to file for you? Yes☐ No☐

Does it allow for assignment of benefits? Yes☐ No☐

MRN:___________________________

INFORMED CONSENT

Agreement

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I AUTHORIZE University Cancer & Blood Center to provide medical care by today's standards. Treatment may include drawing of blood (by venipuncture or finger stick).

I CONSENT to University Cancer & Blood Center use and disclosure of all individually identifiable personal, health, financial, and demographic information (known as Protected Health Information or PHI) including human immunodeficiency virus, psychiatric, drug/alcohol abuse records:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance for medical procedures (where required)
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

The above purposes and all other uses are known collectively as Treatment, Payment and other healthcare operations or TPO.

I AUTHORIZE any physician or healthcare facility to provide upon request and PHI including human immunodeficiency, psychiatric, drug/alcohol abuse records, venereal disease and any other statutory protected diseases to University Cancer & Blood Center when needed for the purposes of TPO.

I also take responsibility for providing enough information order for the office staff to contact me efficiently by mail, telephone, and other forms of communication if necessary. I have been given a copy of University Cancer & Blood Center Practice Privacy Notice. I understand that my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing. I understand that should I choose not to consent to the terms and conditions of University Cancer & Blood Center the practice has the right to and will withhold treatment except where required by law.

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protective health information for non healthcare related activated without specific and explicit authorization.

Effective: 04/13/2003 Revised: 06/03/2015

Signature
I agree to all provisions therein regarding responsibility for the above mentioned in this Informed Consent Document. I understand that diagnosis or treatment of me by University Cancer & Blood Center may be conditioned upon my consent as evidenced by my signature on this document.

Patient Signature_________________________________ Date: ________________

Patient Name: ___________________________________ Date of Birth: ___________________________

MRN:________________________

FINANCIAL RESPONSIBILITY FORM

Agreement

Financial Responsibility

Please read each line below and sign the page to acknowledge that you have read and understand our office policy regarding the payment of amounts that are the responsibility of the patient.

Financial Responsibility

For patients with no insurance coverage, payment is due at the time of service. As a self paying patient you will receive a discounted rate on your first visit as long as payment is made in full on the date of service. If other arrangements have to be made the office visit will be full charge. We accept cash, checks, and all other major credit cards.

As a courtesy to you, we will bill your insurance carrier for all covered services. You will be required to pay all co-payments, deductibles and coinsurances at the time of your visit. All services not paid within 30 days by your insurance company will become your responsibility. It is the patient's responsibility to check their own insurance benefits and coverage.

As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. As a courtesy, we will obtain pre-certification for any procedures or treatments we schedule for you. Please understand pre-certification does not guarantee payment from your insurance company.

For amounts due after insurance has processed the claim (such as unmet deductibles or non-covered services) we will send you three consecutive statements at 30 day intervals.

You have 15 days after the third statement is sent to pay in full the balance indicated on the statement. If no payment is received, your account may be forwarded for collection process for further action, including additional billing fees.

It is the patient's responsibility to notify us of any changes in insurance, mailing address, or contact information.

Your signature below signifies that you have read each item and understand your responsibility to this office as well as our responsibility to you and your care.

Signature

I acknowledge that I have been made aware of financial assistance opportunities at this clinic.

Patient Signature________________________________ Date: _______________

Patient Name: __________________________________ Date of Birth: _________________________

MRN:___________________________

MID LEVEL CONSENT FORM

Agreement

University Cancer & Blood Center utilizes a Physician Assistant and Nurse Practitioner in our office for those levels of our practice that have been approved by the Georgia State Board of Medical Examiners.

Signature

I confirm my agreement to being treated by a Physician Assistant or Nurse Practitioner who is under the supervision of the physicians with University Cancer & Blood Center.

Patient Signature_________________________________ Date: _______________

Patient Name: ___________________________________ Date of Birth: __________________________

MRN:___________________________

AUTHORIZATION TO PROVIDE CONTRACTED SERVICES

Agreement

During your care at University Cancer & Blood Center, your physician may prescribe medications. You have the option of receiving these services from the provider of your choice.

Pharmacy Services

University Cancer & Blood Center has the ability to provide you with many prescribed medications through University Cancer & Blood Center Pharmacy, a facility in which the physician owners have an investment interest. These medications will be dispensed to your physician and transferred to you if you desire. A pharmacist is available to provide you with counseling concerning your medications.

In addition to University Cancer & Blood Center Pharmacy, the following pharmacies are available locally and may dispense your medications if desired:

CVS: 1-800-746-7287

Rite-Aid: 1-800-325-3737

Walgreen's: 1-800-289-2273

Or various independent pharmacies

Signature

I indicate that I understand that I have an option of receiving my prescriptions from the provider of my choice.

Patient Signature_________________________________ Date: ________________

Patient Name: ___________________________________ Date of Birth: __________________________

A Division of University Cancer & Blood Center, LLC

MRN:___________________________

AUTHORIZATION TO PROVIDE COUNSELING SERVICES

Agreement

During your care at University Cancer & Blood Center, your physician may recommend counseling as part of your ongoing cancer care. You have the option of receiving these services from any provider of your choice.

Cancer Counseling Services

University Cancer & Blood Center has the ability to provide you with professional mental health services through the Cancer and Counseling Services. University Cancer & Blood Center employs two oncology social workers, who are available to assist patients and their loved ones in coping with the emotional challenges of diagnosis, treatment, and beyond. Both are licensed mental health professionals who are available to provide counseling services on-site. These services are available as billable to some insurance plans and/or according to a sliding scale fee, for which the physician owners have an investment interest.

In addition to the Cancer Counseling Services, the oncology social work department maintains a list of local and national support services available to assist you in managing the emotional aspects of your diagnosis, treatment, and beyond.

Signature

I understand that I have an option to receive Cancer Counseling Services from the provider of my choice.

Patient Signature_________________________________ Date: _______________

Patient Name: ___________________________________ Date of Birth: __________________________

A Division of University Cancer & Blood Center, LLC

MRN:____________________________

DIAGNOSTIC IMAGING SERVICES

Agreement

During your care at University Cancer & Blood Center, your physician may order a Diagnostic Imaging. You have the option of receiving these services from the provider of your choice.

Diagnostic Imaging Services

University Cancer & Blood Center has the ability to provide you with CT services, Mammograms and Ultrasound in which the physician owners have an investment interest. In addition to University Cancer & Blood Center, Diagnostic Imaging Services are available at the following facilities:

Piedmont Healthcare Systems
706-475-7000

St. Mary's Healthcare System
706-389-3000

American Health Imaging
706-543-6006

Signature

I indicate that I understand that I have an option of receiving my Diagnostic Imaging from the provider of my choice.

Patient Signature__________________________________ Date: ________________

Patient Name: ____________________________________ Date of Birth: ___________________________

UHA UNIVERSITY HEALTH ALLIANCE GASTROENTEROLOGY
A Division of University Cancer & Blood Center, LLC

MRN:______________________

Narcotic Medication Treatment Agreement and Consent Form

Patient Name ____ Date of Birth:___________________

Drug Allergy Information: I have ___ no known drug allergies **OR** ___ the drug allergies listed below:

____

Facility Name: ☐ UHA GASTROENTEROLOGY

Location: ☐ CHASE STREET

Name of Provider Conducting Informed Consent: _______________________

At some time during your course of treatment, you may have problems with pain, and your physician may prescribe narcotic drugs (pain-killer drugs) to help manage your pain. Narcotics are a type of drug that should help with your pain and let you be more active in your daily life. It is not expected that your pain will go away completely. However, there are risks linked with these drugs, and you can have side effects. It is important to be honest with your doctor about your pain and the dose you are taking.

There are risks linked to narcotic drugs, which include but are not limited to:

Addiction: There is a chance that you may become addicted to narcotic drugs.
Allergic reaction: All kinds of allergic reactions can happen including a minor reaction such as a rash or a severe reaction such as swelling of your tongue or throat, or a severe allergic reaction which can cause death.
Incomplete pain relief: The dose of narcotic drugs you are on may not take away all of your pain.
Low testosterone levels in men: Narcotic drugs may cause the levels of the hormone testosterone to drop in men. This could change your mood and energy level. You may not want to have sex.
Physical dependence: You may not feel well if your dose is decreased too much or if you suddenly stop taking narcotic drugs. You may have a runny nose, yawning, goose bumps, stomach pain, loose stools, or body aches, or you may feel easily bothered.
Side effects: There are many side effects of narcotic drugs. You may feel itchy, dizzy, or sick to your stomach. You may throw up. You may have trouble having a bowel movement.
Slowed breathing: If you take a dose that is too high, then you could have slowed breathing. You must only take the dose your doctor tells you to take. Do not use other drugs or drink alcohol while taking narcotic drugs. This can cause death.
Slowed reaction time: You may feel sleepy and slow to react. If this happens, then you should not drive, use heavy machines or guns, be at unsafe heights, or be caring for someone else.
Tolerance: Your body could become used to the dose of narcotic drugs that your doctor tells you to take, and you may not get the pain relief you had before.

Other Choices

If you choose not to take narcotic drugs, then you may have other choices to help with pain such as non-steroidal anti-inflammatory drugs (NSAIDS), antidepressants, or seizure drugs. You may wish to see a doctor who specializes in pain management, or you may decide to do nothing and live with the pain that you have. Your doctor will let you know what other choices may be best for you. How well any other treatment works will depend on your specific health problem.

There may be local, state, or federal laws that your doctor must follow when prescribing narcotic drugs.

If you take narcotic drugs for **90 days or longer in one year**, you must be observed by your doctor. You will have to come to the office for a visit at least once every 3 months. You may need to have:

- a physical exam,
- lab work to test serum, sweat, urine, or blood,
- the number of pills in your medication bottle counted by someone at the practice, or
- an interview to talk about how you are responding to treatment and new health problems that you may have.

You should not take narcotic drugs if you are pregnant. Narcotic drugs can raise the chance of having a miscarriage or having a baby born with a birth defect. Your baby can also be born addicted to the drug.

Treatment Agreement

By signing the final page of this form, you agree that you understand the rules for taking narcotic drugs. If you do not follow these rules, your doctor shall refer you to a specialist or primary care provider, no longer prescribe pain drugs for you, and/or release you from his or her care.

Drug safety

1. You should lock your drugs in a safe place and keep them away from children. We will also review with you the right way to get rid of any extra drugs.
2. Do not sell, share, or let other people use your drugs. This is a crime and can cause overdoses.
3. You are expected to protect your drugs from loss or theft. Stolen drugs should be reported immediately to the police and to your doctor.

Instructions for taking narcotic drugs

1. You should stop taking all pain drugs that you have used in the past unless your doctor has told you it is safe to keep taking them.
2. Do not stop taking your narcotics suddenly, unless otherwise directed by your doctor.
3. Do not drive after a new pain drug is started or after the dose is increased until you are sure it does not make you sleepy or confused.
4. Do not try to cut or crush your drug unless told to do so; taking cut or crushed narcotics could cause death.
5. You must tell your doctor about all drugs you are taking (including herbal and over the counter drugs) and all health problems you are having. Your drug may not work well or may work differently if you have certain health problems.
6. You must tell your doctor about problems you have with any drugs.

Prescriptions and refills

1. Your narcotic drugs will be prescribed by our office only.
2. You may not ask for pain drugs from any other doctors, other than in emergency rooms.
3. Our office will tell you how many refills you are allowed to get and how often you can get them.
4. Never try to change a prescription. If you do this, then it will be reported to the police.
5. Your prescription may not be replaced if it is lost, stolen, or destroyed by accident.

6. **You will need to let our office know three (3) days ahead of time if you need a refill.** Early refills may not be given. To get refills, you must keep your office appointments. Prescriptions will only be given Monday through Friday during normal business hours.
7. **You should use one pharmacy to obtain all narcotic drugs prescribed by your doctor.**

Appointments

1. You should keep all appointments with doctors, therapists, and counselors. If you miss or cancel appointments often, then your doctor may slowly decrease your dose of narcotic drug until you are no longer taking it.
2. You should bring your drug bottles to each office visit.

Health information

1. Your doctor may need to discuss your treatment with pharmacists and other providers.
2. Legal authorities may ask for your pain treatment records which we will provide if requested.

Consent and Agreement to Treatment

NOTE: If you do not believe that you really understand the risks, likely results, other choices, and possible problems of narcotic drugs, please discuss your concerns with your provider. **Do not sign the form on the signature line below until all your questions have been answered.**

I understand all the facts given to me in this form. I give my consent to UCBC physicians to prescribe narcotic drugs for me**. I confirm that I have not given any false health facts and am not seeking treatment under false pretense. I agree to release my doctor and his/her staff from any liability caused by or due to my misuse of narcotic drug(s), including my failure to comply with this Treatment Agreement.** By my signature below I agree that I have had the chance to ask questions about this form, and that all of my questions have been answered.

______________________________ ________________
Signature of Patient or Responsible Party Date

____
Relationship to Patient (if Responsible Party is not Patient)

______________________________ ________________
UCBC/UHA Witness Date

Note to Witness: You have been asked to witness this procedure-specific informed consent. By witnessing this form, you are acknowledging that you have asked and the patient has confirmed to you that he or she: has read the whole form, understands the form as it is written, has had his or her questions answered, and chooses to carry on with the doctor's recommendations.

Physician: I confirm with my signature that I have given the patient this three (3) page form. The patient has had the chance to ask questions, all questions have been answered, and the parient has expressed understanding. Thus informed, the patient has asked that I prescribe narcotic drugs for him or her.

______________________________ ________________
Physician Signature Date

MRN:______________________________

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: August 1, 2022
LAST REVISION DATE: August 1, 2022

THIS NOTICE OF PRIVACY PRACTICES ("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.

ABOUT THIS NOTICE

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and our Business Associates' subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

"Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for treatment or a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request.

The HIPAA law requires us to also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

The following Georgia State Law applies to data breaches and medical records:
We will promptly notify you of any data breaches that may occur where patient's personal data is disclosed no matter the format (O.C.G.A. § 10-1-910 through 10-9-912 and O.C.G.A. § 46-5-214).
You are entitled to a complete copy of your UCBC medical record (OCGA § 31-33-2). When requesting a copy of your medical record, a written release is required. You may be charged for your medical record pursuant to O.C.G.A. §31-33-3.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object, unless required by law. Without your authorization, we are expressly prohibited from using or disclosing your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information.

We will not use or disclose 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. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. 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. If we deny access to the requested information, you can appeal the denial.

Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at alternative locations. We will comply with all reasonable requests, but we reserve the right to request the details in writing. We will not require an explanation for the request as a condition of agreeing to follow it. We also have the option to condition the agreement for alternate confidential communications with assurance that payment of special fees required will be handled.

You have the right to request an amendment to your protected health information – You have the right to request an amendment to health information about you if you think is incorrect or incomplete. We may deny your request if we did not create the protected health information, if the amendment would not be part of our normal record keeping of protected health information, if the amendment would never be included for inspection by any other group or party or if we believe the record is accurate and complete without the amendment. We will not require an explanation for the request for amendment from you as a condition of agreeing to follow it.

If we deny your request for amendment, we'll tell you why in writing within 60 days. You have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of it.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, in paper or electronic form, except for disclosures that are pursuant to an authorization, for purposes of treatment, payment, healthcare operations as defined here, required by specific law, or six years prior to the date of the request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We will also make available copies of our Notice, if you wish to obtain one.

We reserve the right to 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 website.

COMPLAINTS

You may complain to us if you believe your privacy rights have been violated by us. You may reach out to our Compliance Officer by calling our office at (706) 353-4040, sending an email to compliance@universitycancer.com or sending a letter to our office corporate office at 3320 Old Jefferson Rd, #700, Athens, GA 30607 . We will not retaliate against you in any way for filing a complaint.

You can also file a complaint with the Secretary of 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, or calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (706) 353-4040.

Please sign the "Acknowledgment" below. By signing this form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

MRN:______________________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of University Cancer and Blood Center's "Notice of Privacy Practices" for protected health information on the date set forth below.

______________________________ Date of Receipt	______________________________ Patient Date of Birth
______________________________ Patient Name	______________________________ Authorized Personal Representative
______________________________ Patient Signature	______________________________ Signature of Authorized Personal Representative

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FOR USE BY UNIVERSITY CANCER & BLOOD CENTER PERSONNEL ONLY
Complete if patient acknowledgement is not obtained.

An Acknowledgment of Receipt of Notice of Privacy Practices was not received because:

______ Patient refused to sign Acknowledgment

______ Unable to gain signed Acknowledgment due to communication / language or other barrier

______ Patient was unable to sign Acknowledgment due to emergency treatment situation

______ Other (please indicate reason):

______________________________ Signature of UCBC/UHA Representative	______________ Date

____
Printed Name of UCBC/UHA Representative