Maui PACIFIC CANCER INSTITUTE

(808) 249-1600 | Fax (808) 249-1651 | 227 Mahalani Street, Wailuku, HI 96793-2526

PATIENT INFORMATION

Name: _____

Physical address: _____

Mailing address: _____

Home phone number: _____ Work phone number: _____

Cell phone number: _____ Mobile Carrier: _____

Email address: _____ Social security number: _____

Date of birth: _____ Birthplace: _____

Gender: Male _____ Female _____ Marital status: _____

ADDITIONAL INFORMATION

Do you authorize the release of your medical information to anyone other than your insurance carrier?
Please circle one: Yes No

If yes, please specify to whom: _____

If you have an answering machine in your home, may we leave messages on thatmachine?
Please circle one: Yes No

EMPLOYER INFORMATION

Employer: _____

Employer address: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____ Phone number(s): _____

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PRIMARY INSURANCE COMPANY

Company name: _____

Policy number: _____

Group number: _____ Check here if none: _____

Coverage code: _____ Check here if none: _____

Subscriber: _____ Date of birth: _____

SECONDARY INSURANCE COMPANY

Company name: _____

Policy number: _____

Group number: _____ Check here if none: _____

Coverage code: _____ Check here if none: _____

Subscriber: _____ Date of birth: _____

TERTIARY INSURANCE COMPANY

Company name: _____

Policy number: _____

Group number: _____ Check here if none: _____

Coverage code: _____ Check here if none: _____

Subscriber: _____ Date of birth: _____

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PLEASE SPECIFY YOUR ETHNICITY

_____ Hispanic or Latino

_____ Not Hispanic or Latino

_____ Decline to respond

_____ Do not know

PLEASE SPECIFY YOUR RACE

_____ Native Hawaiian or Pacific Islander

_____ Asian

_____ Caucasian (White)

_____ Black or African American

_____ Decline to respond

_____ Do not know

_____ Other. Please specify:

Advanced Directive: _____ YES _____ NO

In order to participate in the US Government's EHR (Electronic Health Record) Incentive Program, also known as HITECH Act, Pacific Cancer Institute is required to ask the above question.

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Name: _____ Appointment date: _____

Date of birth: _____ Age: _____

MEDICAL INFORMATION

What type of cancer have you been diagnosed with and where is it located?

_____

_____

Please list the symptoms that led to your cancer diagnosis:

_____

_____

What symptoms are you currently experiencing?

_____

_____

Please list any cancer-related procedures you have had since your cancer diagnosis:

Date	Procedure/Scans	Physician/Facility	Outcome

Please list any current or past medical illnesses you have:

Illness	Physician	Illness	Physician

Please list any surgeries you have had in the past:

Date	Procedure	Surgeon	Outcome

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Do you have a pacemaker?_____If so, who is your cardiologist? _____

Have you ever been diagnosed with a connective tissue disease such as systemic lupus erythematosus ("Lupus"), systemic sclerosis ("scleroderma"), or mixed connective tissue disease? _____
If so, please specify and note when you were diagnosed: _____
_____

Have you ever had any previous chemotherapy and/or radiation therapy treatments? _____
If so, please specify below:

Date	Hospital or Clinic	Description
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

If there is cancer in your family history, please list here:

Description	Relationship to you
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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SOCIAL HISTORY

Please list any habits:

	Type	Frequency	Number of years	If quit, when?
Tobacco:				
Alcohol:				
Other:				

Occupation: _____ Marital status: _____

Who lives at home with you? _____

Women: Number of pregnancies _____ Number of live births/children: _____

Last mammogram _____

MEDICATIONS

Please list all medications, vitamins and herbal supplements that you are taking:

Description	Dose	Frequency

REVIEW OF SYSTEMS:

Please mark the any of the symptoms below which you are currently experiencing.

Constitutional:
___none
___fatigue
___fever/chills
___night sweats
___change in appetite
___unintentional weight loss
___other:

Head:
___none
___pain
___scars
___masses
___other:

Eyes:
___none
___eye pain
___blurred vision
___double vision
___tearing
___light sensitivity
___dry eye. Left or right or both?
___other:

Ears:
___none
___earache
___changes in hearing
___ringing in ears
___other:

Nose:
___none
___nasal pain
___nasal congestion
___bleeding
___post nasal drip
___other:

Mouth:
___none
___mouth pain
___dry mouth
___altered taste
___bleeding
___other:

Throat:
___none
___pain
___trouble swallowing
___voice hoarseness
___other:

Neck:
___none
___pain
___mass/swelling
___decreased range of motion
___other:

Skin/Nails:
___none
___hair loss
___rashes
___lesion/wounds
___nail changes
___other

Breast:
___none
___pain
___mass
___lesion/wounds
___nipple changes
___nipple discharge
___other:

Cardiovascular:
___none
___chest pain
___palpitations
___cold/cool extremities
___swelling of extremities; Location:_____
___other:

Respiratory:
___none
___trouble breathing
__with exertion;___at rest
___wheezing
___coughing up blood
___other:

Gastrointestinal:
___none
___abdominal pain
___acid reflux
___feeling of getting full early
___nausea/vomiting
___vomiting blood or coffee ground substance
___constipation
___diarrhea
___change in bowel habits
___dark, tarry stool
___rectal bleeding
___other:

Genitourinary:
___none
___pain with urination
___blood in urine
___urination after bedtime; how often _____
___pain with intercourse
___(M) erectile issues
___(F) vaginal bleeding/spotting
___(F) vaginal discharge
___other:

Musculoskeletal:
___none
___decreased range of motion; Location: _____
___joint pain; Location: _____
___muscle pain; Location: _____
___other:

Neurologic:
___none
___disorientation/confusion
___trouble thinking/cognitive issues
___lightheadedness/dizziness
___headache
___vision changes
___motor weakness. Location: _____
___sensory issues. Location: _____
___imbalance/trouble walking
___bladder incontinence
___stool incontinence
___other:

Psychiatric:
___none
___depression
___anxiety
___thoughts of harm to self
___thoughts of harm to others
___mood swings
___other:

Hematologic/Lymphatic:
___none
___swollen or tender lymph nodes
___easy bleeding/bruising
___other:

ALLERGIES

Do you have any allergies to any medications/foods/other substances?

If none, please check here:_____If yes, please list your allergy and your reaction:

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

PHYSICIAN INFORMATION

Referring physician: _____

Primary care physician: _____

Other physicians: _____

PHYSICAL EXAMINATION (to be filled out by nurse)

Height:_____Weight:_____BP:_____P:_____R:_____T: _____

Pain Level:_____/10__Location:_____Oxygen saturation:_____% at RA or____liters of O2

ECOG score: _____

Notice of Privacy Practices

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.

If you have any questions about this Notice of Privacy Practices, please contact the Alliance Privacy Official at (949) 242-5854 or via email sent to privacy@alliancehealthcareservices-us.com.

Alliance HealthCare Services, Inc., its subsidiaries and affiliates, (collectively, "Alliance") is required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to your *Protected Health Information*. We are also required to comply with this Notice of Privacy Practices. We may change its terms in the future and the revised Notice of Privacy Practices will then be effective for all Protected Health Information maintained on or after that date. Our most current Notice of Privacy Practices, as may be revised, is posted on our website – **www.alliancehealthcareservices-us.com**. You may also obtain a copy of our most current Notice of Privacy Practices at your next appointment or you may ask our Privacy Official to send a printed copy to you.

"Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future health care related services. This Notice of Privacy Practices describes how Alliance may use and disclose your Protected Health Information for treatment, payment, and health care operations. It also discusses other purposes permitted or required by law. Additionally, this Notice describes your rights of access and control of your Protected Health Information.

1. Uses and Disclosures of Your Protected Health Information

Permitted Routine Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your Protected Health Information will be used and disclosed to support your care and treatment, to ensure that we will receive payment for charges, and to support our administrative operations.

Descriptions and examples of these permitted routine uses and disclosures include:

Treatment: We will use and disclose your Protected Health Information so that we can provide services to you and to allow us to work with others assisting us with your care. For example, we may disclose your Protected Health Information to your physicians to give them information necessary to diagnose and treat your condition. We may also disclose your Protected Health Information to others, such as pharmacy, medical record and radiology entities, as necessary.

Payment: We will use your Protected Health Information so that we can obtain payment for our services. Your insurance carrier may require us to disclose your Protected Health Information before and/or after services are provided to you. This may include determination of eligibility, verification of your insurance benefits, determination of medical necessity, pre-authorization, and insurance billing.

Health Care Operations: We will use your Protected Health Information for the effective and efficient delivery of services to you. This includes quality assessment, employee training, support and maintenance of our equipment and systems, organization accreditation, and coordination with our business partners and suppliers.

Specifically, we may disclose your Protected Health Information to the facility where you are obtaining your services to allow the local storage of scan films and/or patient records. Before your appointment, we may contact you by telephone to confirm its time and location. At the time of your appointment, you may be asked to "sign in" and we may call you by name when it is time for you to be seen.

We may also share your Protected Health Information with third party "business associates" that perform certain activities (e.g., billing, transcription services, billing and collections, etc.) on our behalf. In these instances, Alliance will have written agreements in place to protect the privacy of your Protected Health Information.

Possible Uses and Disclosures for Which You Do Not Have an Opportunity to Object

There are also some circumstances that require Alliance to use or disclose your Protected Health Information. We must do so without your authorization and you will not have the opportunity to object.

General situations include:

When Required By Law: We may use or disclose your Protected Health Information to the limited extent required by law. You will be notified, if required by law, of any such uses or disclosures.

To Demonstrate Our Compliance: The U.S. Department of Health and Human Services or other regulatory agency may require us to disclose your Protected Health Information so that we can demonstrate our compliance with laws or if non-compliance is suspected.

Specific situations include:

Abuse or Neglect: Consistent with applicable federal and state laws, we may provide your Protected Health Information to a public health, civil authority, or government agency when child abuse, neglect, or domestic violence may have occurred if: 1) a law requires the disclosure, 2) you agree to the disclosure, 3) a law allows the disclosure and the disclosure is needed to prevent potential serious harm to you or someone else, or 4) a law

allows the disclosure, you are unable to agree or disagree, the information is needed for immediate action, and the information will not be used against you.

Criminal Activity: We may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Law Enforcement: We may disclose Protected Health Information for law enforcement purposes. These purposes include 1) limited information requests for suspect identification and location, 2) identifying victims or researching victims of a crime, 3) suspicion of criminal conduct related to a death, 4) investigation of a crime that occurred on our premises, and 5) when a medical emergency has occurred off of our premises and it is likely that a crime has been committed.

Legal Proceedings: We may disclose Protected Health Information in judicial or administrative proceedings, in response to a court order or administrative hearing (if expressly authorized), and, in certain conditions, in response to a subpoena, discovery request, or other lawful process.

Public Health: We may disclose your Protected Health Information to a public health authority for public health activities such as controlling disease, injury, or disability.

Communicable Diseases: We may disclose your Protected Health Information to a person who may have been exposed to certain communicable diseases or may be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose Protected Health Information to health oversight, regulatory, and accreditation agencies for purposes such as audits, investigations, and inspections.

Food and Drug Administration: We may disclose your Protected Health Information as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products (to enable product recalls, repairs or replacements), or to perform oversight activities.

Inmates: If you are in custody, we may disclose your Protected Health Information to your correctional facility or to law enforcement entities related to your care, to ensure the health and safety of others related to your custody or institution, or to maintain the safety, security, law and order of the facility.

Workers' Compensation: We may disclose your Protected Health Information to comply with workers' compensation laws and other similar programs.

National Security and Military Activities: We may disclose your Protected Health Information to federal officials authorized to conduct national security and intelligence activities. If you are in the Armed Forces, we may disclose your Protected Health Information 1) for activities deemed necessary by command authorities, 2) for benefits eligibility determination by the Department of Veterans Affairs, or 3) to a foreign military authority (if you are a member of their military services).

Employment Related Disclosure: We may disclose your Protected Health Information to your employer if: 1) we provide health care services to you at the request of your employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury, 2) your Protected Health Information that is disclosed consists of findings concerning a work-related illness or injury or a workplace- related medical surveillance, 3) your employer needs such findings in order to comply with its obligations under applicable law to record such illness or injury or to carry out responsibilities for workplace medical surveillance, and 4) we provide written notice to you at the time the health care services are provided that PHI relating to the medical surveillance of the workplace and work-related illnesses and injuries is disclosed to your employer.

Student Immunization: We may disclosure your Protected Health Information to a school about you if you are a student or prospective student of the school, with respect to proof of immunization.

Possible Uses and Disclosures for Which You May Object

If the use or disclosure of your Protected Health Information is not routinely permitted or legally required, you may have the opportunity to impose limitations on its use and disclosure.

Specifically, you may limit:

Disclosure to Family Members, Relatives or Personal Representatives: Unless you request limitations, we may disclose your Protected Health Information to members of your immediate family, other relatives, or your legally designated health care decision maker. We will limit disclosures to information directly related to their involvement in your health care. You may prevent this disclosure or you may seek to limit it. You may also designate someone other than those listed above (such as a close personal friend) to whom we may disclose your Protected Health Information.

If you are physically unable to express your objection or limitation, we will proceed as noted above if we believe that doing so is in your best interest. If a family member, relative or personal representative is not present, we may use your Protected Health Information to identify a representative. In the case of emergencies and disasters, we may disclose your Protected Health Information to authorized entities assisting in response and relief efforts.

Fundraising

Your Protected Health Information may be used and disclosed for communications to raise funds for Alliance, but you have a right to opt out of receiving such communications. Any such fundraising communication to you will include the opt-out mechanism.

Uses and Disclosures Permitted Only With Your Written Authorization

In situations not covered above, use or disclosure of your Protected Health Information will occur only with your written authorization. These cases include requests you make to Alliance, as well as those we may receive from third parties. For example, you may request that we disclose some or all of your Protected Health Information to an attorney, consultant, or personal acquaintance. Similarly, Alliance may receive a request from a third party to disclose your Protected Health Information. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your Protected Health Information for marketing purposes, and disclosures that constitute a sale of your Protected Health Information, require your written authorization.

Further, certain federal and state laws require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your Protected Health Information that: 1) is maintained in psychotherapy notes; 2) is about mental health and developmental disabilities services; 3) is about alcohol and drug abuse prevention and treatment; 4) is about HIV/AIDS testing, diagnosis, or treatment; 5) is about communicable disease(s); 6) is about genetic testing; or 7) is about sexual assault. In order for us to use or disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

You may later revoke your authorization, in writing, if you change your mind. Should you change your mind, your revocation will only be effective to the extent we have not previously relied on your revocation in making disclosures of your protected health information.

2. Your Rights

These Are Your Privacy Rights and How You Can Exercise Them:

You have the right to obtain a printed copy of this Notice. You may obtain a copy of this Notice at the time of your appointment or you may contact our Privacy Official at any time to request that a copy be sent to you.

You have the right to inspect and copy your Protected Health Information. You may review and receive a copy of your Protected Health Information contained in our Designated Record Set for as long as we maintain the records. A "Designated Record Set" contains medical, billing and any other records that Alliance uses for making clinical and financial decisions about you.

Requests to inspect or obtain your records must be submitted in writing on a record request form to our Privacy Official. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If we maintain your Protected Health Information in one or more Designated Record Sets electronically and if you request an electronic copy of your Protected Health Information, we will provide you with a copy of your Protected Health Information in the electronic form and format that you request, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed upon by you and us. If you provide us with clear, conspicuous and specific directions, we will send a copy of your Protected Health Information (hard copy or electronic) directly to another person of your choosing. We may charge you a reasonable, cost-based fee for any requested copies.

You have the right to request that we amend your Protected Health Information. Should you disagree with any Protected Heath Information maintained in our Designated Record Set, you may request, in writing to our Privacy Official, that we change it for as long as we maintain it. Alliance is not required to make the changes you request. If your request is denied, you have the right to file a statement of disagreement with our Privacy Official and we may prepare a rebuttal. You will be provided with a copy of any rebuttal; copies of related correspondence will be included with your Protected Health Information. If you do not submit a statement of disagreement, you may request that we provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.

You have the right to request how we provide confidential communications to you. You may request special handling for communication of confidential matters. All such requests must be submitted in writing to our Privacy Official. Alliance will accommodate reasonable requests and we will not require you to provide a reason or explanation for your request. We may, as a condition for our agreement, require you to provide additional contact information or other assurances regarding payment of your health care charges.

You have the right to request restrictions relating to your Protected Health Information. You may request restrictions on the use or disclosure of your Protected Health Information. Requests must be in writing and specify 1) the specific restriction requested and 2) to whom you wish it to apply. Before and during your appointment, you may make the request to any Alliance employee you contact. After your appointment, restriction requests must be forwarded to our Privacy Official.

Alliance is not required to agree to all restriction requests. If we agree to the restriction, we will not use or disclose your Protected Health Information in violation of the restriction unless it is necessary to provide emergency treatment to you. The restriction will take effect after it has been approved. A restriction we agree to is not effective to prevent any uses or disclosures specified in the above section, “Possible Uses and Disclosures for Which You Do Not Have an Opportunity to Object.”

Upon your written request, and except as otherwise required by law, Alliance will restrict disclosures of Protected Information to a health plan for purposes of carrying out payment or health care operations (but not for purposes of carrying out treatment) so long as the Protected Heath Information pertains solely to a health care item or service for which you, or person acting on your behalf (other than the health plan), has paid Alliance out of pocket in full.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information. Your request must be submitted in writing to our Privacy Official. The accounting excludes disclosures for treatment, payment, or health care operations as described in this Notice. It also excludes disclosures we may have made to you, your family members, or designated representatives. Other exceptions, restrictions and limitations may also apply. The accounting will cover a maximum period of six years. You may request a shorter time period for the accounting. After the first request for an accounting within a 12-month period, we may charge you a reasonable, cost-based fee.

You have the right to be notified of a breach of your unsecured Protected Health Information. Alliance will notify you in writing of any such breach (i.e., an unauthorized acquisition, access, use, or disclosure) of your unsecured (i.e., unencrypted) Protected Health Information.

3. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with either Alliance or with the Secretary of the U.S. Department of Health and Human Services. Alliance supports your right to file a complaint and will not take any adverse action against you for doing so.

To file a complaint with Alliance or for additional information about the complaint process, contact the Alliance Privacy Official at (949) 242-5854 or via email sent to privacy@alliancehealthcareservices-us.com.

To file a complaint with the Secretary of the U.S. Department of Health and Human Services, contact:

Director
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F HHH Bldg.
Washington, DC 20201

This Notice is published and effective on August 23, 2013

Maui PACIFIC CANCER INSTITUTE

ALLIANCE HEALTHCARE SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Instructions to Patient

1. Please fully complete, sign and date this form.

2. Please return this form to the Alliance location, Pacific Cacner Institute, where services are performed

I,_____, acknowledge that I have received the Notice of Privacy Practices issued by Alliance HealthCare Services or one of its subsidiaries or affiliates (collectively, "Alliance"). I agree that I will contact Alliance's Privacy Official with any questions that I may have concerning the Notice of Privacy Practices.

_____ _____

Signature of Patient Date

In the event the patient declines acknowledgement of receipt of Alliance's Notice of Privacy Practices, please describe below the good faith efforts used to obtain such acknowledgement and the reason why the acknowledgment was not obtained:

_____

_____

_____

_____

Signature: _____

Name: _____

Title: _____

Date: _____

Instructions to Service Location

After completion, please return this form to the applicable Centralized Billing Office (i.e., Canton or Andover office) for processing.

Maui PACIFIC CANCER INSTITUTE

ALLIANCE HEALTHCARE SERVICES

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions to Patient

1. Please fully complete, sign and date this form.
2. Please return this form to the Alliance location where services are performed

Patient Name:_____ **Patient DOB:**_____

Personal Representative (if applicable):_____ **Authority of Personal Representative:**_____

Address:_____ **Telephone #:**_____

City, State, Zip:_____ **Account # or SS #:**_____

Site of Recent Services:_____ **Date of Recent Services:**_____

Protected Health Information ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future health and related health care services. Consistent with our Notice of Privacy Practices, Alliance HealthCare Services, Inc., its subsidiaries and affiliates, (collectively, "Alliance"), are required to obtain your authorization to permit the following use or disclosure of your PHI. Alliance will not condition your treatment on whether you provide authorization for the requested use or disclosure.

I,_____, hereby authorize Alliance to (check those that apply):

□ Use the PHI described below

□ Disclose the PHI described below to: _____

_____

The specific PHI to be used and/or disclosed under this authorization is: (include relevant detail such as patient name (if authorization is being granted by patient's personal representative), date of service, type of service provided, level of detail to be released, name of documents or information, original source of information, etc.)

_____

_____

_____

I authorize the use and/or disclosure of the PHI specified above for the following purposes:

_____

_____

_____

This authorization shall be in force and effect until_____**or 45 days from the date of my signature below,** whichever is later, at which time Alliance's authorization to use or disclose the PHI specified above expires.

I understand that I have the right to revoke this authorization at any time by sending such written notification to the the applicable Centralized Billing Office (i.e., Canton or Andover office). Such a revocation will not be effective to the extent that Alliance has relied on it for the previous use or disclosure of the PHI.

I understand that information used or disclosed pursuant to this authorization **may be subject to re-disclosure by the recipient and may no longer be protected** by Federal or State law.

I understand that I have the right to refuse to sign this authorization and that I am entitled to receive a copy of this authorization, if signed.

Patient or Personal Representative Signature: _____ ***Date:*** _____

Instructions to Service Location

After completion, please return this form to the applicable Centralized Billing Office (i.e., Canton or Andover office) for processing.

PACIFIC CANCER INSTITUTE

Consent to and Conditions of Treatment | Payment Agreement

Consent to the Pacific Cancer Institute

1. I wish to receive medical care and treatment at the Pacific Cancer Institute. Accordingly, I authorize and give consent to any x-ray, examination, laboratory procedures, diagnostic procedures or any other medical services rendered to me under the general and specific instructions of my attending physicians as may be determined by their professional judgment.

I am aware that I should ask my physician any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of my treatment.

2. I recognize that the Pacific Cancer Institute participates with the medical professional schools. Therefore I give my consent for nursing students to participate in my care under appropriate supervision. This participation will include review of your Protected Healthcare Information.

General Nursing Duties

I understand that Pacific Cancer Institute provides only general nursing care in accordance with the standard practices of Pacific Cancer Institute. If I need or desire more nursing services, such as continuous or special nursing care, it is agreed that I or my legal representative or my physician will be responsible for making arrangements for those extra services.

Consent to Photograph

I authorize Pacific Cancer Institute to photograph (including all forms of imaging) me, or any part of me for medical purposes deemed necessary by this facility or my physicians.

Non-Discrimination

Pacific Cancer Institute treats patients without regard to race, color, religion, ancestry, national origin or handicap.

Disclosure of Health Information

I understand that Pacific Cancer Institute may disclose my health information for the purposes of treatment, payment, quality assurance, outcomes assessment, competence or qualifications review of healthcare professionals, accreditation, licensing, or credentialing activities, health plan claims or healthcare record data analysis, provider clinical performance evaluations, utilization management, research, required audits or other qualified healthcare operations. I understand further that my records may contain entries or information relating to sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or psychiatric impairment, drug and alcohol abuse and other personal information.

PACIFIC CANCER INSTITUTE

Pacific Cancer Institute, may disclose health information to physician(s) or referring physician(s), or others in order to coordinate my current care, to arrange transfers or the provision of other continuing care following the treatment from Pacific Cancer Institute.

Assignment of Insurance Benefits

In the event the undersigned is entitled to insurance benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to Pacific Cancer Institute for application to the patient's bill, and it is agreed that Pacific Cancer Institute shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment. The assignment of such benefits shall in no way obligate Pacific Cancer Institute to delay or relinquish its demand for direct payment from the patient of any portion of the outstanding balance.

Financial Agreement

The undersigned agrees, whether signing as an authorized representative or a patient, that in consideration of the services to be rendered to the patient, the patient is hereby individually obligated to pay the account of Pacific Cancer Institute or any portion that is not covered by ones insurance plan.

The Use of My Name

I understand that it is sometimes necessary to post/say my name for care and efficiency and to allow the health care team to locate me. I give my permission to have my name posted/said for these reasons.

The undersigned certifies that he/she understands the foregoing, and is the patient, or the patient's parent, next of kin, or authorized representative and is duly authorized to execute and accept its terms.

Signature:_____ Date: _____

Signature of Witness: _____

If the patient is a minor or unable to sign, then his/her representative gives the above consent on the patients behalf.

Signature of Representative: _____ Relationship to Patient:_____