Coastal Cancer Center

Patient Registration

MRN: _____

Patient Information

Name:_____ Birth Date:_____ Social Security Number:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

Phone: _____ Cell: _____

Birth Sex:_____ Age:_____

Race:

☐ White or Caucasian
☐ Asian
☐ Hispanic or Latino
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

Ethnicity:

☐ Non-Hispanic or Latino
☐ Hispanic or Latino

Language:

☐ English ☐ Spanish ☐ French ☐ German
☐ Vietnamese ☐ Italian ☐ Mandarin ☐ Other_____

Referring Physician: _____
Preferred Pharmacy Name:_____ Pharmacy Phone Number:_____
Patient's Employer Name:_____ Employer's Phone:_____
Patient's Employer Address:_____

Patient Employment Status: ____Full Time ____Part Time ____Retired ____Disabled

Coastal Cancer Center

Patient Registration

MRN: _____

INSURANCE INFORMATION

Primary Insurance Company:_____ID #: _____ Group #:_____

Policy Holder's Name:_____ DOB:_____ SSN:_____ Employer:_____

Secondary Insurance Company:_____ID#:_____Group#:_____

Policy Holder's Name:_____ DOB:_____ SSN:_____ Employer:_____

Advance Directives

Do you have a living will or AD? ☐ Yes If yes, provide a copy. ☐ No If no, would you like to receive information? ☐ Yes ☐ No

Do you have a DNR? ☐ Yes If yes, provide a copy. ☐ No If no, would you like to receive information? ☐ Yes ☐ No

Do you have a Health Care Durable Power of Attorney? ☐ Yes If yes, provide a copy. ☐ No If no, would you like to receive information?

☐ Yes ☐ No

I authorize the release of any medical information necessary to process insurance claims. I further authorize payment of medical benefits to the physician in the event they file for the insurance.

_____

Patient's or Authorized Individual's Signature Date

Facility Information

Are you currently admitted to a hospital or enrolled in a Hospice or Skilled Nursing Facility?

□ Yes □ No If yes, please fill out the following:

Facility Name:_____
Phone:_____
Address:_____
City:_____ State:_____ Zip:_____

Veterans Administration

Are you currently receiving benefits from the Veterans Administration?

□ Yes □ No If yes, please fill out the following:

VA Name:_____ Address:_____ Phone #:_____

Coastal Cancer Center

Patient Registration

MRN: _____

CCC charges the Patient for all services it renders, regardless of insurance coverage. Please provide all insurance cards to the registrar upon arrival. A copy of insurance cards will be kept which makes it imperative for you, as the Patient, to inform us of a change in your coverage, work, or other financial matters, as soon as it becomes known to you. Medicare, Medicaid, and contracted insurers claims will be filed by this office. All other insurance claims are the responsibility of the Patient. Any assistance completing the forms may be offered as needed. Payment is expected for all services when rendered unless previous arrangements in writing have been agreed upon.

GUARANTEE OF PAYMENT

In consideration for services, the patient and any Guarantor individually guarantee payment of all services provided to the Patient by CCC. This obligation of payment extends to all charges not paid by the Patient's insurance company or, if available, Medicare as stated below. By voluntarily signing this Guarantee, the Patient and Guarantor each agree to the payment of any outstanding charges and expenses arising from all services provided to the Patient. If the applicable insurance company does not pay within 30 days after any payment is due, payment is due from the Patient or Guarantor.

SIGNATURE DATE

SPOUSE DATE

MEDICARE PATIENTS

Medicare policies have coinsurance and deductibles. If Patient does not have supplemental coverage that covers coinsurance and deductible or if Patient has signed an Advance Beneficiary Notice, Patient agrees to be personally and fully responsible for payment. Patient requests that payment of authorized Medicare benefits be paid to CCC for services furnished. Patient authorizes CCC to release to the Centers for Medicare and Medicaid services or its agents, any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE DATE

SPOUSE DATE

Coastal Cancer Center

Patient Registration

MRN: _____

INSURANCE ASSIGNMENT AND AUTHORIZATION AND RELEASE AUTHORIZATION

In order to submit a claim for payment for services covered by a policy or program, such as Medicare, we must have your authorization to release medical information. I (Patient) authorize the release of any medical information relating to my charges with CCC. I authorize CCC to act in my behalf as authorized representative: (1) in the collection of benefits from any responsible third patty through whatever means may be deemed necessary; and (2) in the endorsement of benefit checks made payable to myself and/or participant or insured. I request and authorize that benefit payment be made directly to CCC. Furthermore, I designate CCC as my authorized representative and authorize CCC to act on my behalf to (I) request and receive a copy of the summary plan description; (2) pursue a benefit claim and/or (3) appeal an adverse benefit determination. I understand that I am responsible for payment of my medical charges regardless of the status of any claim.

SIGNATURE (Patient) DATE

SIGNATURE (Guarantor) DATE

CONSENT TO TREAT

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs, and other services and supplies as are considered necessary or beneficial by my physician for my health and well-being. I authorize the use and disclosure of my personal health information for the purposes of treatment and healthcare operations. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

SIGNATURE DATE

COASTAL CANCER CENTER WITNESS DATE

Coastal Cancer Center

Medical History Form

Patient Information

MRN:_____

Name:_____

Primary Care Physician:_____

Preferred Pharmacy:_____

Date of Birth:_____

Referring Physician:_____

Pharmacy Phone:_____

Reason for Visit

Please describe the main reason for your visit.

Personal Cancer History

Cancer Type:_____

Stage if known:_____

Date Diagnosed:_____

Treatments Received, check all that apply

☐ Surgery
☐ Chemotherapy
☐ Radiation
☐ Immunotherapy / Targeted Therapy
☐ None

Details, type and dates

Current Symptoms

Pain Scale

☐ 0 None ☐ 1 Mild ☐ 2 Moderate ☐ 3 Severe ☐ 4 Worst Pain

When did it start?: _____

Location _____

What makes it better or worse

Other Symptoms, check all that apply

☐ Fatigue
☐ Loss of appetite
☐ Shortness of breath
☐ Other
☐ Weight loss
☐ Nausea / Vomiting
☐ Pain, other

Medical History

☐ Cancer
☐ Heart Disease
☐ Lung Disease
☐ Thyroid Disorder
☐ Arthritis
☐ Tuberculosis
☐ Diabetes
☐ High Blood Pressure
☐ Kidney Disease
☐ Asthma
☐ High Cholesterol
☐ Other

Surgeries & Hospitalizations

Reason	Month / Year	Surgery

You may attach a list or bring medication bottles.

Allergies

Substance	Reaction

When was your last Flu vaccination? _____

For Women Only

Are you currently menstruating? ☐ Yes ☐ No If yes, when did your last menstrual period begin

If you are currently post menopausal, give approximate date:_____

Number of children born alive:_____ Number of Miscarriages:_____

Are you on hormone replacement therapy? ☐ Yes ☐ No Do

you have abnormal vaginal bleeding? ☐ Yes ☐ No

Fertility: If you are of reproductive age, generally females age 18 to 40 and males age 18 to 50, do you desire to address fertility regarding your diagnosis and treatment options? ☐ Yes ☐ No

Family History

Any family history of cancer? ☐ No ☐ Yes

If yes, please explain

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____

Tobacco Use: ☐ Never ☐ Former ☐ Current

Packs per day: _____ Years: _____

Alcohol Use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Substance Use Concerns: ☐ No ☐ Yes

Coastal Cancer Center
Medication Guide

MRN: _____

Patient Information

Name:_____ Date:_____

Date of Birth:_____

Your provider must be aware of all the medications you take. This includes all over-the-counter medications and supplements, in addition to any prescribed medications prescribed by your other healthcare providers.

BEFORE YOUR DOCTOR VISIT:

1) Make a list of all your medicines. Please use the form below. If it is easier, you may bring your medications with you to your appointment, and we will assist in the completion of this medication guide.

2) Once completed, be sure to bring this list to all future appointments for ease or maintaining an accurate record of your current medications.

Name of medication	Dose	Frequency	Prescribing Doctor	Why do you take this medicine?

Use another sheet of paper if necessary.

Patient Health Questionnaire-2 (PHQ-2)

NAME_____ DOB_____

MRN_____ Date_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: _____*0*_____+_____+_____+_____

= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

NCCN Guidelines Version 1.2025
Distress Management

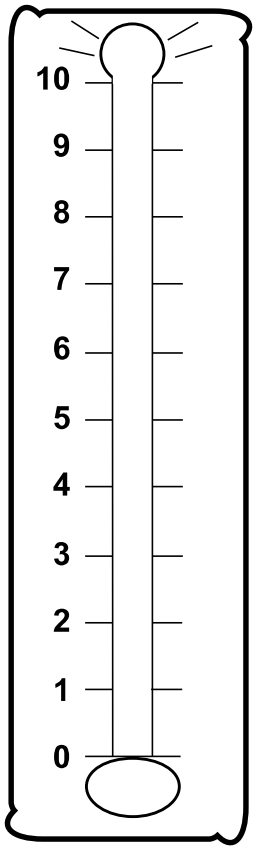
NCCN Guidelines Index
Table of Contents
Discussion

NCCN DISTRESS THERMOMETER

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.

Extreme distress



No distress

PROBLEM LIST

Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)

Physical Concerns
- ❑ Pain
- ❑ Sleep
- ❑ Fatigue
- ❑ Tobacco use
- ❑ Substance use
- ❑ Memory or concentration
- ❑ Sexual health
- ❑ Changes in eating
- ❑ Loss or change of physical abilities

Emotional Concerns
- ❑ Worry or anxiety
- ❑ Sadness or depression
- ❑ Loss of interest or enjoyment
- ❑ Grief or loss
- ❑ Fear
- ❑ Loneliness
- ❑ Anger
- ❑ Changes in appearance
- ❑ Feelings of worthlessness or being a burden

Social Concerns
- ❑ Relationship with spouse or partner
- ❑ Relationship with children
- ❑ Relationship with family members
- ❑ Relationship with friends or coworkers
- ❑ Communication with health care team
- ❑ Ability to have children
- ❑ Prejudice or discrimination

Practical Concerns
- ❑ Taking care of myself
- ❑ Taking care of others
- ❑ Safety
- ❑ Work
- ❑ School
- ❑ Housing/Utilities
- ❑ Finances
- ❑ Insurance
- ❑ Transportation
- ❑ Child care
- ❑ Having enough food
- ❑ Access to medicine
- ❑ Treatment decisions

Spiritual or Religious Concerns
- ❑ Sense of meaning or purpose
- ❑ Changes in faith or beliefs
- ❑ Death, dying, or afterlife
- ❑ Conflict between beliefs and cancer treatments
- ❑ Relationship with the sacred
- ❑ Ritual or dietary needs

Other Concerns:

_____

_____

_____

Note: All recommendations are category 2A unless otherwise indicated.

Coastal Cancer Center

Contact List - HIPAA & Emergency Contacts

MRN: _____

Patient Name: _____ Patient Date of Birth:_____

Date:_____

You have the option to select different types of contacts. You can designate one person to be both a HIPAA and Emergency Contact but, you also can designate separate people as either a HIPAA Contact or an Emergency Contact.

A HIPAA contact is a person who you authorize Coastal Cancer Center to release information about your medical condition, appointments and/or financial information. Any physicians who provide medical care to you don't need to be listed as HIPAA contacts.

It is important for you to name an Emergency Contact. This is a person that you authorize our staff to contact in the event you have a medical emergency while being treated in our office.

Contact		Type of Contact: ☐ HIPAA ☐ Emergency	
Contact Name:			
Phone Number:		Other Phone:	
Relationship:			
Contact		Type of Contact: ☐ HIPAA ☐ Emergency	
Contact Name:			
Phone Number:		Other Phone:	
Relationship:			
Contact		Type of Contact: ☐ HIPAA ☐ Emergency	
Contact Name:			
Phone Number:		Other Phone:	
Relationship:			
Contact		Type of Contact: ☐ HIPAA ☐ Emergency	
Contact Name:			
Phone Number:		Other Phone:	
Relationship:			

_____ (Initials) I understand that I am authorizing Coastal Cancer Center to disclose my personal health information to the individual(s) named above whom I have identified as my HIPAA contact(s).

_____ (Initials) I acknowledge that I have received a copy of Coastal Cancer Center Privacy Practices.

_____ (Initials) I acknowledge that I have the right to change contacts on this list at any time; that I can re-designate the Type of Conduct originally stated' and that I have the right to revoke this contact list.

_____ (Initials) I acknowledge that any revocation of this list must be made in writing.

_____ (Initials) I have read this form, or had it read to me and I understand the consequences of my choices.

_____ (Initials) I understand that refusal to sign this authorization will not impact my ability to obtain Care from Coastal Cancer Center.

Patient Signature Date

MRN: _____

In addition to delivery by United States Postal Service to my home of other place of residence as provided in the Patient Registration, I consent to communication with me through the following methods. I understand that I may revoke or modify this consent at any time by completing the REQUEST FOR COMMUNICATION RESTRICTION FORM. In the event of a communication required by law, such as notice of breach, I acknowledge that the method of communication required by law, such as notice of breach, I acknowledge that the method of communication may be set by law.

Section A: Communication Method

Please choose one or more of the following:

Home Number: _____ Voice Messages Permitted: _____Yes _____No

Cell Number: _____ Text Messages Permitted: _____Yes _____No

Work Number:_____ Voice Messages Permitted: _____Yes _____No

Alternate Number: _____ Voice Messages Permitted: _____Yes _____No

Email Address: _____

Alternate Email: _____

Section B: Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communication

Patients in our practice may be contacted via email and/or text messaging by Coastal Cancer Center or its authorized agents to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provider general health reminders/information.

_____ (Patient Initials) If at any time I provide an email or text address at which I may be contacted. I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above.

_____ (Patient Initials) I understand that this request to receive emails and text messages will apply to all future appointment
reminders/feedback/health information unless I request a change in writing (REQUEST FOR COMMUNICATION RESTRICTION FORM). The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

In some cases, emails and/or text communication will be delivered to you through an encrypted communication format to ensure protection of your health information. If you decline encrypted communications, the email and/or text communication may not be available to you.

Section C: Signature – This document must be signed by the individual, parent of minor child or the Individual's Personal Representative.

I consent to communication by Coastal Cancer Center or its authorized agents with me as specified above.

Signature Date:

If signed by a Personal Representative, please complete the information below.

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, attach a copy of the legal documents. You do NOT have to attach copies of these documents if they are already on file with Coastal Cancer Center.

Personal Representative's Name		Relationship to Individual	
Personal Representative's Address		City, State, ZIP	
Personal Representative's Telephone Number		Personal Representative's E-Mail Address (optional)	

Coastal Cancer Center Patient Portal / Electronic Mail Authorization Form

MRN: _____

Coastal Cancer Center provides secure access to your personal health record through our Navigating Care patient portal. Only you, or those you authorize, will have access to your health information.

Your authorization to activate your personal Navigating Care account and consent to electronic mail is required. If you do not authorize this, we will not send any communication to you electronically.

Your Navigating Care portal will include personal identifying information and other information about your health and medical history, so it is important that you keep your password private. Your password should not be shared with others unless you authorize them to access your account. Please don't share your password with anyone else that is not authorized or keep it in a place where it can be easily accessible to others.

If you choose not to sign this Patient Portal / Electronic Mail Authorization Form, you will not be able to access the Navigating Care patient portal. By authorizing this form, you are consenting for us to email you a link for you to use to establish your account and create a password. The link will be sent after submitting this form, and for your protection, it is designed to expire quickly if not used.

Please contact your physician's office in the event that you have a new email address so we can update your account. Please make sure that the email address that you provide cannot be accessed by any person that you have not authorized.

At any time, you can discontinue use of your Navigating Care patient portal. Please contact your physician's office to assist you with deactivating your account.

_____ I understand that by signing below, I am consenting to use Coastal Cancer Center's Navigating Care Patient Portal / Electronic Mail.

Patient Name:_____ Email Address of Patient:_____

Signature of Patient:_____ Date:_____

Discrimination is Against the Law

MRN: _____

Coastal Cancer Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Coastal Cancer Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Coastal Cancer Center provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services,
contact:
Clinical Services Director &
Privacy Officer Coastal Cancer
Center
8121 Rourk Street
Myrtle Beach, SC 29572

If you believe that Coastal Cancer Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Regulatory Compliance Coordinator
Coastal Cancer Center
8121 Rourk Street
Myrtle Beach, SC 29572

You can also file a civil rights complaint with the:
U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHS Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at: https://www.hhs.gov/ocr

Coastal Cancer Center Section 1557 of the Affordable Care Act Grievance Procedure

MRN: _____

It is the policy of Coastal Cancer Center not to discriminate on the basis of race, color, national origin, sex, age or disability. Coastal Cancer Center has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services.

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Karen McCormick, 3945 E. Paradise Falls Drive, Suite 201, Tucson, AZ 85712, who has been designated to coordinate the efforts of Coastal Cancer Center to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Coastal Cancer Center to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.

A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Coastal Cancer Center relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

Coastal Cancer Center Section 1557 of the Affordable Care Act Grievance Procedure

MRN: _____

The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Regulatory Compliance Coordinator within 15 days of receiving the Section 1557 Coordinator's decision. The Regulatory Compliance Coordinator shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHS Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at: https://www.hhs.gov/ocr

Such complaints must be filed within 180 days of the date of the alleged discrimination.

Coastal Cancer Center will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectfully, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Coastal Cancer Center will provide free language services to people whose primary language is not English, such as: Qualified interpreters and/or information written in other languages.

Coastal Cancer Center

Authorization to Release Protected Health Information (PHI)

MRN: _____

Patient Name:_____ Birth Date:_____

Address:_____ Phone #: _____

I request and authorize Coastal Cancer Center to obtain health information from: _____

Fax #: _____ Phone #:_____ Attn:_____

Information to be released:

- ☐ Medical Records
- ☐ Imaging
- ☐ Procedure Notes
- ☐ Billing
- ☐ Imaging Disc(s)
- ☐ Path Results
- ☐ Labs
- ☐ MD Notes
- ☐ Other: _____

Date(s) of services(s): _____ to _____

RETURN COMPLETED DOCUMENT TO: Coastal Cancer Center, fax – 843.234.2729 or any clinic location.

I understand that:

- This authorization will remain in effect for one year after the date recorded below unless noted here _____.
- I do not have to sign this authorization in order to receive treatment, payment or to be eligible for benefits.
- This authorization can be taken back (revoked) at any time with a written request to the Privacy Officer.
- Revoking this authorization stops further disclosures but cannot undo any disclosure that has already occurred.
- Sending an unencrypted/unsecured email or fax poses the risk of the record being viewed by unknown persons. If you request your records to be emailed or faxed, you accept the risk.

I request and authorize the disclosure of protected health information as marked above.

Signature of Patient or Representative

Printed Name of Patient or Representative

Date

Representative Relationship

Coastal Cancer Center

Telehealth Visit Consent

MRN: _____

Patient Name: _____

Date: _____

Patient Date of Birth: _____

Telehealth Visit Consent

1. I authorize the healthcare providers at Coastal Cancer Center (CCC) to provide the above named patient with treatments and services through the use of Telehealth.
2. I understand that Telehealth has many benefits, including providing timely access to certain specialized services without having to come into the office, as well as potential risks, including technology failures that could interrupt your service or treatment.
3. I understand that Telehealth should not be used for emergency medical conditions.
4. I acknowledge that video image and protected health information will be transmitted electronically through the video conference to the physician and other personnel authorized to receive such information for the purpose of providing treatment.
5. I understand there are inherent limits to telemedicine services, given that it is not a face-to-face consult.
6. I understand there are certain potential privacy and security risks associated with the use of audio- visual technology.
7. I agree that should professional services provided via telehealth not be covered by the above named patient's health insurance plan, the above named patient will assume responsibility for paying all associated costs.

I, the undersigned, have had the form explained to me and fully understand the contents of this authorization. All of my questions have been answered in relation to the Telehealth visit option.

Patient or Authorized Person's Signature

Witness

Physician /APP Obtaining Consent

MRN: _____

CONSENT FOR USE OF LANGUAGE INTERPRETER

Patient Name:_____

I hereby give my permission for Coastal Cancer Center and Doctor to use a language interpreter for the purposes of communicating medical information. I understand that the interpreter will have access to my medical information, only through the interpretation of this information. I understand that the interpreter will NOT have access to my written medical records.

Language Interpretation required: _____
(Sign-Language, Spanish, French, etc.)

Permission Granted by: (Signature of Patient) Date of Signature:

Witnessed by:

ESPANOL

Yo, doy mi consentimiento a Coastal Cancer Center Center y el Doctor

para obtener un interprete para la intencion de communicando information medico. Yo entiende y estoy en acuerdo que el interprete tience acceso a mi informacion medico, solamente para interpretar esta informacion. Yo entiende que el interprete NO tiene acceso a mi datos medicos.

Consentimiento de: *(Firma del paciente o guardián)* Fecha de firma:

Testigo:

Coastal Cancer Center
Acknowledgment of Receipt of Notice of Privacy Practices

MRN: _____

Patient Name:_____ DOB:_____

I have received a copy of the Notice of Privacy Practices from the above named practice.

Patient Signature:_____ Date :_____

For Office Use Only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

_____ An emergency existed & a signature was not possible at the time.

_____ The individual refused to sign.

_____ A copy was mailed with a request for a signature by return mail.

_____ Unable to communicate with the patient for the following reason:

_____

_____

_____

_____Other:_____

_____

Coastal Cancer Center
Financial Policy

MRN: _____

FINANCIAL POLICY

An integral component of Coastal Cancer Center's commitment to excellent patient care includes a team dedicated to assist with financial arrangements. It is our desire to contain medical costs. As a service to the patient, we provide registration, verification and filing of insurance; assist with payment arrangements and work extensively with insurance companies to have claims paid at their maximum benefit, thereby alleviating most of the financial burden and responsibility from the patient.

REGISTRATION

With the first appointment at Coastal Cancer Center, the patient will be asked by the New Patient Representative to complete a Registration Packet, which includes patient and insurance information. This information is vital for correct billing and payment. Along with this packet, we will need to make copies of your insurance cards. When the new patient appointment is set up via telephone, certain information will be obtained at that time. Please remember to bring all of your active insurance cards to the office at each visit.

VERIFICATION

After you have completed the Patient Registration Packet, a Patient Representative will contact your insurance company to verify your benefit coverage. Depending on information supplied by the carrier, it may be necessary for the Patient Representative to discuss coverage issues with you either at the time of your appointment or by telephone.

Please note that Patient Registration and Insurance Verification occurs prior to every visit to assure your coverage is in force and to help contain your medical costs. We ask for your cooperation and assistance with this special service.

REFERRALS

Many managed care plans require that you obtain a referral from your primary care physician (PCP) prior to your visit with a specialist. Therefore, based upon your insurance specifications, it is our policy that you must have the proper referrals prior to your appointment. The Patient Representative maintains files on these referrals and will assist the patient with proper referral procedures from your insurance carrier and PCP.

OFFICE CO-PAYMENTS

It is the policy of this office to collect co-payments at the time services are rendered. These shall be paid as you sign in for your daily appointment. Usually, co-payment amounts are indicated on the insurance card, however, our Patient Representative will be obtaining this information as your insurance benefits are verified and we will ask you for this amount at each visit.

INSURANCE FILING

All primary and secondary insurance policies are filed on the patient's behalf for services rendered. Insurance is a method for you to receive reimbursement for fees you should pay to the physician. Assignment of benefits allows payment to come directly to our office from the insurance company. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on contracts with them, not with our office. It is your responsibility to pay any deductibles, co-insurance, and any other balances not paid by your responsible party for the bill. Patient Statements are mailed monthly outlining insurance filed as well as patient balances due. Patient balances are due and payable within 30 days unless special payment arrangements have been coordinated with the Patient Account Representative.

PATIENT ACCOUNT REPRESENTATIVE

We have a team of Patient Account Representatives that work exclusively on collection efforts of patient account balances due, and claims denied or paid inaccurately by the insurance company. Each Representative is assigned specific physician accounts to work. If you have questions concerning your monthly statement or need assistance with your insurance filing or financial arrangements, please do not hesitate to contact our office.

Coastal Cancer Center

Patient Rights & Responsibilities

MRN: _____

PATIENT RIGHTS

At Coastal Cancer Center, we believe that the protection and support of the basic human rights of freedom of expression, decision and action are important to the healing and well-being of our patients. Therefore, we strive to treat patients with respect and with full recognition of human dignity. Decisions regarding health care treatment will not be based on race, creed, sex, national origin, age, disability, or sources of payment. As a patient of Coastal Cancer Center, you have the right to:

1. Be fully informed in advance about care/services to be provided to you, including the scope of planned care/services and any specific limitations, the expected frequency of visits.
2. Be informed of your financial responsibility for any care/services.
3. Participate in the development and periodic revision or modification of your plan of care.
4. Refuse care, services or treatment after being fully presented the consequences of refusing care, services or treatment.
5. Receive information about the creation of Advanced Directives upon request.
6. Be treated with respect, consideration, and recognition of your dignity and individuality.
7. Be able to identify personnel members through proper identification.
8. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse.
9. Voice grievances/complaints regarding treatment or care or lack of respect to your property, or recommend changes in policy, personnel, or care/service without discrimination, or reprisal.
10. Have your records and communications treated as confidential. You will receive a separate “Notice of Privacy Practices” that explains your privacy rights in detail and how we may use and disclose your protected health information.
11. Receive appropriate care without discrimination in accordance with your providers’ orders.
12. To have your family take part in your care decisions with your express permission.
13. To request and/or be provided with language assistance i.e., interpreter services, if you have a language barrier or hearing impairment. This will be provided at no cost to you to help you actively participate in your care.
14. Be fully informed of your responsibilities.

MRN: _____

PATIENT RESPONSIBILITIES

Your contribution to your health care is vital, and you can be involved in the health care process by fulfilling certain responsibilities. As a patient, you, or your designated representative (if you have one) have a responsibility to:

1. Submit forms, insurance cards or other documents that are necessary to receive services or care from Practice.
2. Keep appointments scheduled with your healthcare provider. If you need to cancel an appointment, you should do so promptly with at least 24 hours before your appointment time when possible.
3. Provide accurate medical, pharmacy and contact information and any changes to such information:
   - Provide, to the best of your ability, accurate and complete information about your present condition, past illnesses, hospitalizations, medications, and other matters related to your health, including information about home and work that may impact your ability to follow the proposed treatment.
   - Tell your care team if you have an Advanced Directive and the intent it contains.
   - Notify your care team of any potential side effects and/or complications that you experience.
   - Tell your caregivers about any changes in your health.
4. Maintain any equipment provided to you by Coastal Cancer Center, if applicable.
5. Notify Coastal Cancer Center staff of any concerns about the care or services provided.
   - Ask questions so that you may understand your health problems and what to reasonably expect during your treatment.
   - Ask questions if you do not understand or need more information.
6. Make Informed Decisions
   - If you are unable to make decisions about your care, your legally appointed decision-maker has a responsibility to make healthcare decisions that are consistent with your values and life goals.
7. Participate in your care and follow the instructions for taking medication as directed.
8. Follow the mutually agreed to treatment plan developed with your provider.
   - Express any concerns about your ability to understand or comply with a proposed course of treatment.
   - You are responsible for the outcomes if you refuse treatment or do not follow your care provider's instructions.
   - Remain adherent to your treatment plan, and work with your Coastal Cancer Center care team to address any obstacles that may prevent you from following your care plan.
9. Accept Financial Responsibilities
   - Provide information necessary for claims processing and maintain personal and financial integrity with respect to healthcare services provided on your behalf.
   - You are responsible for meeting your financial responsibility for any amounts required by your insurance carrier, or any care or services not covered by your insurance.
10. Support Coastal Cancer Center policies that apply to patient care and conduct:
    - Treat all Coastal Cancer Center staff, other patients, and visitors with courtesy and respect. Follow all Coastal Cancer Center rules and safety regulations, and be mindful of noise levels, privacy, and the number of visitors.
    - Respect the privacy and confidentiality of other patients.
    - Refrain from using a smart device to record your experience in audio, video, or photography format in the practice without the consent of everyone involved including Coastal Cancer Center physicians, nurses, and other staff.
    - Express any needs you may have, so we can provide reasonable accommodation.
    - Inform the healthcare team when you have issues or concerns related to your safety.

_____ _____

Patient Signature Date