TERK ONCOLOGY
7017 AC SKINNER PKWY. JACKSONVILLE, FL 32256
T: 888-339-0588 | F:904-520-6801

Patient Registration

Name: ____ Date of Birth: ________________ Age: ______

Address: ____
Street City State ZIP

SS#: ___________________________ Male ☐ Female ☐ Marital Status: (Circle) S M D W
Optional

Home Phone: ______________________________ Mobile Phone: _________________________________

Name of referring doctor: ________________________________ Phone: _________________________

Name of primary care doctor: ____________________________ Phone: _________________________

Email Address: ________________________________

Attention: We will use the address above and all phone numbers and address listed to contact you, mail copy of office visit notes and/or leave messages, and speak to friends or family involved in your care. Please see the Office Manager if you wish to place a restriction on the use of this information for these purposes.

Are you a patient in a skilled nursing home? Yes ☐ No ☐ If yes, where: _________________________

Employed: Yes ☐ No ☐ Employer Name: _____________________ Occupation: _____________________

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or other Pacific Islander ☐ Decline to Answer

Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Spoken Language: ________________________ Preferred Language: ___________________________

Emergency Contact: _______________________ Relation: ____________ Phone: ________________________

Guarantor Name: __________________________________ Relationship to Patient: _____________________
Person responsible for payment if other than patient

Address: ____ Phone#: ________________________

Primary Insurance Information

Name of Insurance: _____________________ Subscriber: ______________________________ DOB: ______________

Member ID#: ________________________ Group #: _________________ Effective Date: _________________

Secondary Insurance Information

Name of Insurance: _____________________ Subscriber: ______________________________ DOB: ______________

Member ID#: ________________________ Group #: _________________ Effective Date: _______________

How did you hear about our practice? ____

Pharmacy Name and Address ____

____ ________________________
Signature of patient or representative Date

New 10/2012

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Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to ___________________ (the "Provider") for any services furnished me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment is effective until revoked by me in writing.

Patient/Guardian Signature: ____Date: __________________

Medi-gap (Medicare supplemental insurance) Assignment of Benefits

I request payment of authorized Medi-gap benefits be made to the Provider and also authorize any holder of medical information about me to release to the Medi-gap insurer listed below any information needed to determine benefits payable for services from the Provider. This assignment is effective until revoked by me in writing.
Medi-gap Insurance Name: ____

Patient/Guardian Signature: ____Date: ______________

General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature: ____Date: ________________

Receipt of Notice of HIPAA Privacy Practices

I have received the_________________________________Notice of Privacy Practice from the Provider.
Name of Practice/Center

Patient/Guardian Signature:____Date: ________________

New 1/2012

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AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164)

I authorize______Any and All Medical Entities___(healthcare provider) to release my medical records to the following individual or entity:

Individual or Entity: _TERK ONCOLOGY fax: 904-520-6801

Patient Name:____ Date of Birth:_____/_____/________

Address:____
Street City State Zip

This authorization for release of information covers the period of healthcare:

From:_______________To__________________ ***OR*** all past, present, and future periods.
Date Date

☐ I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records ☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment ☐ Other (please specify):________________________

The purpose of this release:____

This medical information may used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effective for 365 days from the date of my signature below.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ ___________________________
Signature of patient or personal representative Date

____ ___________________________
Printed name of patient or personal representative Relationship to the patient

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name:____DOB:___________________Acct#:______________

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friends in order to assist with my continuing care. Any information that does not pertain to assisting with my healthcare and any copies of medical records will require a signed HIPAA compliance autho rizati on. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	Name of Individual & Relationship to Patient	Comments/Instructions	Patient/ Guardian Initials

THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

- ☐ Leave a message at home with my spouse or: Name:____

  Relationship:__________________________ DOB:__________________________
- ☐ Leave message on cell phone: Cell phone #:______________________________________
- ☐ Leave message at work: Work phone#:__________________________________
- ☐ Leave message on voicemail: Phone#:__________________________________
- ☐ Leave detailed message on answering machine. Phone#:________________________________
- ☐ Share Information for research purposes.

In order to obtain information by telephone, the party calling the practice or billing department must be able to share the patient identifier/password with the staff.

Patient Chosen Identifier/Password: ____

I **understand** I **may revoke this authorization at any time by notifying** **TERK ONCOLOGY** **in writing.** I **understand** I can **refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility** for **benefits (if applicable).** I **understand that if the person(s) that receive the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.**

____ ______________________________

Signature of Patient or Legal Guardian Date

____ ______________________________

Printed Name of Patient or Legal Guardian Relationship to Patient

rv 1/30/13

Mitchell Terk, M.D. · Jamie Cesaretti, M.D.

E-MAIL CONSENT FORM

Patient's name printed

Patient's address

Patient's e-mail address

Patient's phone number

DO NOT USE EMAIL FOR EMERGENCY, URGENT & SENSITIVE PROBLEMS!

E-mall should never be used for emergency or urgent problems. For a life-threatening emergency, **call 911. For urgent or sensitive problems, call the office at 904-520.6800.** We recommend office visits for all new, complex or sensitive problems. When we are not in the office, the answering message will direct you to an on-call doctor who can give advice or direct you to a source of emergency or urgent care.

1. RISKS OF USING E-MAILTO COMMUNICATE WITH YOUR PROVIDER

The term "Provider" in this consent refers to Mitchell Terk M.D. and the staff. The Providers offer patients the opportunity to communicate by e-mail. However, transmitting patient information by e-mail has risks that patients should consider. Risks include, but are not limited to:

- E-mail can be circulated, forwarded, and stored in paper and electronic files.
- E-mail can be broadcast worldwide or can be received by unintended recipients at home or at work.
- E-mail senders can accidentally type the wrong email address or send to others besides the intended recipient.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be used as evidence in court.
- E-mail can introduce viruses or worms into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must give signed consent to the use of patient information in e-mail, indicating agreement with these conditions:

- All e-mails to or from the patient concerning treatment will be added to the patient's medical record. Therefore, other individuals authorized to access the medical record will have access to those e-mails.
- Provider may forward e-mails internally to Provider's staff as necessary for treatment, payment, and operations. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Provider or staff shall confirm when an e-mail from the patient has been received and read. However, the patient shall not use e-mail for medical emergencies, urgent problems or other time sensitive matters.
- If the patient's e-mail requires or requests a response from Provider, and the patient has not received a response within 3 days, the patient is responsible to follow up to determine whether the intended recipient received the e-mail and when he/she will respond.
- The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- The patient is responsible for informing Provider of any other types of information the patient does not want to be sent by e-mail.
- The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
- Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines or treating patients who have not first been seen in the office.
- It is the patient's responsibility to follow up and/or schedule an appointment If warranted.

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS

To communicate by e-mail, the patient shall:

- Limit or avoid use of his/her employer's computer.
- Inform Provider of changes in his/her email address.
- Confirm that he/she has received and read an e-mail from the Provider.
- Put the patient's name in the body of the e-mail.
- Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear and that all relevant information if provided before sending to Provider.
- Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
- Withdraw consent only by e-mail or written communication to Provider.
- E-mail should be brief, and to the point.

4. ALTERNATE FORMS OF COMMUNICATION

I understand that J may also communicate with the Provider via telephone or during a scheduled appointment and that e-mail is not a substitute for the care that may be provided during an office visit. If no response from email Is received after 3 days, the patient should call the office.

5. TYPES OF E•MAIL TRANSMISSIONS THAT PATIENT AGREES TO SEND AND/OR RECEIVE

Types of information that can be communicated via e-mail with the Provider include prescription refills, referral requests, appointment scheduling requests, billing and Insurance questions, patient education, and clinical consultation. If you are not sure if the issue you wish to discuss should be included in an e-mail, please call Provider's office to schedule an appointment.

6. HOLD HARMLESS

I agree to indemnify and hold harmless the Provider, Southpolnt Cancer Center, its employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider or to use Provider's Web Site (Terkoncology.Com), any arrangements made based on Information obtained at the Site, any products or services obtained through the Site, and any breach by me of these restrictions and conditions. The Provider does not warrant that the functions contained in any materials provided will be uninterrupted or error-free, that defects will be corrected, or that the Provider's Site or the server that makes the Site available is free of viruses or other harmful components.

7. TERMINATION OF THE E-MAIL RELATIONSHIP

Provider has the right to immediately terminate the e-mail relationship with a patient if he/she determines, in his/her sole discretion, that patient has violated the terms and conditions set forth above or otherwise breached this agreement, or has engaged in conduct which the Provider determines, in his/her sole discretion, to be unacceptable. The e-mail relationship between the Provider and the patient will terminate in the event the Provider, in his/her sole discretion, no longer wishes to utilize the e-mail to communicate with all of his/her patients. Patient also has the right to terminate the email relationship by written notice to Provider, at any time.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form and discussed it with the Provider or his/her representative. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. In addition, I agree to the Instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I had were answered.

Patient:______________________ Date:___________ Witness:____________________ Date:__________