TerkOncology
Center for Prostate Care
& Breast Conservation

Dr. Mitchell Terk | Dr. Jamie Cesaretti

904.520.6800 | fax 904.520.6801 | www.terkoncology.com

7017 AC Skinner Parkway, Jacksonville, FL 32256

Full Name: _____ **Date of Birth:** _____ **Age:** _____

SSN (optional): _____ **Gender:** ☐ Male ☐ Female | **Marital Status (circle):** S M D W

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Mobile Phone:** _____

Email Address: _____

Attention: We will use the address above and all phone numbers and addresses listed to contact you, mail copy of office visit notes and/or leave messages and speak to friends and 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.

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

How did you hear about our practice? _____

Employment Information: Are you employed? ☐ Yes ☐ No; **If yes: Employer Name/Occupation:** _____

Are you a patient in a skilled nursing home? ☐ Yes ☐ No; **If yes, please provide Name and Location:**

_____

Demographic Information

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to Answer

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

Spoken Language: _____ **Preferred Language:** _____

Emergency Contact Name: _____ Relation: _____ Phone: _____

Primary Insurance: _____ Subscriber: _____ DOB: _____

Member ID: _____ Group #: _____ Effective Date: _____

Secondary Insurance: _____ Subscriber: _____ DOB: _____

Member ID: _____ Group #: _____ Effective Date: _____

Pharmacy Name and Address: _____ Phone: _____

Responsible Party Name: _____ Relationship: _____ Phone: _____

Patient Signature/Date: _____

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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 ("Provider") for any services furnished 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.

I understand that in Medicare assigned cases, the physician or supplier agrees to accept the Medicare carrier's charge determination as the full charge. I am responsible for the deductible, co-insurance, and any non-covered services.

Patient/Guardian Signature: _____ Date: _____

Medi-gap *(Medicare Supplemental Insurance)* Assignment of Benefits

I request that payment of authorized Medi-gap benefits be made to the Provider. I 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.

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. I authorize the release of any medical or other information to my insurance company as necessary to determine benefits for services rendered.

I understand I am financially responsible for any charges not covered by my health benefits. I am responsible for notifying the Provider of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company processes the claim. I am responsible for the full bill, or any portion of claims denied for payment. I accept financial responsibility for all services or products received.

Patient/Guardian Signature: _____ Date: _____

Receipt of Notice of HIPAA Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices from _____***Terk Oncology***_____.

Patient/Guardian Signature: _____ Date: _____

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Authorization to Obtain/Release Medical Records

(Medical Records Release Authorization Form Required by HIPAA - 45 C.F.R. Parts 160 and 164)

I authorize: Any and All Medical Entities (Healthcare Provider) to release my medical records to

Individual or Entity: _____Terk Oncology / Fax: 904-520-6801_____

Patient First and Last Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Authorization Period

This release covers the following time period:

From: ____ / ____ / ____ To: ____ / ____ / ____ **OR (check) [ ] ALL past, present, and future periods**

Records to Release: *Select one option below

[ ] I authorize the release of **ALL** my medical records, including; Mental health care, Communicable diseases (including HIV/AIDS), and Alcohol/drug abuse treatment

OR

[ ] I authorize the release of my medical records, except for the following (check any that apply):

- [ ] Mental health records
- [ ] Communicable diseases (including HIV/AIDS)
- [ ] Alcohol/drug abuse treatment
- [ ] Other (please specify): _____

The Purpose of this Release: _____

(e.g., medical treatment, consultation, billing, insurance, etc.)

Important Information

This authorization is valid for 365 days from the signature date below. You may revoke this authorization in writing at any time. Revocation won't apply to records already released under this authorization. This release does not affect your treatment, payment, or insurance eligibility. Once disclosed, your information may not be protected under federal/state law.

Signature & Authorization

Signature of Patient or Personal Representative: _____ Date: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

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PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY AND FRIENDS

Name: _____ Date of birth: _____

By signing this form, **I authorize the individual(s) listed below** to receive limited information about my care. I understand that my healthcare provider will use their professional judgment to determine when sharing this information is appropriate to support my ongoing care.

Note: This form does not authorize the release of full medical records or information not related to healthcare support. For that, a signed HIPAA authorization is required. This authorization will remain in effect until revoked in writing.

AUTHORIZED INDIVIDUALS

Name of Individual	*Relationship*

COMMUNICATION PERMISSION

The physician/office has permission to: Please check all that apply.

[ ] Leave a message with above said person(s)

[ ] Leave a message with another person:

Name: _____ Phone: _____

[ ] Leave a message on my phone: Cell #: _____

[ ] Other #: _____

I understand that I may revoke this authorization at any time in writing. My refusal to sign this form will not affect my ability to obtain treatment, payment, or eligibility for benefits. I acknowledge that if the individuals listed are not subject to federal privacy laws, the disclosed information may no longer be protected.

_____

Signature of Patient or Legal Guardian Date

Relationship to Patient: _____

TerkOncology

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-mail 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-MAIL TO 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:_____