

Oncology Therapies of Vista, Inc.

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To Our New Patient:

Thank you for choosing Oncology Therapies of Vista, Inc. for your radiation oncology care. We take great pride in our many years of service to the community and the quality of that service in all aspects of our practice. Please take the time to complete the enclosed forms or arrive early to complete them in the office. Your appointment is:

Date: _____ Time: _____ Dr.: _____

IMPORTANT INFORMATION

Please carefully read and sign our **FINANCIAL POLICY** page. We will request a copy of your insurance card and HMO authorization information if it is required by your health plan. Co-pays will be collected before you see the physician. Your insurance may determine that you have a co-insurance or deductible to pay. You will be billed for that portion at a later date, so please check with your insurance company for benefit information prior to your visit.

The above time has been reserved for you. If you are unable to keep the appointment, please notify our office at least one working day in advance, so that we may provide another patient with an opportunity to see the physician during that time.

Please bring a list of all current medications you are taking. A radiation oncologist will conduct an interview with you and, if desired, your family. You may be examined by the physician either before or after the consultation. During the consultation the physician will take time to discuss openly with you your treatment options, as well as review the role that radiation therapy may play in the treatment of your disease. A lot of information is given to you on this visit and may seem “overwhelming”; therefore, we recommend you bring a list of questions you would like the physician to answer.

Please allow up to 24 hours for prescription refills. All refill requests will need to be reviewed by our physicians to ensure continuity of care.

For more information about our center visit our website at www.onctherapies.com and familiarize yourself with our facility, doctors and staff. You will also find links providing resources and information to help you make informed decisions concerning your care.

If you have any questions or concerns prior to your visit, please don't hesitate to call our office at (760)599-9545.

Directions to our office are on the reverse side of this sheet.

Driving Directions
916 Sycamore Avenue Vista, CA 92081

From 78 East

Take Highway 78 West to Sycamore Avenue Exit
Exit Sycamore Avenue South (Left)
Turn Left on Hibiscus Avenue
Make 1st Right into parking lot
Look for blue sign “Oncology Therapies of Vista”

From 78 West

Take Highway 78 East to Sycamore Avenue Exit
Exit Sycamore Avenue South (Right)
Turn Left on Hibiscus Avenue
Make 1st Right into parking lot
Look for blue sign “Oncology Therapies of Vista”

From Interstate 5 North

Take Interstate 5 North to Highway 78 East
Exit Sycamore Avenue South (Right)
Turn Left on Hibiscus Avenue
Make 1st Right into parking lot
Look for blue sign “Oncology Therapies of Vista”

From Interstate 15 North

Take Interstate 15 North to Highway 78 West
Exit Sycamore Avenue South (Left)
Turn Left on Hibiscus Avenue
Make 1st Right into parking lot
Look for blue sign “Oncology Therapies of Vista”

Oncology Therapies of Vista, Inc.

FINANCIAL POLICY

Oncology Therapies of Vista, Inc. is a provider for many insurance plans and will be listed in your group's provider list if we participate in your plan. Your insurance policy is a contract between you and your insurance company. As a courtesy we will bill your insurance directly and receive payment directly from them, however, to avoid any confusion, be aware that we do expect payment of any applicable deductible, co-payment or co-insurance amounts at the time of service. While our office makes every effort to obtain appropriate authorizations prior to scheduling (i.e. office visits, diagnostic testing, treatments, etc.), it is the responsibility of the patient to know whether authorization is required by their insurance company prior to services being rendered. Statements are mailed monthly to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact the billing office at (760)599-9545 to make payment arrangements, unless a payment schedule already exists.

HMO PLANS

You understand that payment of these services is dependent on prior authorization secured from your primary care physician or health plan and your current eligibility of benefits from your insurance carrier. Should either requirement not be met, you are financially responsible for services rendered.

MEDICARE

We accept assignment for all Medicare patients. Co-payments and deductibles are due and payable at each visit.

CASH PAY PATIENTS

If you do not have insurance, payment is expected at the time of service. For your convenience, we accept Visa and MasterCard. If payment in full at time of service is not possible, payment plans may be available and can be arranged in our Business Office upon your request.

MISCELLANEOUS FORMS

Please be advised, if you need our doctor to complete Department of Motor Vehicles, disability or other physician report forms, there is no charge assessed. However, please allow up to one week for the forms to be completed.

Thank you for choosing Oncology Therapies of Vista, Inc.

I have read and understand the Oncology Therapies of Vista, Inc., financial and claims filing policies.

PRINT PATIENT NAME: _____

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

**NOTICE OF PRIVACY POLICIES
FOR
ONCOLOGY THERAPIES OF VISTA, INC.**

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At Oncology Therapies of Vista, Inc., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective 01/01/03, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit Oncology Therapies of Vista, Inc., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- ∨ Basis for planning your care and treatment
- ∨ Means of communication among the many health professionals who contribute to your care,
- ∨ Legal document describing the care you received,
- ∨ Means by which you or a third-party payer can verify that services billed were actually provided,
- ∨ A tool in educating health professionals,
- ∨ A source of information for public health officials charged with improving the health of this state and the nation,
- ∨ A tool which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Oncology Therapies of Vista, Inc., the information belongs to you. You have the right to:

- ∨ Obtain a paper copy of this notice of information practices upon request,
- ∨ Inspect and copy your health record as provided for in 45 CFR 164.524,
- ∨ Amend your health record as provided in 45 CFR 164.528,
- ∨ Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- ∨ Request communications of your health information by alternative means or at alternative locations,
- ∨ Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- ∨ Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES

Oncology Therapies of Vista, Inc. is required to:

- ∨ Maintain the privacy of your health information,
- ∨ Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- ∨ Abide by the terms of this notice,
- ∨ Notify you if we are unable to agree to a requested restriction, and
- ∨ Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have question and would like additional information, you may contact our Privacy Officer at:

Oncology Therapies of Vista, Inc.
Patty Sampson
916 Sycamore Ave.
Vista, CA 92081
(760) 599-9545

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.

For Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes I your case and other like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill your or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provide that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public. (updated 04/01/7.)

ONCOLOGY THERAPIES OF VISTA, INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of Oncology Therapies of Vista, Inc.'s Notice of Privacy Practices. This Notice describes how Oncology Therapies of Vista, Inc. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

(Signature of Patient or Personal Representative)

(Date)

(Relationship to Patient)

PATIENT REGISTRATION INFORMATION

HMO or other Referral # _____ Co-Payment _____
Please complete both sides of this form.

PATIENT'S PERSONAL INFORMATION Marital Status: Single Married Widowed Male Female

Name: _____ D.O.B.: ____/____/____
Last name *First name* *Middle init.*

Number of Children: _____ Number of Pregnancies: _____ Live Births: _____ Other: _____

Street Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____ Leave Messages? Yes No

Social Security #: _____ - _____ - _____ Driver's License #: _____ State: _____

Employer: _____ Occupation: _____

RESPONSIBLE PARTY INFORMATION Information Same as Above

Responsible Party: _____ D.O.B.: ____/____/____

Relationship to Patient: Self Spouse Other _____ Social Security #: _____ - _____ - _____
Please circle one *Please Explain*

Responsible Party's Home Phone: () _____ Work Phone: () _____

Street Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

Employer's Name: _____ Phone Number: () _____

PATIENT'S INSURANCE INFORMATION (Please present insurance cards at check-in so that copies can be made)

Name of Insured: _____ Is prior auth. required? _____ Deductible per yr. _____

Primary Insurance Co. Name: _____

Your Relationship to Insured: Self Spouse Other My Insurance is: HMO PPO EPO Other

Insurance Billing Address: _____
Street *City* *State* *Zip*

Insurance I.D.#: _____ Group #: _____

Secondary Insurance Co. Name: _____

Your Relationship to Insured: Self Spouse Other My Insurance is: HMO PPO EPO Other

Insurance Billing Address: _____
Street *City* *State* *Zip*

Insurance I.D. #: _____ Group #: _____

OTHER INFORMATION

Who referred you to our office? Please circle one: Physician _____ Friend _____ Directory _____

Primary Care Physician: _____ Medical Oncologist: _____

Surgeon: _____ Other: _____

Pharmacy of Choice: _____ Phone #: () _____

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____

Address: _____
Street City State Zip

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

ASSIGNMENT OF BENEFITS *FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Oncology Therapies of Vista, Inc., for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorneys fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Medicare Patients: I request payment of authorized Medicare benefits be made on my behalf to Oncology Therapies of Vista, Inc. , a Medical Corporation, and any assisting physicians for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Your Signature: _____ **Date:** _____

ONCOLOGY THERAPIES OF VISTA, INC.

916 Sycamore Ave., Vista, CA 92081; Phone: (760) 599-9545 Fax: (760) 599-9545

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with the California and Federal Law concerning the privacy of such information. Failure to provide all information may cause a delay in obtaining information needed to provide you with proper care.

Patient Name: _____ Date of Birth: _____
Address: _____
SSN: _____ Telephone #: _____

OBTAIN INFORMATION FROM:

Physician/Facility Name: _____
Address: _____
Telephone: _____ Fax: _____

DATES TO BE RELEASED:

From: _____ To: _____

RECORDS TO BE RELEASED:

<input type="checkbox"/> Physician Notes	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Lab Results	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> History & Physical
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Chemotherapy Records	<input type="checkbox"/> Radiation Therapy Records
<input type="checkbox"/> Radiation Port Films	<input type="checkbox"/> Films	<input type="checkbox"/> Entire Record

PURPOSE OF REQUEST:

Treatment/Consultation Patient Request Billing/Claims

RECORDS TO BE RELEASED TO:

Oncology Therapies of Vista, Inc.
916 Sycamore Ave., Vista, CA 92081; Phone: (760) 599-9545/Fax: (760) 599-9549

I authorize Oncology Therapies of Vista, Inc. to use and disclose the Protected Health Information specified above.

Signature: _____ Date: _____
(Patient or Authorized Representative)

ONCOLOGY THERAPIES OF VISTA, INC.

Patient Name: _____ Account# _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouses, children or others to call and request the results of tests and procedures. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release appointment information, test, and procedure results to the family members indicated below. This consent form will allow Oncology Therapies of Vista, Inc. to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Oncology Therapies of Vista, Inc. to release appointment information, test and procedure results to the following individuals.

- 1. _____ Relation to Patient: _____
- 2. _____ Relation to Patient: _____

PATIENT SIGNATURE: _____ **DATE:** _____

Authorization to Leave Messages

From time to time it is necessary for representatives of Oncology Therapies of Vista, Inc. to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss test or procedure results, to ask a patient to call the office regarding an issue or concern, or occasionally to re-schedule an appointment. At no time will a representative of our office discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine at home or work.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Home #: _____ Cell#: _____ Work #: _____

PATIENT SIGNATURE: _____ **DATE:** _____

ONCOLOGY THERAPIES OF VISTA, INC.

To help us ensure continuity of care, please provide us with a list of all doctors involved in your care, by completing the form below to the best of your knowledge. Your radiation oncologist will make every effort to involve them in your treatment plan and follow-up care. If at any time, you add, change or drop a physician please let our office know so that we may continue to keep the proper doctors informed. Thank you.

PRIMARY CARE PHYSICIAN:

Name: _____ Phone #: _____
Address: _____

MEDICAL ONCOLOGIST:

Name: _____ Phone #: _____
Address: _____

SURGEON:

Name: _____ Phone #: _____
Address: _____

OTHER:

Name: _____ Phone #: _____
Address: _____

Name: _____ Phone #: _____
Address: _____

Name: _____ Phone #: _____
Address: _____
