cCARE
CALIFORNIA CANCER ASSOCIATES
FOR RESEARCH & EXCELLENCE

WELCOME TO cCARE!

SAN DIEGO LOCATIONS:
4S RANCH
16918 Dove Canyon Rd
Suite 103
San Diego, CA 92127
Ph: 858.649.5100
Fax: 858.649.5099

ENCINITAS
326 Santa Fe Drive
Suite 105
Encinitas, CA 92024
Ph: 760.452.3340
Fax: 760.452.3344

LA JOLLA
9850 Genesee Ave
Suite 560
La Jolla, CA 92037
Cancer Center
Ph: 858.552.1410
Fax: 858.552.0929
Neurosurgery
Ph: 858.909.9033
Fax: 858.429.4009

MURRIETA
25405 Hancock Ave
Suite 206
Murrieta, CA 92562
Ph: 760.733.9191
Fax: 760.733.9192

SAN MARCOS
838 Nordahl Road
Suite 300
San Marcos, CA 92069
Ph: 760.747.8935
Fax: 760.747.7951

FRESNO LOCATION:
FRESNO
7130 N. Millbrook Ave
Fresno, CA 93720
Ph: 559.326.1222
Fax: 559.447.4925

California Cancer Associates for Research and Excellence (cCARE) is the largest full-service, private oncology and hematology practice in California.

With offices in San Diego and Fresno, cCARE offers extensive services and world-class care for every step of your treatment including: oncology, chemotherapy, radiation oncology, hematology, infusion and imaging.

At cCARE we believe that treatment is more than just medicine. It's about compassion, prevention, research and wellness. We know that cancer treatment requires medical intervention, but it is also our belief that a strong will and a solid support group will play vital roles in the healing process. That is why our expert team of board-certified oncologists, hematologists, nurses and other highly-skilled cancer care professionals all work together closely with our patients and their loved ones throughout the course of recovery. It is this compassionate approach, combined with our state-of-the art facilities, comfortable environment and commitment to utilizing the most advanced treatment techniques available that help make cCARE California's premier oncology center.

For your first visit, please complete and sign all forms. You will need to present these forms to the front desk when they are complete.

If you need to reschedule or cancel your new patient appointment, **please call 858.753.6446 at least 24 hours before your visit.**

YOUR FIRST VISIT

To evaluate your health, it is extremely important that we receive your medical records prior to the time of your scheduled visit. Please arrange to have your doctor send these to our office before your initial appointment. To provide you the highest quality of care, your physician will need to review any pathology, surgical reports, x-ray scans, laboratory results, medical notes and in-patient records that are available.

We accept most insurance carriers and our staff will work with you before you come for your initial appointment to ensure that you have the coverage you will need. If you have a managed care plan that requires a referral from your primary care physician, please ensure that you have obtained that referral as it is the patient's responsibility to do so. Referrals occasionally have limits on the number of visits which patients may be allowed and/or an expiration date. Please monitor this information and obtain updated referrals as required. **Co-payments, deductibles and non-insurance covered medical services are due at the time of the service.**

WE ASK THAT PATIENTS ALWAYS:

- Bring insurance cards to each visit. **If there is a secondary insurance plan, a Medicare supplemental plan, or a prescription plan, please make sure that we have all information. Please make sure to bring all your cards.**
- Keep us informed of any change to any vital statistics such as address, telephone number, employment status, marital status or insurance.
- Provide a current list of medications at each office visit; it is necessary that we review all prescription and over the-counter medications currently taken. Please bring your prescription card. Some patients find it more convenient to bring the medication bottles to the appointment. Note that over the counter drugs include vitamins, herbs, aspirin, Tylenol, etc.
- Allow a 48-hour turnaround for prescription refills. Please note that some prescriptions for pain medications do not allow refills, therefore we request that patients contact us prior to running out of any medication.
- **Consider the compromised immune systems of other patients, and refrain from bringing children to your appointments.**
- Write down any questions or concerns that arise to discuss with the physician.

Once a patient has made an appointment, all facets of our services-from the latest research findings to the most advanced technology-will be utilized in providing the highest level of quality medical care. Please complete the patient registration forms **BEFORE** your appointment.

Again, we welcome you and say thank you for choosing our practice. For further information, please visit our website at cCARE.com and should you need additional assistance, please call:

- San Diego - New Patient Department: 858.753.6446
- Fresno - New Patient Department: 559.326.1905

MRN:

cCARE
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NEW PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

Today's Date: _____

Patient Name: _____

DOB: ___/___/___ Age: ___ Gender: ☐ Male ☐ Female ☐ Transgender: ☐ M to F ☐ F to M

SSN: _____ Cell Phone: (_____) _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Address: _____

City: _____ State: _____ Zip Code: _____

May we leave a message on your answering machine / voicemail? ☐ Yes ☐ No

May we send appointment reminder via text? ☐ Yes ☐ No Cell Phone: _____
If not already provided

Email Address: _____ May we email you? ☐ Yes ☐ No

Preferred Language: _____

Ethnicity/Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American
☐ Asian/Pacific Islander ☐ Other

Occupation: _____

☐ Employed/Self Employed ☐ Unemployed ☐ Retired ☐ Disabled

Name of Employer: _____ Work Phone: (_____) _____

Relationship Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Living situation: ☐ Lives Alone ☐ Lives with Family ☐ Lives in Nursing Home
☐ Winter Resident ☐ Year Round Resident

Children: ☐ Yes ☐ No If yes, how many? _____

Primary Care Physician: _____ Phone#: _____

Referring Physician (if different): _____ Phone#: _____

Please list any additional physicians you see: (Include Phone#):

_____ Phone#: _____

_____ Phone#: _____

_____ Phone#: _____

_____ Phone#: _____

Patient Initials _____

MRN:

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NEW PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

Patient Name: _____

Emergency Contact Name: _____

Relationship: _____ Phone#: (_____) _____

Durable Power of Attorney for Healthcare: ☐ Yes ☐ No _____

Relation to you: _____

Living Will for Healthcare: ☐ Yes* ☐ No *Please provide a copy for our records

Primary Insurance Carrier: _____

Name of primary policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's employer: _____

Insurance ID#: _____ Group#: _____

Does plan have prescription coverage? ☐ Yes ☐ No (If yes please provide information below)

Prescription Coverage: _____

Secondary Insurance Carrier: _____

Name of primary policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's employer: _____

Insurance ID#: _____ Group#: _____

Does plan have prescription coverage? ☐ Yes ☐ No (If yes please provide information below)

Prescription Coverage: _____

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

Signature: _____ Date: _____

Patient Initials _____

MRN:

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NEW PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

Patient Name: _____

Reason For This Visit: _____

_____

_____

MEDICAL HISTORY:

(Check the items that apply to you, currently or in the past)

	Date of Diagnosis		Date of Diagnosis
☐ Anemia	_____	☐ GERD/Heartburn	_____
☐ Bleeding Disorder	_____	☐ Hiatal Hernia	_____
☐ Blood Clots	_____	☐ Gallstones	_____
☐ Blood Disorder	_____	☐ Cirrhosis of Liver	_____
☐ Frequent infections	_____	☐ Hepatitis A/B/C	_____
☐ HIV/AIDS	_____	☐ Pancreatitis	_____
☐ Diabetes -Type I, Type II	_____	☐ Kidney Stones	_____
☐ Thyroid Disease	_____	☐ Frequent UTI	_____
☐ High Blood Pressure	_____	☐ Enlarged Prostate	_____
☐ High Cholesterol	_____	☐ Lupus-Autoimmune	_____
☐ Atrial Fibrillation	_____	☐ Reynaud's Syndrome	_____
☐ Congestive Heart Failure	_____	☐ Kidney Disease/Failure	_____
☐ Heart Attack - MI	_____	☐ Rheumatoid Arthritis	_____
☐ Heart Disease	_____	☐ Osteoporosis	_____
☐ Rheumatic Fever	_____	☐ Fracture	_____
☐ Heartburn/Reflux	_____	☐ Stroke	_____
☐ Heart Murmur	_____	☐ Neuropathy	_____
☐ Peripheral Vascular Disease	_____	☐ Parkinson's disease	_____
☐ Asthma	_____	☐ Paralysis	_____
☐ Chronic Lung (COPD)	_____	☐ Seizures	_____
☐ Pneumonia/Bronchitis	_____	☐ Migraines	_____
☐ TB (Tuberculosis)	_____	☐ Shingles	_____
☐ Sleep Apnea	_____	☐ Glaucoma/Cataracts	_____
☐ Colon Polyps	_____	☐ Hearing Loss	_____
☐ Crohn's Disease	_____	☐ Cancer	_____
☐ Diverticulitis	_____	☐ Anxiety	_____
☐ Irritable Bowel Syndrome	_____	☐ Depression	_____
☐ Ulcerative Colitis	_____	☐ Other Psychiatric conditions	_____
☐ Stomach Ulcers	_____	Type _____	

Other Medical History: _____

PAST CANCER OR HEMATOLOGY HISTORY:

Type _____ Date Diagnosed _____ Treating Physician _____

Treatment (Type, Date, and Location of treatment) _____

_____

Patient Initials _____

MRN:

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NEW PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

Patient Name:_____

REVIEW OF SYSTEMS: (Please check any **CURRENT** symptoms you have.)

General:
- ☐ Weight loss
- ☐ Weight gain
- ☐ Poor appetite
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats
- ☐ Fatigue

Eyes:
- ☐ Wear Glasses/Contact Lenses
- ☐ Blurred vision
- ☐ Double vision
- ☐ Changes in vision

Ears, Nose, Throat:
- ☐ Hard of hearing or deaf
- ☐ Ringing in ears
- ☐ Enlarged lymph nodes
- ☐ Chronic sinus problems
- ☐ Sore throat
- ☐ Mouth pain/sores

Changes/Difficulty in:
- ☐ Taste
- ☐ Smell
- ☐ Voice

Cardiovascular:
- ☐ Chest pain/pressure
- ☐ Palpitations
- ☐ Irregular heart beat

Respiratory:
- ☐ Chronic or frequent cough
- ☐ Bloody sputum
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal:
- ☐ Difficulty or painful swallowing
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion
- ☐ Lump or sensation in throat
- ☐ Food sticking
- ☐ Bloating
- ☐ Belching
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal bleeding
- ☐ Black or tarry stools
- ☐ Loss of stool/fecal accident
- ☐ Poor appetite

Genitourinary:
- ☐ Pelvic pain
- ☐ Incontinence
- ☐ Burning or pain on urination
- ☐ Blood in Urine
- ☐ Difficult urination
- ☐ Men: prostate problems

Musculoskeletal:
- ☐ Joint pain
- ☐ Muscle or joint weakness
- ☐ Back pain
- ☐ Bone pain
- ☐ Muscle pain

Neurological:
- ☐ Numbness, tingling
- ☐ Arm or leg weakness
- ☐ Light-headed, dizzy
- ☐ Fainting spells
- ☐ Frequent headaches
- ☐ Tremors
- ☐ Falls

Skin:
- ☐ Rashes or itching
- ☐ Change in skin color or moles
- ☐ Varicose veins

Psychiatric:
- ☐ Anxiety/agitation
- ☐ Depression
- ☐ Crying for no reason
- ☐ Difficulty sleeping
- ☐ Alcoholism
- ☐ Drug problem (now/past)

Hematologic:
- ☐ Easy bruising
- ☐ Gum or nose bleeding
- ☐ Blood transfusion in past
  When?_____

Allergies/Immunology:
- ☐ History of chronic infections
- ☐ History of allergies

Endocrine:
- ☐ Heat or cold intolerance
- ☐ Excessive skin dryness
- ☐ Excessive thirst or urination
- ☐ Weight problem
- ☐ Hot flashes

Breast:
- ☐ Pain/lump
- ☐ Discharge
- ☐ Rash

Gynecology:
- ☐ Age at start of menses:_____
- ☐ Last menstrual period
  _____
- ☐ Vaginal discharge
- ☐ Menstrual irregularity or abnormal bleeding
- ☐ Menopause Age:_____
- ☐ Use of hormones
- ☐ Birth control
  How long?_____
- ☐ Hormone replacement therapy
  How long?_____

Patient Initials _____

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NEW PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

Patient Name:_____

FAMILY MEDICAL HISTORY:

Indicate any family members with cancer, blood disease or other disease.

	Age	Disease	If deceased, cause of death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____

PAST SURGICAL HISTORY:

(Please list any of the surgeries and/or procedures that you have undergone)

Surgery / Procedure	Performing Physician
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Tobacco Use: (Present and/or past)

☐ Never smoked

☐ Quit smoking When?_____ How many years did you smoke?_____yr(s) How many packs?_____/day

☐ Currently smoke ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarettes

How many packs?_____/day How many years?_____

☐ Chewing tobacco ☐ Current ☐ Past How long?_____

Alcohol Use: (Present and/or past)

☐ Non drinker

☐ Beer number of bottles _____ per ☐ Day ☐ Week ☐ Month

☐ Wine number of glasses _____ per ☐ Day ☐ Week ☐ Month

☐ Liquor number of glasses _____ per ☐ Day ☐ Week ☐ Month

Recreational Drug Use: (Present and/or past)

☐ No

☐ Present What type?_____How often?_____

☐ Past What type?_____How often?_____

Work Hazards:

Any occupational hazards (like noise or chemical exposures) ☐ Yes ☐ No If yes, what:_____

Females:

Age at first period_____ Age at last period_____

# of pregnancies_____ # of live births_____ Age at first pregnancy_____

Patient Initials _____

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NEW PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

Patient Name:_____

NUTRITIONAL HISTORY:

Has there been a change in your appetite in the past 6 months? ☐ Yes ☐ No
Have you gained or lost weight (more than 10 lbs.) in 1 month without wanting to? ☐ Yes ☐ No
If yes how much gain or loss?_____
Are you happy with your weight? ☐ Yes ☐ No
If not, are you on a diet and exercise program? ☐ Yes ☐ No
For women: Are you taking any extra calcium? ☐ Yes ☐ No

HEALTH MAINTENANCE:

Sigmoidoscopy/Colonoscopy tests: ☐ Yes ☐ No Date:_____
Findings:_____
Last Esophagogastroduodenoscopy:_____
Last Mammogram:_____ Abnormal Mammogram? When?_____
Last Pelvic or Pap Exam:_____Abnormal Pap? When?_____
Last Bone Density test:_____

VACCINES:

Please check if vaccine was received, and last date it was administered

☐ Influenza shot Date:_____ ☐ Shingles shot Date:_____
☐ Pneumococcal Vaccine ☐ PCV13 ☐ PPSV23 ☐ Other_____
Date:_____

SCANS/IMAGING/PROCEDURES:

(Example: MRIs, CTs, PET/CTs, Echocardiograms, Biopsies, etc.)

Please provide us with a copy of the scans/images/procedure if it has taken place in the last 1-3 years.

Type	Date	Facility	Ordering Physician

Patient Initials _____

MRN:

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NEW PATIENT HISTORY FORM

PLEASE PRINT CLEARLY

Patient Name:_____

ALLERGIES AND SENSITIVITIES:

☐ No known allergies ☐ No known drug allergies

Allergy	Reaction

ALL MEDICATIONS: (ATTACH MEDICATION LIST IF NEEDED)

Name	Strength/Frequency	Prescriber

ALL NON-PRESCRIPTION MEDICATION INCLUDING VITAMINS AND HERBS:

Pharmacy_____ Address_____ Phone#_____

Patient Initials _____

MRN:

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HEALTH INFORMATION MANAGEMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO cCARE AND ITS ASSOCIATES

PLEASE PRINT CLEARLY

PATIENT INFORMATION:

Patient Name: _____ SSN: _____
Please Print

Telephone Number: _____ DOB: _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize the release of information in my medical record from (Provider Name):

_____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Fax _____

Including contents regarding drug or alcohol abuse, psychiatric, psychotherapy notes and HIV related (AIDS) diagnosis and/or test results. Exclusions to the above: _____

_____

INFORMATION TO BE RELEASED TO:

☐ **4S RANCH**
16918 Dove Canyon Rd
Suite 103
San Diego, CA 92127
Ph: 858.649.5100
Fax: 858.649.5099

☐ **ENCINITAS**
326 Santa Fe Drive
Suite 105
Encinitas, CA 92024
Ph: 760.452.3340
Fax: 760.452.3344

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9850 Genesee Ave
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Fax: 760.733.9192

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San Marcos, CA 92069
Ph: 760.747.8935
Fax: 760.466.0078

☐ **FRESNO**
7130 N. Millbrook Ave
Fresno, CA 93720
Ph: 559.326.1222
Fax: 559.447.4925

TYPE OF RECORD:

- ☐ ALL MEDICAL RECORDS (pertinent only) (limited 2 years of information)
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Consultation Report
- ☐ Psychotherapy notes only
- ☐ Radiology reports (Specify): _____
- ☐ Lab Results
- ☐ Evidentiary Examination
- ☐ ER Report
- ☐ Other Information (Specify): _____

PURPOSE OR NEED FOR THIS INFORMATION IS:

(Please check all that apply)

☐ Medical ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

CONTINUED ON BACK

MRN:

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PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

RESTRICTIONS/DURATION/RIGHTS

PLEASE PRINT CLEARLY

- I authorize the release of the specified information from my medical records.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPAA). However, under California law the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose my information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- A photocopy of this release is as effective as the original.
- I have received a copy of this authorization.

SIGNATURE: _____ **DATE:** _____
(Patient/Legal Representative/Guardian)

If signed by other than patient, indicate relationship: _____

Witness: _____ _____
Print Name Signature

(PHYSICIAN PART ONLY) Records obtained in the course of PSYCHIATRIC TREATMENT

The undersigned, the physician, licensed psychologist, or social worker with a master's degree in social work, hereby (approves) (disapproves) the release of information and records. Please note below any restrictions on the release of records. (Note: No approval is required for release to the patient's attorney.)
If denied, please provide reason: _____

Signature: _____ Date: _____
(Physician/Psychologist/Social Worker)

Interpreter Signature if Applicable:

I have accurately and completely read the forgoing document to _____
Patient's or Legal Representative's name

In _____, the patients or legal representative's primary language.
Language

He/she understood all the terms and conditions and acknowledged his/her agreement thereto by signing the document in my presence.

Interpreter's name: _____ Signature: _____

SAN DIEGO Medical Records:	Phone: 760.747.8935	Fax: 760.747.7951
FRESNO Medical Records:	Phone: 559.326.1206	Fax: 559.326.1233

MRN:

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS PATIENT FINANCIAL RESPONSIBILITY FORM

PLEASE PRINT CLEARLY

Patient's Name:_____ DOB:_____

Thank you for choosing cCARE as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

AUTHORIZATION FOR TREATMENT & PAYMENT OF MEDICAL BENEFITS

I give permission to cCARE to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to cCARE.

USE OF PHOTOGRAPHY

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-PRESCRIPTION FOR MEDICATION HISTORY

We may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

PATIENT FINANCIAL RESPONSIBILITIES

- I (or patient's guardian, if minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include but are not limited to:
  - Charge for returned checks.
  - Charge for the copying and distribution of patient medical records.
  - Charge for forms completion.
  - Charge for missed appointments.

PATIENT AUTHORIZATIONS

- By my signature below, I hereby authorize cCARE to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to cCARE. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

Signature of Patient or Guardian_____ Date _____

MRN:

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CONFIRMATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

PLEASE PRINT CLEARLY

To protect your privacy, please let us know how you would like us to contact you and who we may release your private health information (PHI) to on your behalf.

☐ No, please do not discuss PHI with anyone. **WARNING: if you choose this option and you become ill and unable to call or come into the office for assistance we may, in our professional judgment, disclose necessary PHI to another medical professional to ensure you are given appropriate medical care.**

☐ Yes, allow communication with:

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

What kind of PHI may we discuss with your designated family members and/or others involved with your care?

☐ Medical Care ☐ Billing and Payment Information

May We Contact you at:

Home? ☐ Yes ☐ No Number _____ Work? ☐ Yes ☐ No Number _____

Cell? ☐ Yes ☐ No Number _____

Via Email? ☐ Yes ☐ No Email address: _____

May we send appointment reminder via text? ☐ Yes ☐ No

May we leave a message on your answering machine or cell? ☐ Yes ☐ No

Any information? ☐ Yes ☐ No

Limit information to the following: _____

May we leave a message with a family member or other person at your home? ☐ Yes ☐ No

Any information? ☐ Yes ☐ No

Limit information to the following: _____

I _____, understand the above authorization will remain in effect until I change it in writing. I have been given a copy of the Notice of Privacy Practice for cCARE.

_____ _____ _____

Patient Signature Print Name Date

Date of Birth: _____