Columbus Oncology & Hematology
Serving Ohio Since 1987

Jasonway Cancer Center
810 Jasonway Ave.
Columbus, Ohio 43214-4359

Phone: (614) 442-3130
Fax: (614) 442-3150

Dublin Cancer Center
6700 Perimeter Drive
Dublin, Ohio 43016-8063

Westerville Cancer Center
300 Polaris Pkwy, Suite 330
Westerville, Ohio 43082-7813

FIRST VISIT CHECK LIST

The list provided below includes all necessary documents to be completed prior to your first visit. Please complete and sign where applicable before your scheduled appointment time.

- ☐ New Patient Registration Form
- ☐ New Patient Health History
- ☐ Consent to Release Protected Health Information
- ☐ Notice of Privacy Practices
- ☐ My Care Plus – Patient Portal
- ☐ COA Patient Assistance Consent
- ☐ Current Insurance Card(s) to include Pharmacy Benefit - Co-pays are due at the time of service
- ☐ Driver License or other Photo ID
- ☐ Current Medication List or Medication Bottles
- ☐ CD and/or report of past radiology scans/tests (if available)

Thank you for choosing Columbus Oncology Associates, Inc. as your healthcare provider. Our physicians, nurses, and staff are dedicated to providing you with the highest quality of care.

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Patient Name _____ Date _____

Address _____ City _____ State _____ Zip _____

SSN _____ Birthdate _____ Home # _____

Cell # _____ E-mail Address _____

Preferred method of contact: ☐ home phone ☐ cell phone ☐ e-mail

Race (please select): ☐ White ☐ Hispanic ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Non Latino ☐ Decline

Preferred Language: ☐ English ☐ Spanish ☐ Bosnian ☐ Indian ☐ Sign ☐ Other _____

Employer _____ Position _____

Address _____ Phone # _____

Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

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Spouse _____ SSN _____ Birthdate _____

Spouse's Employer _____ Employer Phone # _____

Person to contact in case of an emergency _____ Phone # _____

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Insurance Co.	Insurance Co.
Address	Address
Subscriber	Subscriber
ID #	ID #
Group #	Group #
Effective Date	Effective Date

Referring Physician _____ Family Physician _____

& Phone # _____ & Phone # _____

I authorize Columbus Oncology and Hematology Associates to release to any third party payer, such as an insurance company or government agency, any medical information contained in my records when such material is required in connection with determining a claim for payment.

I authorize Columbus Oncology and Hematology Associates to release any medical information accumulated in the course of my examination or treatment to any other requesting physician, hospital, or nursing home.

I authorize payment directly to Columbus Oncology and Hematology Associates for the surgical and/or medical benefits, if any otherwise payable to me under the terms of my insurance and/or Medicare.

I hereby accept responsibility for payment of services not covered by Medicare or my insurance company.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Date _____ Signature _____
(Patient or Parent if under 18 years of age)

Date _____ Primary Policyholders Signature _____

How did you find out about our practice? _____

Columbus Oncology & Hematology

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BILLING POLICY

Thank you for choosing Columbus Oncology and Hematology. Each of our oncologists is board certified, and these dedicated physicians remain on the cutting edge of advances in medical research and technology to offer care that is not only compassionate and personal, but also informed and innovative. For every person who walks through our doors, we believe in providing comprehensive care, and we foster an environment where your questions will be addressed with kindness and promptness. The following information is provided to avoid any misunderstanding concerning payment of services provided by our office.

- Our office participates with a variety of insurance plans. In order to verify we are in-network with your specific plan, it is best to contact them directly. Please note, we currently do not accept Marketplace plans.
- Please bring your current insurance card(s) to every visit and notify us of any changes in coverage.
- You will be responsible to obtain a referral to our office, if your insurance plan requires such.
- Copays not paid at the time of service, will be assessed a billing fee of **$35.00**.
- COHA will verify eligibility with your payer, and obtain required prior authorization, before starting treatment. If we are unable to verify eligibility or obtain prior authorization, we will notify you prior to beginning treatment.
- Treatment estimates will be communicated to patients before starting treatment, along with pre-payment deposit requirements.
- With consent, COHA will determine if Patient Assistance funds are available, before starting treatment.
- We will submit your claim for you, as long as we receive accurate and complete billing information.
- We accept assignment on Medicare claims; therefore, the twenty percent of Medicare's approved amount is considered patient responsibility, along with any remaining deductible.
- We will make every attempt to notify you when a service may not be covered; however, it is not possible for us to always know when the insurance company may disallow payment as non-covered or not medically necessary. Ultimately, you are financially responsible for payment of services.
- For those patients with no insurance, payment in full is required at the time of service.
- Patients may request an itemized bill of services at any time.
- Statements will be issued for outstanding account balances totaling **$5.00** or more.
- Small Balance Policy
    - Total patient account balances between **$.01 - $4.99** are considered small balance, and will be adjusted to small balance, as they do not meet the minimum statement threshold for processing.
    - Total patient account balances between **($.01) – ($4.99)** are considered small balance credits and will be adjusted to small balance, and not processed for refund.
- All patient balances are considered due in full, unless a payment contract has been established with the billing office.
- Unpaid balances are reviewed and may result in placement with our collection agency, PCB Rossman.
- All returned checks will be assessed a service fee in the amount of **$35.00**.
- Medical records will be provided to a patient free of charge, as a one-time courtesy. Additional requests or authorized third party requests, will incur fees for copying records, as outlined in ORC Section 3701.741.

Patient's Name_____ Date_____

Signature of Patient or Responsible Party_____

Revised: April 12, 2023

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Westerville, Ohio 43082-7813

Name (Last, First , Middle)	Birth Date	Age	Social Security #	Appointment Date

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone	Email Address

Person Completing This Form: ☐ Patient ☐ Other (Relationship to Patient):

Emergency Contacts	Relation	Home Phone	Cell Phone	Work Phone
Address:			Email**:	
Address:			Email**:	

****Email addresses will only be used for Columbus Oncology and Hematology to contact you if unable to reach by phone and in the case of an emergency. Email is <u>not</u> to be used for you to communicate with us under any circumstance.**

☐ Referring Physician:	Phone:	Fax:	☐ Self Referred

Family Doctor	Specialist - Type:	Specialist - Type:	Specialist - Type:
Name:	Name:	Name:	Name:

If anyone else personally referred you to our practice, who?

<u>Sex</u>	<u>Marital Status</u>	<u>Employment Status</u>	
☐ M, ☐ F	☐ S, ☐ M, ☐ Life Partner ☐ W, ☐ D, ☐ Separated	☐ Retired, ☐ Working, ☐ Disabled	<u>Religion:</u>

Occupation: (current and previous)

History of Chemical Exposure? Agents? When?

Are you ALLERGIC to anything? ☐ Yes ☐ No List all Medications/Allergies and describe your reaction

CURRENT MEDICATIONS (Include prescription, over-the-counter and herbals): **** Please attach additional sheet or add to last page**

Name of Medication	Dose	How often taken	Reason for medication	Length of time taken

CURRENT MEDICAL HISTORY:

What is your medical reason for coming to Columbus Oncology and Hematology Associates?

Please give the history of your current problem: (when it started; symptoms; treatment)

PAST MEDICAL HISTORY: Please check ALL previous illnesses and list additional conditions.

☐ Bleeding problems	☐ High blood pressure	☐ Stroke	☐ Seizure	☐ Heart problems
☐ Circulation problems	☐ Lung problems	☐ Diabetes	☐ Liver problems	☐ Thyroid problems
☐ Kidney/urine problems	☐ Psychological/Psychiatric problems	☐ Frequent infections	☐ HIV/AIDS	☐ Tuberculosis

Please provide information below for the conditions you checked above and other conditions including hospitalizations:

Past Surgeries (include type of surgery and date):

Immunizations: ☐ Pneumonia vaccine ☐ N, ☐ Y Date: | ☐ Influenza (Flu Shot): ☐ N, ☐ Y Date: | ☐ Other

SOCIAL HISTORY

ALCOHOL HISTORY

Do you drink alcoholic beverages regularly (at least 1 drink per month)? ☐ Yes currently ☐ Yes but Quit ☐ Never/rarely

If answered yes to either above question, answer the following questions:

Beverage	Total # of Drinks per Day	Total # of Drinks per Week	Number of Years
☐ Beer , ☐ Wine, ☐ Liquor			

If you have quit drinking, how old were you when you quit? Years old

TOBACCO HISTORY

Have you ever smoked at least 100 cigarettes (5 packs) during your lifetime? ☐ Yes currently ☐ Yes but Quit ☐ No

If Yes, When did you first start smoking cigarettes regularly? Age, If quit , how old were you? Age

On average, how many packs do/did you smoke per day? most packs per day

Any ☐ Childhood and/or ☐ Second hand smoke exposure? If yes, number of years, about number of hours/day

Use of any other tobacco products?

☐ Chewing Tobacco, ☐ Snuff or Dip, ☐ Pipes, ☐ Cigars, How much per day, years used

** Interested in Quitting any tobacco products Please ask for more information and options.

RECREATIONAL DRUGS

Have you ever used any recreational (street) drugs? ☐ Yes currently ☐ Yes but Quit ☐ No

If Yes, What agents and how much?

FAMILY HISTORY:

Are you Adopted? ☐ No, ☐ Yes | Are you a Twin? ☐ No, ☐ Yes | What type of twin? ☐ Identical , ☐ Fraternal

Excluding yourself, how many of each of the following blood-related family members do you have?

Brothers: | Sisters: | Sons: | Daughters:

Remember to include those who are no longer living. Include only **full** brothers or sisters.

Complete the table below for each of your blood relatives who has had cancer or a bleeding or blood related problem . .
If it is a grandparent, aunt or uncle, place in the box a "F" if from your **father's side** or "M" if from your **mother's side of the family**.

Name	Relative Type	F or M	Year Born	Still Living	Age Died	Type of Cancer or Blood Problem	Age Diagnosed

Screening and Sexual History:

Colon screening : ☐ Yes, ☐ No | ☐ Colonoscopy | ☐ Sigmoidoscopy | ☐ Annual hemocult | ☐ Barium enema

Date of test perform: Next Due Any Polyps? ☐ Yes, ☐ No

Bone Density : ☐ Yes, ☐ No Date: Result:

To be answered by <u>WOMEN</u> only:

Mammogram: ☐ Yes, ☐ No, Date _____ Result _____ <u>Pap Smear:</u> ☐ Yes, ☐ No , Date _____ Result _____

Age of first menstrual period? _____ Regular monthly menstrual periods? ☐ Yes, ☐ No, if no when last period _____

Are you now on or have you ever taken birth control pills? ☐ Yes, ☐ No, When? _____ How Long _____

Have you ever used estrogen replacement therapy? ☐ Yes, ☐ No, When? _____ How Long? _____

Have you ever had a miscarriage? ☐ Yes, ☐ No, How many? _____ What Term? _____ When?_____

To be answered by <u>MEN</u> only:

Prostate screening: ☐ PSA : Result if known:_____ Date? _____ ☐ Exam : Date _____

For cancer patients only:

Please complete the **TABLE** below for my **<u>PRIOR</u>** cancer, radiation treatment, or chemotherapy that you may have had:

	Don't know	No	Yes	Year	Kind of cancer or type of disease / condition
Prior Cancers (before current illness):					
Prior Radiation Treatment (not dental x-rays or for broken bones):					
Prior Chemotherapy					

General Health Questions: *Attach additional sheets if needed or add to last page

General	Weight Loss?	☐N,☐Y	Decrease in appetite?	☐N,☐Y	Night sweats?	☐N,☐Y
	Fatigue?	☐N,☐Y	Decrease in energy?	☐N,☐Y	Fever?	☐N,☐Y

If any yes, explain and other general complaints?

Eyes and Ears	Change in hearing?	☐N,☐Y	Ear pain?	☐N,☐Y	Change in vision?	☐N,☐Y

If any yes, explain and other seeing or hearing complaints?

Head, Nose, and Throat	Sinus infection/pain?	☐N,☐Y	Nasal Drainage?	☐N,☐Y	Throat pain?	☐N,☐Y

If any yes, explain and other head or necks complaints?

Cardiovascular			Nighttime Shortness of breath?	☐N,☐Y	Lower leg swelling?	☐N,☐Y
Chest pain?	☐N,☐Y		Decrease in ability to exert oneself?	☐N,☐Y	Able to lie flat?	☐N,☐Y

If any yes, explain and other heart complaints?

Pulmonary	Shortness of Breath?	☐N,☐Y	Blood in Sputum?	☐N,☐Y	Cough?	☐N,☐Y

If any yes, explain and other lung complaints?

Gastrointestinal	Difficulty swallowing food?	☐N,☐Y	Indigestion?	☐N,☐Y	Diarrhea?	☐N,☐Y
	Vomiting?	☐N,☐Y	Nausea?	☐N,☐Y	Constipation?	☐N,☐Y
	Abdominal Pain ?	☐N,☐Y	Blood in stool?	☐N,☐Y	Black stool?	☐N,☐Y

If any yes, explain and other abdominal complaints?

Genitourinary	Blood in urine?	☐N,☐Y	Increase in need to urinate?	☐N,☐Y	Difficulty starting urination?	☐N,☐Y
	Burning or pain with urination?	☐N,☐Y	Increase in urination at night?	☐N,☐Y	Dribbling or unable to control urine?	☐N,☐Y

If any yes, explain and other urination complaints?

Hematologic	Bleeding after surgery?	☐N,☐Y	Easy bruising/ bleeding?	☐N,☐Y	Lymph node or gland swelling?	☐N,☐Y
	Prior transfusion?	☐N,☐Y	Any history of blood clots?	☐N,☐Y	Nose bleeds, rectal bleeding or bleeding at other site? (specify)	☐N,☐Y

If any yes, explain and other hematologic complaints?

Neurologic	Headaches, troublesome or frequent?	☐N,☐Y	Decrease in ability to walk?	☐N,☐Y	Seizures?	☐N,☐Y
	Numbness in hands and feet?	☐N,☐Y	Decrease in muscle strength	☐N,☐Y	Tingling in hands/ feet?	☐N,☐Y

If any yes, explain and other neurologic complaints?

Psychiatric	Change in mood?	☐N,☐Y	Depression?	☐N,☐Y	Change in behavior with family/friends?	☐N,☐Y
	Anxious?	☐N,☐Y	Memory loss?	☐N,☐Y	Change in ability to think?	☐N,☐Y

If any yes, explain and other psychiatric complaints?

Endocrine	Diabetes?	☐N,☐Y	Hypothyroidism?	☐N,☐Y	Hyperthyroidism?	☐N,☐Y

If any yes, explain and other endocrinology complaints?

Skin	Rashes?	☐N,☐Y	Infections?	☐N,☐Y	Ulcers or open sores?	☐N,☐Y
	Yellow skin?	☐N,☐Y	If any yes, explain and other skin complaints?			

Any additional comments, information, issues you would like to discuss or provide to us:

Physician Notes: - Office use Only -

☐ **By checking this box, I confirm that I have reviewed this form in its entirety.**

Physician Signature : _____

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CONSENT TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the Columbus Oncology Associates, Inc ("**COA**") to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my health care provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed authorization. This permission will be considered ongoing until I indicate otherwise in writing.

My Protected Health Information may be released to the following individuals:

1) **Name:**_____ **Relationship:**_____ **Phone:**_____

2) **Name:**_____ **Relationship:**_____ **Phone:**_____

3) **Name:**_____ **Relationship:**_____ **Phone:**_____

4) **Name:**_____ **Relationship:**_____ **Phone:**_____

COA STAFF HAVE MY PERMISSION TO LEAVE MESSAGES CONCERNING TREATMENT (i.e., LAB RESULTS) on my:

(Please check all boxes that apply)

☐ **Home Voice Mail. Home Phone number:** _____

☐ **Cell phone. Cell phone number:** _____

☐ **Work Voice Mail. Work phone number:** _____

☐ **NO INFORMATION: I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided.**

_____ _____
Print Name of Patient/Authorized Representative Patient Date of Birth

_____ _____
Patient/Authorized Representative Signature Date Signed

Authorized Representative's authority* to act on the Patient's behalf:

☐ Parent/legal guardian ☐ Power of Attorney

*Evidence of authority must be provided and on file with COA.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Who We Are

This Notice of Privacy Practices ("**Notice**") describes the privacy practices of Columbus Oncology Associates, Inc ("**COA**") and its affiliates Columbus Oncology Associates, Inc., d/b/a Columbus Oncology & Hematology Associates, LLC, their physicians, nurses, and other personnel. It applies to services furnished to you at 810 Jasonway Avenue, Columbus, Ohio 43214, and hospitals and other locations where our physicians, nurses and other personnel provide medical services ("**we**" or "**us**").

II. Our Privacy Obligations

We are required by law to maintain the privacy of your health information ("**Protected Health Information**" or "**PHI**") and to provide you with this Notice of our legal duties and privacy practices with respect to your PHI. We are also obligated to notify you following a Breach of unsecured PHI. When we use or disclose your PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which we describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose PHI, but not your "Highly Confidential Information" (defined in Section IV. C below), in order to treat you, obtain payment for services provided to you and conduct our "Health Care Operations" as detailed below:

- Treatment. We may use and disclose your PHI to provide treatment, for example, to diagnose and treat your injury or illness. We may also disclose PHI to other health care providers involved in your treatment.

- Payment. In most cases, we may use and disclose your PHI to obtain payment for services that we provide to you – for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("**Your Payor**") to verify that Your Payor will pay for health care.

- Health Care Operations. We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may disclose PHI to our Patient Relations Coordinator in order to resolve any complaints you may have and ensure that you have a comfortable visit with us.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Use or Disclosure for Directory of Individuals in Facility. We may include your name, location in Facility, general health condition and religious affiliation in a patient directory without obtaining your authorization unless you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name or members of the clergy; provided, however, that religious affiliation will only be disclosed to members of the clergy.

C. Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

D. Public Health Activities. We may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child or elder abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or

condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

E. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

F. Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

G. Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

H. Law Enforcement Officers. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

I. Decedents. We may disclose your PHI to a coroner or medical examiner as authorized by law.

J. Organ and Tissue Procurement. We may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

K. Research. We may use or disclose your PHI without your consent or authorization if an Institutional Review Board or Privacy Board approves a waiver of authorization for disclosure.

L. Health or Safety. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

M. Specialized Government Functions. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

N. Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

O. As Required By Law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Uses and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. We must obtain your written authorization for most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute the sale of PHI. Additionally, other uses and disclosures of PHI not described in this Notice will be made only when you give us your written permission on an authorization form ("**Your Authorization**"). For instance, you will need to complete and sign an authorization form before we can send your PHI to your life insurance company or to the attorney representing the other party in a lawsuit in which you are involved.

B. Uses and Disclosures of Your Highly Confidential Information. Federal and state law requires special privacy protections for certain highly confidential information about you ("**Highly Confidential Information**"). This Highly Confidential Information may include the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment and referral; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about sexually-transmitted disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (7) is about domestic abuse of an adult with a disability; or (8) is about sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must have Your Authorization.

C. Revocation of Your Authorization. You may withdraw (revoke) your Authorization, or any written authorization regarding your Highly Confidential Information (except to the extent that we have taken action in reliance upon it) by delivering a written statement to the Privacy Officer identified below. A form of Written Revocation is available upon request from the Privacy Officer.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints. If you would like more information about your privacy rights, if you are concerned that we have violated your privacy rights, or if you disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer. Also, you may make a complaint by calling COA Corporate Hotline at (614) 442-3130. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You have the right to request a restriction on the uses and disclosures of your PHI (1) for treatment, payment and health care operations purposes, and (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved in your care or with payment related to your care. For example, you have the right to request that we not disclose your PHI to a health plan for payment or health care operations purposes, if that PHI pertains solely to a health care item or service for which we have been involved and which has been paid out of pocket in full. Unless otherwise required by law, we are required to comply with your request for this type of restriction. For all other requests for restrictions on use and disclosures of your PHI, we are not required to agree to your request, but will attempt to accommodate reasonable requests when appropriate. If you wish to request additional restrictions, please obtain a request form from our Privacy Officer and submit the completed form to the Privacy Officer. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you would like to access your records, please obtain a Record Request Form from the Privacy Officer and submit the completed form to the Privacy Officer. If you request copies, we will charge you a cost-based fee, consistent with Ohio law, and, if you agree in advance, the cost of preparing an explanation or summary of the PHI.

E. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an Amendment Request Form from the Privacy Officer and submit the completed form to the Privacy Officer. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

F. Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years. If you request an accounting more than once during a twelve (12) month period, we will charge you a cost-based fee, consistent with Ohio law, for the accounting statement. We will inform you in advance of any fee and provide you with an opportunity to withdraw or modify the request.

G. Right to Receive a Copy of this Notice. Upon request, you may obtain a copy of this Notice, either by email or in paper format. Please submit your request to:

Privacy Officer
Columbus Oncology Associates, Inc
810 Jasonway Avenue, Suite A
Columbus, OH. 43214
Phone: 614-442-3130

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on **January 1, 2019**.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas around CE and on our Internet site at coainc.cc. You also may obtain any new notice by contacting the Privacy Officer.

VII. Privacy Officer

You may contact the Privacy Officer at:

Privacy Officer: Joseph Hofmeister, MD
Columbus Oncology Associates, Inc
810 Jasonway Avenue, Suite A
Columbus, OH. 43214
Phone: (614) 442-3130
Email: Privacyofficer@coainc.cc

Columbus Oncology & Hematology
Serving Ohio Since 1987

Jasonway Cancer Center
810 Jasonway Ave.
Columbus, Ohio 43214-4359

Dublin Cancer Center
6700 Perimeter Drive
Dublin, Ohio 43016-8063

Phone: (614) 442-3130
Fax: (614) 442-3150

Westerville Cancer Center
300 Polaris Pkwy, Suite 330
Westerville, Ohio 43082-7813

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("**Notice**") provides information about: (1) the privacy rights of our patients; and (2) how we may use and disclose Protected Health Information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to Privacyofficer@coainc.cc or a letter to:

Privacy Officer: Dr. Joseph Hofmeister, MD
Columbus Oncology Associates, Inc
810 Jasonway Ave, Suite A
Columbus, OH. 43214
Phone: (614) 442-3130
Email: Privacyofficer@coainc.cc

By signing this form, you are only acknowledging that you have been provided our Notice.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Print Name of Patient/Authorized Representative

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User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form**. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

_____
Patient Name
(First Name, Middle Initial, Last Name)

_____
Email Address of Patient/Authorized User

_____
Date of Birth of Patient

_____
Physician's Name

Authorized User is:

☐ Patient
☐ Patient's Designee

_____
Patient's Designee's Name (Printed)

_____
Patient's Designee's Signature

_____
Patient's Signature

_____
Date

_____
Signature of Practice Staff
[confirming user's identity and authority]

_____
Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose.

_____
Medical Record Number

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COA PATIENT ASSISTANCE PROGRAM

Patient Consent and Authorization

Columbus Oncology Associates, Inc. ("COA" or "COHA") operates a patient assistance support program to assist its current patients seeking medication discounts that exist from time to time ("Patient Assistance Program"). The Patient Assistance Program researches and identifies drug discount programs, including without limitation drug rebate programs and copayment savings programs owned or operated by drug manufacturers, third-party drug rebate programs, non-profit foundations and other advocacy organizations (collectively, "Savings Programs"), which patients may be eligible for medication discounts. When identified, the Patient Assistance Program delivers patient information to Savings Programs for the benefit of patients. Savings are directly transmitted to patients and are not routed through COHA. "Patient information" includes health data and financial information of the patient that is either in the custody of COHA or has been provided by the patient.

COHA offers the Patient Assistance Program to its patients at no charge, but may receive remuneration from the Savings Programs in exchange for disclosing health data and financial information to Savings Programs and/or for providing patients with support services. COHA operates the Patient Assistance Program in accordance with industry standards and commercially reasonable practices. Support provided through the Patient Assistance Program represents no statement, promise or guarantee by the Program. And, COHA makes no guarantee of drug discounts for patient participation in the Patient Assistance Program.

Consent to Participate

I hereby consent to participate in the Patient Assistance Program for so long as I am a patient of COHA receiving drug therapy treatments. And, I hereby authorize COHA to use and disclose my health data and financial information, including without limitation my identifying health information, health insurance information, medical diagnosis and condition (including lab test results related to such diagnosis or supportive testing), prescription information, and name, address, and telephone number to any Savings Program to which COHA reasonably believes I may be eligible to benefit from drug discounts.

I understand that COHA will use reasonable efforts to identify and seek drug discounts under Savings Programs on my behalf, and **I hereby agree** that in no event will COHA be liable for any damages resulting from or relating the Patient Assistance Program.

Authorization for Disclosure of PHI

I authorize COHA to review and share my protected health information (PHI) with Savings Programs pursuant to the Patient Assistance Program. I understand that there is a potential for the information to be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996, as amended (or HIPAA) and the regulations promulgated thereunder including, without limitation, the Privacy Rule (45 CFR Part 164).

My PHI may include:

- information provided on this form;
- healthcare records related to my treatment and health condition(s);
- payer-related information received from my health insurer;
- prescription, fulfillment, shipment, and other information provided by pharmacies or other sites of care; and
- information to help support my transition of care;

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My authorization and notice of release will remain in effect for as long as I am receiving drug therapy treatments as patient of COHA.

I understand that I may be requested to provide my written consent for continued participation in the Patient Assistance Program and authorization for the disclosure of health and financial data, including PHI, from time to time by COHA. **I understand** that COHA may receive payment from the Savings Programs for disclosing my PHI or operating the Patient Assistance Program.

No Effect on Treatment

I UNDERSTAND THAT SIGNING THIS CONSENT AND AUTHORIZATION FORM IS VOLUNTARY, AND THAT IF I REFUSE TO SIGN THIS FORM, IT WILL NOT AFFECT THE START, CONTINUATION, OR QUALITY OF MY TREATMENT FROM COHA.

Revocation

After I have signed this consent and authorization, I may withdraw it by calling COHA at (614) 442-3130 or by sending a written notice to Columbus Oncology Associates, Inc. The withdrawal goes into effect once it has been received by the Program. If I choose to not sign this authorization or I withdraw it after signing this form, the Patient Assistance Program will not be able to provide me with the support described above after the date of my revocation.

_____	_____/____/_____
Patient Name (Please Print)	Patient Date of Birth
_____	_____
Parent/Legal Guardian Name (Please Print)	Relationship to Patient
_____	_____/____/_____
Patient/Parent/Legal Guardian Signature	Date