PCI Use Only

# PIEDMONT CANCER INSTITUTE P.C.
## 2023 Patient Information Form

**This document is part of your permanent record.**
**Please print clearly.**

Patient Full Legal Name: ______________________________________________
(First) (Middle) (Last)

Patient Address: ______________________________________________

City: ____________________ State: ______________ Zip: __________-__________

Marital Status: ☐ S ☐ M ☐ D ☐ W Gender: ☐ M ☐ F DOB: ____________ Age: ________

Social Security Number:__________-_____-______________

Primary Phone Number: (_______) ________-__________ ☐ Home ☐ Cell ☐ Work

Secondary Phone Number: (_______) ________-__________ ☐ Home ☐ Cell ☐ Work

Email Address: ______________________________@________________.__________

**With which of the following do you identify yourself?** (Please choose all that apply.)

Race: ☐African American or Black ☐American Indian ☐Asian ☐Native Hawaiian/Pacific Islander

☐White ☐Decline to Answer ☐Other, please specify ______________________________

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Non-Latino ☐ Decline to Answer ☐Other __________

Preferred Language: ☐English ☐Spanish

**Employed:** ☐Full-Time ☐Part-Time ☐Active Duty ☐Not Employed

Name of Employer: ________________________ Phone Number:(_____) ______-________

**Student:** ☐Full-Time ☐Part-Time Name of School: ______________________________

**I am:** ☐Retired ☐Disabled

## EMERGENCY CONTACT INFORMATION

Primary Contact: ______________________________ Relationship: ____________
(Spouse, if married)

Home Phone: ( ) - ____________ - ____________
Cell Phone: ( ) - ____________ - ____________
Work Phone: ( ) - ____________ - ____________

Secondary Contact: ______________________________ Relationship: ____________
(other than spouse)

Home Phone: ( ) - ____________ - ____________
Cell Phone: ( ) - ____________ - ____________
Work Phone: ( ) - ____________ - ____________

# 2023 Patient Information Form, continued

PCI Use Only

## INSURANCE INFORMATION

We will request a **copy of your photo ID, insurance and pharmacy cards when you check in**, please make sure you **bring them with you**, so we have your complete and accurate information on file, this is a requirement for us to be able to file any insurance claims for you. Without copies of your cards, there may be a delay in receiving services or require that you be rescheduled.

If you become unable to handle your finances, who will be responsible? ______________________________

Please answer the following:

Do you have a Living Will? ☐Yes ☐No

Do you have a Power of Attorney (POA)? ☐Yes ☐No

If you answered Yes to either question, please provide a copy on your next visit so we can keep it on file.

## PHYSICIAN INFORMATION

Please provide for us with the **full name** and phone number of the physician who referred you to our office:

| | Phone: | (       ) -       - |
|---|---|---|

I was **not referred by a physician**, but referred/recommended by:

| | **OR** | ☐ I am self-referred |
|---|---|---|

**Are you currently seeing any additional physicians? If so, please complete below.**

| List the **FULL** name of your PRIMARY CARE PHYSICIAN (PCP) | Phone Number |
|---|---|
| 1. | (       ) -       - |
| | |
| List the **FULL** name(s) of any additional Specialists/Providers | Phone Number |
| 2. | (       ) -       - |
| 3. | (       ) -       - |
| 4. | (       ) -       - |
| 5. | (       ) -       - |
| 6. | (       ) -       - |

Firearms are **NOT ALLOWED or PERMITTED** for any reason on any of PCI's business locations, premises, offices, or treatment centers.

I verify that the above information is factual and true to the best of my knowledge. I certify that the insurance information I have provided is factual and correct. I understand that I am responsible for notifying PCI with any demographic or insurance changes prior to services being rendered.

______________________________ Signature of Person Completing Form

______________________________ Date

# PIEDMONT CANCER INSTITUTE P.C.

MEDICARE Payer Questionnaire
Attachment A

PCI Use Only

**Patient Name:** ________________________________________ **Date:** ___________________

**- For All Medicare and Medicare Advantage Recipients To Complete -**

**Please complete the following questions:**

A. Are you receiving Black Lung Benefits? ☐YES ☐NO

B. Are your services to be paid by a government program such as a research grant? ☐YES ☐NO

C. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this office/facility?
☐YES ☐NO

1. Yes, DVA is **PRIMARY** for these Services.

| | |
|---|---|
| ✓ | We **ONLY** participate with **Optum VA Community Care Network**. |
| ✖ | We **do not** participate with any OTHER DVA/Veteran plan(s) including Veterans Choice Program (VCP), even if authorization has been obtained and therefore **CANNOT submit any charges to them, please go to 2 below**. |

2. No, If you have Medicare or private commercial insurance, we may be able to file charges for you.
→ See our Financial and Payment Policy including the Uninsured/Self-Pay section as you may be considered a self-pay (cash) patient.

D. Was your illness/injury due to a work-related accident/condition? ☐Yes ☐No, go to E
→ Yes, Workers Compensation is PRIMARY payer ONLY for claims related to work related injuries/illness.

E. Was your illness/injury due to a NON-WORK accident (No-Fault or Liability)? ☐Yes ☐No, go to F
→ Yes, No-Fault insurer is PRIMARY payer ONLY for those services related to the accident.
→ Yes, Liability insurer is PRIMARY payer ONLY for those services related to liability.

F. Are you entitled to Medicare due to Disability?
1. If you are entitled by **DISABILITY**, are you employed? ☐Yes ☐No ☐Never Worked
   a. Yes, Are you **actively employed** by an employer of **100 or more** employees? ☐Yes ☐No

G. Are you entitled to Medicare due to AGE or End Stage Renal Disease (ESRD)?
1. If you are entitled by AGE or ESRD, are you working? ☐Yes ☐Retired ☐ No, Never Worked
   a. Yes, Are you actively employed by an employer of 20 or more employees? ☐Yes ☐No
   b. No, I'm Retired - What is your retirement date? _____ /_____/_______________
2. Is your spouse working? ☐Yes ☐No ☐Retired ☐Never Worked ☐N/A
   a. Yes, Is your spouse **actively employed** by an employer of **20 or more** employees? ☐Yes ☐No
   b. No, Retired - What is your spouse's retirement date? _____ /_____/_______________

______________________________
Patient Signature

# PIEDMONT CANCER INSTITUTE P.C.

## 2023 Patient Financial Responsibility Statement

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We would like to say "**thank you**" for choosing ***Piedmont Cancer Institute, P.C.*** for your hematologic or oncologic care! Our physicians and staff are very concerned about the cost of your health care and want to inform you of our policies regarding payment.

Your clear understanding of our **Patient Financial Responsibility Statement** is important to our professional relationship. We will work with patients to ensure they receive excellent care with minimal financial burden. If you have any questions about our financial policy, insurance reimbursement or your financial responsibilities please do not hesitate to contact our Billing Department at 678-298-3227.

**Insurance** – It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card(s) when you check in and will copy for our records. We will request a copy any time your insurance changes and thereafter annually.

1. Before we are allowed to bill your insurance company for your health care costs, it is extremely important that we obtain complete accurate information about your primary and supplemental insurance companies, including phone numbers, addresses and a copy of your insurance and pharmacy cards. If this information is not provided, you will be required to pay any charges in full at the time of service. We will also use the information you provide to help you with your insurance company's prior/pre-authorization process, if required.

   a. If your insurance changes at any time, we require a **48-hour notice** to verify benefits and **complete required treatment pre-certification or authorizations**, when necessary. Failure to notify our Billing Department within this timeframe may result in a delay in receiving services or require that you be rescheduled.
   b. To maintain accuracy in filing your claims a copy of your picture ID and your insurance card(s) is required at your first visit, any time your coverage changes and yearly.

2. Whenever possible, ***Piedmont Cancer Institute, P.C.*** (hereinafter "**PCI**"), will assist you with your understanding of your insurance policy details. However, PCI can not guarantee confirmation of your coverage or benefits by your insurance company.

3. Payment in full is expected when services are rendered unless other specific arrangements are made in advance with our Billing Department. For your convenience, **we accept Visa, MasterCard, Discover and American Express as well as personal checks, money orders and cash**.

**Co-pays/Coinsurance/Deductibles** – Our policy requires payment for your co-pay, deductible and/or co-insurance at the time of service for office visits and procedures, including treatment. We will file a claim for services on your behalf. In the event there are any additional balances that may be your responsibility, a statement will be sent to you that is to be paid before the end of the month.

**Uninsured/Self-Pay** – with the adoption of the No Surprises Act (NSA) **YOU MUST** sign a **CONSENT PRIOR** to any service being rendered. We offer a discount to all self-pay patients. Payment in full is expected at your first visit. All other ancillary, treatment and future care will be reviewed with you in order to make/plan arrangements for payment.

**Medicare** – We are a participating provider with Medicare. We will submit your claim to Medicare who will process any payment due directly to us. You are responsible for your deductible and co-pays at the time of service**.** If you have a Medigap policy, Medicare will automatically submit your secondary claims for you.

**Medicare Advantage** – We are considered in-network with PFFS and SEVERAL Medicare Advantage PPO, POS or HMO plans that we are contracted with. You are responsible for **verifying** that you are seeing an **IN-NETWORK contracted provider PRIOR to services being rendered**.

a) If you have a **Medicare Advantage** plan that we do not participate with, you may have out-of-network benefits. These benefits typically have a **higher co-pay, co-insurance and/or deductible out-of-pocket cost**.
b) You will be considered a **self-pay, uninsured patient** if you **DO NOT** have out-of-network benefits with payment due at the time of service.

**Medicaid** – We participate with Georgia Medicaid. If you have a managed care plan such as Amerigroup, CareSource, PeachState, or Wellcare, a referral or authorization may be required for each visit. This must be obtained from the Primary Care Physician (PCP) listed on your Medicaid card PRIOR to having services rendered. A co-pay may be applied and will be due at the time a service is rendered.

**NOTE: Not all PCI providers are participating in managed care plans through Medicaid. It is your responsibility to verify your provider is in-network prior to services being rendered**.

**HMO, EPO, POS and PPO Contracted Insurance** – We participate with most major insurance carriers and will file your claim for you. You are responsible for your co-pay, co-insurance and/or deductible at the time of service and for any amounts not covered by your insurance. If coverage is denied for any reason, you are responsible for payment of the entire balance.

**NON-Contracted Medicare Advantage (Out-of-Network) Plans** – If you have a Medicare Advantage plan that we do not participate with, you may have out-of-network benefits. These benefits typically have a **higher co-pay, co-insurance and/or deductible out-of-pocket cost**. You will be considered a **self-pay, uninsured patient** if you do NOT have out-of-network benefits with **payment due at the time of service**.

**Shared, Self-Insured and Limited Liability Insurance Plans** – If you have a “shared”, self-insured or limited liability insurance plan, you may have very limited benefits. Any services such as office visits and treatment not covered by your plan are your full responsibility. It is your responsibility to understand your plan.

**Secondary Insurance** – As a courtesy to you, our Billing Department will file your claim if we have valid information on file.

**Workers’ Compensation** – We accept workers’ compensation ON A **CASE-BY-CASE** BASIS ONLY. You must be approved by PCI and all authorization(s) must be obtained and a copy provided to the billing department BEFORE **ANY** appointment(s) can be made. If this policy is not followed and you receive services in our practice, you will be considered a self-pay patient and be 100% responsible for your charges and we will not file your workers’ compensation claim(s).

**Termination of Benefits** – It is your responsibility to contact us within **48 hours** of any appointment if you have any change in insurance coverage including COBRA benefits (see COBRA section below).

**COBRA** – It is our financial and payment policy that we verify current coverage within **48 hours** of your appointment for all patients who receive COBRA benefits. If current coverage can NOT be verified, you will be considered uninsured/self-pay and be responsible for 100% of charges for services rendered. It is your responsibility to notify us immediately if you have an insurance change.

**Fees** – Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of the care rendered and the skill and expertise required for your care. We have ensured that our fees are comparable to that of other physicians providing the same quality and level of care. In an effort to discount physician fees, many private insurance companies restrict payment, indicating that fees are over their "Usual and Customary" fees for this area. We will not allow insurance companies to set our fees for us.

**Mismatched Information** – We are mandated to use accurate information and will use the legal name and date of birth listed on your photo ID. If your ID and insurance information do not match, we will attempt to confirm your identity matches when verifying benefits. However, based on guidelines from the Center for Medicare and Medicaid Services (CMS) and our insurance contracts, we are required to use the information Medicare and/or your commercial insurance has on file so that we may submit charges for processing on your behalf. This will also be the same information we use on your chart. It is your responsibility to have the inaccurate information corrected, including addresses and date of birth, and to notify us when completed.

**Referrals** – If your insurance carrier requires a referral or authorization for your visit, it is **your responsibility** to make sure that our office receives **current valid authorization**. If you DO NOT have a valid referral or authorization at the time of service, you may be redirected back to your Primary Care Physician to obtain authorization prior to being treated or full payment will be expected at the time of service. Please remember that it is **your responsibility** to make sure we are on your plan's provider listing.

**Specialty Pharmacy Obtained Drugs (White/Brown Bagging) and Contracted Outside Infusion Centers** – Piedmont Cancer Institute, P.C. physicians and staff take our responsibility to provide you safe and effective care very seriously. In order to ensure your safety and maintain best practices for the best outcomes, we feel strongly that we should control the treatment process for you. PCI reserves the right to follow its policy of **buying and billing** for injectable pharmaceutical drugs. If your insurance plan requires you to obtain injectable medications prescribed by your PCI provider for treatment through your contracted "**specialty pharmacy**" where the drug(s) is/are mailed directly to you **(brown bagging)** or shipped directly to us **(white bagging)** it is the policy of Piedmont Cancer Institute, P.C. that we will not accept any drugs this way with the exception of home self-injection. If your contracted "**specialty pharmacy**" includes your receiving treatment in your contracted outside infusion centers, and does not allow PCI to **buy and bill**, we will be unable to treat you in our office due to your insurance coverage mandate. You can attempt to obtain an exception authorization through your employer that will allow PCI to **buy and bill** so that we may treat you in our office with drugs purchased by PCI. If an exception is unable to be obtained, you will be referred back to your insurance company for assistance in obtaining a provider who will participate in your plan's "benefit".

# PIEDMONT CANCER INSTITUTE P.C.

## 2023 Patient Financial Responsibility Statement

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**Pre-Existing Conditions** – Some insurance plans, especially “shared” and “limited coverage” may have pre-existing condition clauses. It is **your responsibility** to understand and know your contract and whether this affects you. When the pre-existing clause is in force, your insurance carrier will not process or pay claims under your contracted agreement and in these circumstances, you will be considered self-pay and be responsible for your entire balance.

**Returned Checks** – Returned checks are subject to a $30 service charge. If multiple returned checks are received, we reserve the right to refuse further checks from you and request that all payments be received in cash, money order, cashier’s check or credit card.

**Non-Payment** – If any account becomes delinquent PCI reserves the right to have a collection agency take over the account. If any account is placed with a collection agency, the patient will be responsible for all costs of collection and any legal proceedings. Timely payment will prevent consequences to your credit rating.

**NON-Contracted Commercial Insurance (Out-of-Network)** – with the adoption of the No Surprise Act (NSA) **YOU MUST** sign a **CONSENT PRIOR** to any service being rendered.

**Signature –**

**I have read and understand our Patient Financial Responsibility Statement and acknowledge that I have been made aware of our financial assistance opportunities by signing below.**

| ______________________________ | ____________________ |
|---|---|
| Signature | Date |

PCI Use Only

# PIEDMONT CANCER INSTITUTE P.C.

## 2023 Assignment of Benefits

I hereby assign all healthcare and medical benefits (i.e. "**Payer**"; Commercial Insurance Coverage, ERISA Plan, Governmental Health Benefit Plan, Medicare, Medicaid, patient financial assistance programs, other third-party payer, etc.) and related rights existing under the "**Payer**" coverage to ***Piedmont Cancer Institute, P.C***. (hereinafter "PCI") and d/b/a ***PHOC Pharmacy*** (hereinafter "PHOC Pharmacy") for services provided to me by PCI and/or PHOC Pharmacy. I hereby certify that the "**Payer**" information that I have supplied PCI and/or PHOC Pharmacy is true and accurate as of the date of service. I am fully aware that having healthcare benefits does not absolve me of my responsibility to ensure that my medical bill is paid in full. I understand different payers have different requirements for payment including, but not limited to, **pre-certifications, authorizations** or that the services be medically necessary. **I understand that it is my obligation to know my Payer's requirements and ensure that they have been fulfilled**. I also understand that my **Payer** may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by the identified "**Payer**". **I agree to immediately notify *Piedmont Cancer Institute, P.C.* (PCI) if any of the information I have supplied changes at any time during my treatment.**

I hereby authorize PCI and/or PHOC PHARMACY to submit claims, on my behalf, to the **Payer** listed on the current benefits card I have supplied PCI and/or PHOC PHARMACY. I hereby instruct and direct my **Payer** to pay PCI directly. If my current policy prohibits direct payment or assignment to PCI and/or PHOC PHARMACY for services, I hereby instruct and direct my **Payer** to make the check payable to me, but to mail it directly to PCI for the professional medical expense benefits allowable, and otherwise payable to me under my current benefits under **Payer**'s policy for payment towards the total charges for medical services rendered. Upon receipt of said check, I authorize PCI and/or PHOC PHARMACY to deposit checks received on my account when made payable to me.

This is a direct and express assignment of my rights and benefits under policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of medical service charges over and above this payment (certain regulations and exceptions apply for Medicare and Medicaid Beneficiaries). **I hereby acknowledge and give my express permission for PCI and/or PHOC PHARMACY or its legal representative to release any of my patient health information, including privileged information (i.e., mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes.** Furthermore, I authorize PCI or its legal representative to obtain information concerning my medical benefits for services or related directly from **Payer** (including but not limited to, the policy or plan governing my benefits or organizations that provide financial assistance).

In the event that my policy prohibits assignment of certain rights (such as right to file appeals or to file suit in state or Federal court) **I expressly authorize PCI at its sole discretion to be my personal representative which allows PCI to:** (1) submit any and all appeals, when my **Payer** denies benefits in whole or part to which I may be entitled; (2) submit any and all requests for benefit information from my **Payer**; and (3) initiate formal or informal complaints to any State or Federal agency that has jurisdiction over my benefits; this includes express permission for PCI or its legal representative to file suit against **Payer** for healthcare and medical benefits to which I may be entitled. I also agree that any fines, interest, attorney fees, or other awarded damages that may be levied against my **Payer** will be paid to PCI for acting as my personal representative.

The assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this Assignment of Benefits shall be considered effective and valid as the original.

_______________________________________ Signature of Patient/Policy Holder

_____________________ Date

# PIEDMONT CANCER INSTITUTE P.C.

PCI Use Only

## 2023 Request and Informed Consent
## Medical Treatment, Procedure and Services

**Do NOT sign this form until you have read it and fully understand its contents**

**Patient Full Legal Name: ________________________________________Date: _______________**
**(Please print clearly)**

I hereby request and consent to medical evaluation and treatment by medical providers and staff employed by Piedmont Cancer Institute, P.C. (hereinafter PCI). Treatment may be delivered by an intravenous (IV), oral (by mouth), intramuscular injection, or subcutaneous injection method. Each medication administered has its own possible risks and adverse effects which will be discussed with me prior to administration.

I **authorize** PCI to provide medical care by today's standards and understand that treatment may include collection of specimens, **including but not limited to blood and urine**. Specimen collection may occur via venipuncture, fingerstick or venous access device.

I understand that if a healthcare worker involved in my care and treatment becomes exposed to certain bodily fluids resulting in the possibility of transmission of a blood borne disease, my blood will be tested for HIV, Hepatitis B, and Hepatitis C to determine risk of exposure.

I understand that PCI utilizes nurse practitioners (NP) and physician assistants (PA), who are certified as advanced practice providers (APP) who practice within the scope approved by the Georgia Board of Nursing and the Georgia Composite Medical Board. I have the right to request to see a physician prior to receiving any service ordered by an APP.

I understand that I have the right to refuse, withdraw or transfer the responsibility of my treatment at any time and agree to inform PCI of any such decision.

I understand that the medical providers and staff employed by PCI will rely on statements about the patient, the patient's medical history and other information in determining the patient's plan of care except in the case of life-saving emergent event care.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of procedures, treatments, or services.

By signing this form, I acknowledge that I have read or had this form read and/or explained to me. I acknowledge that any questions have been answered satisfactorily.

The Request and Informed Consent Medical Treatment, Procedure and Services will remain in effect until revoked by me in writing. A photocopy of this Informed Consent shall be considered effective and valid as the original.

| ________________________________________ | ________________________ |
|---|---|
| Signature of Patient | Date |
| Signature of Person Giving Consent if NOT the Patient | Date |
| Reason Patient is Unable to Sign | Relationship to Patient |

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# PIEDMONT CANCER INSTITUTE P.C.

## 2023 Medication Record

**Patient Full Legal Name: ____________________________ DOB: _____________ Date: ____________**

Please list your **medication allergies** as well as your response to the drug or substance. Please list all your **current medications** – *including prescription and over-the-counter medications as well as vitamins and other supplements*. When complete, please give this form to the medical assistant.

**MEDICATION ALLERGIES**

| Allergy | Response (what happens) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**CURRENT MEDICATIONS**

| Date Started | Name of Medication | Dosage/Strength (mg, drops, puffs, ml) | Directions (How many taken and what time of day taken) |
|---|---|---|---|
| | | | |
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# PIEDMONT CANCER INSTITUTE P.C.

## 2023 Patient Acknowledgement and Informed Consent Form

I hereby give my consent for Piedmont Cancer Institute, P.C. to use and disclose of all individually identifiable personal, health, financial and demographic information (known as **P**rotected **H**ealth **I** nformation or PHI) including human immunodeficiency virus, psychiatric, drug/alcohol abuse records for the purposes listed below and all other uses are known collective as **T**reatment, **P**ayment, and other healthcare **O**perations (TPO):

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance for medical procedures (where requires)
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

I have been given a copy of Piedmont Cancer Institute, P.C.'s Notice of Privacy Practices prior to signing this consent (a paper copy may be requested from the receptionist or downloaded from our website).

Piedmont Cancer Institute, P.C. reserves the right to revise its Notice of Privacy Practices at any time.

A revised Notice of Privacy Practices may be obtained by forwarding a written request to:


Piedmont Cancer Institute, P.C.<br>
Sandra Fleury, Privacy Officer<br>
1800 Howell Mill Rd NW, Suite 800<br>
Atlanta, GA 30318-0922<br>
Telephone: 678-298-3239


I have the right to request that Piedmont Cancer Institute, P.C., restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound to this agreement.

By signing this form, I am consenting to Piedmont Cancer Institute, P.C.'s use and disclosure of my PHI to carry out TPO. I hereby release Piedmont Cancer Institute, P.C.'s and its agents and employees from any and all liabilities, damages, losses, claims and expenses which may arise from the release of the information authorized above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Piedmont Cancer Institute, P.C. may decline to provide treatment to me. A photocopy of this document shall be as valid as the original.

______________________________ Signature of Patient or Legal Guardian

____________________ Relationship to Patient

______________ Date of Birth

______________________________ Print Patient's Name or Legal Guardian

____________________ Date

# PIEDMONT CANCER INSTITUTE P.C.

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## 2023 Consent for Disclosure
## Family Member and/or Personal Representative

Patient Full Legal Name: ________________________________ DOB: ____________________
(Please print clearly)

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for **Piedmont Cancer Institute, P.C.** and Dr.(s):

**Choose all that apply**

| | | | |
|---|---|---|---|
| ☐ Dr. Nikita Amin | ☐ Dr. William Jonas | ☐ Dr. Jay Rhee | ☐ Dr. Eiran Warner |
| ☐ Dr. Vasily Assikis | ☐ Dr. Vipin Lohiya | ☐ Dr. Samantha Shams | |
| ☐ Dr. Jonathan Bender | ☐ Dr. Eric Mininberg | ☐ Dr. Rajni Sinha | |
| ☐ Dr. Trevor Feinstein | ☐ Dr. Minesh Patel | ☐ Dr. Ha Tran | |

and his or her staff to disclose my personal information to the following individual(s):

Name: ________________________________ Relationship: ____________________

Name: ________________________________ Relationship: ____________________

Name: ________________________________ Relationship: ____________________

Name: ________________________________ Relationship: ____________________

☐ I do not authorize Piedmont Cancer Institute, P.C. to communicate with anyone other than me, excluding all disclosures allowed by law.

**Conditions for Disclosure** (check the item(s) that apply):

☐ The practice may disclose my personal health information to the above individual(s) **only** in my presence.

☐ The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

☐ Other condition(s) of disclosure:____________________________________________

________________________________________________________________

I authorize for **Piedmont Cancer Institute, P.C.** to communicate with me regarding my **P**rotected **H**ealth **I**nformation **(PHI)** in the following manner (please check the item(s) that apply):

| | | |
|---|---|---|
| Leave message on my voicemail/cell phone | ☐ Yes | ☐ No |
| Leave message with a family member | ☐ Yes | ☐ No |
| Leave message with my employer | ☐ Yes | ☐ No |
| Send Text/SMS message | ☐ Yes | ☐ No |
| Email | ☐ Yes | ☐ No |

**I understand that this consent may be revoked by me at any time by written notice to the practice.**

Patient Signature: ________________________________ Date: ____________________