MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Referring and Primary Care Physician Information Sheet

Patient Name		Date of Birth	_____ /_____ /_____ *mm dd yyyy*
Appointment Date			
Purpose of this form	To ensure appropriate continuity of care, we will provide your Referring and Primary Physician(s) a copy of the progress notes throughout the duration of your participation on the clinical trial at Mary Crowley. We will also request your records from the physicians you note below.		
Instructions	1. Please list the name(s), specialty, phone and fax number of each of your physicians. Only the persons you list will be receive a copy of the progress notes. 2. Please list "None" if you do not have a Referring or Primary Physician. If you list none, a Primary Physician referral can be provided. Please discuss this option with one of our team members. Mary Crowley does not provide long term care once you have completed your participation on the clinical trial. 3. Please sign the bottom of this sheet to acknowledge that the information provided is complete and accurate.		

Referring Provider and Primary Oncologist Information

Physician's Name	Type	Specialty	Phone Number	Fax Number
	☐ Referring ☐ Primary			
	☐ Referring ☐ Primary			

☐ I authorize Mary Crowley to keep the physicians noted above informed about my participation on the clinical trial.

☐ I do not authorize Mary Crowley to keep the following physicians informed about my participation on the clinical trial.

Please tell us how you heard about us (check one):

☐ Television	☐ Newspaper	☐ Friend or relative	☐ Radio	☐ Internet	☐ Primary Oncologist
☐ Physician: Phone # _____ Fax # _____			☐ Other: Please list: _____		

_____ Patient Signature

_____ Date (mm/dd/yyyy)

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Patient Registration Form (Part 1)

Today's Date			
Your Name			
Date of Birth	_____/_____/_____ *mm dd yyyy*	Age	

By answering the questions below, this is to better serve you. The answers to these questions will not affect your care at Mary Crowley.
Mary Crowley can provide a translator if a caregiver cannot be with you during your visits. The information that is given will be in a language understandable to you.

Primary Language	Primary Language: _____ Do you read or write in your primary language? ○Yes ○No Is anyone helping you fill out this form? ○Yes: Who is helping? _____ ○No: Self Do you speak English? ○Yes ○No Do you write in English? ○Yes ○No Do you read English? ○Yes ○No Are you able to understand English without help from a caregiver or a translator? ○Yes ○No
Primary Race	☐ American Indian ☐ Asian ☐ Black/African American ☐ Other / Unknown ☐ White/Caucasian
Primary Ethnicity	☐ Hispanic or Latino ☐ Non-Hispanic
Gender	☐ Female ☐ Male Other: please specify: _____
Preferred Phone #	
Alternate Phone #	
Email Address:	

Can we leave messages on the numbers listed above? ☐ Yes ☐ No

What is the best method to contact you? ☐ Phone ☐ Email
Are you ok with us leaving a detailed message? ☐ Yes ☐ No
Are you ok with us sending you an email containing personal information? ☐ Yes ☐ No
please note: your contact info will not be used for any unsolicited purposes

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Patient Registration Form (Part 1)

Date	
Patient Name	
DOB	

Emergency Contact #1			
Name		Relationship	
Phone #			
Emergency Contact #2			
Name		Relationship	
Phone #			

Previous Treatment Facilities and Physicians associated with consultations, treatment or follow up care related to your cancer and any other Physicians you regularly see:		
1. Primary Oncologist:	Date:	
2.	Date:	
3.	Date:	
4.	Date:	

Cancer Related Family History: ☐ Adopted

Family Member(s)	Type of Cancer	Deceased? If so, when?

Visual and Hearing:

Do you have any hearing impairments?	Do you have any visual impairments that require correction?
☐ Deaf and use sign language ☐ Wear a hearing aid(s) ☐ Cochlear implant ☐ None	☐ Legally blind and use braille ☐ Wear Glasses ☐ Wear Contacts ☐ Cataracts ☐ Glaucoma ☐ Corrective Surgery (Lasik) ☐ None

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Patient Registration Form (Part 1)

Date	
Patient Name	
DOB	

Reproductive/Sexual History:		
Do you have any children?	☐ Yes, How many? _____ ☐ No	
Number of births _____	Are you sexually active? ☐ Yes ☐ No	
What contraception do you currently use, if any?		
Social History:		
Do you now or have you ever smoked: ☐ Yes ☐ No *(skip the rest of this section)*	If yes, how long have/did you smoke?	_____ Years
	If you quit, when?	_____ (Year)
	What did you smoke and how much per day? ☐ Cigarettes # _____ packs per day ☐ E – Cigarettes # _____ per week ☐ Cigars # _____ per day ☐ Pipe: # _____ per day	
Do you drink any alcoholic beverages? ☐ Yes ☐ No *(skip the rest of this section)*	What do you drink?	
	How much do you drink on average?	
Do you use any recreational drugs? ☐ Yes ☐ No *(skip the rest of this section)*	What do you use?	
	How much do you use on average?	
Have you had the COVID-19 infection? ☐ Yes ☐ No *(skip the rest of this section)*	If yes, specify dates:	
Have you received the COVID-19 vaccine? ☐ Yes ☐ No *(skip the rest of this section)*	Manufacturer: Dates of Vaccination:	
Have you received a COVID-19 booster? ☐ Yes ☐ No *(skip the rest of this section)*	Manufacturer: Dates of Vaccination:	

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Patient Registration Form (Part 1)

Date	
Patient Name	
DOB	

Mary Crowley will work with your support system on your care during a trial.		
Marital Status	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner	
Support System	☐ Self ☐ Spouse / Life Partner ☐ Friend ☐ Religious Community ☐ Adult Child ☐ Nursing Home ☐ In Home Healthcare ☐ Hospice	
Are you currently working? ☐ Yes ☐ No	What kind of work do you or did you do?	
	Does your job limit your availability for appointments? ☐ Yes, please provide details ☐ No	
Other:		

Your Pharmacy Information

Pharmacy Name	
Pharmacy Number	

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Patient Registration Form (Part 1)

Date	
Patient Name	
DOB	

Medication Allergies:

Drug Name	What Happens When You Take This Medicine?	Onset Date

Your Medication List

Please Complete the Following or Attach a Medication List.

Drug Name	Dose	Frequency	Indication/Reason	Start Date

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Patient Registration Form (Part 1)

Date	
Patient Name	
DOB	

Drug Name	Dose	Frequency	Indication/Reason	Start Date

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Patient Registration Form (Part 2)

Patient Name	
Date	

Review of Symptoms
DO NOT UPLOAD TO IKM

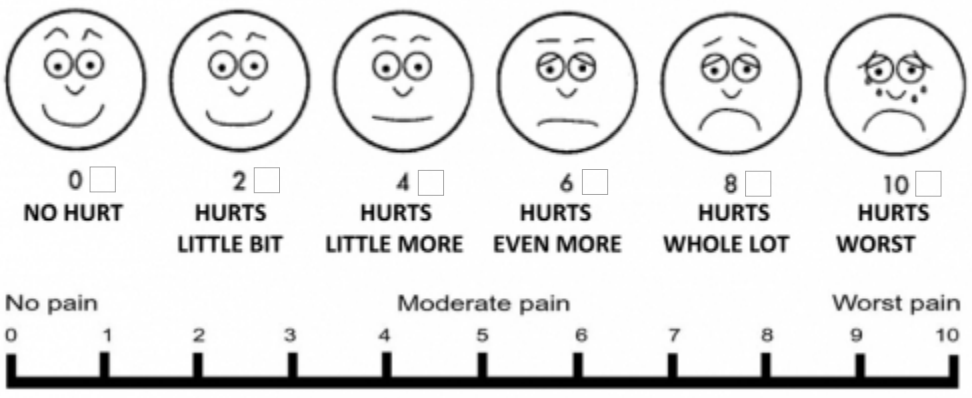
Patient Instructions: Check if you are currently experiencing any of the following conditions.

Body Systems	Check all that apply:		Provider Comments
General / Constitutional	☐ Weight loss ☐ Weight gain ☐ Fever ☐ Chills ☐ Night sweats	☐ Normal Energy level ☐ Fatigue ☐ Pain ☐ Change in level of activities	
Skin	☐ Rash ☐ Nodules ☐ Itchy skin	☐ Wound or injury ☐ Lump	
HEENT	☐ Double vision ☐ Loss of vision ☐ Blind spot in vision ☐ Pink or red eye ☐ Impaired vision ☐ Visual changes ☐ Nosebleed ☐ Difficult to swallow ☐ Hoarseness ☐ Oral ulcers	☐ Gum bleeding ☐ Dry mouth ☐ Sore throat ☐ Runny nose ☐ Mouth pain ☐ Sinus pain ☐ Ringing in the ear ☐ Dizziness ☐ Hearing changes	
Chest/Lungs	☐ Cough ☐ Coughing up bloody mucus ☐Difficulty Breathing	☐ Wheezing ☐ Chest pain when you take deep breaths	
Cardiovascular	☐ Chest pain ☐ Palpitations ☐ Shortness of breath	☐ Swelling in the arm(s) ☐ Swelling in the leg(s)	
Gastrointestinal	☐ Abdominal pain ☐ Abdominal cramping ☐ Nausea ☐ Vomiting ☐ Vomiting blood ☐ Constipation ☐ Diarrhea	☐ Blood in stool ☐ Tarry stools ☐ Yellow skin/eyes ☐ Heartburn ☐ Difficulty swallowing ☐ Loss of appetite ☐ Excessive thirst.	
Genitourinary	☐ Difficulty urinating ☐ Blood in urine ☐ Need to urinate at night	☐ Inability to control urination ☐ Frequent urination	
Neurologic	☐ Confusion ☐ Seizures ☐ Fainting	☐ Dizziness ☐ Migraines ☐ Numbness	

Patient Registration Form (Part 2)

Body Systems	Check all that apply:		Provider Comments
	☐ Tremor ☐ Speech change ☐ Headache ☐ Hiccups ☐ Weakness	☐ Tingling ☐ Changes in coordination or balance ☐ Experience instability leading to falls	
Musculoskeletal	☐ Muscle pain ☐ Swollen joints	☐ Joint redness ☐ Back pain	
Lymph Nodes	☐ Enlargement of lymph nodes		
Endocrine	☐ Hot flashes	☐ Feeling cold	
Allergic / Immunologic	☐ Eczema – red and/or itchy skin ☐ Frequent respiratory infections	☐ Hives ☐ Frequent skin infections	
Psychiatric	☐ Depression ☐ Anxiety	☐ Change in concentration ☐ Change in sleep	
Other Notes:			

Pain Assessment How would you rate your pain on a scale of 0 to 10?



Location of Pain		Provider Comments
What makes it better?		
What makes it worse?		

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE.

Daily Activity Questionnaire

Patient Name: _____ Date:_____

Sedentary Behavior (sedentary activities: watching TV, at a computer, talking on the phone, reading)

- ☐ 1 Most of the day
- ☐ 2 Half of the day
- ☐ 3 Some of the day
- ☐ 4 Rarely

Activities of Daily Living (going to the bathroom, showering, eating)

- ☐ 1 Needs some assistance
- ☐ 2 Slight difficulty
- ☐ 3 Minimal difficulty
- ☐ 4 No problem

Laundry

- ☐ 1 Unable
- ☐ 2 Occasionally
- ☐ 3 Regularly in small steps or with help
- ☐ 4 Regularly without help

Cooking

- ☐ 1 Unable to prepare meals
- ☐ 2 Take-out, breakfast, or simple lunch only
- ☐ 3 Simple microwave or crock-pot meal
- ☐ 4 No problem/regular meals

Housekeeping/Lawn and Garden

- ☐ 1 Unable
- ☐ 2 Light dusting, straighten up
- ☐ 3 Regular housekeeping in smalls steps or with help
- ☐ 4 Fully capable

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE.

Grocery Shopping

- ☐ 1 Unable
- ☐ 2 Occasional (once or twice per month)
- ☐ 3 Frequent, but with assistance
- ☐ 4 No problem

Social Activities (church, temple, family and friends)

- ☐ 1 No longer able
- ☐ 2 Occasional (once or twice per month)
- ☐ 3 Frequent, but with assistance
- ☐ 4 No problem

Driving

- ☐ 1 Unable
- ☐ 2 Very limiting
- ☐ 3 Cautious, local trips
- ☐ 4 Distant trips/traffic

Errands or Light Chores (post office, drop off a child)

- ☐ 1 None
- ☐ 2 One per day
- ☐ 3 Two to three per day
- ☐ 4 No or few restrictions

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE.

Advance Care Planning and Directives Questionnaire

Patient Name:	

Advance Care Planning is a process that helps people learn about the types of healthcare-related decisions that might be needed in the event that they become unable to participate directly in their care. This process allows people to consider those decisions ahead of time; to communicate and share with family, providers and others as needed; and to document their decisions with advance directives. A person may review these documents from time to time to ensure that the advance directives appropriately reflect his or her wishes.

Advance directives include legal documents that go into effect **only** if a person is incapacitated and unable to speak for himself or herself. This could be the result of the person's disease or severe injury—no matter how old the person is. It helps others know what type of medical care the person has determined is best for them. It also allows a person to express their values and desires related to end-of-life care. An advance directive, whether it is a Medical Power of Attorney, a Directive to Physicians (sometimes called a "Living Will"), or other Orders, is a living document—one that can be adjusted as a situation changes because of new information or a change in health.

Mary Crowley would like to learn more about your Advance Care Planning and directives to ensure that our providers and clinical team are aware of your wishes and to help provide you with information related to this topic, as needed. We understand that this topic is difficult for many patients and if you do not wish to complete this questionnaire or provide any further information, we will understand.

Instructions: Please complete the following questions by checking the appropriate box:

Question	Response
1. Do you have a Medical Power of Attorney? 2. Do you have a Living Will?	☐ Yes ☐ No ☐ Yes ☐ No
3. If **yes** to #1 and/or #2, can you bring a copy of the documents to Mary Crowley to be included in your medical record?	☐ Yes ☐ No
4. Who have you decided will make medical decisions for you when you are unable to make decisions?	Name: _____ Relationship: _____ Phone: _____
5. Would you like to learn more about this topic? Our Social Worker will provide informational documents to you for review.	☐ Yes ☐ No

MARY CROWLEY
CANCER RESEARCH CENTERS
HOPE LIVES HERE.

Request for Release of Information from Medical Records

Patient Name		**DOB**	

The patient listed above has been referred to the Mary Crowley Cancer Research. Please release the selected medical records to the location checked below.

- ☐ Entire medical record
- ☐ All Consult and Progress Reports
- ☐ All Radiation records (including flow sheets)
- ☐ All CT scan, X-Ray, MRI and Bone Scan report along with a CD (or send films only if CD is not available)
- ☐ Last 3 months of lab reports
- ☐ All Pathology Reports
- ☐ All previous & current treatment records (ex. chemotherapy infusion record/flowsheets)
- ☐ A complete list of medications including supplement
- ☐ Other:

_____

_____

_____

Mailing Address and Contact Information	☒ 7777 Forest Lane, Building C 707 Dallas, TX 75230 (Tel) 972-566-3000 - (Fax) 972-566-3099

Thank you for your assistance.

Patient Signature:	
Date:	

NOTICE OF PRIVACY PRACTICES

Effective September 23, 2022

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

At Mary Crowley Cancer Research, we believe that your health information is personal. We keep records of the care and services that you receive at our facilities. We are committed to keeping your health information private, and we are also required by law to respect your confidentiality.

This Notice describes the privacy practices of Mary Crowley Cancer Research (Mary Crowley). This Notice applies to all of the health records that identify you and the care you receive at Mary Crowley. We are legally required to give you this Notice and to follow the terms of the Notice that is currently in effect.

At any time, you have the right to choose someone to act for you. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you.

We are required by law to maintain the privacy and security of your protected health information, and we will let you know promptly if a breach occurs that may have compromised this. The physicians and other caregivers at Mary Crowley who are not employed by Mary Crowley exchange information about you as a patient with Mary Crowley employees. These healthcare practitioners may also give you other privacy notices that describe their office practices.

All of these medical staff and caregivers may share your health information with each other for reasons of treatment, payment, and healthcare operations as discussed below.

HOW MARY CROWLEY MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

When you become a patient of Mary Crowley, we will use your health information within Mary Crowley and disclose your health information outside Mary Crowley for the reasons described in this Notice. The following categories describe some of the ways that we will use and disclose your health information.

Treatment. We use your health information to provide you with healthcare services. We may disclose your health information to physicians, nurses, technicians, medical or nursing students, or other persons at Mary Crowley who need that information to take care of you. For example, a physician treating you for a broken leg may need to ask another physician if you have diabetes because diabetes may slow the leg's healing process. This may involve talking to physicians and others not employed by us. We also may disclose your health information to people outside Mary Crowley who may be involved in your healthcare, such as treating physicians, home care providers, pharmacies, drug or medical device experts, and family members.

Payment. We may use and disclose your health information so that the healthcare you receive may be billed and paid for by you, your insurance company, or another third party. For example, we may give information about surgery you had here to your health plan so it will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive so we can get prior payment approval or learn if your plan will pay for the treatment.

NOTICE OF PRIVACY PRACTICES

Effective September 23, 2022

Healthcare Operations. We may use your health information and disclose it outside Mary Crowley for our healthcare operations. These uses and disclosures help us operate Mary Crowley to maintain and improve patient care. For example, we may use your health information to review the care you received and to evaluate the performance of our staff in caring for you.

We also may combine health information about many patients to identify new services to offer, what services are not needed, and whether certain therapies are effective. We may also disclose information to physicians, nurses, technicians, medical students, and other persons at Mary Crowley for learning and quality improvement purposes. We may remove information that identifies you so people outside Mary Crowley may study your health data without knowing who you are.

Contacting You. We may use and disclose health information to reach you about appointments and other matters. We may contact you by mail, telephone or email. For example, we may leave voice messages at the telephone number you provide us, and we may respond to your email address.

Health-Related Services. We may use and disclose health information about you to send you mailings about health-related products and services available at Mary Crowley.

Philanthropic Support. We may use general demographic information about you, such as name, address and phone number, and dates you received services from us to contact you in an effort to raise donations to support Mary Crowley and its operations. If you do not want the practice or fundraising staff to contact you for fundraising activities, please notify your main point of contact for the clinical trial or email privacy@marycrowley.org.

Medical Research. We perform medical research. Our clinical researchers may look at your health records as part of your current care, or to prepare or perform research. They may share your health information with other Mary Crowley researchers. All patient research conducted at Mary Crowley goes through a special process required by law that reviews protections for patients involved in research, including privacy. We will not use your health information or disclose it outside Mary Crowley for research reasons without either getting your prior written approval or determining that your privacy is protected.

Legal Matters. We will disclose health information about you outside Mary Crowley when required to do so by federal, state, or local law, or by the court process. We may disclose health information about you for public health reasons, like reporting births, deaths, child abuse or neglect, reactions to medications or problems with medical products. We may release health information to help control the spread of disease or to notify a person whose health or safety may be threatened. We may disclose health information to a health oversight agency for activities authorized by law, such as for audits, investigations, inspections, and licensure.

NOTICE OF PRIVACY PRACTICES

Effective September 23, 2022

AUTHORIZATIONS FOR OTHER USES AND DISCLOSURES

As described above, we will use your health information and disclose it outside Mary Crowley for treatment, payment, healthcare operations, and when permitted or required by law. We can use or share health information about you to address worker's compensation claims, for law enforcement purposes, or in response to a lawsuit or other legal action. We will also share health information about you with organ procurement organizations and with a coroner, medical examiner or funeral director in the event of death. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. We are not allowed to disclose genetic information without your written consent. We are allowed to disclose HIV/AIDS-related information and child and/or adult abuse information only (1) under certain limited circumstances and/or (2) to specific recipients. We will not use or disclose your health information for *other* reasons without your written authorization. For example, you may want us to release medical information to your employer or to your child's school. These kinds of uses and disclosures of your health information will be made only with your written authorization. You may revoke the authorization, in writing, at any time, but we cannot take back any uses or disclosures of your health information already made with your authorization.

We may not use, disclose, or sell your protected health information for marketing purposes without your permission. You may be removed from any mailing list of Mary Crowley upon your written request.

YOUR RIGHTS REGARDING HEALTH INFORMATION

Right to Accounting. You may request an accounting, which is a listing of the entities or persons (other than yourself) to whom Mary Crowley has disclosed your health information without your written authorization.

The accounting would not include disclosures for treatment, payment, healthcare operations, and certain other disclosures exempted by law. Your request for an accounting of disclosures must be in writing, signed, and dated. It must identify the time period of the disclosures and the Mary Crowley facility that maintains the records about which you want the accounting. We will not list disclosures made earlier than 6 years before your request. Your request should indicate the form in which you want the list (for example, on paper or electronically). You must submit your written request to the medical records department of Mary Crowley. We will respond to you within 60 days.

We will give you the first listing within any 12-month period free, but we will charge you for all other accountings requested within the same 12 months.

Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you have the right to ask us to amend your medical records. Your request for an amendment must be in writing, signed, and dated. It must specify the records you wish to amend, identify the Mary Crowley facility that maintains those records, and give the reason for your request. You must address your request to the Privacy Official of Mary Crowley that maintains the records you wish

to amend. Mary Crowley will respond to you within 60 days. We may deny your request; if we do, we will tell you why and explain your options.

Right to Inspect and Obtain Copy. You have the right to inspect and obtain a copy of your completed health records unless your physician believes that disclosure of that information to you could harm you. You may not see or get a copy of information gathered for a legal proceeding or certain research records while the research is ongoing. Ask us how to do this. We may charge a fee for processing your request. We will respond to you within 15 business days of your written request. If Mary Crowley denies your request to inspect or obtain a copy of the records, you may appeal the denial within Mary Crowley.

Right to Choose Someone to Act for You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Right to Request Restrictions. You have the right to ask us to restrict the uses or disclosures we make of your health information for treatment, payment, or healthcare operations, but we do not have to agree. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

You also may ask us to limit certain health information that we use or disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Again, we do not have to agree. A request for a restriction must be signed and dated, and you must identify the Mary Crowley facility that maintains the information. The request should also describe the information you want restricted, say whether you want to limit the *use* or the *disclosure* of the information *or both*, and tell us who should not receive the restricted information. You must submit your request in writing to the medical records department of the Mary Crowley facility that maintains the information you want restricted.

We will tell you if we agree with your request or not. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request for confidential communications must be in writing, signed, and dated. It must identify Mary Crowley as making the confidential communications and specify how or where you wish to be contacted. You need not tell us the reason for your request, and we will not ask. You must send your written request to the medical records department of Mary Crowley making the confidential communications. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this

NOTICE OF PRIVACY PRACTICES

Effective September 23, 2022

Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a paper copy of this Notice at any of our facilities or by calling Mary Crowley.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Mary Crowley or with U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** To file a complaint with Mary Crowley, you must submit your complaint in writing to the Privacy Office. You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE

Mary Crowley may change this Notice at any time. Any change in the Notice could apply to medical information we already have about you, as well as any information we receive in the future. The new notice will be available upon request, on our website, and in our offices.

If you have questions about this Notice, you may telephone the number shown below for the Privacy Official.

MARY CROWLEY CANCER RESEARCH CENTERS OFFICES:

- Mary Crowley Medical Research Center dba Mary Crowley Cancer Research Centers, 7777 Forest Lane, Building C 707, Dallas, TX 75230
- Mary Crowley Cancer Research Centers, 12222 Merit Drive, Suite 1500, Dallas, TX 75251

MARY CROWLEY PRIVACY OFFICIAL

Contact Name: Michelle Richey
Address: Mary Crowley Cancer Research, 7777 Forest Lane, C-707, Dallas, TX 75230
Contact Number: 972-566-3000
E-mail: mrichey@marycrowley.org
Privacy email: privacy@marycrowley.org

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), as updated by the 2013 HIPAA Final Omnibus Rule, I have certain rights to privacy regarding my protected health information.

I have been provided Mary Crowley's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (a copy for my records is available in office in print form). I have been given for my review such Notice of Privacy Practices prior to signing this acknowledgement. I understand that Mary Crowley has the right to change its Notice of Privacy Practices from time to time and that I may contact Mary Crowley at any time at the address below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may revoke this consent in writing at any time, except to the extent that Mary Crowley has taken action relying on this consent.

Name (please print): ________________________________

Signature: _________________________________

Date: ___________________________

I am a parent or legal guardian of _________________(patient name). I have received a copy of Mary Crowley's Notice of Privacy Practices effective September 23, 2022

Name (please print): ________________________________

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _________________________________

Date: ___________________________

Mary Crowley Cancer Research
7777 Forest Lane, C-707
Dallas, Texas 75230
www.marycrowley.org
972.566.3000

****

[note on second page]

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective [date] given to individual on _____, (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation

_____

☐ Telephone contact

_____

☐ Mailing _____

☐ Email _____

☐ Other _____

Staff Name (please print): _____

Title: _____

Signature: _____

Date: _____

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Notification & Acknowledgement of Patient Financial Responsibilities

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

To find out what your insurance plan covers and what your financial obligation may be, you will meet with a Texas Oncology financial counselor on the day of your initial visit. You may also call the customer service or member services department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance.

Mary Crowley Cancer Research is an independent tax-exempt charity engaged in medical research. The medical staff at Mary Crowley is employed by Texas Oncology PA under a service agreement by which Texas Oncology PA also performs billing services.

Patients with insurance questions or concerns at Mary Crowley Cancer Research– Medical City may also contact the Texas Oncology Business Office at 1-855-425-9808.

While you may have insurance coverage to pay your medical bills, you are ultimately responsible for all charges. You are responsible to notify us of your insurance and to provide the necessary information about your insurance plan; therefore, please have your current insurance card with you at all times, as well as a photo ID such as a driver's license, military ID, or government issued ID.

Make sure that both your physician and hospital are listed as a participating provider by your insurance company. It is possible that only the physician or only the hospital participates with your insurance plan. If not listed, contact your plan's customer service department to verify.

It is your responsibility to know your insurance company's patient responsibilities and procedures. If proper procedures are not followed, you may be liable for full payment of the bill. If your insurance company requires a referral and/or prior authorization, contact your primary care physician prior to seeing a specialist.

A referral may be required to see a specialist, while a prior authorization is usually required for laboratory tests or medical procedures.

If your insurance company requires a referral and/or prior authorization and you do not have one, you may not be seen for your scheduled appointment, or you will be responsible for full payment of your bill at the time of service.

If your specialist requires more visits than your insurer approves or if the referral has expired, you must contact your primary care physician for another referral and/or prior authorization.

At Mary Crowley Cancer Research, all consult or re-consult visits are billed to your insurance company. You may be responsible for co-insurance or a co-payment amount. Subsequent screening and treatment visits will be billed per details noted in the “What are the Costs” section of the informed consent form you sign. The clinic staff will go over this section during the informed consent process and prior to you signing the consent form. If you disagree, have questions or need clarification regarding the costs that may be billed to you or your insurance company, please notify the clinic staff prior to signing the consent form.

MARY CROWLEY CANCER RESEARCH
HOPE LIVES HERE™

Notification & Acknowledgement of Patient Financial Responsibilities

If you are admitted to the hospital during the course of your participation in the study and the hospital admission is not required by the study, you or your insurance company will be responsible for cost of your hospital stay. If you don't have insurance, you will be admitted to the nearest county hospital. Mary Crowley is not responsible for costs related to your hospital stay.

Acknowledgement: I acknowledge I have read and fully understand my financial responsibilities and have had all my questions answered. I do hereby expressly guarantee payment in full of any and all charges incurred for services rendered or to be rendered to me. Further, I agree to pay all attorney fees and court costs incurred by Mary Crowley in the collection of amounts for which I am responsible. I understand that a copy of this agreement is available upon request. I authorize the release of any medical or other information necessary to process this health insurance claim. I also request payment of benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider for services provided.

Signature: _____

Print Name: _____

Date: _____

Patient Name: _____ **DOB:** _____ **MRN:** _____

TREATMENT & PRESCRIPTION CONSENT

I consent to evaluation, testing and treatment as directed by my physicians or his/her designee. I understand that this includes all Texas Oncology locations.

Telemedicine:

You have the right, as a patient, to be informed about your treatment options, including whether to receive telemedicine services. This disclosure is to make you more knowledgeable to decide whether to give or withhold your consent to receive telemedicine services.

I understand that my treating provider believes it would be beneficial for me to receive services from the Telemedicine Provider through a live, interactive video conference without having to travel to the Telemedicine Provider's location. Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the Telemedicine Provider to see and communicate with the patient in real-time.

Treatment via telemedicine consultation is similar, but not identical, to an in-person consultation, but unlike an in-person visit, the Telemedicine Provider can only see my image and hear my voice and does not have the benefit of his/her other senses, so a limited physical examination will take place during the video conference. I understand that persons other than the Telemedicine Provider may be present at the telemedicine site in order to operate the video equipment, and they will take reasonable steps to maintain confidentiality of the information obtained. I may choose to: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask the non-medical personnel to leave the telemedicine room; and/or (3) terminate the video conference at any time.

Potential Benefits of Telemedicine Services:

1. Access to care is improved by enabling me to obtain the Telemedicine Provider's expertise without having to travel to the Telemedicine Provider's location.
2. Medical services can be delivered more efficiently.

Possible Risks of Telemedicine Services:

1. The video connection may not work or may stop working during the visit.
2. The audio or video transmission may not be clear enough to be relied upon.
3. My medical data may be intercepted by an unauthorized party during transmission.
4. Technical failures may cause delays in medical evaluation and treatment or loss of information.

If any of these issues occur, the services may be stopped. Texas Oncology will attempt to reestablish the service or, if that is not possible, reschedule the visit. No warranty or guarantee is made as to the outcome of receiving telemedicine services.

I understand that the responsibility for operation of the technology involved in a telemedicine consultation occurring at my home (if applicable) remains with me, and the responsibility for operation of the technology involved at the Telemedicine Provider's site remains with Texas Oncology.

Patient Name: _____ **DOB:** _____ **MRN:** _____

I acknowledge I will receive a bill from the Telemedicine Provider. I understand (check one):

☐ My health plan(s) cover(s) telemedicine services, but I am still responsible for and agree to pay my portion of the charges for covered services under my health plan(s), including deductibles and co-payments.

☐ My health plan(s) do(es) not cover telemedicine services. I have previously received and signed a form acknowledging my financial responsibility for the Telemedicine Provider's services.

I have read this document and understand the risks and benefits of telemedicine services. Ihave had the opportunity to have my questions answered, and I consent to receive telemedicine services from the Telemedicine Provider. I authorize the release of any relevant medical information about me to the Telemedicine Provider, staff of the Telemedicine Provider, and my healthcare plan/payer (if applicable).

☐ I consent to the sharing of the results/notes from my Telemedicine appointment with my Primary Care and/or Referring physician(s).

Prescriptions:

In addition, I voluntarily consent to provide Texas Oncology access to and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Texas Oncology may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this consent will be valid and remain in effect as long as I attend or receive services from Texas Oncology, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I certify that I have read this for, or I has been read to me.

Signature of Patient/Legally Authorized Representative: _____ Date:_____

Relationship to Patient (if Patient not signing): _____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader/Translator Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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.

About Us
In this Notice, we use terms like "we," "us," "our," or "Practice" to refer to **Texas Oncology**, its physicians, employees, staff and other personnel. All of the sites and locations of **Texas Oncology** follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

Purpose of This Notice
This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities
We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information without your written authorization:
For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another health care provider to be sure they have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company, or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third-party "business associates" that perform various services on our behalf, such as transcription, billing, and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

We may ask you to sign your name to a sign-in sheet at the registration desk, and we may call your name in the waiting room when we call you for your appointment.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Individuals Involved in Your Care or Payment for Your Care and Notification: If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

If you would like us to refrain from releasing your health information to a family member or friend who is involved in your care, you must make your request in writing and submit it to the Medical Records Manager of your local Texas Oncology office.

We may use or disclose your information to notify or assist in notifying a family member, personal representative, or any other person responsible for your care regarding your physical location within the Practice, general condition, or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status, and location.

We are also allowed to the extent permitted by applicable law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state, or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:
- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the identity, description, and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:
- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- Activities related to the quality, safety, or effectiveness of FDA-regulated products;
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement authorities to identify or apprehend an individual.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation, or banking of organs, eyes, or tissues.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the president and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing your health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.
- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.
- Sale of Your Health Information: We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information
You have the following rights regarding the health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment, or health care operations. **In most circumstances, we are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to your local Texas Oncology office. We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to your local Texas Oncology office. We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to your local Texas Oncology office. You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to your local Texas Oncology office.

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to your local Texas Oncology office. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact your local Texas Oncology office. You may also obtain a paper copy of this Notice at our website, www.TexasOncology.com

Changes to This Notice
We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the waiting area of your local Texas Oncology office. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, www.TexasOncology.com

Complaints
If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: **Texas Oncology at 1-888-864-ICAN (4226) and ask for the Privacy Officer**. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

Questions
If you have questions about this Notice, please contact **Texas Oncology at 1-888-864-ICAN (4226) and ask for the Privacy Officer**.

Patient Name: _____ **DOB:** _____ **MRN:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Oncology is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. **Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.**

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Oncology.

Patient Name (Please Print): _____

Signature of Patient/Legally Authorized Representative: _____

Date: _____

Relationship to Patient (if Patient not signing): _____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader/Translator Signature: _____ Date: _____

Texas Oncology Use Only
Date Acknowledgement Received: _____

-OR-

Reason acknowledgment was not obtained:

_____

_____

_____

Please return completed form to the appropriate physician's office.

Patient Name: _____ **DOB:** _____ **MRN:** _____

AUTHORIZATION TO RELEASE INFORMATION

I consent to the verbal release of information about my health with the people listed below. This may include any information about my health status, including my condition, symptoms, test results, medications, billing, and scheduling.

Contact Name: _____

Relationship to patient: _____

Phone Number: _____

Check this box to make this your emergency contact ☐

Contact Name: _____

Relationship to patient: _____

Phone Number: _____

Check this box to make this your emergency contact ☐

I understand this authorization will remain in effect until revoked by me in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information have acted in reliance on this authorization.

_____ _____

Signature of Patient / or Personal Representative Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____ _____

Name of Personal Representative Relationship to Patient

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

_____ _____

Reader/Translator Signature Date

Please return completed form to the appropriate physician's office.