



Caring for People with Cancer

6600 66th St. N.
Pinellas Park, FL 33781

Frank L. Franzese, M.D.

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Board Certified in Radiation Oncology

**PLEASE FILL OUT THE
ENCLOSED FORMS AND
BRING THEM WITH YOU TO
YOUR APPOINTMENT**

Dear Mr., Mrs., Ms., Dr. _____,

We welcome you to WellSpring Oncology. Thank you for the trust you are placing in us to be your caregivers.

This information packet is designed to introduce you to our physicians, staff, Center and the integrated services we offer. In addition, the packet contains three important forms that we ask you to complete *before your first visit*:

- **Patient History**--This important information will allow your doctor to better understand your medical, family and social history.
- **Assignment of Benefits**
- **Consent Forms**

You will also find your "Patient Rights and Responsibilities" that we encourage you to examine carefully. "Advanced Directives" are also available to you upon request. We have worked very hard to assemble the finest and most caring medical professionals for your personal care. At any point, should you have questions or concerns, feel free to ask any of us. It will be our privilege to help you.

The relationship patients have with their doctors is deeply personal. You have our promise that we will consult with you prior to any treatment so you can make informed choices. We invite you to include your family in this consultation process as well.

We believe in treating the whole person, not just the disease. There are numerous educational and psychosocial resources we can make available to you. Support groups are also a vital part of WellSpring and we offer meetings for patients, caregivers and families. We also have a counselor available for one-on-one support for those who would find it helpful. Please ask any questions you might have at any time during your treatment with us at WellSpring. We are open Monday-Friday from 8:00a.m. to 5:00p.m. You may also call our WellSpring concierge for assistance.

Should you have an emergency that is life threatening, please call 911. Your physician can also be reached after office hours by dialing 727-343-0600.

Warmest regards,

Frank L. Franzese, M.D., Debra Freeman, M.D., Craig R. Miercort, M.D. Robert J. Miller, M.D. & Zucel Solc, M.D.



Welcome to WellSpring Oncology! We appreciate your confidence in choosing our organization to provide you with the best radiation treatment and care available. We will make every effort to offer you care and compassion during your course of treatment and follow-up.

We understand the expense associated with the treatment of cancer can be overwhelming, especially if surgery and chemotherapy is also involved. We will always bill your insurance first. If there is any patient responsibility we will bill you. We offer various payment methods including credit card, check, debit card, cash, money order and payment plans for your co-pays and deductibles due. If you are a self-pay patient, please see me for assistance.

Should you have the need for financial assistance, please see the list of organizations below and attached:

Chronic Disease Fund:	1-877-968-7233	www.pparx.org
Partnership for Prescription Assistance:	1-888-477-2669	www.copays.org
Patient Advocate Foundation:	1-800-532-5274	www.patientadvocate.org
American Cancer Society:	1-800-227-2345	www.cancer.org
The HealthWell Foundation:	1-800-675-8416	www.healthwellfoundation.org
Senior Life Services:	1-800-548-3249	

Our payment plans do not charge interest and are handled "in-house." Please see me for details should you be interested in arranging a payment plan.

WellSpring has also established a fund called "The Giving Tree" to assist patients in need with some of their daily living expenses. The Giving Tree is a small, non-tax deductible fund. Please see any of our staff for more information. We have numerous fund raisers during the year and encourage patients and their families to participate or just come and watch! The events are on the calendar in the lobby and highlighted in our newsletter.

Warmest regards,

Janet McNamara
Patient Financial Coordinator
(727) 344-6240

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Patient's Name: _____ Today's Date: _____
Last First M.I. () Home Telephone

Home Address: _____ Mailing Address: _____
Street Street
City State Zip City State Zip

Date of Birth Age M F Sex Social Security Number Single Married Divorced Widowed
Marital Status

Email address: _____ **(Will only use to inform you of important WellSpring events)**

Race: Caucasian _____ Black _____ Asian _____ Hispanic _____ Other (specific) _____

Employer: _____ () _____
Name Telephone
Address Occupation

Responsible Party: _____ () _____
Name Relationship Telephone

Emergency Contact: _____ () _____
Name Relationship Telephone

Referring M.D. _____ Primary Care M.D. _____

Other physicians involved in your care: _____

- If You have Hospice or are in a Skilled Nursing Facility Please Tell the Front Desk -

Primary Ins: _____ Telephone: () _____

Insured Name: _____ DOB: _____ Group#: _____ Policy #: _____

Secondary Ins: _____ Telephone: () _____

Insured Name: _____ DOB: _____ Group#: _____ Policy #: _____

- I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
- I authorize my insurance carrier to release information regarding my coverage to Well Spring Cancer Center, L.L.C. (WSCC).
- My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to WSCC. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payment to WSCC.
- I understand that I have a right to request and receive a Notice of Privacy Practices from WSCC.

This Agreement/Consent Shall Remain In Effect Unless Revoked By Me In Writing

I have read and received a copy of the above statement and accept the terms. A duplicate of the statement is considered the same as original.

 Patient's Signature Date/Time: _____ a.m./p.m.
Circle one

 Responsible Party Signature Relationship Date/Time: _____ a.m./p.m.
Circle one

 Witness Date/Time: _____ a.m./p.m.
Circle one



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize WellSpring Cancer Center to use and disclose in any form or format a copy of the entire medical record concerning individual but only as follows to: _____ for the purpose(s) of (be specific) _____. I specifically authorize you to use and disclose the following types of super-confidential information (initial where appropriate). A copy of this signed, dated authorization shall be as effective as the original.

_____ HIV Records (including HIV test results) and sexually transmissible diseases

_____ Alcohol and substance abuse diagnosis and treatment records

_____ Psychotherapy records

PLEASE CHECK ONE:

The undersigned does hereby release, hold harmless and agree to indemnify WellSpring Cancer Center, its employees and agents for any and all liability (included but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until WellSpring Cancer Center is in actual receipt of a signed revocation or until the records retention period required under Federal and Florida Law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or receipt of this signed authorization; and that I may refuse to sign this authorization.

I do not authorize this information be released.

Print Patient Name

Signature of Patient

Date _____

Print Patient's Representative

Signature of Patient's Representative

Relationship to patient

Date _____



6600 66th Street North
Pinellas Park, FL 33781

Frank P. Franzese, MD
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Robert J. Miller, MD
Craig R. Miercort, MD
Zucel Solc, MD

Consent to Use and Disclose Health Information
Acknowledgement of Receiving the Notice of Privacy Practices

I understand that WellSpring Oncology is a healthcare provider and that they may share my health information for treatment, billing and healthcare operations. I have been given a copy of WellSpring's Notice of Privacy Practices that describes how my health information is used and shared. I understand WellSpring Oncology has the right to change this notice at any time. I may obtain a current copy by contacting the Front Desk or by visiting the Web site at www.wellspringoncology.org.

I hereby authorize all WellSpring Oncology physicians and/or staff to discuss my medical condition and treatment plan with the following people:

_____	_____	_____
Name of person	Relationship to patient	Phone Number
_____	_____	_____
Name of person	Relationship to patient	Phone Number
_____	_____	_____
Name of person	Relationship to patient	Phone Number
_____	_____	_____
Name of person	Relationship to patient	Phone Number

I understand this consent to disclose my health information may be revoked and/or changed in writing at any time. **Unless the above names are changed by me, this authorization will never expire.**

My signature below also constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

Signature of Patient or Legal Representative

Date

Print Patient Name

If signed by legal representative, relationship to patient : _____



DIRECTIONS TO WELLSRING

**6600 66th Street North
Pinellas Park, FL 33781**

We are at the cross roads of 66th Street North and 66th Avenue North.

From the South: Take any east-west avenue to 66th Street North and turn north on 66th Street North. We are the cross street just north of the Tampa Bay Orthopedic Surgery Center with a teal colored metal roof. Turn left on 66th Avenue and then right in the second driveway.

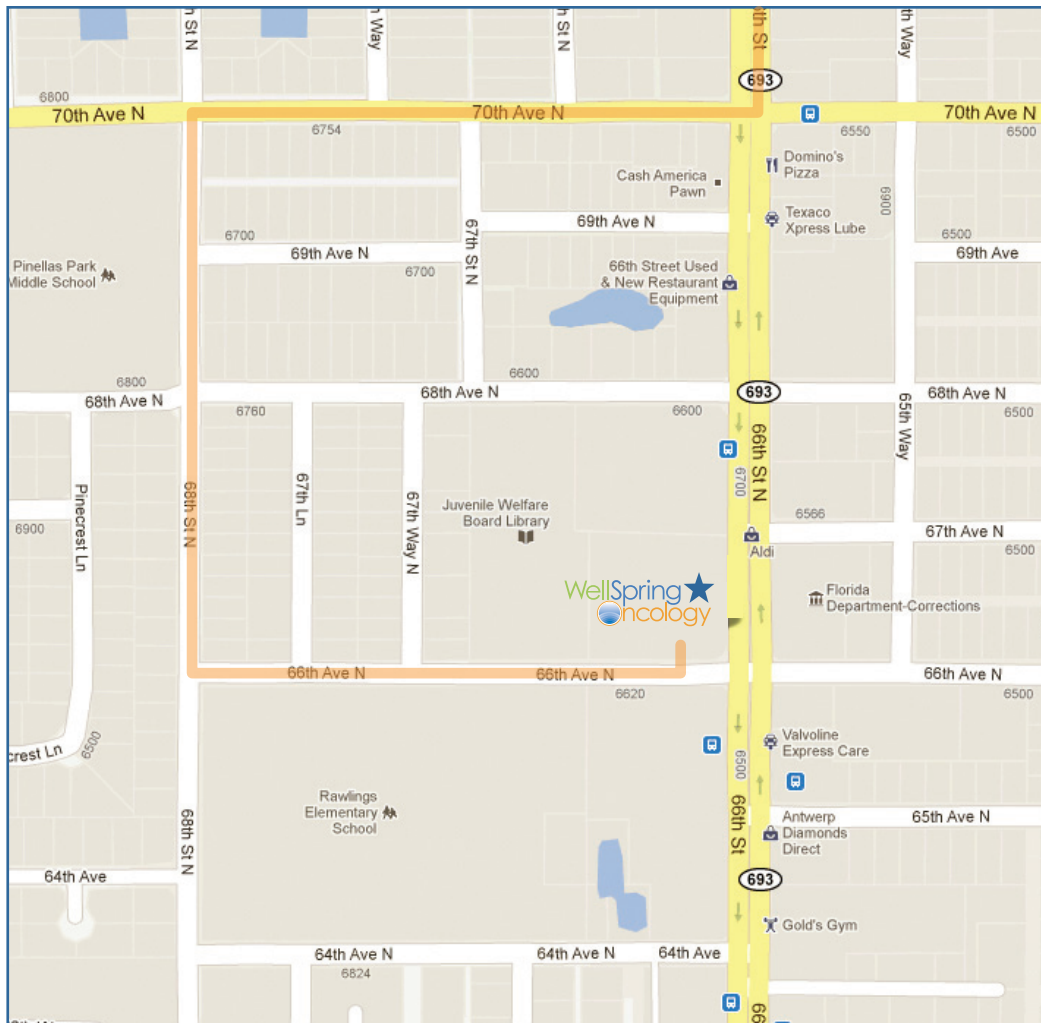
North County: Go south on U.S. 19 and get off on the St. Pete Beach exit. This is 66th St. North. Travel about 5 miles past Bryan Dairy Rd. and Park Blvd to 66th Avenue North, turn right and then right into the second driveway.

Clearwater: Go south on Belcher Rd. and turn left on Park Blvd. and take it to 66th Street North. Turn right by the St. Pete College Health Education Building. Go down 3 blocks to 66th Avenue North and turn right and then right into the second driveway.

I-275: Take the Park Blvd/Gandy Blvd exit and head west on Park Blvd. to 66th Street North. Turn left or go south on 66th Street North to 66th Avenue (about 3 blocks) and turn right and then right into the second driveway.

Thank you for letting us care for you. To ensure your safety as you visit us, please find the following driving directions for your convenience.

How to Get Back on 66th Street North



Directions from WellSpring Oncology Parking Lot

Turn RIGHT on 66th Ave. N

Turn RIGHT on 68th St. N

Turn RIGHT on 70th Ave. N

Turn LEFT at the STOP LIGHT on 66th St. N

Health History Questionnaire

6600 66th St. N. Pinellas Park, FL

Name: _____ D.O.B.: _____ Date: _____

Referring Physician: _____ Family Physician: _____

Other physicians involved in your care: _____

In order for us to develop a comprehensive treatment plan, we need to clearly and completely understand your current and past medical history. In preparation for your consultation with Dr. _____, please take a moment to provide the following information. Everything disclosed here will be kept **strictly confidential**, but please feel free to leave blank any areas you are unsure on or do not wish to provide.

What is your primary medical reason (diagnosis) that brings you to our office? _____

Please give a brief history of your current problem (when it started; symptoms; impact on daily living):

Have you received any treatment for your **current** diagnosis of cancer? (*Please **list** the type and date of treatment you have received including **prior surgery, chemotherapy, hormone therapy, radiation treatment and/or complimentary/alternative therapies**.*)

Type of Treatment for <u>Current</u> Cancer	Date of Treatment

Allergies: ___ Yes ___ No (*If yes, please list below*)

Type of Allergy	Description of Reaction

Medications including vitamins, minerals, herbal and nutritional supplements: (Please list and bring to appt.)

Medication/Supplement	Dose	Frequency (times per day)	Started	Stopped

Medical History: (Please check all current or previous illnesses or conditions.)

- | | |
|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Glaucoma/Cataracts | <input type="checkbox"/> Jaundice/Liver Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Prostate Problems/BPH |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Alzheimers/Dementia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Emotional/Mental Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Pacemaker/Defibrillation | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood disorder/Blood Clots |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Bone Disease/Osteoporosis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Heart Murmur | Specify _____ |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cancer (Specify Type and Treatment: _____) |
| <input type="checkbox"/> Heartburn/Reflux | _____ |
| <input type="checkbox"/> Irritable Bowel Syndrome | _____ |
| <input type="checkbox"/> Colitis/Chrohn's | _____ |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Other _____ |

Surgical Procedures, Previous Hospitalizations, and Tests/Exams:

(Please check all that applies and specify where and when)

___ Biopsy: *Where(What Facility)?* _____ *When (Date)?* _____

___ Colonoscopy: *Where (What Facility)?* _____ *When (date)?* _____

Gynecologic:

___ Mammogram: *Where (What Facility)?* _____ *When (date)?* _____

___ Pap Smear: *Where (What Facility)?* _____ *When (date)?* _____

Other Surgical Procedures, Previous Hospitalizations, and Tests/Exams:

What (Procedure)?	Where was it done?	When was it done (Date)?

Social History:

What is/was your occupation? _____

Are you retired? _____ Education through grade? _____

Have your been exposed to any chemicals or radiation? _____

Whom do you live with? _____

Do you have children and their ages? _____

Hobbies/Exercise: _____

Spiritual/Religious Practices or Needs: _____

Do you have Transportation/Financial Needs? _____

Tobacco Use (past or present): ___ **Yes** ___ **No** If you indicated **Yes** , list the type of tobacco products you have or currently use and amount per day, the date/age you started and stopped(if applicable):

Exposure to second-hand smoke: ___ **Yes** ___ **No**

Alcohol Use: ___ **Yes** ___ **No** If you indicated **Yes**, list the type and amount of alcohol you currently or previously drank and the date/age you started and/or you quit:

Family History of Cancer: (*Type of cancer, cause of death?*) **None:** _____

Father: _____

Mother: _____

Grandparents: _____

Siblings: _____

Children: _____

Current (within the last month) Review of Systems (Check all that apply)

Constitutional

- Appetite Loss
- Fatigue
- Fever
- Weakness
- Weight Change
- Chills
- Night Sweats

Eyes

- Blurred vision
- Excessive tearing
- Double vision
- Visual Difficulties

Ear/Nose/Mouth/Throat

- Difficulty swallowing
- Pain swallowing
- Ear pain
- Nose bleeds
- Esophagitis
- Hearing ability
- Mouth dryness
- Oral bleeding
- Ear infections
- Sinus infections
- Phlegm production
- Taste altered
- Ringing in ears

Neck

- Masses
- Muscle Weakness
- Pain
- Range of Motion
- Swelling

Skin

- Hair loss
- Blisters
- Bruising
- Dry Skin
- Facial burning
- Nails
- Light sensitivity
- Itchy skin
- Rash/Hives

Breast

- Breast masses
- Nipple discharge
- Nipple changes
- Pain

Heart

- Arrhythmias
- Chest pain
- Leg swelling
- B/P drop on rising
- Palpitations

Respiratory

- Cough
- Shortness of breath
- Coughing up blood
- Pleuritic chest pain
- Wheezing

Gastrointestinal

- Abdominal pain
- Change in bowel habits
- Constipation
- Diarrhea
- Heartburn
- Vomiting blood
- Bloody Stools
- Dark/black stools
- Hemorrhoids
- Nausea
- Feeling full
- Vomiting

Genitourinary (Male only)

- Burning with urination
- Frequency
- Blood in urine
- Impotence
- Incontinence
- Night urination
- Scrotal swelling
- Urgency

Hematologic/Lymphatic

- Easy bruising
- Lymph node swelling
- Frequent infections

Genitourinary (Female only)

- Urinary burning
- Frequency
- Genital masses
- Blood in urine
- Incontinence
- Sexual dysfunction
- Urgency
- Vaginal discharge/bleeding
- Age started period _____
- Menopause age _____
- Birth control #years _____
- Hormones #years _____
- Pregnancies _____
- Live births _____
- Age of 1st pregnancy _____

Musculoskeletal

- Arthritis
- Bone pain
- Joint pain
- Muscle weakness
- Range of motion

Neurologic

- Confusion
- Dizziness
- Balance/Difficulty walking
- Headaches
- Memory loss
- Numbness/tingling
- Paralysis
- Seizures
- Sensory problems

Psychiatric

- Delusions
- Hallucinations
- Depression
- Mood swings

Endocrine

- Diabetes
- Hot flashes
- Menstrual irregularities
- Thyroid disease

Do you have written Advance Directives? ____ Yes ____ No If yes, could you bring us a copy for our records?
____ Yes ____ No

Do you have a living will? ____ Yes ____ No

Do you have a Do Not Resuscitate form on file with your PCP? ____ Yes ____ No If yes, could you bring us a
copy for our records? ____ Yes ____ No

Have you appointed anyone as Power of Attorney for you? ____ Yes ____ No

If yes, who? _____ Relationship to you _____

Do you reside in a nursing home? If so, which home? _____

Are you being cared for under Hospice coverage? ____ Yes ____ No

Our **mission** at WellSpring is to support both the physical and emotional needs of the patient and family. We understand that receiving a diagnosis of cancer can be frightening and confusing. We invite you to share any additional concerns or feelings. By understanding your needs, we can work together to provide comprehensive and compassionate care and support your return to health.

Patient Signature/Date

Reviewed with Patient by Physician/Nurse and Date



6600 66th Street North Pinellas Park, FL 33781

AUTHORIZATION TO REQUEST MEDICAL RECORDS

Name: _____ Date of Birth: _____

SSN#: _____ Telephone #: _____

I authorize (list all physicians) _____

to disclose to WellSpring Oncology my medical information for my treatment at WellSpring Oncology.

Medical information to be disclosed (please check all that apply):

- Complete copy of medical record History & Physical Physician Progress notes
- Lab Reports Consultation Reports Nurse/Clinical Notes
- X-Ray Reports X-Ray Films

Other Diagnostic Reports (please specify) _____

Re-disclosure of records from the following facility: _____
(Patient to initial block when asking for re-disclosure)

I understand this could include information of a super confidential nature relating to:
(Patient to check and initial appropriate block)

- Acquired immune deficiency syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV) documentation and/or testing results.
- Psychiatric care documentation
- Alcohol and/or drug abuse documentation

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this information. **Unless otherwise revoked, this authorization will expire 1 year from the date of this signature.**

WellSpring Cancer Center, L.L.C., its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SIGNED: _____
Patient signature _____
Date

Legal representative and relationship to patient if patient is unable to sign _____
Date

WITNESS: _____

Date

PATIENT'S RIGHTS AND RESPONSIBILITIES

RIGHTS

AS A PATIENT, I HAVE THE RIGHT TO:

1. Full information about my rights and responsibilities as a patient.
2. Receive an explanation of my diagnosis, benefits of treatment, alternatives, recuperation, risks and an explanation of consequences if treatment is not pursued.
3. An explanation of all rules; regulations and services provided by WellSpring Cancer Center, L.L.C., the days and hours of service and provisions for possible emergency care, including telephone numbers.
4. Choose the type of medical plan that is best suited to my particular situation and work with the physician members within my healthcare plan.
5. Participate in development of a plan of care including Advance Directives.
6. Refuse participation in any protocol or aspect of care including investigational studies and freely withdraw my previously given consent for further treatment.
7. Disclosure of any teaching programs, research or experimental programs in which the facility is participating.
8. Full financial explanation and payment schedules prior to beginning treatment.
9. Receive professional care without discrimination, regardless of race, creed, color, religion, national origin, sexual preference, handicap, sex or age.
10. Be treated with courtesy, dignity and respect of my personal privacy by all employees of WellSpring Cancer Center, L.L.C.
11. Be free of physical/mental abuse and/or neglect by all employees of WellSpring Cancer Center, L.L.C.
12. Complain or file grievance with the Patient Representative or Office Manager without fear of retaliation or discrimination.
13. Confidential treatment of my condition, medical record and financial information.
14. Access to my personal records and obtain copies upon written request.
15. Assistance and consideration in the management of pain.

RESPONSIBILITIES

AS A PATIENT, I HAVE THE RESPONSIBILITY TO:

1. Disclose accurate and complete information related to physical condition, hospitalizations, medications, allergies, medical history and related items.
2. If required by my health plan, obtain proper referrals/authorizations for treatment and/or physician visits from my Primary Care Provider.

Patient Rights & Responsibilities ~Page 2~

3. Participate in developing a Plan of Care and provide copies of any Advance Directives or Living Will to my physician.
4. Assist in maintaining a safe, peaceful and efficient ambulatory environment.
5. Provide new/changed information related to my health insurance to the business office and be prepared to meet my agreed patient responsibility/co-pay during my office visit.
6. Contact the office when unable to keep a scheduled appointment.
7. Cooperate in the planned care and treatment developed for me.
8. Request more detailed explanations for any aspect of service I don't understand.
9. Inform my physicians and nurses of any changes in my condition or any new problems or concerns.
10. Relate my levels of discomfort and/or pain and perceived changes in my pain management to my physician.
11. Inform my physician or nurse when I am going to need a prescription refill before my supply is gone.
12. Communicate any temporary or permanent change in my address or telephone number, which might hinder contact by the staff.

WELLSPRING ONCOLOGY NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Created as a Result of the Health Insurance
Portability and Accountability Act of 1996 (HIPAA)

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

If you have any questions about this notice, please contact:
our Privacy Officer at (727) 343-0600.

A. OUR COMMITMENT TO YOUR PRIVACY

Wellspring Oncology is dedicated to maintaining the privacy of your protected health information (PHI). We are required by law to maintain the confidentiality of health information that identifies you. This notice describes information about privacy practices that will be followed by our clinical and office personnel.

In conducting our business, we will create records regarding your health, health status, treatment, and services we provide to you. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time of treatment. We are required by law to give you this notice and provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

This Notice of Privacy Practices is provided to every patient with whom the practice has a direct treatment relationship, and is provided no later than the patient's first treatment date after April 13, 2003. The practice asks each such patient to sign a Patient Consent for Use and Disclosure of Protected Health Information and also an acknowledgement of receipt of this Notice of Privacy Practices. Refusal to sign will be noted in the medical record.

The terms of this notice apply to all records containing PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices whenever there is a material change to the uses or disclosures, the individual's rights, the practice's legal duties, or other privacy practices stated in the Notice. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE OR ABOUT OUR HEALTH
PRIVACY INFORMATION POLICIES, PLEASE CONTACT:**

**Privacy Officer
Wellspring Oncology
6600 66th Street N
Pinellas Park, FL 33781
(727) 343-0600**

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

Your PHI may be used and disclosed by our practice in the ways detailed in this Notice. The practice reasonably ensures that the PHI it requests, uses and discloses for any purpose is the minimum amount necessary. The practice also makes reasonable efforts to ensure that PHI is only used by, and disclosed to, individuals that have a right to the protected health information, and makes reasonable efforts to verify the identity of those using or receiving the information.

The practice treats all qualified individuals as personal representatives of patients. Qualified personal representatives are limited to: an agent under a Power of Attorney for Health Care, a guardian with authority to access medical records or make health care decisions, an attorney-in-fact under a mental health declaration, a health care surrogate, or an individual with written authorization from a competent patient to access medical records.

The following are cases in which minors do not need parental consent, and in which the parents would not be entitled to the relevant PHI without the minor's authorization:

- Medical examination and testing for STDs (including HIV)
- Voluntary admission into a substance abuse facility
- Blood donations
- Emancipated minors
- Outpatient mental health diagnostic / evaluation services (over age 13)
- Outpatient crisis intervention therapy / counseling services (over age 13)
-

c) Emancipated Minors: *The following persons under the age of 18 are considered emancipated minors and do not need parental consent for any health care, and therefore their parents or guardians would not be personal representatives:*

- Unmarried minor females who are pregnant may consent to health care and treatment relating to their pregnancy
- Unmarried minor females who have a minor child
- Married minors (including widowed and divorced)
- Minors emancipated by court order
- Minors enlisted in military service

d) Incapacitated Adults: *Persons over the age of 18 who have been deemed incompetent by a court, or have been determined by an attending physician to be incapable of making informed health care decisions: Either situation must be documented in the patient's health record. Legal representatives include:*

- Court-appointed Guardian
- Durable Power of Attorney (DPOA): Appointed by the patient, with authority defined. Read the DPOA to determine authority to access PHI.
- Healthcare Surrogate: Appointed by the patient, but usually not effective until the patient is declared mentally or physically incapacitated by a specified number of physicians. Read the document to determine the effective date or event and other relevant criteria.
 - (a) *Authority to make health care decisions includes access to PHI.*
 - (b) *Authority to act may be limited, i.e. only for purposes of end-of-life decisions, in which case the surrogate may only have access to PHI pertaining to end-of-life decisions.*

1. Treatment. We may use health information about you to provide you with medical treatment or services. For example, we may use your PHI to schedule or report the results of laboratory or X-ray tests that help us diagnose an illness. Your PHI might be used or disclosed in ordering a prescription for you in writing, by phone or fax at a pharmacy. People who work for our practice – including doctors, nurses, office staff or other personnel– may use or disclose your PHI in order to treat you, or to assist consulting doctors, therapists, or others in your treatment. We may also disclose your PHI to family members who assist in your care, such as your spouse, children or

parents, if we feel it is necessarily for your treatment. We may contact you at any home, work or other phone number at which you have agreed to be notified; or by regular mail.

2. Payment. We may use and disclose your PHI to bill and collect payment for the services and items you receive from us. We may contact your health insurer to verify that you are eligible for benefits. We may provide your insurer with details regarding your treatment to determine if the insurer will pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties, including family members, that may be responsible for such costs. We may also use your PHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. For example, we may use your PHI to evaluate the quality of care we provided to you, for peer review, or for cost-management and business planning activities related to the practice.

D. USES AND DISCLOSURES NOT REQUIRING SEPARATE AUTHORIZATION

Please notify us if you do not wish to be contacted for appointment reminders, treatment alternatives or health-related products and services. If you advise us in writing at the address listed at the top of this Notice, or on the Patient Consent for Use and Disclosure of Protected Health Information, that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

1. Appointment Reminders. Our practice may use and disclose PHI in contacting you by phone or mail at any phone number or address we have on file to remind you of an appointment.

2. Treatment Options. Our practice may use and disclose PHI to inform you of potential treatment options or alternatives.

3. Health-Related Products and Services. Our practice may use and disclose PHI to inform you of health-related products or services that may be of interest to you.

4. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member if we obtain your verbal or written agreement, or if you do not object to such a disclosure when given the opportunity. We may disclose health information to family or friends if we conclude in our professional judgment, under the circumstances, that you would not object. For instance, we may assume you agree to our disclosure of PHI if you bring your spouse or friend into the exam room with you when treatment is provided or discussed. As another example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

If you cannot give consent due to a medical emergency, physical or mental incapacity, or your absence, we may determine, in our professional judgment, that disclosure to your family member or friend is in your best interest. In that case, we will disclose only health information relevant to the person's involvement in your care. For example, if a person brought you to the emergency room, we may inform them that you had a heart attack and give them updates on your status. Or if you are physically unable to pick up a prescription or medical supply, we may disclose information to a person who can then obtain the needed item for you.

E. USE AND DISCLOSURE OF PHI IN SPECIAL SITUATIONS

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law. As required by law, the practice discloses PHI to public health officials. This includes reporting of communicable diseases and other conditions,

sexually transmitted diseases, lead poisoning, Reyes Syndrome, and mandated reports of injury, medical conditions or procedures, or food-borne illness. This may also include, but is not limited to, adverse reactions to immunizations, cancer, adverse pregnancy outcomes, death, and birth.

As required by law, the practice discloses PHI to the proper authorities regarding victims of abuse, neglect, or domestic violence about any minor, disabled adult, nursing home resident, or person over 60 years of age whom the practice reasonably believes to be a victim of abuse or neglect. This includes child abuse and neglect, elder abuse and exploitation, abused and neglected nursing home residents, or abuse of a disabled adult. If not required by law, this information is disclosed only if the individual agrees to the disclosure. The practice informs the individual of such reporting unless: a) the practice, in its professional judgment, believes informing the individual would place him or her at risk of serious harm, or b) the practice would be informing the individual's personal representative who is believed by the practice to be responsible for abuse, neglect or other injury, and the practice believes in its professional judgment that informing this personal representative would not be in the patient's best interests.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. This information may be used and released for audits, investigations, licensure issues, and other health oversight activities which may include but are not limited to hospital peer review, managed care peer review, or Medicaid or Medicare peer review; other civil, administrative, and criminal procedures or actions; and other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Judicial and Administrative Proceedings. Our practice may use and disclose your PHI for judicial and administrative proceedings in response to a court or administrative order. Disclosure will be limited to PHI expressly authorized by the order. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process not accompanied by a court or administrative order, but only if we are satisfied that a reasonable effort has been made by the requestor either a) to inform you of the request and allow you to raise objections, or b) to obtain a qualified protective order from a court or administrative tribunal.

4. Law Enforcement. We may disclose PHI for law enforcement purposes to law enforcement officials. The information sought must be relevant and material, the request must be specific and limited to amount reasonably necessary, and it is not possible to use de-identified information.

- The practice releases limited PHI to identify or locate a suspect, fugitive, material witness or missing person only as approved by a person authorized to act on behalf of the individual.
- The practice discloses limited PHI about a suspected victim of a crime if the individual agrees to disclosure;
- The practice discloses PHI about a deceased individual if the practice suspects that death resulted from criminal conduct and such disclosure is approved by persons authorized to act on behalf of the deceased individual.
- The practice discloses PHI that the practice judges to constitute evidence of criminal conduct that occurred on covered entity's premises.
- The practice discloses PHI relating to emergency health care as required or permitted by law, such as test results of those involved in automobile accidents.
- The practice may disclose PHI when the practice has reasonable cause to believe the patient's ability to safely drive may be impaired.

5. Serious Threats to Health or Safety. Our practice may use and disclose your PHI to public health and other authorities as required by law when necessary to avert a serious threat to the health and safety of yourself, another individual or the general public.

6. Specialized Government Functions. Our practice may use and disclose your PHI as required by law for military and veterans' activities, national security and intelligence activities, and other activities.

7. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

8. Emergency and Disaster relief. Our practice may disclose your PHI to appropriate authorities when necessary for treatment, identification, health or safety in the event of an emergency or disaster due to natural or other causes. In those instances where the practice has not previously provided its Notice of Privacy Practices to a patient who receives direct treatment in an emergency situation, the practice provides the Notice to the individual as soon as practicable following the provision of emergency treatment.

9. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs. Worker's compensation is not covered under HIPAA, but a signed authorization usually is not required for release of PHI in worker's compensation cases, because such release of PHI is required by law.

10. Deceased Patients. Our practice may release PHI to a medical examiner, coroner or funeral director as required by law. The attending physician is required to sign the death certificate and provide the coroner with a copy of the decedent's protected health information.

11. Organ and Tissue Donation. Our practice may use and disclose your PHI to facilitate organ, eye or tissue donations.

12. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written Authorization to use your PHI for research purposes except when an Institutional Review Board or a Privacy Board determines that a waiver of your authorization satisfies the following:

- (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following:
 - (A) an adequate plan to protect the identifiers from improper use and disclosure;
 - (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and
 - (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
- (ii) the research could not practicably be conducted without the waiver; and
- (iii) the research could not practicably be conducted without access to and use of PHI.

13. Other Uses and Disclosures of Health Information: Our practice will obtain your written Authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. We will provide the patient, upon request, with a copy of any Authorization requested by the practice and signed by the patient. If you give us written Authorization to use or disclose health information about you, you may revoke that Authorization in writing at any time. If you do revoke an Authorization, we will no longer use or disclose information about you for

the reasons covered by the Authorization, but we cannot take back any authorized uses or disclosures already made.

Our practice does not use or disclose PHI to an employer or health plan sponsor for underwriting or related purposes, for facility directories, to brokers and agents, or for fundraising. In addition, automobile insurance, homeowners insurance, and similar policies that provide coverage for health care expenditures **are not covered** under HIPAA, in most circumstances. A signed authorization is required prior to releasing PHI to such entities. If an individual wants the practice to release information for any of these purposes, a written Authorization must be submitted to the practice.

A specific written authorization, different from the Authorization and Consent mentioned above, is required to disclose or release records, even for treatment, related to mental health treatment, genetic information, alcoholism treatment, drug abuse treatment or HIV/Acquired Immune Deficiency Syndrome (AIDS) information.

F. YOUR INDIVIDUAL RIGHTS REGARDING YOUR PHI

You have the following Individual Rights regarding the PHI that we maintain about you:

1. Right to Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Privacy Officer, Wellspring Oncology 6600 66th Street N. Pinellas Park, FL 33781** specifying the requested method of contact, or the location where you wish to be contacted. You do not need to give a reason for your request. Our practice will accommodate **reasonable** requests, with reasonableness determined solely based on the administrative difficulty of complying with the request. The practice will not refuse a request if the requestor indicates that the communication will cause endangerment, or based on any perception of merits of the requestor's request.

2. Right to Request Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request.** However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Privacy Officer, Wellspring Oncology 6600 66th Street N. Pinellas Park, FL 33781**. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

3. Right to Inspection and Copies. You have the right to inspect and obtain a copy of the PHI in the presence of a practice employee. This includes information that may be used to make decisions about you, including patient medical records and billing records. PHI from outside sources, such as hospital records, laboratory or X-ray reports, and records from previous physicians, may be inspected and copied in the same manner as records generated by the practice. All requests to inspect records will be documented, and the practice will respond to requests in a timely fashion. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

To request inspection and copying of records, you must submit your request in writing to **Privacy Officer, Wellspring Oncology 6600 66th Street N. Pinellas Park, FL 33781**.

4. Right to Amendment. You may ask us to amend your health information or billing record if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. The practice documents all requests for amendment,

responds to requests in a timely fashion, and informs individuals of their appeal rights when a request is denied in whole or in part. If we deny your request, we will provide a written denial in a timely fashion. You may submit a written statement of one page or less in length if you disagree with a denial. Your statement must include the reason for your disagreement.

To request an amendment, your request must be made in writing and submitted to **Privacy Officer, Wellspring Oncology 6600 66th Street N. Pinellas Park, FL 33781**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Right to Accounting of Disclosures. Our practice tracks all disclosures of a patient's PHI that are a) not for the purposes of treatment, payment and health care operations; b) not made to the patient or a person involved in his care, c) not made as a result of a patient authorization, and d) not made for national security or intelligence purposes or to correctional institutions or law enforcement officials. Documentation of uses of your PHI as part of the routine patient care in our practice is not required. Examples of routine use are the doctor sharing information with the nurse, or the billing department using your information to file your insurance claim. All patients have the right to request an "accounting of disclosures."

All requests for an "accounting of disclosures" must specify a time period, which may be up to, but not longer than, six (6) years from the date of disclosure. The request may not include dates before April 14, 2003. The practice will respond within 60 days to a request for accounting of disclosures. If the practice intends to provide the accounting for disclosures but cannot do so within 60 days, the requestor will be informed of the reason for the delay and the date the practice expects to fulfill the request. Only one 30-day extension is permitted. To obtain an accounting of disclosures, you must submit your request in writing to **Privacy Officer, Wellspring Oncology 6600 66th Street N. Pinellas Park, FL 33781**.

6. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice at **Privacy Officer, Wellspring Oncology 6600 66th Street N. Pinellas Park, FL 33781 (727) 343-0600**. All complaints must be submitted in writing, must describe the acts or omissions that are the subject of the complaint, and must be filed within 180 days of the time the patient became aware, or should have become aware, of the violation. The practice investigates each complaint and may, at its discretion, reply to the patient or the patient's agent. You may also submit a complaint to the **Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70 61 Forsyth Street, S.W. Atlanta, GA 30303-8909, Voice Phone (312) 886-2359) Fax (312) 886-1807 TDD (312) 353-5693**. Any complaint filed with the Department of Health and Human Services must be in writing, must name the practice, describe the acts or omissions that are the subject of the complaint, and must be filed within 180 days of the time the patient became aware or should have become aware of the violation. **Wellspring Oncology will not take any adverse action against a patient for filing a complaint, either directly or through an agent, against the practice.**

7. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a paper copy of this notice at any time. To obtain a paper copy of this notice, contact **Front Desk, Wellspring Oncology 6600 66th Street N. Pinellas Park, FL 33781**. You may also obtain a copy from the practice website, www.wellspringoncology.org.