Welcome to Cancer Specialists of North Florida, Beaches office. Our physicians treat a wide variety of blood disorders (anemia, blood clots, etc.) as well as cancer diagnoses. For your convenience we have enclosed your new patient packet. Please complete all forms in their entirety. Completing the packet in advance will allow you to see the doctor more quickly. Please arrive early enough to complete any additional paperwork and keep your appointment on time.

Some essential items to bring with you to your appointment are:
- Completed new patient packet
- List of medications
- Insurance card(s)
- Photo ID
- Co-pay
- A list of questions and/or concerns

Please note the following office policies:
- Please refrain from wearing strong perfumes or body lotions as this can distress patients who are currently under treatment.
- There is a $20 charge for completing forms (for example, FMLA and disability)
- There will be a $25 charge if you do not keep your confirmed appointment
- Co-pays/ co-insurance and outstanding balances will be collected at time of visit

Our office is located next to Baptist beaches Hospital at 1375 Roberts Drive, Suite 103, Jacksonville Beach, Florida 32250. Directions can be found on our website www.cancerspecialistsnf.com

It is our goal to provide you with all the support and information you need in a timely manner. Should you have any questions regarding your upcoming appointment, please contact us at (904)997-3800. We look forward to seeing you.
MEDICAL INFORMATION SHEET

Name: ________________________________    Date: _________________

Reason for Referral to CSNF?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Previous Medical Illnesses:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Past Surgeries:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Allergies: (medicine, tape, etc.)
________________________________________________________________________
________________________________________________________________________
**PATIENT HISTORY QUESTIONNAIRE**

Patient Name: ___________________________ Date of Birth: ___________________________

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>YEAR</th>
<th>ILLNESS</th>
<th>YEAR</th>
<th>ILLNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td>Neurologic Disorders/Stroke</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Liver Disease</td>
<td></td>
<td>Emotional Disorders</td>
</tr>
<tr>
<td>Blood Disorders</td>
<td></td>
<td>Thyroid Disease</td>
<td></td>
<td>HIV Positive/AIDS</td>
</tr>
<tr>
<td>Heart Disease (CHF, MI)</td>
<td></td>
<td>Cancer</td>
<td></td>
<td>COPD/ Asthma</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td>Skin Disease</td>
<td></td>
<td>Crohn's disease or Ulcerative colitis</td>
</tr>
</tbody>
</table>

Other:

**IMMUNIZATIONS**

If yes, provide approximate year received

<table>
<thead>
<tr>
<th>Influenza (Flu)</th>
<th>Yes ☐</th>
<th>No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumococcal</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
</tbody>
</table>

Other:

**SURGERIES/HOSPITALIZATIONS / INJURIES**

List all hospitalizations, operations, tests, procedures, and severe injuries

<table>
<thead>
<tr>
<th>Date</th>
<th>Type of Operation, Test, Procedure, or Severe Injury</th>
<th>Physician &amp; Medical Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PREVIOUS RADIATION TREATMENT**

<table>
<thead>
<tr>
<th>Area of Treatment</th>
<th>Date of Test</th>
<th>Medical Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FAMILY HISTORY**

List any blood relative who has ever been diagnosed with cancer or blood disorder

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Type of Cancer or Blood Disorder</th>
<th>Age at Diagnosis</th>
<th>Deceased Y or N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Revised 09/2019
### RECENT DIAGNOSTIC TESTS

<table>
<thead>
<tr>
<th>Test</th>
<th>Date of Test</th>
<th>Medical Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT Scans / X-Rays:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PET Scans / Bone Scans:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound(s):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI(s):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy(s):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram(s):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SOCIAL HISTORY

<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>Occupation:</th>
<th>Working</th>
<th>Retired</th>
<th>Not Working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
<td>Type</td>
<td>How much / How often</td>
<td>Quit?</td>
</tr>
<tr>
<td>Recreational Drug Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OTHER FAMILY MEDICAL HISTORY / CONDITIONS

<table>
<thead>
<tr>
<th>Age</th>
<th>Other Health Conditions (i.e. Diabetes)</th>
<th>Deceased Y or N</th>
<th>Age of Death</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Adopted | | | | |
| Father: | | | | |
| Mother: | | | | |
| Brother | Sister | | | |
| Brother | Sister | | | |
| Brother | Sister | | | |

### FOR WOMEN ONLY

<table>
<thead>
<tr>
<th>Onset of Menstruation:</th>
<th>Number of Live Births:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Last Menstrual Cycle:</td>
<td>Abnormal Menstruation: Y or N</td>
</tr>
<tr>
<td>Number of Pregnancies:</td>
<td>Hot Flashes: Y or N</td>
</tr>
<tr>
<td>Age at First Pregnancy:</td>
<td>Age of Menopause:</td>
</tr>
<tr>
<td>Other:</td>
<td>Hormone Replacement: Y or N</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OTHER:

________________________________________

_____________________________  _______________________
Patient Signature:             Date:

________________________________________

_____________________________  _______________________
Physician Signature:           Date:
Patient Name: ________________________________  DOB: ___________________

**CURRENT MEDICATIONS / SUPPLEMENTS AND ALLERGIES**

*PLEASE BE SPECIFIC*

If start/stop dates unknown, please give approximate month and year

<table>
<thead>
<tr>
<th>Medication - Name of Drug</th>
<th>Strength of Drug</th>
<th>Daily Dose How Taken</th>
<th>Date Started</th>
<th>Prescribing Doctor (FIRST, LAST)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example:</td>
<td>XX mg</td>
<td>X per day</td>
<td></td>
<td>Dr Sample Smith</td>
</tr>
<tr>
<td>Enter your medication here</td>
<td>XX mg</td>
<td>X per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>XX mg</td>
<td>X per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>XX mg</td>
<td>X per day</td>
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<td></td>
<td>XX mg</td>
<td>X per day</td>
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<td>XX mg</td>
<td>X per day</td>
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<td></td>
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<tr>
<td></td>
<td>XX mg</td>
<td>X per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Allergies**

<table>
<thead>
<tr>
<th>Example: Penicillin</th>
<th>Reaction</th>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breathing Difficulties</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
### PATIENT DEMOGRAPHICS

#### PATIENT INFORMATION:

- **Social Security Number:**
  - Last: __________  First: __________  MI: ___  Suffix: __________
- **Address:**
  - __________
- **City:** __________  **State:** __________  **Zip:** __________
- **Permission to call:**
  - Home:   [Y] [N]  Cell:   [Y] [N]  Work:   [Y] [N]
- **Sex:**
  - [M]  [F]
- **DOB:** __________  **Birthplace:** __________
- **E-mail Address:** __________

#### PHYSICIAN INFORMATION:

- **Referring Physician:**
  - __________
- **Primary Care Physician:**
  - __________
- **Phone Number:**
  - __________

#### MARITAL STATUS:

- [ ] Single  [ ] Married  [ ] Separated  [ ] Widowed  [ ] Divorced  [ ] Unmarried Partners

#### EMPLOYMENT STATUS:

- [ ] Full Time  [ ] Part Time  [ ] Self Employed  [ ] Not Employed  [ ] Retired  [ ] Military Duty  [ ] Disabled

- **Occupation:** __________
- **Employer:** __________  **Employer Contact #:** __________

#### STUDENT:

- [ ] Full Time  [ ] Part Time  [ ] Not A Student

#### RACE:

- [ ] American Indian or Alaska Native  [ ] Black or African American  [ ] Asian
- [ ] Native Hawaiian or Pacific Islander  [ ] White  [ ] Do not wish to provide

#### ETHNICITY:

- [ ] Hispanic  [ ] Not Hispanic  [ ] Do not wish to provide  [ ] English  [ ] Other: __________  [ ] Do not wish to provide

#### PREFERRED LANGUAGE:

- __________

#### EMERGENCY CONTACT INFORMATION:

- **Relationship:** __________  **Last:** __________  **First:** __________
- **Address:** __________
- **City:** __________  **State:** __________  **Zip:** __________
- **Home Phone:** __________  **Work Phone:** __________  **Cell Phone:** __________

- **Home Care Facility:** __________

- **Patient Signature/Representative:** __________  **Date:** __________

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**Revised 5/17**

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**CANCER SPECIALISTS of NORTH FLORIDA**
General Consent for Treatment

As a patient of Cancer Specialists of North Florida I hereby request and authorize the physicians and staff of Cancer Specialists of North Florida to provide me with the recommended medical treatment, diagnostic procedures, and nursing care that they deem necessary, including, but not limited to diagnostic procedures, diagnostic x-rays, medical examinations, intravenous procedures; laboratory testing, treatments, twelve lead electrocardiograms, venipunctures, or other services of a routine or medical nature.

I am aware that the practice of medicine is not an exact science and I acknowledge that NO guarantees have been made to me as the result of any medical examinations or treatments. I am also aware that in the practice of medicine other unexpected risks or complications not discussed may occur. I also understand that during the course of any proposed procedure or treatment, unforeseen conditions may be revealed requiring the performance of additional procedures. If additional procedures are required in non-emergency circumstances I will be provided with additional educational information so I may make an informed decision. Additional consent forms may be provided to me.

I am aware that some of the medications I receive may cause drowsiness, sleepiness, dizziness, and/or fatigue. If affected I agree not to drive, operate heavy machinery, or do other dangerous activities. I may need to make arrangements for someone else to drive me and I understand that if I am unable to make alternative transportation arrangements my treatment may be delayed until such time as I can find an alternative driver.

I understand that all information pertaining to my care will remain a confidential part of my medical record as it relates to the Health Insurance Portability and Accountability Act.

PATIENT NAME: ___________________________ PATIENT DATE OF BIRTH: _______________ DATE: ______________

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: ___________________________ RELATIONSHIP: ______________

REASON PATIENT DID NOT SIGN: ___________________________ Translator ID: ___________________________

WITNESS SIGNATURE: ___________________________ DATE: ______________

Revised 1/18
E-PRESCRIBING CONSENT FORM

STAFF USE ONLY

Patient Name: ____________________ DOB: ______________ Form Completed By: ____________________

The US Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing reduces medication errors while enhancing patient safety. Cancer Specialists of North Florida will now be electronically submitting your prescriptions.

Cancer Specialists of North Florida has the ability to provide you with many prescribed medications through Cancer Specialists of North Florida’s own Florida Specialty Pharmacy. Your prescriptions medications may be dispensed by Florida Specialty Pharmacy and if you desire, you may have your prescriptions delivered to your local Cancer Specialists of North Florida office. Your physician’s office will act as your agent so your prescription can be transferred to you. Of course, you have the option of receiving your prescriptions from the pharmacy of your choice.

Alternative Pharmacy Information:

Pharmacy Name: ___________________________ Phone Number: ___________________________

Address: __________________________________ Fax Number: ___________________________

City: ___________________________ State: _____________ Zip: ___________________________

CONSENT FOR MEDICATION HISTORY

Medication history provides the prescriber with information about medications the patient is already taking, which will minimize the number of adverse drug events and minimize any misunderstanding with other providers. While prescribing your medication(s), including but not limited to narcotic medications, it is useful to have your medication history available.

☐ By signing below, I hereby provide informed consent for Cancer Specialists of North Florida to obtain and use my external prescription medication history, including but not limited to narcotics history, from all my other healthcare providers and/or third party pharmacy benefit payors for my treatment.

By not giving consent, Cancer Specialists of North Florida will not be able to prescribe any narcotics for me.

PATIENT NAME: ___________________________ DATE OF BIRTH: ______________ DATE: ______________

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: _______________________________________

RELATIONSHIP: ___________________________ REASON PATIENT DID NOT SIGN: _______________________________________

Translator ID: ___________________________
AUTHORIZATION FOR RELEASE OR REQUEST OF PROTECTED MEDICAL INFORMATION
FROM MEDICAL RECORD FOR TREATMENT, PAYMENT HEALTH CARE
OPERATIONS, HOSPITALIZATION, AND QUALITY OF CARE.

IF YOU DO NOT WISH TO ALLOW CANCER SPECIALISTS OF NORTH FLORIDA TO RELEASE OR REQUEST YOUR ENTIRE MEDICAL RECORD PLEASE MARK THE RELEVANT BOXES UNDER THE “SPECIAL AUTHORIZATION” SECTION SO WE MAY FOLLOW YOUR SPECIFIC INSTRUCTIONS. IF NO EXCLUSIONS ARE NECESSARY, PLEASE COMPLETE THE AUTHORIZATION & SIGNATURE SECTION ONLY.

This release or request is intended for purposes of providing and/or obtaining medical information related to your health care to or from parties including, but not limited to: Cancer Specialists of North Florida (provider(s), staff, or agent(s)), referring provider(s), imaging provider(s), and/or health insurer(s).

SPECIAL AUTHORIZATION TO DISCLOSE PROTECTED CONFIDENTIAL INFORMATION

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH/GENETIC RECORDS are protected by Federal Regulation 42 CFR, Part 2 and/or state law. Release of such records requires specific consent from you. By signing this document I hereby grant such specific consent to Cancer Specialists of North Florida as indicated below. I UNDERSTAND that my records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted disease, acquired immune deficiency syndrome (AIDS), Human immunodeficiency virus (HIV) infection, and/or genetic analysis and testing.

AS PART OF THE MEDICAL RECORDS LISTED ABOVE, I DO NOT WANT THE FOLLOWING INFORMATION RELEASED:

<table>
<thead>
<tr>
<th>Drug, Alcohol or Substance Abuse</th>
<th>HIV/AIDS related information and/or records</th>
<th>Mental health information and/or records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic information and/or records</td>
<td>Hospitalizations (Admission/Discharge/Diagnosis)</td>
<td>Sexually transmitted diseases</td>
</tr>
</tbody>
</table>

IF ANY BOX IS MARKED, I UNDERSTAND THAT MY COMPLETE RECORD MAY BE GIVEN TO ME SO THAT I MAY REVIEW AND SEND THE SPECIFIC RECORDS REQUESTED TO THE RECEIVER OF INFORMATION. I FURTHER UNDERSTAND THAT A DISCUSSION WITH THE OFFICE MANAGER OR REPRESENTATIVE MAY BE REQUIRED.

RIGHT TO REVOKE AUTHORIZATION

I UNDERSTAND THAT I MAY REVOKE THIS CONTINUOUS AUTHORIZATION AT ANY TIME BY SUBMITTING A NEW COPY OF THIS FORM TO CANCER SPECIALISTS OF NORTH FLORIDA WITH THE EXCLUSIONS MARKED IN THE ABOVE “SPECIAL AUTHORIZATION TO DISCLOSE PROTECTED CONFIDENTIAL INFORMATION” SECTION. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION IF REQUESTED. THIS FORM IS INVALID IF MODIFIED.

AUTHORIZATION & SIGNATURE

I hereby authorize the disclosure or use of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, health care operations, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that the organization authorized to receive the information could potentially re-disclose my protected health information and therefore, I release Cancer Specialists of North Florida from all liability arising from this disclose of my health information. I understand and agree that I am financially responsible for the following fees associated with my request(s): copying charges and postage related to the production of my information. I understand that the charge for this service is $1.00 per page for the first 25 pages and $0.25 for each page in excess of 25 pages, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

PATIENT NAME: __________________________  PATIENT DATE OF BIRTH: ______________  DATE: ______________

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: __________________________  RELATIONSHIP: ______________

REASON PATIENT DID NOT SIGN: __________________________  Translator ID: __________________________

WITNESS SIGNATURE: __________________________  DATE: ______________

Revised 5/18
AUTHORIZATION FOR RELEASE OR REQUEST OF PROTECTED MEDICAL INFORMATION FROM MEDICAL RECORD(S) FOR SPECIFIED ORGANIZATIONS AND/OR PEOPLE

REQUEST FOR INFORMATION (ONLY THE PATIENT OR PATIENT’S LEGAL REPRESENTATIVE MAY CONSENT TO THE FOLLOWING):

ORGANIZATION PROVIDING INFORMATION

Name:__________________________________________
Address:________________________________________
Phone: (________) Fax: (________)

ORGANIZATION REQUESTING INFORMATION

Name:__________________________________________
Address:________________________________________
Phone: (________) Fax: (________)

INFORMATION TO BE DISCLOSED SHALL INCLUDE ALL MEDICAL RECORDS UNLESS INDICATED OTHERWISE BELOW:

☐ Medical Notes/Summary  ☐ All Lab Reports  ☐ Dates From:___________ To:___________
☐ Radiation Therapy Reports  ☐ Diagnostic Imaging Reports  ☐ Other:
☐ Operative/Procedure Reports  ☐ Patient Demographic Info. (name/address)  ☐ Other:
Records requested to be sent by: ☐ FAX (Patient must initial approval)  ☐ PRINTED (Patient will pick up)  Date Records are needed:___________

SPECIAL AUTHORIZATION TO DISCLOSE PROTECTED CONFIDENTIAL INFORMATION

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH/GENETIC RECORDS are protected by Federal Regulation 42 CFR, Part 2 and/or state law. Release of such records requires specific consent from you. By signing this document I hereby grant Cancer Specialists of North Florida such specific consent as indicated below. I understand that my records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted disease, acquired immune deficiency syndrome (AIDS), Human immunodeficiency virus (HIV) infection, and/or genetic analysis and testing.

AS PART OF THE MEDICAL RECORDS LISTED ABOVE, I DO NOT WANT THE FOLLOWING INFORMATION RELEASED:

☐ Drug, Alcohol or Substance Abuse  ☐ HIV/AIDS related information and/or records  ☐ Mental health information and/or records
☐ Genetic information and/or records  ☐ Hospitalizations (Admission/Discharge/Diagnosis)  ☐ Sexually transmitted diseases

IF ANY BOX IS MARKED, I UNDERSTAND THAT MY COMPLETE RECORD MAY BE GIVEN TO ME SO THAT I MAY REVIEW AND SEND THE SPECIFIC RECORDS REQUESTED TO THE RECEIVER OF INFORMATION. I FURTHER UNDERSTAND THAT A DISCUSSION WITH THE OFFICE MANAGER OR REPRESENTATIVE MAY BE REQUIRED.

RIGHT TO REVOKE AUTHORIZATION

I understand that I may revoke this continuous authorization at any time by submitting a new copy of this form to Cancer Specialists of North Florida with the exclusions marked in the above "Special Authorization to Disclose Protected Confidential Information" section. I further understand that I have a right to receive a copy of this authorization if requested. This form is invalid if modified.

AUTHORIZATION & SIGNATURE

I hereby authorize the disclosure or use of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, health care operations, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the related information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release Cancer Specialists, LLC from all liability arising from this discloser of my health information. I understand and agree that I am financially responsible for the following fees associated with my request(s): copying charges and postage related to the production of my information. I understand that the charge for this service is $1.00 per page for the first 25 pages and $0.25 for each page in excess of 25 pages, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

PATIENT NAME:__________________________________________  PATIENT DATE OF BIRTH:____________________  DATE:____________________

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE:________________________  RELATIONSHIP:________________________

REASON PATIENT DID NOT SIGN:________________________________________  Translator ID:________________________

WITNESS SIGNATURE:________________________  DATE:____________________
ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES / PHYSICIAN OWNERSHIP / HIPAA

1. I understand that it is my responsibility to provide Cancer Specialists of North Florida ("CSNF") with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). CSNF is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a private pay patient and be financially responsible for the total amount of the services provided. I will notify CSNF immediately upon any change in my insurance.

2. I understand that in consideration of the services provided, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at CSNF which are not covered or reimbursed by my insurance. Furthermore, I am responsible for any applicable deductible, co-payments, and/or coinsurance prior to the provision of services. CSNF will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. If I have Medicare, I will complete an Advance Beneficiary Notice ("ABN") form for non-covered services. Should my account be referred to a collection agency or attorney for collection, I agree to pay all costs of collection, including interest and attorney’s fees and costs.

3. I authorize my insurance carrier to release information regarding my coverage to CSNF. I also authorize agents of any hospital, treatment center or previous physician(s) to furnish CSNF copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician, other health professional or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within CSNF.

4. 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 CSNF. 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 payments to CSNF.

5. I acknowledge that I have received a copy of the CSNF’s Physician Ownership Disclosure.

Pursuant to Fla. Stat. 934.03 tape recording CSNF staff without obtaining prior permission is strictly forbidden and unlawful.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") ACKNOWLEDGEMENT

CSNF is required by law to provide you with a copy of our Notice of Privacy Practices ("Notice"), which describes how your health care information is used and disclosed. To ensure our records are accurate, please complete and sign below and return this form to our receptionist to acknowledge that you have been provided with a copy of our Notice. I acknowledge that CSNF may use and disclose de-identified health information for purposes of data collection and statistical analysis. De-identified information is information from which all personal identification has been removed. This means the health information can no longer be identified as yours and is no longer considered protected under HIPAA. I acknowledge the use or disclosure of my Protected Health Information ("PHI") by CSNF for the purposes of Treatment, Payment, and Health Care Operations.

I have received a copy of the Notice of Privacy Practices and understand I have the right to review prior to signing this document.

I authorize the following contacts to be fully involved in my care and I agree that these contacts shall have access to all of my PHI, which may include, but is not limited to the diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted disease, Acquired Immune Deficiency Syndrome ("AIDS"), Human Immunodeficiency Virus ("HIV") infection, and/or genetic analysis and testing. This consent for disclosure includes both health and financial information as it relates to my care.

CONTACTS

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THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THE ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITIES AGREEMENT, AS WELL AS THE PHYSICIAN OWNERSHIP DISCLOSURE AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ACKNOWLEDGEMENT.

Patient Signature/Representative: __________________________________________ Date: __________

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

☐ I request CSNF not to disclose my Protected Health Information to certain groups that I will name in the Restrict Disclosure form.

CSNF Revised 2/20/19
1. A copy of the patient’s insurance/prescription card (s), and government issued ID will be retained for CSNF’s record.

2. It is the patient’s responsibility to notify CSNF immediately of any changes with his/her insurance, eligibility, or enrollment into Hospice program or Skilled Nursing Facility. **The patient will be responsible for any charges that are not paid by the patient’s insurance company if the information provided is inaccurate and/or not up to date.**

3. When applicable, co-payment, co-insurance, and/or deductible are due at the time of service (including labs and/or office visits). Unless otherwise arranged, the patient will not be seen/treated if the amount due is not paid on, or prior to, the date of service.

4. The Patient Financial Counselor, *Patricia Walsh* is available to discuss payment arrangements for the patient’s co-payment and/or deductible in cases where the patient is unable to make payment due to a financial hardship. There may be resources available for qualified applicants, with additional documentation being required. The Patient Financial Counselor for this site can be reached at (904) 997-3800.

5. Failure to show for a confirmed appointment and/or failure to cancel an appointment within 24 hours prior notice may result in a $25.00 fee that will be added to the patient’s account.

6. There will be a onetime charge of $20 added to the patient’s account for completion of FMLA/short term disability forms that exceed one page in length.

7. There is a Licensed Clinical Social Worker, *Laura Fox* available to discuss additional patient assistance programs and resources available to eligible patients, in addition to being available to patients and their families to aid with the challenges that arise after diagnosis and during treatment. The social worker can be reached at (904) 997-3800

(PATIENT’S SIGNATURE) __________________________________ (DATE) ___________________
SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his/her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English (see Addendum A).

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, sex, national origin, religion, physical handicap, or source of payment (see Addendum A).

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.
NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS (ADDENDUM A)

Cancer Specialists, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cancer Specialists, LLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cancer Specialists, LLC:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as: ○ Qualified sign language interpreters
  ○ Written information in other formats (large print, audio, accessible electronic formats, other formats) □ Provides free language services to people whose primary language is not English, such as: ○ Qualified interpreters
  ○ Information written in other languages
• If you need these services, contact Beth Page, Director of Compliance and Business Resources

If you believe that Cancer Specialists, LLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Beth Page, Director of Compliance and Business Resources
7015 A C Skinner Pkwy, Suite 1
Jacksonville, FL 32256
Ph: 904-538-3664
Fx: 904-538-4496
Beth.Page@csnf.us

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Beth Page, Director of Compliance and Business Resources is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LIMITED ENGLISH PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

ATTENTION: if you speak English, language assistance services, free of charge, are available to you. Call 904-302-8932.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 904-302-8932.