MC RADIATION ONCOLOGY CENTER
3100 SW 62ND AVE ♦Miami, FL 33155
Phone: (305) 714-0094 ♦ Fax: (305) 907-5313

Michael Smith, M.D
Radiation Oncologist

Dear Patient,

Attached please find forms that **MUST BE COMPLETED** before coming to your consultation appointment. On the day of your appointment please bring these forms along with your Insurance and ID card, and any referrals that are needed. This is being done to help expedite the patient flow in the department.

Thanking you in advance for your cooperation.

The Radiation Oncology Department

Date:

Time:

Location: 3100 SW 62ND AVE.
Miami, FL 33155
(305) 714-0094

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Dear Patient:

Welcome to the MC Radiation Oncology Center. We would like to outline some information to help make your visits with us as easy as possible.

Our department is located on the first floor of the George E. Batchelor Research and Academic Pavilion at the Nicklaus Children's Hospital with parking available in the yellow garage across the facility as well as valet parking. There are also two other garages on campus with parking available for your convenience. Be sure to remember which garage you parked in. Your first stop is the reception desk next to the patient waiting area. Please bring **identification** such as a driver license or a social security card as well as **all** the completed forms you have received. If you have any trouble filling out forms or have additional questions, please contact the office and our receptionist will gladly assist you before your arrival. Please arrive 30 minutes before your first appointment to help expedite this process and patient flow in the department.

- **Insurance and referrals:** If your insurance carrier requires the use of special forms, please bring **two completed forms** in with you. If your insurance carrier requires a referral, you will need **to bring a copy.** The referral should be for up to **40** treatments. (The actual number of treatments will be decided by your radiation oncologist during your consultation and is usually less than 40 treatments.) If your insurance carrier requires precertification, your referring physician must obtain the precertification prior to registration.

Following your registration, take a seat in our waiting area as our Radiation Oncology Nurse will come get you.

Your visits are divided into a carefully planned series of steps through which you become acquainted with our personnel and procedures while we determine your needs and custom design and begin your treatment. The appointments you will have are as follows:

1. **Consultation.** Radiation Oncology Nurse will provide a complete assessment during the first consult including patient vitals, pain level, medication prescribed, allergies, and education about safety issues and radiation side effects. Once a week during the course of radiation treatment the nurse will conduct a site-specific assessment and new complaints. The nurse is going to inform you if you need to have lab work done as per Radiation Oncologist request due to abnormal blood count and other images procedures prescribed. The nurse is going to see patient on follow ups with Radiation Oncologist after treatment. Please bring new complaints, medication and imaging records any time for review.
2. **Simulation.** Your next appointment, about an hour long, is a treatment planning session we call "simulation". This simulation includes a CT scan of the area of your body to be treated. It takes place in the CT room. The radiation therapist will position you on the CT table and make an immobilization device if needed to ensure that you are as comfortable as possible, as the

goal is to position you the same way every day during your radiation treatment. This enables us to plan a treatment that is tailored to your particular needs and the specific location of your disease. At the completion of this "simulation", the Radiation Therapist will create tiny tattoos dots using permanent ink in the area, these will enable us to reproduce your treatment field exactly in your subsequent visits. He or she will also take photographs of the treatment area and a face photo.

3. **Verification/Portal Films and Beginning of Treatment.** A few days after simulation, you will return for pre-treatment portal also called "dry-run" of the CT treatment plan. This will take place in the Tomotherapy treatment room. That day the radiation therapist will provide you with your daily treatment schedule. The length of your treatment period is determined by your radiation oncologist and can be anywhere from two to eight weeks. There are several methods by which radiation is delivered, but the most common is external beam radiation therapy, usually given five days a week. External beam radiation is a painless procedure and only requires that you remain still for a few minutes. The duration of each radiation treatment takes about 10 to 15 mins.

As with all medical treatments, radiation may have side effects, which your physician and other staff members will discuss with you. Since radiation is a local treatment, any side effects will generally be limited to the area being treated (for instance, nausea if your stomach is being treated, or hair loss if we are treating your head). However, please be assured that external beam radiation will usually not interfere with your daily activities and be able to interact normally with family and friends.

You will be seen once a week by your Radiation doctor. You should discuss questions you have about treatment side effects and treatment outcome. He or she might also request that additional studies be done, such as blood tests, x-rays or CAT scans.

The Department of Radiation Oncology can make arrangements for you to see a social worker or a dietitian. The social worker can provide counseling, financial and insurance information, educational materials and help you get in touch with community resources. The dietitian is available to assist patients with nutritional concerns and problems. Tell your Radiation Oncologist, Nurse or Radiation Therapist if you would like an appointment to see either of them.

We know this is a difficult time in your life and everyone in our department wants to help you get through it with a minimum amount of stress. Staff physicians, nurses, therapists, office personnel – all are here to serve you, answer your questions and concerns and refer you to the appropriate people as necessary. If you would like to obtain even more detailed information about radiation, chemotherapy and specific cancers prior to your beginning treatment, you may contact The National Cancer Institute at 1-800-4-CANCER or your local American Cancer Society.

With our best wishes,

The Staff
Department of Radiation Oncology

Check all that apply:

☐ CHANGE OF ADDRESS ☐ NEW PATIENT

☐ CHANGE OF INSURANCE

MC RADIATION ONCOLOGY CENTER
REGISTRATION-PLEASE FILL OUT COMPLETELY

Patient Name: _____ Date of Birth: _____ Sex: _____

Social Security: _____ Address: _____

City: _____ State: _____ Country: _____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Email Address: _____ Race: _____ Ethnicity: _____

Gender Identity: _____ Religious Background: _____

Preferred Language: _____ Employment Status: _____ Marital Status: _____

Spouse Name: _____ Spouse Phone Number: _____

Emergency Contact: _____ Relationship To Patient: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Referring Physician Name: _____

Office Phone Number: _____ Office Address:_____

City: _____ State: _____ Country: _____ Zip: _____

If Patient Under 18 Please Complete (*If Different then Emergency Contact*)**:**

Parent or Guardian Name: _____

Date of Birth: _____ Address: _____

City: _____ State: _____ Country: _____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

INSURANCE INFORMATION

We will be submitting to your insurance carrier(s) and need a copy of your id card(s)

Primary Insurance: _____ Policy Number: _____

Group Number: _____ Effective Date: _____

Insured's Name: _____ Insured's Date Of Birth: _____

Secondary Insurance: _____ Policy Number: _____

Group Number: _____ Effective Date: _____

Insured's Name: _____ Insured's Date Of Birth: _____

Check all that apply:

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the carrier(s) listed above and assign directly to MC Radiation Oncology Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Print Name: _____ Insurance Number: _____

Signature: _____ Date: _____

I request that payment of authorized medigap benefits be made either to me or on my behalf to MC Radiation Oncology Center for any medical services furnished me by MC Radiation Oncology Center. I authorize any holder of medical information about me to release to my medigap insurer any information needed to determine these benefits payable for related services.

I hereby give MC Radiation Oncology Center permission to use and disclose all protected health information for treatment, payment, or health care operations.

_____

Signature

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Michael Smith, M.D
Radiation Oncologist

To: Physician / Medical Facility: _____

Address: _____

Phone: _____ Fax: _____

Please Release My:

_____ Hospital / Treatment Records specifically operative, pathology and discharge reports

_____ X-Rays and Scans ( ) with reports ( ) reports only

_____ Pathology ( ) slides and reports ( ) reports only

_____ Other: _____

For the Following Date(s) of Service: _____

To: MC Radiation Oncology Center
3100 SW 62ND AVE
Miami, FL 33155
Phone: (305) 714-5313
Fax: (305) 907-5313

I, _____ , give permission for the above records, x-rays, scans, and/or slides

(please print full name)

to be released to the MC Radiation Oncology Center as indicated above.

I further give permission for my radiation oncology physician(s) to forward my records to other physicians and/or other medical facilities felt to be necessary and appropriate in the management of my medical condition.

Patient Address: _____

_____

Date of Birth: _____

Patient Signature: _____ Date: _____

(A Reproduction of this Authorization will be as valid as the original and will remain in effect for (1) year from the above date.)

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Michael Smith, M.D
Radiation Oncologist

PATIENT'S NAME: _____

PHYSICIAN LIST: (Please be as complete as possible)

Referring Physician: _____ Phone: _____F ax: _____

Address: _____

Primary Physician: _____ Phone: _____ Fax: _____

Address: _____

Other(s): (surgeon, medical oncologist, gynecologist, etc.)

Name: _____ Phone: _____ Fax: _____

Address: _____

Name: _____ Phone: _____ Fax: _____

Address: _____

Name: _____ Phone: _____ Fax: _____

Address: _____

Name: _____ Phone: _____ Fax: _____

Address: _____

Name: _____ Phone: _____ Fax: _____

Address: _____

Name: _____ Phone: _____ Fax: _____

Address: _____

Name: _____ Phone: _____ Fax: _____

Address: _____

MC RADIATION ONCOLOGY CENTER NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Information may be shared among members of the practice where necessary to provide treatment to the patient, obtain payment for the treatment and carry on routine business operations for the practice. (TPO)

In addition, the practice may disclose PHI (Protected Health Information) without patient consent or authorization to further certain public policy objectives including:

- Where disclosure is required by law;
- For a judicial or administrative proceeding;
- For public health activities;
- For health oversight activities:
- To report incidents of abuse, neglect or domestic violence;
- For law enforcement purposes;
- To avert a serious threat to health and safety;
- For national security and intelligence activities and protective services;
- For certain military and veterans activities and benefits;
- For health, safety and security of prison inmates or other detainees;
- To facilitate organ, eye or tissue donation, and
- Coroners, medical examiners, and funeral director.

By law, our practice must have your written permission (authorization) to use or give out your personal medical information for any purpose that is not stated in this notice.

Patients' Privacy Right Under HIPAA

The privacy regulations grant patients' the following rights regarding their PHI (Protected Health Information):

- The right to Notice of Practice's Privacy Practices for PHI;
- The right to inspect and copy their PHI;
- The right to request amendment or correction of their PHI;
- The right to receive an accounting list that provides information about disclosures of their PHI that were made to third parties for purposes other than treatment, payment and health care operations and other than those disclosures that were authorized by the individual;
- The right to request that the practice further restrict the way it uses or discloses their PHI;
- The right to request that the practice communicate with them by alternative means or at alternate locations. The practice will do their best to accommodate all reasonable requests.

If you believe our practice has violated your privacy rights as indicated in this notice, you may file a complaint with our practice in writing or call out office at 305-714-0094 and ask to speak to our Compliance Officer. No one will retaliate or take action against you for filing a complaint.

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NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Social Security Number: _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of MC Radiation Oncology

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

Address:

_____

_____

Telephone:

_____(primary)

_____(secondary)

MC RADIATION ONCOLOGY CENTER
OUR FINANCIAL POLICY

Thank you for choosing MC ROC as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read, and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE, if you do not have any insurance. Payment may be made by cash or check.

Regarding Insurance: We accept assignment of insurance benefits. You are responsible for any co-pays, co-insurance and deductibles and for payment of any non-paid amounts as per your insurance company. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Regarding Insurance Plans where we are a participating provider, all co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, please refer to the above paragraph. If your insurance company does not cover the nature of your medical problem you are responsible for payment of bills related to that non-covered medical problem.

If your insurance company requires you to obtain a referral from your primary care physician in order to see the Specialist, please follow the following procedures to avoid non-payment of your bill by your insurance company.

1. The patient is responsible for obtaining any necessary referrals before the Specialist may see you as a patient.
2. As per your insurance company, if you do not have the proper referral when you go to a Specialist appointment, we must reschedule your appointment since your insurer will deny payment on all claims not having a proper referral.
3. The patient is always responsible for keeping track of how many visits to a Specialist each referral will cover. New updated referral and the obtaining thereof is always the patient's responsibility.
4. Please have your referral sent, faxed (#383-0064) or brought to the office with you at time of visit.

Missed Appointments: Please notify us if you are unable to keep your appointment. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please understand that we are abiding by the rules and regulations of your insurance company. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X_____ Date:_____
Signature of Patient or Responsible Party

X_____ Date:_____
Signature of Co-Responsible Party

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Radiation Oncologist

Authorization for Release of Information

I hereby authorize MC Radiation Oncology Center to release information including, if any psychiatric or psychological information, infectious or contagious disease information (including AIDS confidential information, and/or information about drug or alcohol abuse or treatment of the same) for the health records of:

Covering the periods from: _____to: _____

Date of Birth: _____ SSN#: _____

Information to be released:

- ☐ Copy of Radiation Oncology Records
- ☐ Other _____

Information to be released to: (Please include name and address):
_____
_____
_____
_____

Purpose or disclosure: _____

I have read and understand the Consent for Release of Radiation Oncology Records, and have voluntarily and knowingly signed such consent.

Signature of Patient or Representative: _____
Date_____

HIPPA COMPLIANCE
AUTHORIZATION TO USE AND/OR DISCLOSE CONFIDENTIAL INFORMATION

INTRODUCTION: This authorization gives Michael D. Smith, M.D., d/b/a MC Radiation Oncology Center and its employees and agents (the

"Practice") permission to use and/or disclose health information about you, including the release of medical records.

You may refuse to sign this authorization. If you refuse to sign this authorization, it will not affect your ability to obtain treatment by the. Practice, but you will not receive research-related treatment if you do not authorize use or disclosure of information for purposes of the research, and you will not receive health care intended for the purpose of evaluation by a third party (such as your employer or state agencies in connection with a workers' compensation claim) if you do not authorize use by or disclosure of the information to that party.

You have a right to revoke this authorization. You may revoke this authorization at any time in writing except to the extent that we already have relied on it. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:

Michael D. Smith, M.D., 3100 SW 62ND Avenue, Miami, FL 33155 Attn: Privacy Officer

Re-disclosure of Information. Health information disclosed pursuant to this authorization may be subject to re-disclosure if it is not otherwise protected by the federal privacy rule or another privacy law.

PATIENT NAME: _____Date of Birth: _____

Home Address: _____Home Telephone:_____

1. COVERED HEALTH INFORMATION. This is a specific description of the health information to be used and/or disclosed

_____
_____

In the event that any of the foregoing information contains genetic information, venereal disease-related records, tuberculosis-related records, mental health records (other than psychotherapy notes), drug and alcohol treatment records and/or HIV/AIDS-related diagnosis and treatment information (i.e., information regarding any HIV-related test, infection or illness including AIDS), I also authorize release of such information. (strike if not authorized)

2. PERSONS ENTITLED TO INFORMATION. Name of the person(s), or class of persons, to whom the Practice may disclose my health information and, if applicable, **the address** to which I instruct the Practice to send that information:

_____

3. PURPOSE OF REQUESTED USE OR DISCLOSURE (complete one item):

□ I have initiated this Authorization and do not elect to provide a statement of purpose other than that the use and/or disclosure is at my request.

□ The purposes of the requested use and/or disclosure are the following:

_____

4. EXPIRATION (complete one item):

□ This Authorization shall be in force and in effect until: _____
(enter specific date of expiration of this authorization or write "NONE" for no expiration. You may revoke this authorization at any time as mentioned above)

AGREEMENT: I have read (or have had read to me) this Authorization and understand its terms. I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I knowingly and voluntarily authorize Michael D. Smith, M.D., and its employees and agents to use and/or disclose my health information in the manner described in this Authorization.

Signature: _____

DATE:

Printed Name: _____

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Michael Smith, M.D
Radiation Oncologist

Dear Patient or Patient's Family:

Under Florida Law (26:2H-62) it is the responsibility of the attending physician to inquire of you whether you have an Advanced Directive for Health Care (Living Will). Please advise us. If you have such a document, please provide us with a copy that may be included in your office record in this office. Please advise us of any future changes in this written directive.

It is your right under Florida to have such a written Advance Directive for Healthcare. Should you desire more information about this please inquire of us and we will provide information.

Kindly acknowledge by signing below that we have fulfilled our obligation to notify you. Note that this paper is not in anyway binding, is not a living will and has nothing at all to do with your regular will.

ACKNOWLEDGED BY:

_____ Date:_____

Patient

_____ Date:_____

Family Member if patient is unable to sign

Advanced Directive: Discussed and present_____

Advanced Directive: Discussed and patient refused_____

Advanced Directive: Not discussed, documented or present_____

If none, do you have a surrogate? _____Yes _____No

Name:_____