TEXAS BREAST SPECIALISTS

MRN: _____

New Patient & Family History

Today's Date: _____

Patient Information

Patient Name: _____
First Name Last Name Middle or Maiden

Age: _____ Date of Birth: _____ Sex (assigned at birth): ☐ Male ☐ Female ☐ Unknown

Home Address: _____
Address City State Zip Code

Telephone (1st call): _____ Type: ☐ Cell ☐ Family Member ☐ Home ☐ Neighbor ☐ Work

Telephone (2nd call): _____ Type: ☐ Cell ☐ Family Member ☐ Home ☐ Neighbor ☐ Work

Email: _____ Preferred Contact Method: ☐ Phone ☐ Email

Emergency Contact (#1): _____ _____ _____
Name Relationship Telephone

Emergency Contact (#2): _____ _____ _____
Name Relationship Telephone

Please select one (1) response from each of the following six (6) categories:

1. Preferred Language:

☐ Arabic ☐ English ☐ Farsi/Persian ☐ Filipino/Tagalog
☐ German ☐ Hindi ☐ Japanese ☐ Korean
☐ Russian ☐ Spanish ☐ Vietnamese ☐ Other, please specify: _____

If you need an interpreter for your visit, please notify reception upon arrival or inform the virtual agent once connected for telehealth visits.

2. Race:

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other
☐ Unknown
☐ Choose Not to Disclose

3. Gender Identity:

☐ Male
☐ Female
☐ Female-to-Male (FTM)/Transgender Male/Trans Man
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Genderqueer, neither exclusively male nor female
☐ Additional gender category or other, please specify; _____
☐ Choose Not to Disclose

4. Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other
☐ Unknown
☐ Choose Not to Disclose

5. Pronouns:

☐ He/Him/His
☐ He/Him/His or They/Them/Theirs
☐ She/Her/Hers
☐ She/Her/Hers or They/Them/Theirs
☐ They/Them/Theirs
☐ Choose Not to Disclose

6. Sexual Orientation:

☐ Lesbian, gay, or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Something else, please describe: _____
☐ Don't Know
☐ Choose Not to Disclose

Care Coordination

Referring Physician: _____ Phone: _____ Fax: _____

_____
Address City State Zip Code

Primacy Care Provider: _____ Phone: _____ Fax: _____

_____
Address City State Zip Code

Other Provider: _____ Phone: _____ Fax: _____

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

TEXAS BREAST SPECIALISTS

MRN: _____

New Patient & Family History

Today's Date: _____ Patient Name: _____ Date of Birth: _____
First Last Middle or Maiden

Habits

Do you use any of the following?

Alcohol: ☐ Yes ☐ No What type? _____ How much? _____ How often? _____ If quit, when? _____

Tobacco: ☐ Yes ☐ No What type? _____ How much? _____ How often? _____ If quit, when? _____

Caffeine: ☐ Yes ☐ No What type? _____ How much? _____ How often? _____ If quit, when? _____

Recreational Drugs:

☐ Yes ☐ No What type? _____ How much? _____ How often? _____ If quit, when? _____

Diet and Nutrition

Have you had a weight change in the last 3 months? ☐ Yes ☐ No If yes, number of pounds lost _____, gained _____

Check the word(s) that best describe your diet: ☐ Regular ☐ Soft ☐ Liquid ☐ Diabetic ☐ Supplements ☐ Other: _____

Describe your appetite: ☐ Good ☐ Fair ☐ Poor

Are you diabetic? ☐ Yes ☐ No If Yes, what type: _____

If Yes, how is it controlled: ☐ Diet ☐ Oral Medications ☐ Insulin ☐ Other: _____

Physical Activity

Do you need to use any of the following? (check all that apply): ☐ Cane ☐ Walker ☐ Wheelchair ☐ Oxygen ☐ Other: _____

How much time do you spend exercising each week? _____ What type of exercise? _____

Please select one (1) of the following activity statuses:

- ☐ Fully active.
- ☐ Restricted in physically strenuous activity, ambulatory and able to do light work.
- ☐ Walk without aid, capable of all self-care. Up and about more than 50% of waking hours.
- ☐ Capable of only limited self-care, confined to bed or chair more than 50% of waking hours.
- ☐ Completely disabled; cannot do any self-care; totally confined to bed or chair.

Disability Status

1. Are you deaf or do you have serious difficulty hearing? ☐ Yes ☐ No ☐ Choose Not to Disclose
2. Are you blind or do you have serious difficulty seeing, even when wearing glasses? ☐ Yes ☐ No ☐ Choose Not to Disclose
3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older) ☐ Yes ☐ No ☐ Choose Not to Disclose
4. Do you have serious difficulty walking or climbing stairs? (5 years old or older) ☐ Yes ☐ No ☐ Choose Not to Disclose
5. Do you have difficulty dressing or bathing? (5 years old or older) ☐ Yes ☐ No ☐ Choose Not to Disclose
6. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older) ☐ Yes ☐ No ☐ Choose Not to Disclose

Occupation

Are you currently employed or working: ☐ Yes ☐ No

Work Schedule is: ☐ Full-time ☐ Part-time ☐ Sick Leave ☐ Retired ☐ Disabled

Current employer and profession (former if retired): _____

Family Information

Marital Status: ☐ Divorced ☐ Life Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Unknown

Who lives with you? (Please check all that apply): ☐ I live alone ☐ Spouse ☐ Children ☐ Parents ☐ Friend ☐ Other: _____

Who helps at home? _____

Do you have daily transportation available? ☐ Yes ☐ No

Please list the number of and ages of dependents in the table below:

Dependents	Daughters	Sons	Stepchildren	Adopted	Foster	Parents/Grandparents
Number of Each:						
Ages:						

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

CONFIDENTIAL
Version TBS 3.1

TEXAS BREAST SPECIALISTS

MRN: _____

New Patient & Family History

Today's Date: _____ Patient Name: _____ Date of Birth: _____
First Last Middle or Maiden

Reproductive History

Often people diagnosed with cancer have concerns about sexual activity or sexuality. Do you have such concerns? ☐ Yes ☐ No

If yes, what are your concerns? _____

Do you or have you taken hormones replacement therapy (HRT)? ☐ Yes ☐ No

↳ If yes, please record below. Please note that this includes testosterone replacement therapy (TRT) and birth control pills.

Name or Description	Type	Start (Date or Year)	End (Date or Year)

For Women Only:

Date of last menstrual period: _____ Number of pregnancies: _____

Age at last period (menopause): _____ Number of live births: _____

Age at first menstrual period: _____ Age at first live birth: _____

Have you breast fed: ☐ Yes ☐ No If Yes, for how long (months): _____

Have you had your uterus removed? ☐ Yes ☐ No If Yes, Age: _____

Have you had your ovaries removed? ☐ Yes ☐ No If Yes, Age: _____

If Yes, which ovary was removed? ☐ Both ☐ Left Ovary ☐ Right Ovary

For Men Only:

Impotence (Erectile Dysfunction): ☐ Yes ☐ No Have you had any changes in Sex Drive: ☐ Yes ☐ No

Family History

Have you or any member of your family undergone genetic testing for cancer? ☐ Yes ☐ No

If yes, what were the results of the testing? _____

Is there any family history of cancer, blood disorders, cardiovascular disease, or other medical problems? If so, record below:

Relationship	Name	Status	Current Age *or* Age at Death	Medical Problem or Diagnosis	Age of on set
Mother		☐ Living ☐ Deceased			
Father		☐ Living ☐ Deceased			
Children		☐ Living ☐ Deceased			
Brother(s)		Living Deceased			
Sister(s)		Living Deceased			
Maternal Grandmother		☐ Living ☐ Deceased			
Maternal Grandfather		☐ Living ☐ Deceased			
Paternal Grandmother		☐ Living ☐ Deceased			
Paternal Grandfather		☐ Living ☐ Deceased			
Aunt(s)		Living Deceased			
Uncle(s)		Living Deceased			
Cousin(s)		Living Deceased			

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

TEXAS BREAST SPECIALISTS

MRN: _____

Past Medical History

Today's Date: _____ Patient Name: _____ Date of Birth: _____

First Last Middle or Maiden

What is your understanding of why you are being seen: _____

Please list all other Diagnosis and Conditions. If additional space is needed, then please copy this page.

Diagnosis / Conditions	Physician Name	Physician Office #	Date Occurred

Please list here any past surgeries with approximate age at which performed (include minor surgeries, tonsillectomy, tumors, etc.).

Surgery / Injury / Hospitalization	Physician Name / Hospital	Physician Office #	Date Occurred

Have you ever received radiation, radium, radioactive implants, or cobalt treatments in the Past? ☐ Yes ☐ No

Have you had x-rays in the last six (6) months: ☐ Yes ☐ No If Yes, name of facility: _____

Have you ever received chemotherapy or immunotherapy? ☐ Yes ☐ No If Yes, please describe: _____

Do you have any metallic implants (spine, hip, knee, etc.)? ☐ Yes ☐ No If Yes, please describe: _____

Are you claustrophobic (fearful of being in enclosed or narrow spaces): ☐ Yes ☐ No If yes, how is it controlled: _____

Do you have any religious or cultural beliefs that prohibit receiving blood products? ☐ Yes ☐ No

Do you have a pacemaker/defibrillator? ☐ Yes ☐ No

Preventive Health Maintenance

Please provide dates for each or answer "none" or "N/A":

Screenings:
- Last mammogram: _____
- Last pap smear: _____
- Last colonoscopy: _____
- Last dental exam: _____
- Last bone density (DEXA) scan: _____
- Last prostate/PSA exam: _____
- Last CT Chest Lung screening: _____

Vaccines:
- Last pneumonia vaccine: _____
- Last Flu vaccine: _____
- Last HPV Vaccine: _____
- Last COVID Vaccine: _____
- Last Hepatitis B Vaccine: _____

Advanced Directives

Have you executed a Medical Power of Attorney (MPOA)? ☐ Yes ☐ No

Have you executed a Directive to Physicians (Living Will)? ☐ Yes ☐ No

Have you executed an Out-of-Hospital Do Not Resuscitate (OOH-DNR)? ☐ Yes ☐ No

Would you like to learn about our Advance Care Planning Program? ☐ Yes ☐ No

If you have signed one of these legal documents, please speak to the nurse regarding your decisions and bring a copy with you to your appointment.

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

TEXAS BREAST SPECIALISTS

MRN: _____

Medication and Allergy List

Today's Date: _____ Patient Name: _____ Date of Birth: _____
First Last Middle or Maiden

Pharmacy Information

_____ _____
Pharmacy Name Phone Number

_____
Address City State Zip Code

Medications

Please list all prescriptions, vitamins, herbs, and over-the-counter medications that you are currently taking and/or bring your medications with you to your appointment. If additional space is need then please copy this page.

Medication (include prescription, over the counter and/or vitamins)	**Strength**	**Dose**	**How many times a day**

* * Allergies * *

Medication/Drug (include prescription, over the counter and/or vitamins)	**Describe Reaction**

Have you ever had any problems with anesthesia? ☐ Yes ☐ No If Yes, please describe: _____

Have you ever had an allergic reaction to: ☐ Contrast Dye ☐ Iodine ☐ Shellfish ☐ Latex

If Yes, what type of reaction did you have: Hives Shortness of breath Other: _____

Additional Comments and/or Information: _____

_____

_____

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

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

TEXAS BREAST SPECIALISTS

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PRESCRIPTION HISTORY CONSENT

I voluntarily consent to provide Texas Oncology access to and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

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

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

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

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

Relationship to Patient (if Patient not signing): _____

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

Reader/Translator Signature: _____ Date: _____

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

TEXAS BREAST SPECIALISTS

MRN: _____

Review of Systems

Today's Date: _____ Patient Name: _____ Date of Birth: _____

First Last Middle or Maiden

Height: _____ Weight: _____

What symptoms are you currently having? (Indicate all that apply)

CONSTITUTIONAL	YES	SKIN	YES	ENDOCRINE	YES
Chills		Breast Discharge (☐ L or ☐ R)		Thyroid Problems	
Fever		Breast Lump (☐ L or ☐ R)		Cold Intolerance	
Poor Appetite		Hives		Excessive Hunger	
Weakness		Mole Change(s)		Excessive Thirst	
Weight Gain		Rashes		Heat Intolerance	
Weight Loss		Skin Lesion			
EYES	**YES**	**GASTROINTESTINAL (GI)**	**YES**	**NEUROLOGIC**	**YES**
Blurred Vision		Blood in Stool		Anxiety	
Dizzy Spells		Chronic Stomach Pain		Balance Problems	
Double Vision		Clay-Colored Stools		Confusion	
Eye Pain		Constipation		Depression	
Failing Vision		Diarrhea		Dizziness	
Glasses or Contacts		Heart Burn		Headache	
Glaucoma		Hemorrhoids		Memory Loss	
See "Floating Lights"		Nausea/Vomiting		Nervous Breakdown	
Change in Vision		Ulcers		Numbness/Tingling	
		Vomit blood		Personality Changes	
				Seizures	
				Speech Changes	
HEAD & NECK	**YES**	**GENITOURINARY (GU)**	**YES**	**MUSCULOSKELETAL**	**YES**
Chronic Nose Obstruction		Blood in Urine		Arthritis	
Dental Problems		Burning or Pain when Urinating		Back Pain	
Difficulty Swallowing		Dark Urine		Bone Pain	
Discharge from Ear(s)		Frequent Urination		Fractures	
Dry Mouth		Incontinence		Joint Stiffness	
Ear Pain (☐ L or ☐ R)		Infections		Limited Motion	
Hearing Aid (☐ L or ☐ R)		Kidney Stones		Muscle Jerking	
Hearing Loss (☐ L or ☐ R)		Urinate often at Night		Paralysis	
Hoarseness				Problems Walking	
Mouth Sores		Men only…		Swelling of Extremities	
Mouth/Throat Bleeding		Erectile Dysfunction		☐ L or ☐ R Sided Weakness	
Painful Swallowing					
Persistent Neck Rigidity		Women only…			
Repeated Nose Bleeds		Vaginal Bleeding			
Ringing in Ears		Vaginal Discharge			
Toothache					
CARDIOVASCULAR	**YES**	**RESPIRATORY**	**YES**	**HEMATOLOGIC**	**YES**
Ankles Swelling		Chronic Cough		Anemia	
Chest Pain		Coughing up Blood		Bleeding Problems	
Circulation Problems		Difficulty breathing		Blood Clots	
High Blood Pressure		Dry Cough		Easily Bleeds	
High Cholesterol		Productive Cough		Easily Bruises	
Low Blood Pressure		Short of Breath			
Pacemaker/Defibrillator		Spit up Blood		**IMMUNOLOGIC**	**YES**
Palpitations		Uses Oxygen _____ L/min		Food Allergies	
		Wheezing/Asthma		Seasonal Allergies	

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

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

TEXAS BREAST SPECIALISTS

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AUTHORIZATION TO RELEASE INFORMATION

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

Contact Name: _____

Relationship to patient: _____

Phone Number: _____

Check this box to make this your emergency contact ☐

Contact Name: _____

Relationship to patient: _____

Phone Number: _____

Check this box to make this your emergency contact ☐

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

_____ _____

Signature of Patient / or Personal Representative Date

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

_____ _____

Name of Personal Representative Relationship to Patient

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

_____ _____

Reader/Translator Signature Date

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

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

TEXAS BREAST SPECIALISTS

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ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES

1. I understand that I am responsible for charges not covered or reimbursed by my insurance carrier and/or benefits provider at the time of service. I agree, in the event of nonpayment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier and/or benefits provider to release information regarding my coverage to Texas Oncology P.A.
3. 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 Texas Oncology P.A. This assignment covers 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 and/or benefits provider prohibits an assignment of benefits, I hereby instruct and direct my insurance carrier and/or benefits provider to make benefits checks payable to me and mail it to the attention of my name "in care of" to the following address:

   c/o Texas Oncology, P.A.
   12377 Merit Dr., Ste. 700
   Dallas, TX 75251

4. I authorize Texas Oncology to pursue administrative appeals and file suit for payment and all other causes of action, including but not limited to ERISA claims, and to pursue legal action against me if I fail to endorse any payment(s) I receive to Texas Oncology.

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

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

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

Relationship to Patient (if Patient not signing): _____

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

Reader/Translator Signature: _____ Date: _____

Texas Oncology Use Only
Date Acknowledgement Received: _____

TEXAS BREAST SPECIALISTS

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network provider. hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or must pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:
Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Texas law protects patients with state-regulated health insurance from surprise medical bills in emergencies or when they didn't have a choice of doctors. The law bans doctors and providers from sending surprise medical bills to patients in those cases.

Certain services at an in-network hospital or ambulatory surgical center
When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or genetic services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You are **never** required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

The Texas surprise billing law applies to state-regulated insurance plans, the Employee Retirement System of Texas and the Teacher Retirement System of Texas. It covers out-of-network diagnostic imaging providers, emergency care providers, facility-based providers (i.e., physicians who work in a hospital or similar facility setting), and laboratories. If you get services from one of those providers and you have one of the covered plans, the provider may not balance bill you unless they notify you in writing and get your written consent to be balance billed before providing the service. For example, an in-network provider may order imaging or lab tests from an out-of-network diagnostic imaging provider or lab. If state law applies, the out-of-network provider may not balance bill you for a covered health care service or related supply if it is in connection with a health care service performed by your in-network provider, unless you sign a balance billing waiver and give up your protections.

When balance billing isn't allowed, you also have these protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost.

Under the law, health care providers need to give patients who don't have certain types of health care coverage or who are not using certain types of health care coverage an estimate of their bill for health care items and services before those items or services are provided.

You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.

If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

If you believe you've been wrongly billed, you may contact the federal U.S> Department of Health and Human Services at (800) 985-3059 or the Texas Department of Insurance at (800) 252-3439.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit https://www.tdi.texas.gov/medical-billing/surprise-balance-billing.html for more information about your rights under Texas law.

TEXAS BREAST SPECIALISTS

PATIENT BILLING

Texas Oncology provides both quality medical and financial care to our patients. Patient confidentiality is maintained while receiving appropriate payment for the medical care provided. The following is a detailed summary of our policies and procedures regarding patient billing.

1. Patients must pay co-pays at the time of service with an accepted method of payment. Texas Oncology accepts all major credit cards (Visa, MasterCard, Discover, and American Express) and ACH (direct bank payments).
2. All payments received will be electronically processed and receipts are available upon request.
3. Patients will receive a Good Faith Estimate (GFE) of expected charges for all ordered and/or scheduled services from a Business Office representative upon request if the insurance will not fully cover all services and/or the patient is self-pay, underinsured or declared indigent.
    a. Patients may also request a Good Faith Estimate of expected charges at any time.
    b. Additional items or services that convening providers or convening facilities recommend as part of the course of care must be scheduled or requested separately and are not reflected in the Good Faith Estimate.
    c. Information provided in the Good Faith Estimate is only an estimate regarding items or services reasonably expected to be furnished at the time presented to the patient and that actual items, services, or charges may differ from the estimate.
    d. Good Faith Estimates are not service contracts and do not require the patient to obtain the items or services from any of the providers or facilities identified in the estimate.
    e. Patients have the right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially more than the expected charges included in the Good Faith Estimate. Please contact your physician's Business Office for additional details our visit our website at www.texasoncology.com.
4. Patients should promptly notify the Business Office of any changes in insurance coverage, billing address, legal name, referring physician, or when admitted to an inpatient rehabilitation or Skilled Nursing Facility (SNF).
5. Primary, secondary, and tertiary insurance claims for services rendered will be filed by the Business Office.
6. After a payment is made by the insurance company, the Business Office will reconcile the explanation of payment. The patient will be billed for the unpaid amount unless a contract with an insurance carrier prohibits it.
7. Any claim denied due to patient ineligibility, benefit limits, or services not covered will be billed directly to the patient unless a contract with the insurance carrier prohibits it.
8. If a patient receives direct payment from an insurance company or a patient advocacy program, specifically indicated as payment for services rendered, Texas Oncology reserves the right to submit the balance due to an outside collection agency.
9. Patients may request an alternative billing address.
10. A patient may consent to release financial information to others acting on their behalf. Consent may be updated at any time by contacting their physician's Business Office.
11. Patients may request an itemized statement of billed charges and payments at any time.
12. Patient billing statements will be mailed out every 30 days with a return envelope and patients may enroll in paperless statements. Any patient balance over 45 days may receive a letter or phone call to collect or to arrange a payment plan.
13. Patients may receive text messages and/or email notifications, regarding their outstanding balances to the contact information on file. A patient may request to opt in or out of text and/or email notifications at any time by contacting their physician's Business Office. Message frequency varies. Message and data rates may apply.
14. Patients may pay balances online using the secure Online Bill Pay portal at www.texasoncology.com. For questions regarding statements, billing, or online payments, please call toll free 1-855-425-9808.
15. Patients may enroll in interest free payment plans to pay balances, please call toll free 1-855-425-9808.
16. Texas Oncology does not charge interest for amounts past due; however, we reserve the right to submit any unpaid invoices over 120 days to a third-party collection agency. The third-party collection agents may utilize all demographic information provided in manual or automated efforts to communicate regarding unpaid balances. This includes, but is not limited to, home telephone, cellular telephone, employment telephone, and any form of digital communications including, but not limited to, text messages, emails, and/or automatic telephone dialing systems.
17. Any billing questions regarding oral medications are addressed by the pharmacist/pharmacy staff.
18. Patients may receive Beneficiary Notification Letters or other notifications if their insurance plan offers a value-based care or concierge care programs in which Texas Oncology participates.

Questions or complaints should be directed to the Texas Oncology main Business Office at 1-800-758-7608.

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

TEXAS BREAST SPECIALISTS

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FINANCIAL RELEASE OF INFORMATION

As the patient, you are in control of the financial records pertaining to your medical care. We will not disclose financial information without your consent unless there is evidence of legal authority for another individual to act on your behalf or the law otherwise permits the disclosure.

Texas Oncology may disclose and discuss financial matters of your account with the individuals recorded on the *Authorization to Release Information* form. Please note that staff will ask for key identifying elements that assist in establishing the individual's identity. This may include the patient's full legal name, date of birth, address, telephone number, guarantor, subscriber, or other unique personal identifiers.

To revoke consent at any time for authorized individuals please contact your physician's Business Office directly. You shall be required to complete another Authorization to Release Information form.

COLLECTION AND USE OF SOCIAL SECURITY NUMBERS

Texas Oncology collects Social Security Numbers (SSNs) for claims and reimbursement purposes. Your personal information is maintained securely and accessed only to complete essential business functions.

OPTIONAL: By indicating your government-issued Social Security Number in the field below, you consent to Texas Oncology's collection and use of this information:

			-			-				

ACKNOWLEDGMENT OF RECEIPT OF PATIENT FINANCIAL DOCUMENTS

Please acknowledge the following statements:

☐ I acknowledge receipt of the *Patient Billing* form and understand the terms and conditions.

☐ I acknowledge receipt of the *Your Rights and Protections Against Surprise Medical Bills*.

☐ I acknowledge receipt of the *Financial Release of Information* form and understand the terms and conditions.

☐ I acknowledge receipt of the *Collection and Use of Social Security Numbers* form and understand the terms and conditions and that providing my Social Security Number is optional.

Please sign and date below:

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

Relationship to Patient (if Patient not signing): _____

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

Reader/Translator Signature: _____ Date: _____

Questions or complaints should be directed to the Texas Oncology main Business Office at 1-800-758-7608.

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

TEXAS BREAST SPECIALISTS

NOTICE OF PRIVACY PRACTICES

Effective Date: September 19, 2024

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

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

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

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

How We May Use or Disclose Your Health Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PROHIBITED USES: Federal law prohibits use and disclosure of your health information for criminal, civil, or administrative investigations or proceedings for the "mere act of" seeking, obtaining, providing, or facilitating reproductive health care that was legal when it was provided is prohibited. This type of information cannot be shared without first getting an assurance from the third party requesting your health information that the information will not be used to charge you with a crime.
Examples of reproductive health care include but are not limited to; birth control, pregnancy screening, prenatal care, miscarriage management, pregnancy termination, and other types of care, procedures, services, and supplies used for the diagnosis and treatment of conditions related to the reproductive system.

Texas Oncology will obtain a written and signed attestation in the following circumstances from the person requesting the information that it will not be used to charge you with a crime.

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

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

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

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

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

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

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

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

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

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.
- Marketing and Fundraising: We may only use and disclose your health information for marketing or fundraising purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.
- Sale of Your Health Information: We may sell your health information only with your written authorization.
- Drug Treatment Records: Records related to the diagnosis, treatment and/or rehabilitation of Substance Abuse Disorder may not be used or disclosed in a civil, criminal, administrative, or legislative proceeding against the individual absent written consent from the individual or a court order.

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

If you give permission to share your identifiable health information with a person or business, the information may no longer be protected. There is a risk that your information will be released to others without your permission.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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

Patient Name (Please Print): _____

Signature of Patient/Legally Authorized Representative: _____

Date: _____

Relationship to Patient (if Patient not signing): _____

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

Reader/Translator Signature: _____ Date: _____

Texas Oncology Use Only
Date Acknowledgement Received: _____

-OR-

Reason acknowledgment was not obtained:

_____

_____

_____

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

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

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ELECTRONIC SIGNATURE DISCLOSURE AND CONSENT

This Electronic Signature Disclosure and Consent sets forth the terms and conditions governing my consent to sign documents electronically through, and my use of, the Texas Oncology, P.A. electronic registration or portal software.

1. I acknowledge and agree that my electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature in a non-electronic form.
2. I understand that the electronically stored copy of my signature, any written instruction or authorization, and any other document provided to me by Texas Oncology, P.A. is considered to be the true, accurate, and complete record, legally enforceable in any proceeding to the same extent as if such documents were originally generated and maintained in printed form.
3. I agree not to contest the admissibility or enforceability of the electronically stored copy of this document and any other documents.
4. I may decline to electronically sign this document and withdraw my consent to sign this document electronically by contacting Texas Oncology, P.A. directly.
5. I may contact Texas Oncology, P.A. separately to request to sign these documents on paper or to receive a paper copy of the signed documents.
6. I agree to the terms and conditions of this document on behalf of myself or as the representative or legal guardian of the patient on whose behalf I am signing this document.

By signing below, I acknowledge that I have read and agree to the information above.

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

Relationship to Patient (if Patient not signing): _____

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

Reader/Translator Signature: _____ Date: _____

Texas Oncology Use Only
Date Acknowledgement Received: _____

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