

NEW PATIENT HISTORY FORM

CONTACT INFORMATION

Legal First Name _____ Last Name _____

Preferred Name _____ D.O.B. _____

Home Address _____
Street City State Zip

Phone Numbers (H) _____ (C) _____ (W) _____

Email Address _____

Social Security Number: _____

****This information is needed to verify your identity with insurance providers for processing claims.****

Sex Assigned at Birth ☐ Male ☐ Female ☐ Intersex ☐ Other please specify: _____ ☐ Choose not to disclose

Gender Identity ☐ Male ☐ Female ☐ Non-binary ☐ Trans-Male ☐ Trans-Female ☐ Other

Preferred pronouns ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____

Race (Select all that apply) ☐ Asian ☐ Black or African American ☐ Latino/ Latina/Latinx ☐ Native American or First American

☐ Native Hawaiian and Pacific Islander ☐ White ☐ Other Race _____ ☐ I wish not to disclose

Ethnicity _____ Preferred Language _____

Health Care Providers

Referring Physician _____

Primary Care Physician _____

OB/GYN Physician _____

Pain Management or Other _____

Please list any other physicians you would like to receive copies of information

Name

Problem Cared For

1. _____

2. _____

3. _____

Please list your preferred pharmacy below:

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____ ☐ Please check if mail-order pharmacy.

Emergency Contact

Name: _____ Relationship: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Preferred Contact #: _____

PERSONAL MEDICAL HISTORY

Are you currently on Oxygen (O₂)? ☐ Yes ☐ No

Please list all current prescriptions and over-the-counter medications. Include herbals, supplements, and vitamins below:

Medication	Dosage (ex. mg. ml.)	How often?	When prescribed?

Legal Name _____ D.O.B. ____/____/____

Allergies

Latex Allergy ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list the medication (include dyes or contrasts) and type of reaction:

1. _____
2. _____
3. _____
4. _____

Hospitalizations

Please list all hospitalizations within the past 2 years

Date	Reason for Hospitalizations	Where	Doctor

Surgeries/Procedures

Please list all surgeries and procedure details and year occurred (e.g. pacemaker, dental extractions)

Date	Type of Surgery or Procedure	Where	Doctor

Previous Treatment for Cancer (if applicable)

Radiation Therapy _____

Chemotherapy/Immunotherapy/Targeted Therapy _____

Hormone Therapy _____

Blood Transfusions

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, did you have a reaction? ☐ Yes ☐ No Date of last transfusion _____

Legal Name _____ D.O.B. ____/____/____

Please check if you had or currently have any of the following:

☐ Anemia		☐ High Cholesterol	
☐ Anxiety		☐ Jaundice/Hepatitis Type:	
☐ Arthritis		☐ Kidney Disease	
☐ Asthma		☐ Liver/Gallbladder Disease	
☐ Blood Disorder/Blood Clots		☐ Measles/Mumps/Rubella/Chicken Pox	
☐ Bladder Problems		☐ Mental Illness	
☐ Cancer type:		☐ Migraine or Frequent Headaches	
☐ Chronic Pain		☐ Sexually Transmitted Infections (Herpes, HIV)	
☐ Colitis/Crohn's Disease		☐ Seizure Disorder	
☐ Autoimmune Disorder (ex. Lupus)		☐ Skin Disease (eczema, psoriasis, hives)	
☐ COPD/Emphysema		☐ Stroke	
☐ Congestive Heart Failure		☐ Thyroid Problem	
☐ Depression		☐ Other medical problems not listed. List below.	
☐ Diabetes			
☐ Heart Condition (Afib, Heart Attack)			
☐ High Blood Pressure			

Exam/Vaccine History

List month/year you last had:

Flu Vaccine _____ Hepatitis Vaccine _____ Pneumonia Shot _____ COVID-19 Vaccine (date of last dose) TB _____
Test (PPD) _____ Eye Exam _____ Dental Visit _____ Tetanus Shot _____ Shingles Rectal _____
Exam _____ Colonoscopy/Sigmoid Exam _____ or Stool Blood Test _____

Assigned Male at Birth Only

Last PSA screening _____ Last prostate exam: _____

Assigned Female at Birth Only

Age at first menstrual period _____ If still menstruating, date of last period _____
Age at menopause _____ Have you ever taken birth control pills? ☐ Yes ☐ No If yes, how long? _____ Yrs
Do you currently use birth control? ☐ Yes ☐ No If yes, what type? _____
Have you ever taken fertility drug treatments? ☐ Yes ☐ No
Have you ever taken hormone replacements? ☐ Yes ☐ No If yes, how long? _____ Yrs
Are you currently taking hormone replacements? ☐ Yes ☐ No If yes, what type? _____ Number of pregnancies _____
Number of live births _____ Age at first childbirth _____
Did you breastfeed? ☐ Yes ☐ No If yes, how long? _____
Have you had a hysterectomy? ☐ Yes ☐ No If yes, when? _____
Are your ovaries intact? ☐ Yes ☐ No If no, when were they removed? _____
Year of last:
Pap Test _____ ☐ Normal ☐ Abnormal Breast Exam _____ ☐ Normal ☐ Abnormal
Mammogram _____ ☐ Normal ☐ Abnormal
Do you perform monthly self-breast exam? ☐ Yes ☐ No

Legal Name _____ D.O.B. ____/____/____

SOCIAL HISTORY

Relationship Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner Living Arrangement

☐ Alone ☐ With spouse ☐ With significant other or roommate

☐ Supervised Living ☐ Other _____

Do you have children? ☐ Yes ☐ No If yes, how many? _____ Are your children: ☐ Biological ☐ Adopted Do you have any of the following:

☐ Organ Donor Card ☐ Health Care Proxy ☐ Power of Attorney ☐ Living Will

If you have signed any of these legal documents, please bring copies to your next appointment. Would you like more information on any of these? ☐ Yes ☐ No

Do you have Medical Power of Attorney, Living Will, or Out-of-Hospital Do Not Resuscitate Forms? ☐ Yes ☐ No

Advance Care Planning (ACP) is an ongoing process of learning about the choices we each have for our future medical care.

Would you like more information about Advance Care Planning? ☐ Yes ☐ No

Is there someone who you would like to list as your primary contact regarding your healthcare? ☐ Yes ☐ No

Name _____ Relationship _____ Phone _____

Are you currently employed? ☐ Yes ☐ No ☐ Retired

Occupation (previous if retired) _____ Employer _____

Are you a Veteran? ☐ Yes ☐ No

If yes, Branch _____ Years served _____ Active combat? ☐ Yes ☐ No Discharge year _____

Do you now or did you ever:

Smoke cigarettes/cigars/pipes/vaping/chewing tobacco? ☐ Yes ☐ No

If yes, # of pack(s)/day _____ # of yrs _____ When did you quit? _____

Consume alcohol? ☐ Yes ☐ No

If yes, # of drinks/day _____ Drinks/week _____ When did you quit? _____

Consume cannabis? ☐ Yes ☐ No

If yes, # times/day _____ # times/week _____ When did you quit? _____

Use illegal drugs? ☐ Yes ☐ No

If yes, which ones? _____ When did you quit? _____

Do you wear sunscreen? ☐ Yes ☐ No

Do you follow a specific diet or have any dietary restrictions (i.e., low-sodium, vegan, keto, etc.)? ☐ Yes ☐ No

If yes, please describe _____

Do you have any food allergies ☐ Yes ☐ No

If yes, please describe _____

Do you exercise regularly? ☐ Yes ☐ No

If yes, please describe and how often _____

Legal Name _____ D.O.B. ____/____/____

Legal Name _____ D.O.B. ____/____/____

Relative	Alive or Deceased? Age at death _____	Ever diagnosed with Cancer? ☐ Yes ☐ No ☐ Unknown	Age at Cancer diagnosis	Type of Cancer (breast, lung, colon, etc.)	Other Medical Problem (heart disease, diabetes, etc.)
Biological Mother	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
Biological Father	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
Maternal Grandmother	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
Maternal Grandfather	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
Paternal Grandmother	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
Paternal Grandfather	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
Biological Siblings					
☐ Brother ☐ Sister	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
☐ Brother ☐ Sister	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
☐ Brother ☐ Sister	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
☐ Brother ☐ Sister	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
Biological Children					
☐ Daughter Son ☐	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
☐ Daughter Son ☐	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
☐ Daughter Son ☐	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
☐ Daughter Son ☐	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
Additional:					
Other Relatives (ex. cousin, aunt or uncle)					
	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			
	☐ Alive ☐ Deceased Age at death _____	☐ Yes ☐ No ☐ Unknown			

Legal Name _____ D.O.B. _____ / _____ / _____

Are you currently experiencing any of the following? Check all that apply in both columns.

CONSTITUTIONAL

- ☐ No problems or concerns ☐
Recent weight loss
☐ Recent weight gain ☐
Fevers / chills
☐ Night sweats
☐ Excessive itching ☐
Food supplements
_____ Number of meals daily

EYES

- ☐ No problems or concerns ☐
Glaucoma
☐ Cataracts ☐
Vision Loss
☐ Other: _____

EAR, NOSE, MOUTH, THROAT

- ☐ No problems or concerns ☐
Hearing Loss
☐ Dental Problem ☐
Hoarseness
☐ Nose bleeds
☐ Other: _____

CARDIOLOGY

- ☐ No problems or concerns ☐
High blood pressure
☐ Heart Murmur
☐ Rapid/irregular heartbeat ☐
Chest pain / tightness
☐ Pacemaker / Defibrillator ☐
Ankle swelling
☐ Leg cramps at night
☐ Other: _____

RESPIRATORY

- ☐ No problems or concerns
☐ Asthma / Bronchitis/ Emphysema ☐
Shortness of breath
☐ Cough that produces blood
☐ Other: _____

GASTROINTESTINAL

- ☐ No problems or concerns ☐
Loss of appetite
☐ Heartburn or indigestion
☐ Stomach pain or discomfort ☐
Frequent nausea / vomiting ☐
Recurrent diarrhea
☐ Constipation ☐
Bloody stools
☐ Black, tarry stools
☐ Difficulty swallowing
☐ Other: _____

ENDOCRINE

- ☐ No problems or concerns ☐
Thyroid problems
☐ Blood sugar problems ☐
Excessive sweating
☐ Other: _____

GENITOURINARY

- ☐ No problems or concerns ☐
Difficulty urinating
☐ Frequent / painful urination ☐
Recurrent bladder infection ☐
Vaginal itching / discharge ☐
Sexual problems
☐ Blood in urine
☐ Other: _____

MUSCULOSKELETAL

- ☐ No problems or concerns ☐
Difficulty walking
☐ Joint aches or stiffness ☐
Painful legs / feet
☐ Back ache / pain
☐ Other: _____

NEUROLOGICAL

- ☐ No problems or concerns ☐
Difficulty concentrating ☐
Headache
☐ Dizziness / fainting/blackouts ☐
Numbness hands/ feet
☐ Seizures / convulsions ☐
Memory changes
☐ Other: _____

PSYCHOSOCIAL

- ☐ No problems or concerns ☐
Nightmares
☐ Anxious / nervousness ☐
Trouble sleeping ☐
Lonely / depressed ☐ Work
/ family problems ☐ Tire easily
☐ Other: _____

SKIN / BREAST

- ☐ No problems or concerns ☐
Sores / rashes
☐ Moles
☐ Nipple discharge
☐ Change in breast size ☐
Lump / pain
☐ Other: _____

HEMATOLOGIC / LYMPHATIC

- ☐ No problems or concerns ☐
Easy bleeding / bruising ☐
Anemia or blood problem ☐
Frequent infections
☐ Swelling of glands
☐ Swelling of hands / feet
☐ Other: _____

ALLERGIC / IMMUNOLOGIC

- ☐ No problems or concerns ☐
Facial swelling ☐
Tightening of throat ☐ Hives
☐ Other: _____

Patient Assistance and Responsibility Declaration

I authorize Lowcountry Oncology Associates, a partner of OneOncology, to disclose and submit my personal and medical information to insurance carriers and financial assistance programs as necessary on my behalf. This authorization shall remain in effect until formally revoked by me in writing.

Date:

SSN:

Patient Name:

Date of Birth: / /

Number of people living in your household:

Veteran: Yes No

Monthly or Yearly Income:

Income verification from tax returns, bank statements or payroll stubs may be required.

Patient Signature:

Financial Assistance

Lowcountry Oncology Associates Financial Counselors are available to assist in identifying potential financial assistance through foundations or copay card programs, which may help reduce out-of-pocket expenses, including deductibles and coinsurance for medications prescribed by your physician. Application submission does not guarantee approval, as program approval is determined by the drug manufacturer or foundation and may be subject to specific eligibility criteria. Participation in these programs is voluntary, and assistance availability is not guaranteed. If approved, you will be notified of your award, and information may be sent by mail. Please be advised you may still have a remaining balance, as these programs may not cover all charges.

Responsibility Statement

Insurance serves as a means for reimbursement of fees paid to the physician for services rendered but does not eliminate the obligation for payment. The allowances or reimbursement percentages are determined by your insurance providers contract with you, not our office. You are responsible for covering any applicable deductible, co-insurance, and any outstanding balance not paid by your insurance company. While we will assist in facilitating reimbursement, the ultimate responsibility for payment remains with you.

Financial Assistance Authorization

I authorize income verification and inquiries through third party vendors such as Experian Health to determine eligibility for financial assistance. I authorize enrollment on my behalf with non-for-profit organizations for out- of-pocket patient assistance for which I may qualify. I understand this is not a guarantee of payment on or for my out-of-pocket responsibility. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as the original.

Financial Counselor

Kayleigh Durden-Shuty

(p) 843-619-2240

(E) Kayleigh.Durdenshuty@oneoncology.com

HIPAA Disclosure Release Form and Communication Preferences

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner(s) (Check All That Apply):

- | | |
|---|--|
| ☐ Cell Telephone <ul style="list-style-type: none"> ☐ Leave message with detailed information ☐ Only leave message with call back details ☐ Work Telephone <ul style="list-style-type: none"> ☐ Leave message with detailed information ☐ Only leave message with call back details | ☐ Home Telephone <ul style="list-style-type: none"> ☐ Leave message with detailed information ☐ Only leave message with call back details ☐ Written Correspondence <ul style="list-style-type: none"> ☐ Mail to my home address on file. ☐ Mail to the address listed below: |
|---|--|

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand the identity of designees must be verified before release of PHI.

Authorized Designees:

Name: _____	Relationship: _____	Telephone: _____
Name: _____	Relationship: _____	Telephone: _____
Name: _____	Relationship: _____	Telephone: _____
Name: _____	Relationship: _____	Telephone: _____

***This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke this authorization in writing.***

- ***I understand I have the right to revoke this authorization, in writing, at any time.***
- ***I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.***

Patient/Legal Representative Print Name

Patient/Legal Representative Signature

Date



Conditions of Service and Patient Rights and Responsibilities

In this document, **"Patient"** means the person receiving treatment. **"Patient Representative"** means any person acting on behalf of the Patient and signing as the Patient's representative. Use of the word "I," "you," "your" or "me" may in context include both the Patient and the Patient Representative. With respect to financial obligations "I" or "me" may also, depending on the context, mean financial guarantor "Guarantor."

"Provider" means the practice and may include Lowcountry Oncology Associates physicians and/or staff, which may include but are not limited to: Oncologists, Radiologists, Radiation Oncologists, Physician Assistants, Nurse Practitioners, Social Workers, Behavioral Health Practitioners, as well as certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors, or assignees acting on their behalf.

1. **Consent to Treatment.** I consent to medical care and procedures recommended by my provider, including emergency care, lab tests, x-rays, imaging, diagnostics, and other treatments. I also allow residents and supervised trainees to participate in or observe my care as part of their training. I consent to blood-borne disease testing, such as hepatitis, HIV, or AIDS, if ordered by my provider or protocol, and understand that side effects are usually minor, like brief pain, burning, bleeding, or soreness at the needle site. Test results will be kept confidential in my medical record.
2. **Consent to Treatment Using Telemedicine.** I consent to the use of Telemedicine, which allows my healthcare providers to share my medical information for diagnosis, treatment, follow-up, or education. My information may be shared with third parties as needed, and confidentiality protections still apply. I understand there are risks, such as technical problems or delays, and results cannot be guaranteed. I may withhold or withdraw consent at any time without affecting my care or benefits.
3. **Financial Agreement.** I understand the practice may bill my insurance. I (the Patient or Guarantor) agree to pay any remaining balance not covered by insurance, including coinsurance, deductibles, non-covered services, or unpaid amounts due to policy limits or exclusions. If I overpay, the extra may be applied to other outstanding balances before a refund. I can request a free, itemized billing statement. For patients with government or certain private insurance coverage, payments may be adjusted according to the program or plan rules.
4. **Professional services rendered by independent contractors and practitioners are not part of the practice bill.** I understand and acknowledge that the independent contractors and advanced practice professionals providing services to me at the practice are not agents or employees of the practice. I understand that I may not actually see or be examined by all physicians or other advanced practice professionals participating in my care; for example, I may not see the radiologists or pathologists participating in my care. I understand that, in most instances, there will be a separate charge for professional services rendered by these providers and that I will receive a bill for these professional services that is separate from the bill for practice services.
5. **Legal Relationship between Practice and Physicians and Advanced Practice Professionals.** Independent physicians and advanced practice professionals are responsible for their own actions, and the practice shall not be liable for the acts or omissions of any such independent physicians and/or advanced practice professionals. To the extent that any duty to perform any care, procedure, service, and/or treatment is imposed upon the practice, the responsibility for the performance of such care, procedure, service, and/or treatment is delegated to the applicable healthcare professionals.
6. **Assignment of Benefits.** I assign my insurance benefits to the provider and authorize direct payment to the provider for services, including emergency care. I understand that my insurance may be supplemental to other coverage, and accepting insurance payment does not prevent the provider from collecting any remaining balance from other sources. I agree to help the provider collect payment from any responsible party, including allowing the provider to act on my behalf if needed. If I receive payment directly for my care, I will promptly forward it to the provider. I also authorize the provider to pursue claims, appeals, or legal remedies for any unpaid or underpaid benefits on my behalf and to access necessary documents or information from insurers or other parties. This assignment is full and unconditional, but it does not take away my right to recover payment from my insurer or health plan.



7. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the practice or physician by the Medicare or Medicaid program.
8. **Outpatient Medicare Patients.** Medicare does not provide coverage for "self-administered drugs" or drugs that you normally take on your own, with only a few limited exceptions. If you get self-administered drugs that are not covered by Medicare Part B, we may bill you for the drug. However, if you are enrolled in a Medicare Part D Drug Plan, these drugs may be covered in accordance with Medicare Part D Drug Plan enrollment materials. If you pay for these self-administered drugs, you can submit a claim to your Medicare Part D Drug Plan for a possible refund.
9. **Consent to Photographs, Video, Digital, and Audio Recordings.** I acknowledge that the practice's security, quality improvement, patient care, healthcare operations, and/or risk management activities may involve photographs, video, digital or audio recordings, and/or other images of me, including telephone calls, being recorded, and I consent to such images and recording. I understand that the practice retains the ownership rights to the images and/or recordings. Images and/or recordings in which I am identified will only be used and disclosed as permitted by law.
10. **Consent to Telephone Calls, Email or Text Message.** I authorize the use of any email address or telephone number I provide (including email addresses or telephone numbers that I provide for my family or designated representatives) (whether wireless or a landline and including email addresses and telephone numbers forwarded or transferred from provided information) for receiving information relating to my healthcare services and financial obligations, including healthcare-related information and financial communications. I expressly agree and consent that you or your customer service personnel and collection agents may contact me by telephone, on a recorded line and/or using automated dialing technology, at any telephone number I have provided or obtained, or any number forwarded or transferred from that number, regarding the services rendered or my related financial obligations. I represent (if I am not the patient) that I am authorized by the patient to receive calls, text messages, or email messages on their behalf and that I am involved in assisting in the patient's care and/or payment. Methods of contact may include pre-recorded/artificial voice messages and/or automated dialing devices. I represent that I am the account holder for any telephone number(s) provided and am responsible for notifying the provider of any changes or updates.

I understand that emails and text messaging are unencrypted and that there is some risk that information included in unencrypted messages may be intercepted or received by unintended third parties and/or stored or archived by service providers and system operators. Information included in such messages may include name, date/time of appointments, physician/practice name or specialty, patient account number, or other information related to financial obligation or services. Message and data rates may apply. Message frequency may vary. Additional text messaging terms may be located on the Practice's website and may be updated. To stop receiving a certain text message type, I understand that I can opt out by notifying Lowcountry Oncology Associates in writing but may continue receiving text messages of other types subject to separate opt-out notification. For assistance or questions, contact Lowcountry Oncology Associates (843) 790-8280.
11. **Use and Disclosure of Information.** I consent to providers using and disclosing health information about me for purposes of treatment, payment, healthcare operations, public health, and other purposes permitted by applicable law. Information covered by this consent includes history and physical records, emergency records, laboratory reports, pharmacy claims and prescription history, physician office notes, nurse notes, discharge summaries, genetic, psychological, psychiatric, intellectual disability, and substance abuse disorder information, and information about infectious diseases including blood borne diseases such as HIV and AIDS. This consent applies to uses and disclosures for coordinated care or case management purposes; to any person or entity involved in payment on the Patient's behalf, including to verify coverage; and to my employer's designee when services are related to a workers' compensation claim. If I am covered by Medicare or Medicaid, I authorize the release of my healthcare information to the Social Security Administration or appropriate state agency for payment of a claim. Providers participate, or may participate, in Health Information Exchanges (HIEs) to share health information for purposes permitted by law. Unless I notify provider in writing that I desire to opt-out, I consent to my health information being shared as described above.



12. **Other Acknowledgments.**

- **Weapons/Explosives/Drugs.** I understand and agree that if the practice at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage on my person or with my belongings, the practice may terminate the practice/patient relationship.

Acknowledgment of Notice of Patient Rights and Responsibilities. I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law. I understand that I can provide an advance directive to the provider, and I can request information about formulating an advance directive at registration or thereafter.

Acknowledge (Initial)

Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the provider may use and disclose my health information. I understand that this information may be disclosed electronically by the provider and/or the provider's business associates. I understand that I may contact the practice Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge (Initial)

Acknowledgment: I have been given the opportunity to read and ask questions about the information contained in this form, specifically including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the providers.

Acknowledge (Initial)

I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, certify I have read and understand these Conditions of Physician Practice Services and have signed knowingly, freely, voluntarily, and agree to be bound by its terms. I have received no promises, assurances, or guarantees as to the results of any medical treatment or services. If insurance coverage is insufficient, denied, or unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Date

Time

Patient/Patient Representative Signature

Witness Signature and Title

Additional Witness Signature and Title:

(required for Patients unable to sign without a representative or Patients who refuse to sign)

Additional Signature and Title

If you are not the Patient, please identify your relationship to the Patient. **(Mark relationship(s) from list below):**

☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Healthcare Power of Attorney ☐ Guarantor ☐ Other (Please specify)

Patient & Visitor Code of Conduct

In order to effectively provide medical treatment to you, we require commitment by staff, patients, and visitors alike. Mutual trust and respect can help us provide the right treatment plan, in a safe and respectful environment that promotes healing.

We have outlined the Code of Conduct expectations for all Patients and Visitors designed to help make your appointment or visit successful:

- Patients, visitors, and staff will address each other in a respectful manner.
- Patients are encouraged to speak with their providers about their therapeutic care plan.
- This is a smoke free campus. Tobacco and vaping use is forbidden on campus grounds.
- Visitors may be limited based on patient condition, space, or safety concerns.
- Patients and visitors are expected to follow reasonable instructions from healthcare staff related to safety, infection control, treatment, and facility operations.
- Weapons, illegal or dangerous items, alcohol, marijuana, and illicit drug use, as well as possession of related paraphernalia is forbidden in all areas and campus grounds.
- Patients, visitors, and staff will refrain from exhibiting threatening or abusive behavior towards each other. We have zero tolerance for threatening or abusive behavior.
- When possible, staff will attempt to address concerns through respectful communication and de-escalation. However, ongoing, or severe violations may result in immediate action to ensure safety.
- Threatening or abusive behavior includes, but is not limited to verbal threats, yelling, intimidation, harassment, physical gestures, unwanted physical contact, damage to property, or refusal to follow reasonable staff instructions related to safety or care delivery.
- Recording, photography, or video/audio streaming of staff, patients, or clinical conversations is not permitted without express consent from all involved parties, except as allowed by law. Unauthorized recording may result in removal from campus.

A safe and respectful environment is central to promoting a healing environment, therefore, if the above-mentioned expectations are not followed:

- **Patients:** If you choose not to comply with your therapeutic care plan or the above expectations, we may discharge you or your appointment. For subsequent appointments or admissions, we will follow our standard continuity of care practice and seek to have you cared for by the same care team.
- **Visitors:** If you fail to comply with the above expectations, you may be asked to leave campus and may be restricted from future visitation privileges.

Acknowledgement

I acknowledge that I have received, read, and understand the Patient & Visitor Code of Conduct

Name: _____

Signature: _____

Date: _____