SAGE
Hematology and Oncology

13943 N 91st Ave, Building H, Suite 101,
Peoria, AZ 85381
(623)-254-7271 (Office)
www.sagehemonc.com

18715 N. Reems Rd,Suite 140,
Surprise, AZ 85374
(888)-388-1953 (Fax)

GENERAL CONSENT FOR CARE AND TREATMENT

WELCOME TO SAGE HEMATOLOGY AND ONCOLOGY.

AS A PATIENT YOU HAVE THE RIGHT TO BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED SURGICAL, MEDICAL OR DIAGNOSTIC PROCEDURE TO BE USED, AS WELL AS THE RISKS AND HAZARDS INVOLVED, SO THAT YOU MAY MAKE AN INFORMED DECISION WHETHER OR NOT TO UNDERGO ANY SUGGESTED TREATMENT OR PROCEDURE. YOU HAVE THE RIGHT TO DISCUSS THE TREATMENT PLAN WITH YOUR PHYSICIAN ABOUT THE PURPOSE, POTENTIAL RISKS AND BENEFITS OF ANY TEST ORDERED FOR YOU. IF YOU HAVE ANY CONCERNS REGARDING ANY TEST OR TREATMENT RECOMMENDED BY YOUR HEALTH CARE PROVIDER, WE ENCOURAGE YOU TO ASK QUESTIONS.

AT THIS INITIAL POINT IN YOUR CARE, NO SPECIFIC TREATMENT PLAN HAS BEEN RECOMMENDED.
THIS CONSENT FORM IS SIMPLY AN EFFORT TO OBTAIN YOUR PERMISSION TO PERFORM THE EVALUATION NECESSARY TO IDENTIFY THE APPROPRIATE TREATMENT AND/OR PROCEDURE FOR ANY IDENTIFIED CONDITION(S).

THIS CONSENT PROVIDES US WITH YOUR PERMISSION TO PERFORM REASONABLE AND NECESSARY MEDICAL EXAMINATIONS, TESTING AND TREATMENT.

BY SIGNING BELOW, YOU ARE INDICATING THAT
(1) YOU INTEND THAT THIS CONSENT IS CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED;
AND (2) YOU CONSENT TO TREATMENT AT THIS OFFICE OR ANY OTHER SATELLITE OFFICE UNDER COMMON OWNERSHIP.

THE CONSENT WILL REMAIN FULLY EFFECTIVE UNTIL IT IS REVOKED IN WRITING.

YOU HAVE THE RIGHT AT ANY TIME TO ASK ADDITIONAL QUESTIONS OR TO DISCONTINUE OR DECLINE SERVICES.

I HEREBY AUTHORIZE A PHYSICIAN AND/OR MID-LEVEL PROVIDER (NURSE PRACTITIONER, PHYSICIAN ASSISTANT, OR CLINICAL NURSE SPECIALIST), ALONG WITH OTHER NECESSARY HEALTHCARE PROFESSIONALS OR DESIGNEES, TO CARRY OUT REASONABLE AND NECESSARY MEDICAL EXAMINATIONS, TESTS AND TREATMENT FOR THE UNDERLYING CONDITION THAT HAS MOTIVATED ME TO REQUEST CARE AT THIS FACILITY. IF FURTHER TESTING OR INVASIVE PROCEDURES ARE NECESSARY, I WILL BE REQUESTED TO READ AND SIGN ADDITIONAL CONSENT FORMS PRIOR TO THE PROCEDURE(S) OR TEST(S).

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENTS.

_____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____
PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_____
RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE OF WITNESS DATE

_____
PRINTED NAME OF WITNESS

NEW PATIENT QUESTIONNAIRE

PATIENT NAME: _____

DOB: ____/____/____ AGE: _____ ❑ MALE ❑ FEMALE

SS#:_____

PRIMARY ADDRESS:

_____

CITY: _____ STATE:_____ ZIP: _____

HOME PHONE: (_____)_____

CELL PHONE: (_____)_____
MAY WE SEND YOU TEXT MESSAGES REGARDING YOUR APPOINTMENT? ❑ YES ❑ NO

OTHER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PREFERRED LANGUAGE: _____

<u>EMPLOYMENT STATUS:</u>

❑ EMPLOYED/SELF EMPLOYED ❑UNEMPLOYED ❑RETIRED ❑DISABLED

OCCUPATION (OR FORMER OCCUPATION):_____

NAME OF EMPLOYER: _____WORK PHONE: (_____) _____

RACE:
❑ NATIVE AMERICAN OR ALASKA NATIVE
❑ ASIAN
❑ AFRICAN AMERICAN
❑ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
❑ CAUCASIAN ❑ OTHER

NEW PATIENT QUESTIONNAIRE

PRIMARY CARE PHYSICIAN: _____

PHONE: _____

I WAS REFERRED HERE BY DR. _____

PHONE: _____

PLEASE LIST ANY ADDITIONAL PHYSICIANS YOU SEE: (INCLUDE PHONE #):

_____PHONE: _____

_____PHONE: _____

PHARMACY NAME, ADDRESS AND PHONE NUMBER:

_____

EMERGENCY CONTACT NAME #1: _____

RELATIONSHIP: _____

PHONE: (_____) _____

EMERGENCY CONTACT NAME #2: _____

RELATIONSHIP: _____

PHONE: (_____) _____

ADVANCED DIRECTIVES: DO YOU HAVE-

❑ A LIVING WILL
❑ DNR
❑ DURABLE POWER OF ATTORNEY

IF YES, PLEASE BRING A COPY WITH YOU.

NEW PATIENT QUESTIONNAIRE

MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- ❑ ANEMIA
- ❑ BLEEDING DISORDER
- ❑ HEART DISEASE/ATRIAL FIB
- ❑ HYPERTENSION
- ❑ PULMONARY EMBOLISM/DVT/BLOOD CLOTS
- ❑ DIABETES
- ❑ URINARY INFECTION OR KIDNEY DISORDER
- ❑ NEUROLOGICAL DISORDER/ STROKE
- ❑ ARTHRITIC CONDITIONS
- ❑ PSYCHIATRIC DISORDER/ILLNESS
- ❑ COPD/ASTHMA
- ❑ THYROID DISEASE
- ❑ SEIZURES OR EPILEPSY
- ❑ CHOLESTEROL DISORDER
- ❑ SLEEP APNEA
- ❑ OTHER

PLEASE LIST ANY OTHER MEDICAL ILLNESSES OR PROBLEMS WITH DETAILS AND DATES:

_____

_____

BLOOD TRANSFUSION HISTORY

PLEASE LIST ANY BLOOD TRANSFUSIONS YOU'VE HAD AND THE APPROXIMATE DATE(S):

_____

_____

NEW PATIENT QUESTIONNAIRE

PRIOR CANCER TREATMENT

DO YOU CURRENTLY HAVE CANCER?
❑ YES ❑ NO

TYPE OF CANCER AND YEAR DIAGNOSED:

_____

TREATMENT: ❑ SURGERY ❑ CHEMOTHERAPY ❑ RADIATION ❑ RADIATION IMPLANTS

HOSPITAL/DOCTOR'S OFFICE WHERE YOU RECEIVED TREATMENT:

NAME:_____

ADDRESS/PHONE:_____

TYPE OF CANCER AND YEAR DIAGNOSED

_____

TREATMENT: ❑ SURGERY ❑ CHEMOTHERAPY ❑ RADIATION ❑ RADIATION IMPLANTS

HOSPITAL/DOCTOR'S OFFICE WHERE YOU RECEIVED TREATMENT:

NAME:_____

ADDRESS/PHONE:_____

SURGERY HISTORY
PLEASE LIST ANY SURGERIES YOU HAVE HAD AND THE APPROXIMATE DATE

PROCEDURE	DATE	COMPLICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NEW PATIENT QUESTIONNAIRE

HEALTH MAINTENANCE

DATE OF LAST BONE DENSITY: _____ ABNORMAL ❑

DATE OF LAST PAP SMEAR: _____ ABNORMAL ❑

DATE OF LAST MAMMOGRAM: _____ ABNORMAL ❑

DATE OF LAST COLONOSCOPY: _____ ABNORMAL ❑

OBSTETRICS HISTORY
ARE YOU CURRENTLY PREGNANT? ❑ YES ❑ NO

OF PREGNANCIES: _____ # OF BIRTHS: _____ # OF MISCARRIAGES: _____

FAMILY MEDICAL HISTORY

PLEASE INDICATE ANY MAJOR CONDITIONS, INCLUDING CANCERS, THAT YOUR IMMEDIATE FAMILY MEMBERS HAVE HAD.

RELATIVE	CONDITION AND DESCRIPTION	IF DECEASED WHAT AGE?
MOTHER	_____	_____
SIBLING	_____	_____
SIBLING	_____	_____
SIBLING	_____	_____
GRANDPARENT	_____	_____
GRANDPARENT	_____	_____
OTHER	_____	_____

SOCIAL HISTORY

DO YOU CURRENTLY SMOKE? ❑ YES ❑ NO
PREVIOUS SMOKER? ❑ YES ❑ NO
YEARS SMOKED:_____ PACKS PER DAY: _____
DO YOU USE OTHER TOBACCO PRODUCTS? ❑ YES ❑ NO
CONSUME ALCOHOL? ❑ YES ❑ NO HOW MANY DRINKS PER WEEK: _____
MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED/WIDOWER

NEW PATIENT QUESTIONNAIRE

LIST OF CURRENT MEDICATIONS:

INCLUDE PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS, COLD REMEDIES, VITAMINS, "ALTERNATIVE MEDICATIONS" AND HOMEOPATHIC MEDICATIONS.

PLEASE INCLUDE DOSAGE AND FREQUENCY.

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____
13._____
14._____
15._____
16._____
17._____
18._____
19._____
20._____

DO YOU HAVE ADDITIONAL MEDICATIONS NOT LISTED ABOVE? ❑ YES ❑ NO
IF YES, PLEASE ENUMERATE AT END OF QUESTIONNAIRE.

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS OR OTHER SUBSTANCES?
❑ YES ❑ NO PLEASE LIST ALLERGIES AND REACTIONS:

_____
_____

ARE YOU ALLERGIC TO IODINE OR CONTRAST?: ❑YES ❑ NO ❑UNKNOWN
DO YOU HAVE METAL IN YOUR BODY?
IF YES, WHERE? _____
HAVE YOU HAD ANY MRI'S RECENTLY?
IF YES, ANY ISSUES?_____

NEW PATIENT QUESTIONNAIRE

REVIEW OF SYSTEMS

PLEASE INDICATE ALL THAT YOU HAVE EXPERIENCED WITHIN THE LAST 6-12 MONTHS.

GENERAL

❑ WEIGHT LOSS ❑ FEVER ❑ CHILLS ❑ NIGHT SWEATS ❑ FATIGUE

EYES

❑ VISION CHANGES ❑ EYESIGHT PROBLEMS ❑ EYE PAIN

CARDIAC

❑ CHEST PAIN ❑ PALPITATIONS ❑ LEG SWELLING ❑ LEG PAIN
❑ SHORTNESS OF BREATH AT REST OR ON EXERTION

GASTROINTESTINAL

❑ NAUSEA ❑ VOMITING ❑ DIARRHEA ❑ CONSTIPATION ❑ DARK STOOLS
❑ BRIGHT RED BLOOD IN STOOL ❑ ABDOMINAL PAIN, IF YES, WHERE?_____

SKIN

❑ RASH, IF YES THEN WHERE?_____ ❑ CHANGE IN MOLE ❑ OPEN WOUND
❑ INFECTED OR DRAINING WOUND? IF YES, WHERE?_____

NEUROLOGIC

❑ HEADACHE ❑ CONFUSION ❑ DIZZINESS
❑ WEAKNESS IN YOUR ARMS OR LEGS ❑ NUMBNESS IN YOUR ARMS OR LEGS

HEMATOLOGIC

❑EASY BLEEDING ❑EASY BRUISING ❑HEAVY PERIODS ❑BLEEDING FROM GUMS

PSYCHIATRIC

❑ DEPRESSION ❑ ANXIETY ❑TROUBLE SLEEPING

ENDOCRINE

❑ HOT FLASHES ❑ ENLARGED BREASTS ❑ HAIR LOSS

OTHER (LIST ANY SYMPTOMS WE SHOULD BE AWARE OF):

❑_____
❑_____
❑_____
❑_____

AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED

I HEREBY AUTHORIZE SAGE HEMATOLOGY AND ONCOLOGY (SHO) TO OBTAIN AND USE MY PHOTOGRAPH FOR IDENTIFICATION AND MEDICAL DOCUMENTATION PURPOSES IN THE SHO'S ELECTRONIC MEDICAL RECORD (EMR) SYSTEM.

AS EVIDENCE OF MY AGREEMENT, I CONFIRM THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION FORM FOR MY RECORDS.

_____

PATIENT NAME (PRINT)

_____

PATIENT OR GUARANTOR (SIGNATURE)

_____

DATE

AUTHORIZATION OF RELEASE OF RECORDS

I, _____ GIVE PERMISSION TO RELEASE MY COMPLETE MEDICAL RECORDS

FROM THE OFFICE OF :

_____

_____

(NAME AND ADDRESS OF PROVIDER)

TO SAGE HEMATOLOGY & ONCOLOGY:
13943 N 91ST AVE, BUILDING H, SUITE 101, PEORIA, AZ 85381

FAX: 888-388-1953
TELEPHONE NUMBER: 623-254-7271

I UNDERSTAND THAT MY RECORDS WILL BE SENT VIA SECURE METHODS.
I UNDERSTAND MY NOT SIGNING THIS DOCUMENT DOES NOT PREVENT ME FROM RECEIVING CARE.

BY SIGNING THIS AUTHORIZATION FOR RELEASE OF MY RECORDS, I UNDERSTAND I AM GIVING FULL PERMISSION FOR SAGE HEMATOLOGY AND ONCOLOGY (SHO) TO RECEIVE COPIES OF ANY MEDICAL, PSYCHIATRIC, AIDS-RELATED SYNDROMES, HIV TESTING, ALCOHOL AND/OR DRUG ABUSE RELATED INFORMATION FOR THE ABOVE LISTED PERSON(S)

- I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT, IF I CHOOSE TO REVOKE MY CONSENT, I MUST SUBMIT A WRITTEN STATEMENT THAT IS SIGNED BY ME.
- I UNDERSTAND THAT SAGE HEMATOLOGY AND ONCOLOGY MUST IMMEDIATELY COMPLY WITH MY REQUEST TO REVOKE CONSENT, EXCEPT TO THE EXTENT THAT IT HAS ALREADY TAKEN SOME ACTION THAT WAS BASED ON MY ORIGINAL CONSENT

THIS CONSENT IS VALID INDEFINITELY UNTIL THERE IS WRITTEN COMMUNICATION RECEIVED TO REVOKE.

_____
PATIENT NAME (PRINT)

_____
PATIENT DATE OF BIRTH

_____
PATIENT OR GUARANTOR (SIGNATURE)

_____
DATE

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I AUTHORIZE THE RELEASE OF PROTECTED HEALTH INFORMATION THAT IS REQUIRED TO CARRY OUT TREATMENT, OR FOR PAYMENT OF HEALTHCARE OPERATIONS ON MY BEHALF.

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND AM AWARE OF THE FOLLOWING:

- I UNDERSTAND THAT ONCE SAGE HEMATOLOGY AND ONCOLOGY AGREES TO MY RESTRICTIONS, IT MUST COMPLY WITH THOSE RESTRICTIONS. I HAVE THE RIGHT TO PLACE RESTRICTIONS ON THE WAY MY PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED.
- I HAVE A RIGHT TO REVOKE MY CONSENT FOR THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AT ANY TIME. I UNDERSTAND THAT, IF I CHOOSE TO REVOKE MY CONSENT, I MUST SUBMIT A WRITTEN STATEMENT THAT IS SIGNED BY ME.
- I UNDERSTAND THAT SAGE HEMATOLOGY AND ONCOLOGY MUST IMMEDIATELY COMPLY WITH MY REQUEST TO REVOKE CONSENT, EXCEPT TO THE EXTENT THAT IT HAS ALREADY TAKEN SOME ACTION THAT WAS BASED ON MY ORIGINAL CONSENT.
- SAGE HEMATOLOGY AND ONCOLOGY HAS RESERVED THE RIGHT TO CHANGE FROM TIME TO TIME OUR PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. WHENEVER WE CHANGE OUR PRACTICES, WE WILL MODIFY THE NOTICE ACCORDINGLY; AND WE WILL INFORM YOU, PLACING THE AMENDMENT DATE AT THE BOTTOM OF THE POSTED NOTICE.

TERMINATING THE PROVIDER-PATIENT RELATIONSHIP

IT IS THE POLICY OF THIS PRACTICE TO MAINTAIN A COOPERATIVE AND TRUSTING PROVIDER-PATIENT RELATIONSHIP WITH ITS PATIENTS. WHEN SUCH A PROVIDER-PATIENT RELATIONSHIP HAS NOT BEEN FORMED OR A PROVIDER-PATIENT RELATIONSHIP IS NO LONGER PROCEEDING IN A MUTUALLY PRODUCTIVE MANNER, IT IS THE POLICY OF THIS PRACTICE TO TERMINATE THE PROVIDER-PATIENT RELATIONSHIP WITHIN THE BOUNDS OF APPLICABLE STATE AND FEDERAL LAWS, RULES, AND REGULATIONS; THE AMERICAN MEDICAL ASSOCIATION GUIDELINES, AND THIS POLICY SO THAT THE PATIENT CAN DEVELOP THE TYPE OF TRUSTING RELATIONSHIP WITH ANOTHER PROVIDER THAT IS ESSENTIAL TO SUCCESSFUL CONTINUED CARE AND TREATMENT. THE TYPES OF CIRCUMSTANCES THAT CAN RESULT IN TERMINATION INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING: NONCOMPLIANCE WITH TREATMENTS RECOMMENDED BY THE PRACTICE, PHYSICIAN, OR OTHER HEALTHCARE PROVIDER, FAILURE TO PAY, CONSISTENT WITH OUR FINANCIAL POLICY, CONSISTENT FAILURE TO KEEP APPOINTMENTS, THREATENING OR ABUSIVE BEHAVIOR DIRECTED AT OFFICE STAFF, PROVIDERS, OR PATIENTS, PATIENT IS DECEPTIVE/LIES, PATIENT ABUSES MEDICATION, OR PATIENT DECIDES TO LEAVE THE PRACTICE.

I UNDERSTAND THAT ON OCCASION SAGE HEMATOLOGY AND ONCOLOGY MAY NEED TO CONTACT ME CONCERNING HEALTH MATTERS. ON THESE OCCASIONS I GIVE PERMISSION TO:

PLEASE CHECK ONE OF THE FOLLOWING:

❑ I GIVE PERMISSION TO THE EMPLOYEES OF SAGE HEMATOLOGY & ONCOLOGY (SHO), TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO ME AND THE FOLLOWING INDIVIDUAL(S):

NAME: _____ RELATION: _____ PHONE: _____
NAME: _____ RELATION: _____ PHONE: _____
NAME: _____ RELATION: _____ PHONE: _____

❑ I REQUEST THAT ALL MY PROTECTED HEALTH INFORMATION BE DISCLOSED ONLY TO ME AND NO OTHER INDIVIDUAL(S).

I UNDERSTAND THAT I MAY REVOKE OR CHANGE THIS CONSENT AT ANY TIME BY FILLING OUT ANOTHER CONSENT FORM TO REPLACE THIS ONE.

_____
PATIENT NAME (PRINT)

_____ _____
PATIENT OR GUARANTOR (SIGNATURE) DATE

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

NAME OF PRIMARY POLICY HOLDER:_____
POLICY#/GROUP ID: _____
POLICY HOLDER'S DATE OF BIRTH: _____
POLICY HOLDER'S SS#: _____
POLICY HOLDER'S EMPLOYER: _____
DOES PLAN HAVE PRESCRIPTION COVERAGE? ❑ YES ❑ NO

SECONDARY INSURANCE CARRIER: _____

NAME OF SECONDARY POLICY HOLDER:_____
POLICY#/GROUP ID: _____
POLICY HOLDER'S DATE OF BIRTH: _____
POLICY HOLDER'S SS#: _____
POLICY HOLDER'S EMPLOYER: _____
DOES PLAN HAVE PRESCRIPTION COVERAGE? ❑ YES ❑ NO

PHARMACY INSURANCE CARRIER: _____
NAME OF PHARMACY POLICY HOLDER: _____
POLICY#/BIN# _____

I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE.
I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO UPDATE SHO OF ANY CHANGES TO MY INSURANCE PLAN AND/OR INSURANCE INFORMATION IMMEDIATELY THEY BECOME EFFECTIVE OR I MAY BE HELD LIABLE FOR THE FULL BALANCE OF MY TREATMENT.
I HEREBY ASSIGN BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR, AND AUTHORIZE HIM/HER TO FURNISH INFORMATION REGARDING MY ILLNESS TO MY INSURANCE CARRIER.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT PAID FOR BY MY INSURANCE.

_____
PATIENT NAME (PRINT)

_____
PATIENT OR GUARANTOR (SIGNATURE)

_____
DATE

FINANCIAL POLICY AND ACKNOWLEDGEMENT

THANK YOU FOR CHOOSING SAGE HEMATOLOGY AND ONCOLOGY AS YOUR HEALTH CARE PROVIDER. WE ARE COMMITTED TO BUILDING A SUCCESSFUL PHYSICIAN-PATIENT RELATIONSHIP WITH YOU. YOUR COMPLETE UNDERSTANDING OF OUR PATIENT FINANCIAL POLICY IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP. IF YOU HAVE ANY QUESTIONS REGARDING OUR FINANCIAL POLICY, PLEASE DISCUSS WITH OUR BUSINESS OFFICE.

THE PATIENT OR THE GUARANTOR IS RESPONSIBLE FOR PAYMENT OF SERVICES THAT ARE RENDERED BY SAGE HEMATOLOGY & ONCOLOGY. PLEASE PRESENT YOUR INSURANCE CARDS AT EACH VISIT. SAGE HEMATOLOGY & ONCOLOGY WILL SUBMIT CLAIMS FOR YOUR VISIT AND MAKE EVERY ATTEMPT TO COLLECT PAYMENT. YOU ARE RESPONSIBLE FOR ALL CO-PAYMENTS COINSURANCE AND DEDUCTIBLES ON THE DAY OF SERVICE. PAYMENTS WILL BE COLLECTED PRIOR TO ANY TREATMENT THAT IS DEEMED YOUR RESPONSIBILITY BY YOUR INSURANCE PLAN.

IF YOU ARE BEING ASKED TO PAY A CO-PAYMENT OR CO-INSURANCE AND YOU FEEL THAT YOU HAVE MET YOUR MAXIMUM OUT OF POCKET, PLEASE CONTACT THE BILLING MANAGER, AIDA AT (623)-254-7271 FOR ASSISTANCE.

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS BEFORE RECEIVING SERVICES. ALL INSURANCE INFORMATION MUST BE PROVIDED AT THE TIME OF SERVICE. IT IS YOUR RESPONSIBILITY TO NOTIFY SAGE HEMATOLOGY & ONCOLOGY OF ANY CHANGES IN YOUR ADDRESS, CONTACT INFORMATION AND /OR INSURANCE COVERAGE.

WE WILL BILL YOUR PRIMARY AND SECONDARY INSURANCE. IN ORDER TO PROPERLY BILL YOUR INSURANCE PLAN, WE REQUIRE THAT YOU DISCLOSE ALL INFORMATION INCLUDING PRIMARY AND SECONDARY INSURANCE, AS WELL AS, ANY CHANGE OF INSURANCE INFORMATION. FAILURE TO PROVIDE NECESSARY INFORMATION WILL RESULT IN PATIENT RESPONSIBILITY FOR THE ENTIRE BILL.

ONCE YOUR INSURANCE PLAN HAS PROCESSED AND PAID FOR SERVICES RENDERED, WE WILL BILL YOU FOR WHAT YOUR INSURANCE PLAN DETERMINES IS YOUR RESPONSIBILITY FOR SERVICES. YOUR INSURANCE PLAN DETERMINES YOUR CO-PAYS, DEDUCTIBLES, CO-INSURANCE AND COVERAGE. WITH ALL THE VARIETIES OF INSURANCE PLANS AND POLICIES, WE ASK THAT YOU PLEASE BE FAMILIAR WITH YOUR PLAN AND BENEFITS. THE TERM OF YOUR INSURANCE POLICY IS BETWEEN YOU AND YOUR INSURANCE COMPANY.

SHOULD YOUR INSURANCE PLAN DELAY PAYMENT DUE TO DOCUMENTATION REQUESTED FROM YOU FOR SERVICES ALREADY RENDERED, WE WILL ALLOW NO MORE THAN 60 DAYS FROM DATE OF SERVICE THEN YOU WILL BE HELD FINANCIALLY RESPONSIBLE.
HEALTHCARE PROVIDERS ARE REQUIRED BY INSURANCE PLANS TO FILE CLAIMS IN A TIMELY MANNER OR BE DENIED. IT IS CRUCIAL YOU RESPOND TO ANY QUESTIONNAIRES YOU RECEIVE FROM YOUR INSURANCE PLAN.
IF YOUR INSURANCE PLAN IS NOT CONTRACTED WITH US AND CLAIMS ARE PROCESSED OUT-OF-NETWORK OR DENIED YOU WILL BE RESPONSIBLE FOR CHARGES NOT COVERED.

WE DO NOT BILL ANY THIRD-PARTY LIABILITY INSURANCE (AUTO, HOMEOWNER).

REFERRALS AND AUTHORIZATION
WITH THE VARIETY OF HEALTH PLANS REQUIRING A MANDATORY REFERRAL/OR AUTHORIZATION, WE WILL INITIATE THE REQUEST TO YOUR PRIMARY CARE PHYSICIAN (PCP). WE ASK THAT YOU CONFIRM WITH YOUR PCP A REFERRAL/OR AUTHORIZATION HAS BEEN SENT TO US. IF NO REFERRAL IS RECEIVED PER YOUR PLAN REQUIREMENT, WE WILL NEED TO RE-SCHEDULE YOUR APPOINTMENT.

FINANCIAL POLICY AND ACKNOWLEDGEMENT

PLEASE NOTE THERE WILL BE A CHARGE OF $25.00 OR YOUR OFFICE CO-PAY (WHICHEVER IS HIGHER) IF YOU CANCEL, RESCHEDULE OR "NO SHOW" FOR AN APPOINTMENT LESS THAN 48 HOURS IN ADVANCE.

IN THE EVENT THAT YOUR INSURANCE CARRIER DOES NOT PAY YOUR CLAIM FOR ANY REASON, YOU WILL ULTIMATELY BE RESPONSIBLE FOR PAYMENT SERVICES RENDERED BY SAGE HEMATOLOGY & ONCOLOGY. UPON REVIEW OF YOUR ACCOUNT AT 60 DAYS PAST ORIGINAL BILL SUBMISSION DATE, THE BALANCE OF YOUR ACCOUNT NOW FALLS TO YOUR FULL FINANCIAL RESPONSIBILITY. IF YOU ARE UNCLEAR OF YOUR INSURANCE BENEFITS, YOU WILL NEED TO CONTACT YOUR INSURANCE CARRIER FOR CLARIFICATION OF COVERAGE.

IF YOU ARE WAITING FOR COVERAGE TO BECOME EFFECTIVE OR HAVE NO INSURANCE, PAYMENT IN FULL WILL BE EXPECTED ON THE DAY SERVICES ARE RENDERED.

WE ACCEPT CASH, CHECK, DEBIT CARDS AND ALL MAJOR CREDIT CARDS SUCH AS, VISA, MASTER CARD, AMERICAN EXPRESS AND DISCOVER. THERE WILL BE A $30.00 SERVICE CHARGE FOR RETURNED CHECKS.

COMPLETION OF FORMS: OUR FEE FOR COMPLETING ANY TYPE OF FORM (S) IS $25.00 AND IS REQUIRED TO BE PAID PRIOR TO COMPLETION

DELINQUENT ACCOUNTS OVER 90 DAYS WILL BE PLACED FOR COLLECTIONS WITH A THIRD PARTY COLLECTION AGENCY AND A FEE OF 33% OF THE BALANCE WILL BE ADDED TO THE TOTAL AMOUNT DUE. THIS AMOUNT SHALL BE IN ADDITION TO ANY OTHER COSTS INCURRED DIRECTLY OR INDIRECTLY TO COLLECT AMOUNTS OWED SUCH AS COURT COSTS, ATTORNEY FEES AND ALL OTHER EXPENSES.

I HAVE READ AND UNDERSTAND THE PATIENT FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. BY SIGNING BELOW, I ASSUME FULL RESPONSIBILITY FOR ANY BALANCE OWED AFTER MY INSURANCE PLAN HAS PAID.

NOTE: EVEN IF YOU REFUSE TO SIGN THIS FORM AND YOU ELECT TO RECEIVE SERVICES, YOU ARE STILL 100% RESPONSIBLE FOR ANY FEES.

_____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE

AUTHORIZATION FOR COMMUNICATION BY TEXT AND EMAIL

I AUTHORIZE SAGE HEMATOLOGY AND ONCOLOGY (SHO) TO CONTACT ME BY SMS TEXT MESSAGE OR EMAIL FOR HEALTH-RELATED AND BILLING NOTIFICATIONS, INCLUDING APPOINTMENT REMINDERS.

I MAY OPT-OUT OF RECEIVING THESE COMMUNICATIONS AT ANY TIME BY CONTACTING SAGE HEMATOLOGY AND ONCOLOGY.

I UNDERSTAND THAT TEXT MESSAGES AND/OR EMAIL ARE NOT A SUBSTITUTE FOR PROFESSIONAL MEDICAL ATTENTION.

BY AFFIXING MY SIGNATURE HEREUNDER, I ATTEST THAT I AM THE PERSON LEGALLY ACCOUNTABLE FOR ALL MOBILE AND/OR EMAIL ACCOUNT USAGE AND THAT AM 18 YEARS OF AGE OR OLDER. CONCURRENTLY, I ACKNOWLEDGE MY APPROVAL OF THE TERMS AND CONDITIONS GOVERNING THE USE OF TEXT MESSAGING SERVICES AND EMAIL NOTIFICATIONS, AND THAT REVOCATION OF MY CONSENT REMAINS AN OPTION.

IF THE DESIRE TO DECLINE RECEIVING ANY INFORMATION VIA TEXT AND/OR EMAIL ARISES, I ACKNOWLEDGE THAT GRANTING CONSENT LATER REMAINS AN OPTION.

TEXT CELL #_____ EMAIL:_____

ADDRESS:_____

_____

PATIENT NAME (PRINT)

_____

PATIENT OR GUARANTOR (SIGNATURE)

_____

DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

WHEN YOU SIGN THIS FORM, YOU ACKNOWLEDGE THAT YOU HAVE RECEIVED, OR HAVE BEEN INFORMED OF THE RIGHT TO RECEIVE, A COPY OF THE SAGE HEMATOLOGY AND ONCOLOGY (SHO) NOTICE OF PRIVACY PRACTICES. YOU CAN INQUIRE AT THE FRONT DESK OF ANY SHO FACILITY OR SEND A WRITTEN REQUEST TO THE OFFICE TO OBTAIN A HARD COPY OF THE NOTICE, WHICH IS AVAILABLE AT:

SAGE HEMATOLOGY AND ONCOLOGY
13943 N 91ST AVE, BUILDING H, SUITE 101, PEORIA, AZ 85381

Alternatively, you can review and print the Notice of Privacy Practices by visiting https://www.sagehemonc.com/shonpp

_____

PATIENT NAME (PRINT)

_____

PATIENT DATE OF BIRTH

_____

PATIENT OR GUARANTOR (SIGNATURE)

_____

DATE

HIPAA Notice of Privacy Practices

Revised 2023

Effective as of April/20/2023
Revised April/20/2023

Sage Hematology and Oncology
13943 N. 91st Ave, Building H. Suite 101
Peoria, AZ 85381
623-254-7271

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically.

We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

Aida Golnazarian	623-254-7271	aidag@sagehemonc.com
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices. Provided By HCSI– Revised March 2013