Memorial Cancer Center

Welcome to the Cancer Center – Radiation Oncology:

As with anything new, we want to make sure that you are aware of clinic rules. These rules help us take care of you and all the other patients we serve.

If you have any questions, we would be happy to answer them.

- The Radiation Oncology office is a SCENT FREE ZONE. Please avoid wearing anything that has a fragrance. Smells can cause patients to have nausea.
- All prescriptions require a 72 hour turn-around time. Please plan accordingly.
- We are not a walk-in clinic, therefore, appointments are required.
- The physicians in this clinic do not complete medical cannabis paperwork.
- This clinic and the hospital (as well as the grounds) are completely smoke free. If you have a strong smell of tobacco or marijuana, you may not been seen.
- No weapons are permitted.
- ALL paperwork requires FIVE working days to complete before pick up.
- You must keep your appointments and notify the office if you need to reschedule. More than two missed appointments, without notice, may lead to termination as a patient in this clinic.
- Nurses are available from 8:00 a.m. to 5:00 p.m., Monday through Friday. You will receive a call back (almost always) the same day. Please only call once. If you feel it is an emergency, please notify us that you are going to the Emergency Room.
- If you are admitted to the hospital, please let the hospital physician know to call us.
- If you arrive more than 15 minutes late for your appointment, you may be rescheduled.
- Arriving too early for your appointment does not mean you will be seen any sooner than your scheduled appointment time.
- Patients on oxygen are asked to bring their own tank, allowing enough oxygen for approximately 2 hours. Your oxygen carrier may also deliver to our office.
- Please notify the Front Desk of any change in insurance, address or phone numbers.
- All VA and/or Triwest patients: Please verify that you have a current authorization.
- Please minimize cell phone use when seeing the Physician.

Sincerely,

Elizabeth L. Martinez

Elizabeth (Lisa) Martinez
Radiation Oncology Office Manager
Clinic Phone Number: 575-556-5800

Lynn Fletcher, RN, BSN, MBA, CPPS
Director of the Cancer Program
Clinic Phone Number: 575-521-1554

Notice of **Privacy Practices**

EFFECTIVE DATE – **March 2017**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS INFORMATION CAREFULLY. This notice applies to **Memorial Medial Center** and the doctors and other healthcare providers practicing at this facility.

It is our legal duty to protect the privacy and security of your information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We are providing this notice so that we can explain our privacy practices. We must follow the duties and privacy practices described in this notice or the current notice in effect. For more information about our privacy practices, to place a complaint or report a concern or conflict, call the number listed below:

Memorial Medical Center
Privacy Officer - Sheena Albright
575-532-7435 Sheena.Albright@LPNT.net

Or, if you prefer to remain anonymous, you may call the toll-free number listed below and an attendant will handle your concern anonymously.
1-877-508- LIFE (5433)

You also may also send a written complaint to the United States Department of Health and Human Services if you feel we have not properly handled your complaint. You can use the contact listed above to provide you with the appropriate address or visit **http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.** Under no circumstance will you be retaliated against for filing a complaint. We reserve the right to change our policies and notice of privacy practices at any time. If we should make a significant change in our policies, we will change this notice and post the new notice. You can also request a copy of our notice at any time.

We may use health information about you for your treatment purposes, to obtain payment, or for healthcare operations and other administrative purposes. We may use your information in treatment situations if we need to send or share your medical record information with professionals who are treating you. For example, a doctor treating you for an injury asks another doctor about your overall health condition. We can use and share your health information to bill and receive payment from health plans or other entities. We will give your information to your health insurance plan such as Medicare, Medicaid or other health insurance plans so it will pay for your services. Your information will be used when processing your medical records for completeness and to compare patient data as part of our efforts to continually improve our treatment methods. We may disclose your information to business associates with whom we contract to provide service on your behalf that require the use of your health information. We can use and share your health information to run our practice, improve your care and contact you when necessary. We may contact you or disclose certain parts of your health information to our associates or related foundations for fundraising purposes. You have the right to opt out of receiving such fundraising communications. We may share certain information with a person(s) you identify as a family member, relative, friend or other person that is directly involved in your care or payment for your care, or to your "Lay Caregiver" or appointed Personal Representative if you tell us who these individuals are. If it becomes necessary, we will notify these individuals about your location, general condition or death. In addition, we may need to disclose medical information about you to an entity assisting in disaster relief efforts so that your family can be notified about your condition, status and location. If you have a clear preference for how we share your information, talk to us. Tell us what you want us to do, and we will follow your instructions. If you are not able to tell us your preference, for example if you are unconscious, we may also share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will never share your information unless you give us written permission in these cases: for marketing purposes or the sale of your information.

Under certain circumstances, we may be required to disclose your health information without your specific

authorization. Examples of these disclosures are: requirements by state and federal laws to report cases of abuse, neglect, or other reasons requiring law enforcement; for public health activities; to health oversight agencies; for judicial and administrative proceedings; for death and funeral arrangements; for organ donation; for special government functions including military and veteran requests and to prevent serious threats to health or public safety such as preventing disease, helping with product recalls, and reporting adverse reactions to medications. We may also contact you after your current visit for future appointment reminders or to provide you with information regarding treatment alternatives or other health-related services that may be of benefit to you. We will obtain your written authorization for any other disclosures beyond the reasons listed above. Remember, if you do authorize us to release your information, you always have the right to revoke that authorization later. We will be happy to honor that request unless we may have already acted.

As a patient, you have rights regarding how your information can be used and disclosed. These rights include access to your health information. In most cases, you have the right to look at or receive a copy of your health information. This may take up to 30 days to prepare, and there may be a preparation fee associated with making any copies. You can ask for an accounting of disclosures. This is a list of instances in which we have disclosed your information for reasons other than treatment, payment and operations that you have not specifically authorized but that we are required to do by law (see section on how your information may be used and disclosed). We can provide you one list per year without charge; all additional requests in the same year will be subject to a nominal charge. If you believe that the information we have about you is incorrect or if important information is missing, you have the right to request that we amend or correct your paper or electronic medical records. There may be some reasons that we cannot honor your request for which you submit a statement of disagreement. You can also request that your health information be communicated to you at an alternate location or address that is different from the one we received when you were registered. If you pay for your service in full up front, you can ask that we not disclose information about your treatment to your health plan. Finally, you can request in writing that we not use or disclose your information for any reasons described in this notice except to persons involved in your care, or when required by law or in emergency situations. We are not legally required to accept such a request, but we will try to honor any reasonable requests.

Lastly, a note about health information exchanges: we may provide your health information to a health information exchange (HIE) and a patient portal called My HealthPoint in which we participate. An HIE is a health information database where other healthcare providers caring for you can access your medical information from wherever they are if they are members of the HIE. These providers may include your doctors, nursing facilities, home health agencies or other providers who care for you outside of our hospitals or practices. For example, you may be traveling and have an accident in another area of the state. If the doctor treating you is a member of the HIE in which we participate, he or she can access information about you that other providers have contributed. Accessing this additional information can help your doctors provide you with well-informed care quickly because he or she will have learned about your medical history, allergies or prescriptions from the HIE. The patient portal "My Healthpoint" is a mechanism by which you can access your health information online after your care and treatment. If you do not want your medical information to be placed in the patient portal and shared with HIE-member healthcare professionals, you can opt out by submitting the opt out form. It will take five business days for the opt out to go into effect. Note that if you opt out, providers may not have the most recent information about you which may affect your care. You can always opt in at a later date by revoking the opt out form in writing.

Memorial Cancer Center

Radiation Oncology

"Committed to delivering personalized, quality patient care."

Questions or concerns regarding quality of care, abuse, neglect or exploitation may be directed to the New Mexico Department of Health at:

Telephone Hotlines: 1-800-752-8649 or 1-800-445-6242

Adult Protective Services: 1-800-797-3260

Hotline Hours of Operation:
Monday – Friday
8:00 a.m. to 5:00 p.m.
(Mountain Time)
(Closed weekends and state holidays)

Quality of care concerns may also be directed to The Joint Commission at 1-800-994-6610
Email: compliant@jointcommission.org
Hours of Operation: 8:30 a.m. to 5:00 p.m. Central Time (Monday-Friday)

ALL INFORMATION IS KEPT CONFIDENTIAL

Patient/Representative Signature:_____

Date:_____

SIGNATURE ABOVE ACKNOWLEDGES RECEIPT OF INFORMATION

Memorial Cancer Center

Radiation Oncology New Patient Process Guide

Welcome to our Clinic,

Consultation: Today you are here for a Radiation Consultation with one of our Radiation Oncologist, Dr. Cherie Hayostek or Dr. Gregory Willis. In today's visit you will first meet with one of our nurses to go over some of the information you filled out in your new patient packet and also to obtain any clinical information the doctor needs before meeting with you. The nurse will review this information with the doctor before seeing you. We suggest during this time you write down any questions or concerns you have, as you will be provided a lot of information during the consultation. We want to ensure at the end of you consultation all your questions are answered and you are comfortable with the information that was provided to you.

CT Simulation: If you choose to proceed with Radiation Treatment you will be given an appointment time for a CT simulation or at the doctors request it may be performed on the same day of the consultation. A CT simulation is a scan of the area of your body to be treated with radiation. The CT images acquired during your scan will be reconstructed and used to design the best and most precise treatment plan for you. You will **not start** radiation treatment on the day of your simulation unless the doctor informs you otherwise. After your CT simulation is performed one of our Radiation Therapists will provide you with a start date and time for Radiation Treatment. The CT simulation will be discussed with you in more detail before it is performed, in case you have additional questions.

Treatment Planning: The final process before starting Radiation Treatment is performed by the Dosimetrist and the Doctor to calculate a specialized radiation treatment plan just for you. You are not present in the clinic during this time, as the information obtained from your CT simulation will provide them with the information they need. We will also be obtaining authorization at this time for Radiation Treatment if required by your insurance carrier to ensure service will be covered for the entire course of your treatment. We thank you for choosing Memorial Cancer Center for your Radiation Oncology Services.

_____Patient/Guardian Signature Date_____

Memorial Cancer Center

RADIATION ONCOLOGY REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First name:	Middle Initial:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status : Single / Married / Divorce / Widow

Place of Birth	Date of Birth:	Social Security #:	Age	Sex: ❑ Male ❑ Female	Best time for appt reminder call? AM PM

Street address:	Home phone: ( )	Cell phone: ( )

P.O. Box:	City:	State:	Zip Code:

Occupation:	Employer:	Employer phone: ( )

If retired: Date_____ If Disabled: Date:_____

INSURANCE INFORMATION

Person responsible for bill:	Date of Birth: / /	Address (if different):	Home phone #: ( )

Is this person a patient here?

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is patient covered by insurance? ❑ Yes ❑ No

Primary insurance:

Subscriber's name:	Subscriber's S.S. #:	Date of Birth / /	Policy #:	Group #:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary insurance (if applicable):	Subscriber's name:	Policy #:	Group #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Is your visit accident related? ❑ Yes ❑ No Type of accident: ❑ Auto ❑ Workers Comp ❑ Other Explain _____

BLACK LUNG PROGRAM.....❑ Yes ❑ No Spouse Retirement
Are the services for a patient under 65 and entitled to Medicare solely on the basis of ESRD?.....❑ Yes ❑ No Date:_____
Is the patient covered by an Employer Group Health Plan (an employer with 100 or more employees) where the primary insured (patient, spouse, or parent) is employed?.....❑ Yes ❑ No
Did the patient begin dialysis or enter the hospital for a transplant less than 33 months ago?.....❑ Yes ❑ No
IF ALL THREE YES, THE EGHP IS PRIMARY TO MEDICARE - Name and address of EGHP:_____

Are the services for this patient covered by the Veteran's Administration or other federal program such as the Public Health Service?
❑ YES - THE VA/PHS IS PRIMARY TO MEDICARE ❑ No

CONDITIONS OF TREATMENT

CONSENT TO TREATMENT: The undersigned hereby consents to the administration and performance of all diagnostic procedures and treatments which, in the judgement of my physician, may be considered necessary and advisable.
RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and to obtain reimbursement, the hospital or attending physicians may discuss portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable for all or any portion of the hospital's charge including, but not limited to, insurance companies, health care service plans, or workers' compensation carriers.
AGREEMENT OF INSURANCE BENEFITS: The undersigned authorizes whether he/she signs as agent or patient, direct payment to the hospital or physicians, medical groups and practitioners of any insurance benefits otherwise payable to the undersigned for his/her hospitalization at a rate not to exceed the hospital's regular charges. It is agreed that payment to the hospital, pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this agreement.

_____ Date:_____
Patient/Guardian Signature

Memorial
Cancer Center
Radiation Oncology

Patient's Home Medication List

Patient Name:_____ Date of Birth:_____

Are you allergic to any medication? ☐ Yes ☐ No If yes, list the medication and symptoms or reaction (Example: severe rash, upset stomach, vomiting, difficulty breathing)

Medication	Describe Symptoms or Reaction

☐ Check box if you do not take any home medications, herbals, supplements, vitamins, teas or other remedies.

Date of last flu vaccination_____ Date of last pneumonia vaccination_____
Date of last tetanus vaccination_____

INSTRUCTIONS FOR COMPLETING YOUR MEDICATION LIST

- List ALL medications you take at home
  - o List prescription medications your doctor orders for you, medications you buy off the shelf, herbals, vitamins, supplements, teas or other remedies.
  - o Include medications you take every day and medications you take only when you need them, for example: allergy medicine, laxatives, antacids

- If you need more space, continue medication list on back.

Medication Name	Dose (mg, puffs, drops, units)	Route (mouth, patch, injection)	When you take it (how many times per day)	Reason (why you take it)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Memorial
Cancer Center

Radiation Oncology

PHYSICIAN INFORMATION

(PLEASE LIST YOUR PRIMARY CARE PHYSICIAN AND ANY ADDITIONAL PHYSICIANS WHO HAVE PARTICIPATED IN YOUR CARE)

PRIMARY CARE PHYSICIAN:_____
ADDRESS:_____
PHONE NUMBER:_____

OTHER PHYSICIANS

PHYSICIAN:_____
ADDRESS:_____
PHONE NUMBER:_____

PHYSICIAN:_____
ADDRESS:_____
PHONE NUMBER:_____

PHYSICIAN:_____
ADDRESS:_____
PHONE NUMBER:_____

PHYSICIAN:_____
ADDRESS:_____
PHONE NUMBER:_____

Memorial
Cancer Center

Radiation Oncology

PHARMACY OF CHOICE

PLEASE SELECT (WRITE IN) ONE

• ___ FAMILY PHARMACY	1205 S. SOLANO
• ___ CVS PHARMACY	940 N Main St
• ___ CVS PHARMACY	3011 N. MAIN ST.
• ___ SAM'S CLUB	2711 N. TELSHOR
• ___ SAV-ON PHARMACY	1285 EL PASEO
• ___ SAV-ON PHARMACY	2551 E. LOHMAN AVE.
• ___ SAV-ON PHARMACY	2501 N. MAIN
• ___ WALMART	3331 RINCONADA BLVD
• ___ WALMART	1550 S. VALLEY
• ___ WALMART	571 S. WALTON BLVD.
• ___ WALGREENS	3990 E. LOHMAN (NEAR ROADRUNNER)
• ___ WALGREENS	3100 N. MAIN
• ___ WALGREENS	2300 E. LOHMAN (NEAR WALMART)
• ___ WALGREENS	1250 EL PASEO
• ___ WALGREENS	3490 NORTHRISE (NEAR WALMART)

• ___ OTHER: _____

Memorial
Cancer Center
Radiation Oncology

CONSENT FOR FAMILY MEMBERS

Date: _____

I, _____, understand my rights as a patient and the role my providers take to ensure my privacy.

This letter is to inform the staff of Memorial Radiation Oncology permission to allow the following individuals access to my medical information.

I assign primary responsibility to the first person listed because I understand it is difficult for the staff at Memorial Radiation Oncology to speak to multiple family members.

	NAME	PHONE #	RELATIONSHIP
1			
2			
3			
4			

This list can be reviewed at any time.

Printed Name:_____

Signature:_____

Date:_____

EMERGENCY CONTACTS

Primary Contact:_____

Relationship:_____

Phone Number (s):_____

Secondary Contact: _____

Relationship:_____

Phone Number(s):_____

Memorial Cancer Center

Radiation Oncology
2450 S. Telshor Blvd., Bldg. B
Las Cruces NM 88011
Phone: 575-556-5800 Fax: 575-556-5899

AUTHORIZATION TO OBTAIN INFORMATION FROM OTHER PROVIDERS

NAME_____

DOB_____

SOC SEC#_____

This authorization is to OBTAIN medical records from another provider. Please fill in ALL the information requested: leave NO Blanks. Print full name and address of individual or institution from whom records are to be requested.

Records Requested From: _____

NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

The purpose of this disclosure is: _____

Please specify the extent of information you wish released.

A. Records of inpatient, outpatient, or emergency service for the following condition or injury:
_____

B. Records of the period from_____ to _____

C. Specific records needed are:

- ☐ Admission face sheet
- ☐ Discharge summary
- ☐ History/physical exam
- ☐ Operative report
- ☐ Pathology report
- ☐ Consultation report
- ☐ Orders/progress notes
- ☐ Laboratory report
- ☐ X-ray report
- ☐ Electrocardiogram report
- ☐ Emergency dept report
- ☐ Entire chart
- ☐ Other:_____

D. Records of treatment for drug/alcohol abuse and/or psychiatric illness and/or AIDS and/or HIV. In authorizing release of information regarding treatment of psychiatric illness, I understand that I have a right to examine and get a copy any information disclosed under the terms of this release (N.M. Stat. Ann 43-1-19.) (If the patient is a minor, the patient and legal representative must sign here and below. At least one signature is needed in this section in ALL cases.)

Signature:_____Date: _____ Signature:_____Date: _____

This authorization shall be considered invalid after 6 months (60 days for drug/alcohol abuse records), from the date of signing. Medical information gathered by you after the date of authorization signing is not to be released. The authorizing party may revoke this authorization at any time by notifying the individual/institution from which records were requested. I agree that my individual/institution from which records were requested received my written notice to revoke this authorization. I understand that I can receive treatment at Memorial Medical Center even thought I have not signed an authorization to obtain my medical records from other providers.

I hereby authorize you to provide the above medical information to Memorial Medical Center. In furtherance of this authorization, I do hereby waive all provisions of law related to the disclosure hereby authorized.

Patient Signature_____ Date_____

If the patient unable to sign, give reason _____

Signature of legally authorized representative _____ Date _____

Relationship to patient _____ Witness Signature _____ Date _____

PLEASE ADDRESS REPLIES TO THE ATTENTION OF:

MEMORIAL CANCER CENTER
RADIATION ONCOLOGY
2450 S. TELSHOR BLVD, BLDG B
LAS CRUCES, NM 88011

Memorial Cancer Center

Radiation Oncology
2450 S. Telshor Blvd, Bldg B
Las Cruces NM 88011

575 556-5800 Fax 575 556-5899

AUTHORIZATION FOR RELEASING INFORMATION FROM MEDICAL RECORDS

NAME_____

DATE OF BIRTH_____

SOC. SEC. #_____

PT. ACCT. #_____

This authorization is to RELEASE MEMORIAL MEDICAL CENTER MEDICAL RECORDS. Please fill in **ALL** the information requested; leave **NO** blanks. This authorization will not be considered valid if all the information is not provided.

Send To: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize Memorial Medical Center to provide the above-named person(s) or company access to my medical records for the purpose of review, examination, and provision of such copies as may be requested.

The purpose of this disclosure is: _____
Please specify the extent of information you wish released.

A. Records of Inpatient, Outpatient, or Emergency Services whether such records were generated at Memorial Medical Center or were obtained from a previous provider, which relate to my care and treatment, except (specify what kind of information you do NOT want released):_____

_____

B. Records of the period from _____ to _____

C. Records of treatment for drug/alcohol abuse and/or psychiatric illness and/or AIDS and/or HIV. In authorizing release of information regarding treatment of psychiatric illness I understand that I have a right to examine and copy any information disclosed under the terms of this release (N.M. Stat. Ann. § 43-1-19). If the patient is a minor, the patient and the legal representative must sign here and below. At least one signature is needed in this section in **ALL** cases.

Signature _____ Date_____ Signature _____ Date_____

This authorization shall be considered invalid after 6 months or 60 days for drug and alcohol abuse records, from the date of signing. Medical information gathered after the date of authorization signing will not be released. The authorizing party may revoke this authorization at any time by notifying MMC in writing. Send revocation to: Health Information Management Director, Memorial Medical Center, 2450 S. Telshor Blvd., Las Cruces, NM 88011-5076. I agree that my revoking the authorization will not have any effect on any information which MMC has already released before they received my written notice to revoke this authorization.

I understand that I can receive treatment at Memorial Medical Center even though I have not signed an authorization for release of my medical records.

In furtherance of this authorization, I do hereby waive all provisions of law relating to the disclosures hereby authorized.

Patient Signature _____ Date_____

If patient unable to sign, give reason _____

Signature of legally authorized representative _____ Date_____

Relationship to patient _____ Witness' Signature_____ Date_____

ANY REDISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED

Authorization For Releasing Information
821-030 (Rev. 04/15) Page 1 of 1

ROIAUTH

Memorial Medical Center
Las Cruces, NM

USE LABEL OR PRINT PATIENT ID HERE

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements so that we may proceed with the care and treatment ordered by your physician.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).

2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.

3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.

4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.

6. **CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

7. **CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contacted, unless I notify the hospital to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the hospital.

8. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

9. **INFECTION CONTROL CONSENT:** To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS. HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital if, for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood. I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

10. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS AND OTHER HEALTH CARE PROVIDERS:** I understand that most or all of the health care providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist and others, are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PA's), Nurse Practitioners (NP's), and Certified Registered Nurse Anesthetists (C.R.N.A.'s) are independent contractors and are not employees, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors. I understand that I may ask my Health Care Provider to verify if they are a Hospital employee or an independent contractor.

    I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.
    I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

11. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT ADMISSION, TRANSFER, OR DISCHARGE:** I authorize Hospital to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility (ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

12. **ELECTION TO PARTICIPATE IN HEALTH INFORMATION EXCHANGE(S):** I hereby authorize Hospital to provide a copy of my medical record or portions thereof to any health information exchange or network with which Hospital participates and to any other participant in such health information exchange or network for purposes of treatment, payment, and health care operations and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or network with which Hospital participates may be found in the Notice of Privacy Practices, which is available on the Hospital website, and this list may be updated from time to time if and when Hospital participates with new health information exchanges or networks. Hospital participates in the LifePoint health information exchange, which is operated by business associates of Hospital identified in the Notice of Privacy Practices, including LifePoint Corporate Services General Partnership. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

13. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

14. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

    ☐ I object to having my name, location and general condition listed in the facility directory.

15. **ELECTION TO REQUEST INTERPRETIVE SERVICES:** In accordance with Sect. 60, of Title VI, the Hospital is committed to ensuring that all patients receive equal access to medical care. To achieve this goal, interpretive services may be utilized or requested at no cost to you.

16. **PATIENT RIGHTS:** I have received a copy of the Patient Rights. I understand these rights and if I have further questions, I will ask the nursing staff.

17. **CONSENT TO PHOTOGRAPH:** I consent to photographs, video or other images where deemed medically necessary by my physician before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of my medical record.

18. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

    ☐ I have executed an Advance Directive
    ☐ I have not executed an Advance Directive
    ☐ I would like to formulate an Advance Directive and receive additional information

19. **OTHER ACKNOWLEDGEMENTS:**

    a. Personal Valuables: I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, other prosthetic devices, electronic devices such as cell phones, laptops, electronic readers, iPads/Pods and all other such devices. I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables; however, except as required by law, the hospital is not liable for any loss or damage to property that is secured in the safe.

    b. Smoke Free Facility Policy: The Hospital is a smoke free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.

    c. Weapons / Explosives / Drugs: I understand and agree that the hospital is a weapons, explosives, illegal substance or drug and alcohol free facility. I understand that while I am a patient at the Hospital I may not have these items in my room or with my belongings. If the hospital believes I have any of the above mentioned items the hospital may search my room and belongings. If found, the items may be confiscated, disposed appropriately or turned over to the law enforcement authorities.

20. **MATERNITY PATIENTS:** If I deliver an infant(s) while a patient of this hospital, I agree that each provision of this Consent for Services and Financial Responsibility applies to the infant(s).

21. **AGREEMENT AS TO FORUM SELECTION (where lawsuits shall be filed):** The patient or patient's representative, and Memorial Medical Center, including employees and agents Memorial Medical Center, rendering or providing medical care, health care, or safety, professional or administrative services in any way related to health care to patient (all of the above referred to as "health care"), agree: in the event of a dispute or claim, any lawsuit, which in any way relates to health care provided to the patient shall only be brought in the Third Judicial District Court, Dona Ana County, Las Cruces, New Mexico, and in no event will any such lawsuit ever be brought in any other place. The provisions of this paragraph, as to where suit shall be brought, are mandatory.

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

I have read and fully understand this Patient Consent and Financial Agreement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Signature of Patient or Legal Representative for Health Care Hospital Services if Other Than Patient

Date and Time

Relationship to Patient

Reason patient is Unable to sign

Signature of Witness

Date and Time

USE LABEL OR PRINT PATIENT ID HERE

Memorial Cancer Center

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. FINANCIAL POLICY: The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

Date: _____

Memorial Cancer Center

LifePoint Health Information Exchange (HIE) Talking Points

What is a Health Information Exchange?

A Health Information Exchange is a product that allows for the secure storage of and controlled access to patient health information.

What is the advantage of consenting to participate in the HIE?

By granting consent, you help ensure that participating providers who are involved in the treatment, payment, or operations of your care have access to as much of your medical information as possible in order to make the best decisions about your care and recommended treatment.

Who has access to this information?

Once consent is received, the patient's information will be visible to participating providers who are involved in the patient's care through a secure website.

Is this information used for anything other than to inform your health care providers?

No – never! This information is only used by providers and their staff to help ensure the best recommendations around your health care treatment decisions. It is the same information that could be obtained using regular mail and faxes, however, because you have consented to HIE participation, the information can be securely accessed and available to the providers much quicker.

Can I choose what information is shared?

No – if you decide to consent, then all information within your health record is shared. Please keep in mind that the information is accessed only by those providers who have access and they must log in to a secure website to access it. Also, there is a process for monitoring who has logged in and accessed the information.

If I don't consent, will it change my care in any way?

No – it is completely up to you if you decide to consent – your care needs will be met whether you consent or not. However, the more complete information that a provider has access to, the better the health care decision recommendations are likely to be.

Can I revoke consent in the future?

Yes – you have the right to revoke consent at any time. When this has been documented, your data will cease being visible to participating providers. Please note however that information may have been shared with other participating providers during the time you did give consent.

Memorial
Cancer Center

ELECTION TO ***NOT*** PARTICIPATE IN HEALTH INFORMATION EXCHANGE(S)

I have been told of my right to decline to participate, as well as the potential benefits involved in my participation, in the sharing of my health information in the Health Information Exchange(s). I realize that I may change my mind and choose to participate at any time through written notification to the Memorial Medical Center Privacy Officer.

I acknowledge that my decision to decline participation in the Health Information Exchange(s) does not affect Memorial Medical Center's ability to make disclosures of my health information that are otherwise permissible by law.

I **decline** to participate in the Health Information Exchange(s) at this time.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____ _____

Relationship of Representative Reason patient is unable to sign, i.e. Minor or Legally Incompetent