Hoag Memorial Hospital Presbyterian

HOAG ONCOLOGY SPECIALTY CARE CLINIC:

(CARES CLINIC, ADVANCED SKIN CANCER CLINIC, SARCOMA CLINIC, LUNG CLINIC)

Located in the Hoag Family Cancer Center Building

1 Hoag Drive, 3RD Floor, Suite 122, Newport Beach, CA 92663

hoag
Hoag Family Cancer Institute

Directions

From South County (John Wayne Airport)

Take the 405 (San Diego) Freeway NORTH to the 55 (Costa Mesa) Freeway SOUTH. The 55 freeway empties into Newport Blvd. Stay on Newport Blvd. and you will head towards the beach and Pacific Coast Highway. You will see Hoag Hospital on your right (Hospital Drive) but pass the hospital and take the Pacific Coast Highway turn (right to Highway One – and go right when it empties onto PCH).
Do not go on the overpass to Balboa Peninsula or you will have gone pass PCH.

The first street light (immediately seen) is Hoag Drive and turn right. You will then turn right toward the Advanced Technology Pavilion (on your left) and the Hoag Cancer Center is the free standing building next to the Advanced Technology Pavilion. You can park anywhere (structures or in front of the cancer center).

From Los Angeles

Take the 405 (San Diego) Freeway SOUTH to the 55 (Costa Mesa) Freeway SOUTH. The 55 freeway empties into Newport Blvd. Stay on Newport Blvd. and you will head towards the beach and Pacific Coast Highway. You will see Hoag Hospital on your right (Hospital Drive) but pass the hospital and take the Pacific Coast Highway turn (right to Highway One – and go right when it empties onto PCH).
Do not go on the overpass to Balboa Peninsula or you will have gone pass PCH.

The first street light (immediately seen) is Hoag Drive and turn right. You will then turn right toward the Advanced Technology Pavilion (on your left) and the Hoag Cancer Center is the free standing building next to the Advanced Technology Pavilion. You can park anywhere (structures or in front of the cancer center).

DIRECTIONS FROM INSIDE THE BUILDING

Enter the Cancer Center at ground level from the parking lot in front of the building. The elevator is located to your left as you walk in the front door. Go up to the third floor. Then go down the hall on the right and we are located in suite 122 in the Oncology Specialty Care Clinic. We are the first door on your right after you go past the windows.

Hoag Family Cancer Institute

CURRENT TREATING PHYSICIAN LIST

Name:		Best Contact Phone #:	
E-mail:		Secondary Phone #:	
Pharmacy:		Pharmacy Phone #:	

Send Records to ✓	PHYSICIAN	CURRENT TREATING PHYSICIAN CONTACT INFORMATION *Please either type in the fields below or print out and hand write. Check mark on the left indicates the physician you want your records sent to; **a complete separate signed authorization is required.***
☐	Referring:	
	Specialty:	
	Address:	
	Phone:	
	Fax:	
☐	Physician:	
	Specialty:	
	Address:	
	Phone:	
	Fax:	
☐	Physician:	
	Specialty:	
	Address:	
	Phone:	
	Fax:	
☐	Physician:	
	Specialty:	
	Address:	
	Phone:	
	Fax:	
☐	Physician:	
	Specialty:	
	Address:	
	Phone:	
	Fax:	

PATIENT LABEL

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

PATIENT RECORD OF DISCLOSURES

Please provide us with a telephone number at which you may be reached during the day in case we need to contact you regarding your daily appointment(s).

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Cell Telephone: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other: _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ OK to mail to my work/office address:
  _____
  _____
- ☐ OK to Email to this address:
  _____
- ☐ OK to Fax information to this number:
  _____

☐ Ok to Email regarding Cancer Center services or classes. Email address:
_____

Optional: I authorize Hoag Hospital to discuss my treatment and care with:

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

Patient Signature: _____ Date: _____ Time: _____

Print Name: _____ Date of Birth: _____

* Please notify us if any of your information changes*

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses on disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

OUT- PATIENT MEDICATION RECONCILIATION
UPON ENTRY TO HOSPITAL

Date of Procedure/Visit: _____ Primary Care Physician (PCP): _____

Date: _____ Time: _____ PCP Phone #: _____

Acknowledgement: I confirm that this is a complete and accurate list of my (patient's) current medications, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information.

Name of person completing this form: _____

ALLERGIES: List all allergies to medications, herbs, food, latex, IV contrast, and other. Describe the reaction.
☐ None (Example: Sulfa – rash)

_____

_____

_____

CURRENT MEDICATIONS: List your prescriptions, herbal, and over-the-counter medicines you take.
☐ None ☐ Patient poor historian/No family present/Unable to obtain information at this time

Medication Name	Dose	Frequency	Reason	Upon Discharge Change in Regimen
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

Discharge – Additional Prescriptions and Specific Medication Instructions:
1.
2.
3.
4.
5.

PATIENT INSTRUCTIONS: Above is the list of medications you indicated that you are currently taking. Resume taking your current medications, noting any checked boxes which indicate a change in your current medication regimen. Remember to follow the new medication instructions as directed. All medication changes or new prescriptions will be relayed to your referring physician. Please contact the physician who prescribed your medications if you have any questions. Your signature below means you understand these instructions.

_____ _____ _____ A.M./P.M.
[Patient/Parent/Conservator/Guardian] [Date] [Time]

_____ _____ _____ A.M./P.M.
[MD or Authorized Staff] [Date] [Time]

Original – Patient Photocopy – Chart

[2517]

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

Irvine • Newport Beach

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Hoag Memorial Hospital Presbyterian ("Hoag") including Hoag entities, may share my health information for treatment, billing and healthcare operations. I have been provided a copy of Hoag's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Hoag has the right to change this notice at any time. I may obtain an additional copy by contacting the hospital registration office or by visiting the website at www.hoag.org.

I acknowledge receipt of the Notice of Privacy Practices of Hoag Memorial Hospital Presbyterian.

Patient's Name: _____

Signature: _____ Date: _____
[Patient/Parent/Conservator/Guardian]

If signed by other than patient, indicate relationship: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgement was not obtained:

☐ Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgement of Receipt.

☐ Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices.

☐ Other: _____

Patient's Name: _____

Hoag Staff Signature: _____

Date: _____

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

Irvine • Newport Beach

CONDITIONS OF ADMISSION - OUTPATIENT

The undersigned patient is admitted to Hoag Memorial Hospital Presbyterian ("Hospital") for inpatient, outpatient and / or emergency treatment subject to the following terms and conditions:

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURE, TERM/DURATION OF CONSENT
   The undersigned consents to the procedures that may be performed during this outpatient service treatment or services, or any other services, whether inpatient, outpatient, or emergency, performed at any Hospital facility while this consent remains in effect, which may include, but are not limited to, laboratory procedures, x-ray examinations, MRI, ultra sound or other out patient services. This consent will remain in full force and effect and be valid for the period of one year from date of the signing by the patient at Section 11 below, or until consent has been revoked in writing.

2. NURSING CARE
   This hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his / her legal representative. The Hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that the patient is not provided with such additional care.

3. PHYSICIANS ARE INDEPENDENT MEDICAL PRACTITIONERS
   All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, emergency department physician, anesthesiologist, hospitalist, and the like, are independent medical practitioners and are not employees or agents of the hospital. They have merely been granted the privilege of using the Hospital for the care and treatment of their patients. Physician fees are billed separately from Hospital charges, and, therefore, patients may receive multiple bills. Initial Here: _____

   The patient is under the care and supervision of his/her attending physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or Hospital services rendered to the patient under the general and special instructions of the physician.

4. PERSONAL BELONGINGS
   The patient is encouraged to leave personal items at home. The Hospital maintains a fireproof safe for the safekeeping of money and valuables. The Hospital is not liable for the loss or damage to any money, jewelry, documents, or other personal property items brought onto hospital property. The Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars ($500) unless a written receipt for a greater amount has been obtained from the Hospital. Initial Here: _____

5. MATERNITY PATIENTS
   If the patient delivers an infant(s) while a patient of this Hospital, the undersigned agrees to these same Conditions of Admission on behalf of the infant(s). Initial Here: _____

6. PARTICIPATION IN MEDICAL EDUCATION / TEACHING PROGRAMS

The undersigned acknowledges and understands that the Hospital participates in teaching programs and as such the training of physician fellows through a Medical Education Program, nurses and other health care personnel takes place at the Hospital and these individuals may participate in the operation, special diagnostic or therapeutic procedures, or treatment specified above under appropriate supervision and the undersigned hereby consents to such participation.

7. CONSENT TO PHOTOGRAPH

The undersigned consents to be photographed (includes video or still photography, in digital or any other format, and any other means of recording or reproducing images) while receiving treatment at the Hospital, with the understanding that the images from such photography may be used only for the patient's treatment or for Hospital health operations such as peer review or medical education, as the Hospital or the patient's treating physician(s) deem appropriate, but for no other purposes.

8. FINANCIAL AGREEMENT

The undersigned agrees, whether he / she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he / she hereby individually obligates himself / herself to promptly pay the account of the Hospital in accordance with the regular rates and terms of the Hospital, including its charity care and discount payment policies, if applicable. The undersigned understands that all physicians and surgeons, including the radiologist, pathologist, emergency department physician, anesthesiologist, hospitalist, and others, will bill separately for their services. Should any account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Initial Here: _____

9. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned assigns and authorizes, whether he / she signs as agent or as patient, direct payment to the Hospital of any insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services. It is agreed that payment to the Hospital, pursuant to this authorization, by an insurance company shall discharge the 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 paid according to this assignment.

10. HEALTH PLAN (INSURANCE) OBLIGATION

This Hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from the Admitting and Registration Office. The Hospital has no contract, express or implied, with any plan that does not appear on the list. It is the patient's obligation to assure that the patient's health plan has authorized the services to be provided by the Hospital. The undersigned agrees that he / she is individually obligated to pay the account of the Hospital in accordance with the regular rate and terms of the Hospital, including its financial assistance policies, if he / she belongs to a plan which does not appear on the above-mentioned list or if the patient fails to obtain the health plan's authorization.

All physicians and surgeons, including the radiologist, pathologist, emergency department physician, anesthesiologist, hospitalist, and others, will bill separately for their services. It is the responsibility of the undersigned to determine if physicians providing services to the patient contract with the patient's health plan, if any. Initial Here: _____

Patient Identification

11. ACKNOWLEDGEMENTS

a. This is to acknowledge that the undersigned has received the Patient Information which includes, Steps to Improve the Safety of Your health Care, *Rights and Responsibilities as a Patient,* and *Your Right to Make Decisions about Medical Treatment* (Advance Healthcare Directive information).

b. The undersigned acknowledges and understands that from time to time, the Hospital may provide services to its hospital patients through the use of outside resources or under arrangements with third parties, including, for example, services provided to Hospital patients by specialty reference laboratories or Hoag Orthopedic Institute. In these circumstances, the Hospital retains professional and administrative responsibility for all services provided to its Hospital patients by these outside resources.

Initial Here: _____

12. TELEPHONE CONSUMER PROTECTION AND CAN-SPAM ACTS

By providing us with a telephone number for a cellular or other wireless device, you agree that, in order for us or our service providers to service your account(s) (including contacting you about obtaining potential financial assistance for your account(s)), or to collect any amounts you may owe, we, our agents, representatives, or other service providers may contact you which could result in charges to you. You expressly consent that methods of contact may include using pre-recorded and artificial voice messages and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with your account number(s) and is not a condition of purchasing property, goods, or services. You are not required to initial this section as a condition of admission.

If Opting Out please check: ☐ Initial Here: _____

The undersigned certifies that he / she has read the Conditions of Admission, received a copy, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ _____ _____ A.M./P.M.
[Signature of Patient/Parent/Conservator/Guardian] [Date] [Time]

_____ _____
[If signed by other than patient, indicate relationship] [Hospital Representative]

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Obligation provisions above.

_____ _____ _____ A.M./P.M. _____
[Signature of Financially Responsible Party] [Date] [Time] [Hospital Representative]

Interpreter's Statement:

The foregoing document was translated by the interpreter (listed below) to the patient or legal representative in the patient's or legal representative's primary language (indicate language): _____. He/she understood all of the terms and conditions and acknowledged his/her agreement with the above document.

_____ ☐ Interpreter Service
[Interpreter Name and Identification Code – Print]

_____ _____ _____ A.M./P.M.
[Witness] [Date] [Time]

Patient Identification

AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS
Hoag Memorial Hospital Presbyterian

Dear Patient:

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization:

Notice of Rights and Other Information:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to Hoag Hospital, Health Information Department, One Hoag Drive, Newport Beach, CA 92658. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.

- I have a right to receive a copy of this authorization.

- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Patient Name: _____

Date of Birth: _____

Use of disclosure: I hereby authorize Hoag Memorial Hospital Presbyterian to disclose the information listed below to: (List the person/organization authorized to receive this information.)

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

☐ Mail ☐ Patient will pick up

☐ Family member will pick up: Name: _____ Phone: _____

Requested Media: ☐ Paper ☐ CD

This authorization applies to the following:

☐ All health information pertaining to any medical history, mental or physical condition and treatment received, OR

☐ Only the following records or types of health information: Date of Service: _____

☐ ED Records ☐ History & Physical ☐ Consults ☐ Operative Report

☐ Discharge Summary ☐ MD Progress Notes ☐ MD Orders ☐ Nurse's Notes

☐ EKG, EMG, EEG ☐ Radiology Reports ☐ Anesthesia Records ☐ Lab/Pathology Reports

☐ Radiology Film/CD, Type: _____ ☐ Other: _____

I specifically authorize release of the following information (check as appropriate):

☐ Alcohol/drug treatment information ☐ HIV Test Results ☐ Mental Health Treatment Information

A separate authorization is required to authorize disclosure or use of psychotherapy notes.

Purpose for use/disclosure: ☐ Patient Request ☐ Further Medical Care ☐ Insurance OR ☐ Other: _____

Expiration: This authorization expires (insert date): _____

Signature: _____ Date: _____ Time: _____AM/PM
[Patient/Legal Representative]

If signed by other than patient, indicate legal relationship to patient: _____

Print Name (Legal Representative): _____

Processed by: _____ Date: _____ Time: _____

Request to Other Providers to Release Copies of Medical Records to HOAG MEMORIAL HOSPITAL PRESBYTERIAN

Dear Patient:

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization:

Notice of Rights and Other Information:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the facility/provider listed on page 2. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Complete request information on reverse side...

Patient Name: _____ Date of Birth: _____

Use of disclosure: I hereby authorize:

Name/Organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To release copies of my records to:

☐ Hoag Memorial Hospital Presbyterian – Irvine
16200 Sand Canyon Ave, Irvine, CA 92618
☐ Mail ☐ Fax #: _____ ☐ Attn: _____

☐ Hoag Memorial Hospital Presbyterian – Newport Beach
One Hoag Drive, PO Box 6100, Newport Beach, CA 92658-6100
☐ Mail ☐ Fax #: _____ ☐ Attn: _____

This authorization applies to the following:

☐ All health information pertaining to any medical history, mental or physical condition and treatment received, OR

☐ Only the following records or types of health information: Date of Service: _____
Service type: ☐ Inpatient ☐ Outpatient ☐ Emergency

☐ ECU Records ☐ History & Physical ☐ Consults ☐ Operative Report
☐ Discharge Summary ☐ MD Progress Notes ☐ MD Orders ☐ Nurse's Notes
☐ EKG, EMG, EEG ☐ Radiology Reports ☐ Anesthesia Records ☐ Lab/Pathology Reports
☐ Other: _____

I specifically authorize release of the following information (check as appropriate):

☐ Alcohol/drug treatment information ☐ HIV Test Results ☐ Mental Health Treatment Information

A separate authorization is required to authorize disclosure or use of psychotherapy notes.

Purpose for use/disclosure: ☐ Patient Request ☐ Further Medical Care ☐ Insurance OR
☐ Other: _____

Expiration: This authorization expires (insert date or event): _____

_____ _____ _____ A.M./P.M.
[Signature] [Date] [Time]

If signed by other than patient, indicate legal relationship to patient: _____

Witness: _____

REQUEST TO PROVIDE RECORDS TO HOAG
Side 2 of 2 NS80260 Rev 03/11/15

[7715]

Original – Chart Copy – Patient

MR #

CARES Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances (for example) cocaine, heroin, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use _____Pharmacy,

located at _____,

telephone number _____, for filling prescriptions for all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.

_____ _____

Patient Name (Please Print) **Patient Signature**

_____

Date