NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

Account # _____
Receiver's Initials _____
Receiving Date _____

PATIENT REGISTRATION

PATIENT INFORMATION

Name _____ Social Security No. _____

Home Address: _____ Apt. #_____ City _____ St. _____ Zip _____

County _____ Phone _____ Cell _____ Preferred Contact Number _____

Birth Sex ____ Age ____ Birth Date ___/___/_____ Marital Status _____ ☐ Student ☐ Full Time ☐ PartTime Where? _____

Gender Identity: ☐ Male ☐ Female ☐ Choose not to disclose ☐ Additonal gender category or other, please specify _____
☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Genderqueer, neither exclusively male nor female
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Unknown

Sexual Orientation: ☐ Choose not to disclose ☐ Straight or heterosexual ☐ Bisexual ☐ Lesbian, gay, or homosexual
☐ Something else ☐ Unknown

Race: ☐ White or Caucasian ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Other _____

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Other or Undetermined _____

Language: ☐ English ☐ Spanish ☐ French ☐ German ☐ Vietnamese ☐ Italian ☐ Mandarin ☐ Other _____

Patient's Employer Name _____ Employer's Phone _____

Patient's Employer Address _____

Patient Employment Status ☐ Full Time ☐ Part Time Are you or your spouse a military retiree? If yes, print retiree's full name: _____
☐ Retired Date Retired _____ ☐ Disabled ☐ Self-Employed ☐ Other, Occupation _____

Spouse's Name _____ Birth Date ___/___/_____

Primary Care Physician: _____ Referring Physician: _____

EMERGENCY CONTACT

Name _____ Relationship _____

Home Address: _____ Apt. # _____

City _____ St. _____ Zip _____ Preferred Contact Number _____

INSURANCE INFORMATION

Primary
Insurance Company _____ ID # _____ Group # _____

Policy Holder's Name _____

Policy Holder's Employer _____ Policy Holder's DOB ___/___/_____ Policy Holder's SSN _____

Secondary
Insurance Company _____ ID # _____ Group # _____

Policy Holder's Name _____

Policy Holder's Employer _____ Policy Holder's DOB ___/___/_____ Policy Holder's SSN _____

Do you have a living will? ☐ Yes If yes, provide a copy. ☐ No If no, would you like to receive information? ☐ Yes ☐ No

Do you have a DNR? ☐ Yes If yes, provide a copy. ☐ No If no, would you like to receive information? ☐ Yes ☐ No

Do you have a Health Care Durable Power of Attorney? ☐ Yes If yes, provide a copy.
☐ No If no, would you like to receive information? ☐ Yes ☐ No

NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

NEW PATIENT HEALTH QUESTIONNAIRE

NAME: _____ AGE: _____ BIRTHDATE: _____

REASON FOR TODAY'S VISIT: _____ REFERRING MD: _____

MEDICAL HISTORY: Check **ALL** that apply to your **medical history**. Include the date you were diagnosed.

☐	AIDS	☐	Diabetes Mellitus type 2
☐	Anemia	☐	DVT/Blood Clot-Acute
☐	Anxiety	☐	DVT/Blood Clot-Chronic
☐	Arthritis	☐	Emphysema
☐	Asthma	☐	GERD (gastroesophageal reflux disease)
☐	Atrial Fibrillation (A-Fib)	☐	Heart Attack / Myocardial Infarct
☐	Bowel Obstruction	☐	Hepatitis A
☐	Cirrhosis of Liver	☐	Hepatitis B
☐	Congestive Heart Failure (CHF)	☐	Hepatitis C
☐	Chronic Obstructive Pulmonary Disease (COPD)	☐	High Cholesterol
☐	Chronic Renal Insufficiency	☐	HTN (high blood pressure)
☐	Colostomy	☐	Hyperlipidemia
☐	Coronary Artery Disease	☐	Hypothyroidism
☐	Dementia	☐	Joint Replacement
☐	Depression	☐	Liver Disease
☐	Diabetes Mellitus type 1	☐	Lupus
☐	Osteoporosis	☐	Rheumatoid Arthritis
☐	Peripheral Vascular Disease (PVD)	☐	Sepsis
☐	Personal History of Pneumonia	☐	Stroke/Cerebrovascular accident
☐	Presence of Aortocoronary Bypass Graft	☐	Thyroid Disease
☐	Presence of Cardiac Pacemaker	☐	Tuberculosis (of lung)
☐	Pressure Sore Ulcer	☐	Vascular Disease
☐	Pulmonary Embolism (PE)	☐	

Do you have any allergies? ☐ **Yes** ☐ **No** If yes, Name _____

_____

_____

List other past medical history: _____

_____

_____

_____

_____

_____

List other past surgeries: _____

_____

_____

_____

_____

_____

_____

_____

List other past procedures: _____

_____

_____

_____

_____

_____

_____

_____

Last date of most recent colonoscopy? _____

Last date of most recent Cologuard test? _____

CURRENT MEDICATIONS

List **ALL** medication that you are currently taking, prescribed and not prescribed including herbs and supplements.

DRUG NAME	DOSE	FREQUENCY	LAST FILL DATE	DRUG NAME	DOSE	FREQUENCY	LAST FILL DATE

Last date of most recent Lung Cancer screening CT? _____

Smoking: Never_____ Yes, occasional_____ Yes, but quit_____ Yes, active_____

Number of years? _____ Packs per day? _____ Years since quit? _____

Have you received the pneumonia vaccine? ☐ **Yes** Date _____ ☐ **No**

Have you received the flu vaccine? ☐ **Yes** Date _____ ☐ **No**

Have you received the COVID-19 vaccine? ☐ **Yes** Dose 1 Date _____ Dose 2 Date _____ ☐ **No**

If Yes to receiving the COVID-19 vaccine, what brand of vaccine did you receive? _____

(Johnson & Johnson, Pfizer, Moderna, Novavax)

CANCER FAMILY HISTORY - YOU and YOUR FAMILY'S Cancer History (Please be as thorough as possible)

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

	CANCER	YOU AGE of Diagnosis	PARENTS / SIBLINGS / CHILDREN	CURRENT AGE / AGE AT DEATH	RELATIVES on your MOTHER'S SIDE	CURRENT AGE / AGE AT DEATH	RELATIVES on your FATHER'S SIDE	CURRENT AGE / AGE AT DEATH
☐ Y ☐ N	**EXAMPLE:** *BREAST CANCER*	*45*			*AUNT* *COUSIN*	*45* *61*	*GRANDMOTHER*	*53*
☐ Y ☐ N	**BREAST CANCER**							
☐ Y ☐ N	**OVARIAN CANCER**							
☐ Y ☐ N	**UTERINE / ENDOMETRIAL CANCER**							
☐ Y ☐ N	**COLON / RECTAL CANCER**							
☐ Y ☐ N	**10 or more LIFETIME COLON POLYPS (Specify #)**							
☐ Y ☐ N	**OTHER CANCER(S) (Specify cancer type)**	*Among others, consider the following cancers: Benign Breast Biopsies, Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Thyroid Disease, Uterine Fibroids, Other Benign Tumors*						

☐ **Y** ☐ **N** Are you of Ashkenazi Jewish descent?

☐ **Y** ☐ **N** Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?

FAMILY HISTORY

	Age	Deceased	Age at Death	Cause of Death	Other Illness
Father ……	_____	YES NO	_____	_____	_____
Mother	_____	YES NO	_____	_____	_____
Brother	_____	YES NO	_____	_____	_____
Brother	_____	YES NO	_____	_____	_____
Brother	_____	YES NO	_____	_____	_____
Sister …….	_____	YES NO	_____	_____	_____
Sister …….	_____	YES NO	_____	_____	_____
Sister ..……..	_____	YES NO	_____	_____	_____
Maternal Grandmother	___ ____	YES NO	_____	_____	_____
Maternal Grandfather	_____	YES NO	_____	_____	_____
Paternal Grandmother	_____	YES NO	_____	_____	_____
Paternal Grandfather	_____	YES NO	_____	_____	_____
Other	_____	YES NO	_____	_____	_____
Other	_____	YES NO	_____	_____	_____
Other	_____	YES NO	_____	_____	_____

SOCIAL HISTORY

Will you need an interpreter? ☐ **Yes** ☐ **No**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Partnered** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Living Arrangement: ☐ **With Spouse/Partner** ☐ **Alone** ☐ **With Child(ren)** ☐ **With Relative** ☐ **With Non-Relatives**
☐ **Shelter/Homeless** ☐ **Care Facility** _____ ☐ **Other** _____

Have you identified a primary care giver? ☐ **Yes** ☐ **No** If yes, Name _____ Contact Number _____

Occupation _____

Activity Level: ☐ **Sedentary** ☐ **Light Exercise** ☐ **Moderate Exercise** ☐ **Vigorous Exercise**

Nutrition: ☐ **Regular Diet** ☐ **Restricted Diet** ☐ **Tube Feeding** ☐ **Other** _____

Alcohol: Never_____ Yes, occasional_____ Yes, but quit_____ Yes, active_____

Number of days per week? _____ Number of drinks per day? _____ Years since quit? _____

Other drugs: Never_____ Yes, occasional_____ Drugs _____

Within the past 12 months, we worried whether our food would runout before we got money to buy more
☐ **Often True** ☐ **Sometimes True** ☐ **Never True**

Within the past 12 months, the food we bought just didn't last and we didn't have money to get more
☐ **Often True** ☐ **Sometimes True** ☐ **Never True**

Transfusion History? History of Transfusion Date _____ ☐ No Transfusion History

☐ No Transfusion Reaction ☐ Transfusion Reaction/Symptoms _____

What is your highest level of education? ☐ High school or less ☐ College ☐ Graduate Degree or higher

Computer literacy: Do you have regular access to a computer, tablet or smart phone? ☐ **Yes** ☐ **No**
If not, does your caregiver have access to a computer, tablet or smart phone? ☐ **Yes** ☐ **No**
How often do you use email? ☐ Daily ☐ Weekly ☐ Other _____

MALE REPRODUCTIVE POTENTIAL

Surgeries impacting reproductive potential: ☐ Orchiectomy ☐ Vasectomy
☐ Other male sterilization procedure _____

Contraception: ☐ Does Not Use ☐ Does Use ☐ N/A

FEMALE REPRODUCTIVE POTENTIAL

Are you or could you be pregnant: ☐ **Yes** ☐ **No** ☐ **N/A**

Menarche

☐ Age of Menarche _____ ☐ Menopause (age) _____ ☐ Date of last menstrual cycle _____

Surgeries impacting reproductive potential

☐ Hysterectomy ☐ Bilateral salpingo-oophorectomy ☐ Tubal Ligation ☐ Other sterilization procedure

Contraception

☐ Does not use ☐ Does use
☐ Type used _____ ☐ Years of use _____ ☐ N/A

Birthing History

☐ Age at first pregnancy _____ ☐ # of pregnancy _____

Hormone Replacement Therapy

☐ None ☐ Yes
☐ Estrogen _____ ☐ Years of Estrogen use _____ ☐ Other _____

When was your last pap smear? _____ Normal? _____ ___ Abnormal? _____

When was your last mammogram? _____ Normal? ____ ___ Abnormal? _____

NEW PATIENT HEALTH QUESTIONNAIRE - BREAST HEALTH

Have you ever had a Breast Biopsy? ☐ **Yes** ☐ **No** If yes, when? _____ Outcome? _____

Have you had your Uterus removed? ☐ **Yes** ☐ **No** If yes, when? _____ Outcome? _____

Have you had your Ovaries removed? ☐ **Yes** ☐ **No** If yes, when? _____ Outcome? _____

Servings per day: Coffee _____ Tea _____ Cola _____ Chocolate _____

Breast Health Information: Please list any previous breast problems or breast surgery:

_____

_____

_____

_____

Review of Systems:

Have you recently had any of the following? (Please state **YES** if present and check if given choices.)

Constitutional: ☐ Weight loss or gain (If so, how much) _____ ☐ Cold or flu ☐ Fatigue/Lethargy

Neurological: ☐ Blindness ☐ Fainting ☐ Weakness on one side ☐ Seizures

Respiratory: ☐ Smothering ☐ Wake up short of breath ☐ Persistent cough ☐ Difficulty Breathing Deeply

Cardiovascular: ☐ Short of breath lying flat ☐ Chest pain like a heart attack ☐ Swelling (where?): _____

Gastrointestinal: ☐ Indigestion ☐ Vomiting ☐ Diarrhea ☐ Blood in stool ☐ Constipation

Urinary: ☐ Trouble passing urine ☐ Frequency ☐ Urgency ☐ Pain

Musculoskeletal: ☐ Shoulder, Back, Neck or Chest Pain ☐ Arthritis ☐ Muscular or Joint Pain/Tightness
☐ Stiffness ☐ Limited Range of Motion ☐ Weakness ☐ Difficulty in Daily Tasks (Dressing, etc.)

Skin Disorders: ☐ Explain: _____

Lymphatic: ☐ Swelling in glands

Psychiatric: ☐ Depression ☐ Anxiety ☐ Suicidal thoughts: _____

Endocrine: ☐ Excessive thirst or urination ☐ Feeling too hot or cold

Preferred Pharmacy Name:_____

Pharmacy Phone Number: _____

Patient Signature:_____ Date: _____

NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

FINANCIAL POLICY

An integral component of Tennessee Oncology's commitment to excellent patient care includes a team dedicated Patient Accounting staff to assist with financial arrangements. It is our desire to contain medical costs. As a service to the patient, we provide registration, verification and filing of insurance; assist with payment arrangements, and work extensively with insurance companies to have claims paid at their maximum benefit, thereby alleviating most of the financial burden and responsibility from the patient.

REGISTRATION

With the first appointment at Tennessee Oncology, the patient will be asked by the Front Desk receptionist to complete a Registration Packet, which includes patient and insurance information. This information is vital for correct billing and payment. Along with this packet, we will need to make copies of your insurance cards. When the new patient appointment is set up via telephone, certain information will be obtained at that time. Please remember to bring all of your active insurance cards to the office at each visit.

VERIFICATION

After you have completed the Patient Registration Packet, a Registrar will contact your insurance company to verify your benefit coverage. Depending on information supplied by the carried, it may be necessary for the Registrar to discuss coverage issues with you either at the time of your appointment or by telephone.

Please note that Patient Registration and Insurance Verification occurs every six months to assure your coverage is in force and to help contain your medical costs. We ask for your cooperation and assistance with this special service.

REFERRALS

Many managed care plans require that you obtain a referral from your primary care physician (PCP) prior to your visit with a specialist. Therefore, based upon your insurance specifications, it is our policy they you must have the proper referrals prior to your appointment. The Office Registrar maintains files on these referrals and will assist the patient with proper referral procedures from your insurance carrier and PCP.

OFFICE CO-PAYMENTS

It is the policy of this office to collect co-payments at the time services are rendered. These shall be paid as you sign in for your daily appointment. Usually, co-payment amounts are indicated on the insurance card, however, our Registrar will be obtaining this information as your insurance benefits are verified and we will ask you for this amount at each visit.

INSURANCE FILING

All primary and secondary insurance policies are filed on the patient's behalf for services rendered. Insurance is a method for you to receive reimbursement for fees you should pay to the physician. Assignment of benefits allows payment to come directly to our office from the insurance company. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on contracts with them, not with our office. It is your responsibility to pay any deductibles, co-insurance, and any other balances not paid by your responsible party for the bill. Patient Statements are mailed monthly outlining insurance filed as well as patient balances due. Patient balances are due and payable within 30 days unless special payment arrangements have been coordinated with the Patient Account Representative. If you do not have insurance, a separate self-pay financial agreement will be provided to you.

PATIENT ACCOUNT REPRESENTATIVE

We have a team of Patient Account Representatives that work exclusively on collection efforts of patient account balances due and claims denied or paid inaccurately by the insurance company. Each Representative is assigned specific physician accounts to work. If you have questions concerning your monthly statement or need assistance with your insurance filing or financial arrangements, please do not hesitate to contact your Representative at (615) 329-0570.

Reorder from Performance Business Forms, Inc.
Specify File **NBC-3000** (08/24)

NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

www.nashvillebreastcenter.com

Electronic Communication Consent Form

Tennessee Oncology understands how important communication is to provide quality patient care. Clinic appointment reminders and messages about medications from Park Pharmacy greatly benefit our patients. Messages regarding patient financial and account information are just as important. To access our patient portal, Tennessee Oncology will need to send an invitation link to your email address. Occasionally, you may receive general information about Tennessee Oncology and other health-related topics. By providing your email address and /or cell phone number, you consent to receive electronic communications from Tennessee Oncology.

Please check only one preference below.

( ) I want both email and text messages
( ) I want only text messages
( ) I want only email messages
( ) Opt-out of all electronic communications

Please print all information neatly and legibly

Patient Name: _____

Date of Birth: _____ Email Address: _____

Cell Phone: _____

Tennessee Oncology uses reasonable administrative and technical safeguards in accordance with applicable laws when transmitting information to you. We also acknowledge that there are relevantly low risks when communicating via email or text. However, we cannot control what happens to a communication once it is delivered to your device. Therefore, please be aware that by consenting to receive communications via email or text, you are agreeing to accept the risks of information being intercepted or viewed by persons with access to your phone or email. We further cannot guarantee secure transmission once the message(s) go outside of Tennessee Oncology's network. Please contact our Privacy Officer with questions about this section.

You have the right to revoke this consent by sending written notice to:

Privacy Officer
Tennessee Oncology, PLLC
2004 Hayes Street | Suite 800
Nashville, TN 37203
Phone: 615-514-3035

Patient Signature:_____ Date: _____

NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

NOTICE OF PRIVACY PRACTICES

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.

TENNESSEE ONCOLOGY, including its offices and clinics, makes and keeps records of your medical and billing information. While you are a patient at TENNESSEE ONCOLOGY, we will use and disclose your medical information –

- To provide treatment to you and to keep a recored describing your care,
- To receive payment for the care we provide,
- To administer and conduct business relating to the services and facilities of the Practice, and
- To comply with federal and state law.

This Notice summarizes the ways TENNESSEE ONCOLOGY (the "Practice") and those noted below may use and disclose medical information about you. It also describes your right and our duties regarding the use and disclosure of your medical information. This Notice applies to all records of your care held within the Practice. When we use the word "we" or "Practice" we mean all the persons/entities covered by this Notice and listed below, its locations, medical professionals and other persons/companies who assist us with your treatment, payment or our business as a health care provider.

We are required by law –

- To keep your medical information confidential,
- To make available to you this Notice of our legal duties and privacy practices with respect to your medical information; and
- To follow the terms of the Notice that is currently in effect.

PERSONS/ENTITIES COVERED BY THIS NOTICE

- All physicians, employees, staff, and other Practice personnel;
- All Practice locations (available on our website at www.tnoncology.com
- Persons or entities performing services for the Practice under agreements containing privacy and security protections or to which disclosure of medical information is permitted by law;
- Persons of entities with whom the Practice participates in managed care arrangements;
- Our volunteers and medical, nursing and to other health care students; and
- Research organizations.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

We use and disclose medical information in the ways described below.

Treatment. We may use your medical information to provide medical treatment or services to you. We may disclose medical information about you to doctors, nurses, technicians, therapist, medical, nursing or other health care students, or other personnel taking care of you inside and outside of our Practice. We may use and disclose your medical information to coordinate or manage your care. As examples, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process, or the doctor may need to tell the dietitian if you have diabetes so you can have appropriate meals. The Practice may share your medical information with other health care providers to schedule the tests and procedures you need, such as prescriptions, laboratory tests and x-rays. We also may disclose your medical information to health care facilities if you need to be admitted to or receive treatment at a facility, hospital, a nursing home, a home health provider, rehabilitation center, etc. We also may disclose your medical information to people outside the Practice who are involved in your care while you are here or after you leave the Practice, such as other health care providers, family members, hospitals or pharmacists.

Payment. We may use and disclose your medical information so that the treatment and services you receive can be billed and collected from you, an insurance company or other person. As examples, we may give your insurance company (e.g., Medicare, Medicaid, CHAMPUS/TRICARE, or a private insurance company) information about treatment you received so your insurance company will pay us for our services. We also may tell your insurance company about a treatment you are going to receive in order to determine whether you are eligible for coverage or to obtain prior approval from the company to cover payment for the treatment. We could disclose your information to a collection agency to obtain overdue payment. We might also be asked information to a regulatory agency or other entity to determine whether the services we provided were medically necessary or appropriately billed. We may also disclose information to third-parties that arrange for or provide financial assistance to you related to treatments or medications. For example, we may provide information about you to a non-profit or pharmaceutical company who has coupons available to assist you in payment for medications.

Health Care Operations. We may use and disclose your medical information for any operational function necessary to operate the Practice, including uses/disclosures of your information such as in the following examples: (1) Conducting quality or patient safety activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination, and contacting of health care providers and you with information about treatment alternatives; (2) Reviewing health care professionals' backgrounds and grading their performance, conducting training programs for staff, students, trainees, or practitioners and non-health care professionals; performing accreditation, licensing, or credentialing activities; (3) Engaging in activities related to health insurance benefits; (4) Conducting or arranging for medical review, legal services, and auditing functions; (5) Business planning, development, and management activities, including things like customer service, resolving complaints; sale, transfer or combine of all or part of the Practice entity and the background research related to such activities; and (6) Creating and using de-identified health information or a limited data set or having a business associate perform combine data or do other tasks for various operational purposes.

As additional examples, we may disclose your medical information to physicians on our Medical Staff who review the care that was provided to patients by their colleagues. We may disclose information to doctors, nurses, therapists, technicians, medical, nursing or other health care students, and Practice personnel for teaching purposes. We may combine medical information about many patients to decide what services the Practice should offer, and whether new services are cost-effective and how we compare from a quality perspective with other hospitals/Practices. Sometimes, we may remove your identifying information from your medical information so others may use it to study health care services, products and delivery without learning who you are. We may disclose information to other health care providers involved in your treatment to permit them to carry out the work of their facility or to get paid. We may provide information about your treatment to an ambulance company that brought you to the Practice so that the ambulance company can get paid for their services.

Patient Portal/Other Patient Electronic Correspondence. We will use and disclose information through a secure patient portal which allows you to view, download and transmit certain parts of your medical information (e.g. lab results) in a secure manner when using the portal. However, if you choose to store, print, email or post the information using technology outside the secure patient portal, it may not be secure. Further, if you email us medical or billing information from a private email address (such as Yahoo, Gmail, etc.) your information will not be encrypted unless you use a secure messaging portal to us. Request to email your medical or billing information to a private email address (such as a Yahoo, Gmail, etc.) may not be encrypted by us when it is sent to you–therefore secure transmission cannot be guaranteed and you accept that risk. If you request us to post your information in drop boxes, on flash drive, CDs, etc., your information may not be encrypted and may not be secure. We are not responsible if this confidential information once released from our secure portal is redisclosed by an authorized recipient. We are not responsible for subsequent damage, alteration or misuse of the data. We may communicate with you by email, text, or through the patient portal or other electronic resources unless you choose to opt out.

Health Services, Products, Treatment Alternatives and Health-Related Benefits. We may use and disclose your medical information in providing face-to-face communications; promotional gifts; refill reminders or communications about a drug or biologic; case management or care coordination, or to direct or recommend alternative treatments, therapies, providers, or settings of care; or to describe a health-related product/service (or payment for such or to offer other health-related products, benefits or services that may be of interest to you. We may use and disclose your medical information to contact and remind you of an appointment for treatment or medical care.

Fundraising. We may use and disclose your medical information to raise money for the Practice or non-profit foundations. The Practice is allowed to disclose certain parts of your medical information to others involved in fundraising, unless you tell us you do not want such information used and disclosed. For example, the Practice may disclose to the Foundations demographic information, like your name, address, other contact information, telephone number, gender, age, date of birth, the dates you received treatment by the Practice, the department that provided you service, your treating physician, outcome information, and health insurance status. You have a right to opt-out of receiving fundraising requests. If you do not want the Practice to contact you for fundraising, please notify the Privacy Office at 615-514-3035 or at Privacy@TNonc.com.

Individuals Involved in Your Care or Payment for Your Care. We may use release your medical information if you become incapacitated to the person you named in your Durable Power of Attorney for Health Care (if you have one), or otherwise to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you). We may give information to someone who helps pay for your care. In addition, we may disclose your medical information to an entity assisting in disaster relief efforts so that your family can be notified about your condition. HIPAA also allows us at certain times to speak with those who are/were involved in your care/payment activities while being treated as a patient and/or even after your death, if we reasonably infer based on our professional judgment that you would not object. If you do not wish for us to speak with a specific person about your care, you should notify the Privacy Officer and ask about the Restriction Policy and Form.

Research. We may use release your medical information for research purposes if you have provided written authorization or when a research study has been reviewed and approved by an Institutional Review Board. Under limited circumstances, Researchers may access your medical information to determine whether you would be an appropriate participant in a research study. Most research projects, however, are subject to a special approval process and require your informed consent. Limited or unidentifiable information may be provided to researchers in some circumstances. Your consent would be required if a researcher will be involved in your care, if we take tissue samples, or will have access to your name, address or other information that identifies you. However, the law allows some research to be done using your medical information without requiring your written approval.

Required By Law. We will disclose your medical information when federal, state or local law requires it. For example, the Practice and its personnel must comply with child and elder abuse reporting laws and laws requiring us to report certain diseases or injuries or deaths to state or federal agencies.

Emergency. If you need emergency treatment and we are required by law but are unable to get your consent to disclose information, we will attempt to obtain consent as soon as practical after treatment.

Serious Threat to Health or Safety. We may use and disclose your medical information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Organ and Tissue Donation. If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to aid in its organ or tissue donation and transplantation process.

Military and Veterans. If you are a member of the U.S. or foreign armed forces, we may release your medical information as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Minors. If you are a minor (under 18 years old), the Practice will comply with the applicable State law regarding minors. We may release certain types of your medical information to your parent or guardian, if such release is required or permitted by law.

Public Health Risks. We may disclose your medical information (and certain test results) for public health purposes, such as –

- To a public health authority to prevent or control communicable diseases (including sexually transmitted diseases), injury or disability,
- To report births and deaths,
- To report child, elder or adult abuse, neglect or domestic violence,
- To report to FDA or other authority reactions to medications or problems with products,
- To notify people of recalls of products that may be using,
- To notify a person who may have been exposed to a disease or may be at risk for getting or spreading a disease or condition,
- To notify employer of work-related illness or injury (in certain cases), and
- To a school to disclose whether immunizations have been obtained.

Health Oversight Activities. We may disclose your medical information to a federal or state agency for health oversight activities such as audits, investigations, inspections, and licensure of the Practice and of the providers who treated you at the Hospital. These activities are necessary for the government to monitor the health care system, government programs, and compliance with laws.

Lawsuits and Disputes. We may disclose your medical information to respond to a court or governmental agency request, order or a search warrant. We also may disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone else involved in a dispute.

Law Enforcement. Subject to certain conditions, we may disclose your medical information for a law enforcement purpose upon the request of a law enforcement official or to report suspicion of death resulting from criminal conduct or crime on our premise or for emergency or other purposes.

Medical Examiners and Funeral Directors. We may disclose your medical information to a coroner or medical examiner or funeral director so they may carry out their duties.

National Security. We may disclose your medical information to authorized federal officials for national security activities authorized by law.

Protective Services. We may disclose your medical information to authorized officials so they may provide protection to the President of the United States and other persons.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may release your medical information to the correctional institution or a law enforcement officer. This release would be necessary for the Practice to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the law enforcement officer or the correctional institution.

Incidental Disclosures. Although we train our staff in privacy, due to the way treatment and billing occurs, your medical or billing information may be overheard or seen by people not involved directly in your care. For example, your visitors or visitors visiting other patients on your treatment floor could overhear a conversation about you or see you getting treatment; or as in this example, another patient or their family member may see your name on a sign-in sheet during check-in process at clinic's front desk area. Please inform our staff if you do not want your name visible for others to see.

Business Associates. Your medical or billing information could be disclosed to people or companies outside our Practice who provide services to us. We make these companies sign special confidentiality agreements with us before giving them access to your information. They are also subject to fines by the federal government if they use/disclose your information in a way that is not allowed by law.

Note: Stage law provides special protection for certain types of health information, including information about alcohol or drug abuse, mental health and AIDS/HIV, and may limit whether and how we may disclose information about you to others. Federal law provides additional protection for information that results from alcohol and drug rehabilitation treatment programs.

YOUR PRIVACY RIGHTS

Right to Review and Right to Request a Copy. You have the right to review and get a copy of your medical and billing information that is held by us in a designated record set (including the right to obtain an electronic copy if readily producible by us in the form and format requested). The Medical Records Department at medicalrecords@TNonc.com has a form you can fill out to request to review or get a copy of your medical information, and can tell you how much your copies will cost. The Practice is allowed by law to charge a reasonable cost-based fee for labor, supplies, postage and the time to prepare any summary. The Practice will tell your if it cannot fulfill your request. If you are denied the right to see or copy your information, you may ask us to reconsider our decision. Depending on the reason for the decision, we may ask a licensed health care professional to review your request and its denial. We will comply with this person's decision.

Right to Amend. If you feel your medical information in our records is incorrect or incomplete, you may ask us in writing to amend the information. You must provide a reason to support your requested amendment. We will tell you if we cannot fulfill your request. The Medical Records Department at medicalrecords@TNonc.com can help you with your request.

Right to an Accounting of Disclosures. You have the right to make a written request for a list of certain disclosures the Practice has made of your medical information for the past 6 years or within a certain period of time. This list is not required to include all disclosures we make. For example, disclosure for treatment, payment, or Practice administrative or operation purposes, disclosures made before April 14, 2003, disclosure made to you or which you authorized, and other disclosures are not required to be listed. The Medical Records Department at medicalrecords@TNonc.com can help you with this process, if needed.

Right to Request Restrictions on Disclosures. You have the right to make a written request to restrict or put a limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on your medical information that we disclose to someone involved in your care or the payment for your care, like a family member or friend. ***We are generally not required to agree to your request, except as follows:***

- Payor Exception: If otherwise allowed by law, we are required to agree to a requested restriction, it (1) the disclosure is to your health insurance plan for purposes of carrying out payment or health care operations and (2) the medical information to be restricted relates solely to a health care item or service for which all parties have been pain in full out of pocket.

If we do agree to a request for restriction, we will comply with your request unless the information is needed to provide you with emergency treatment or to make a disclosure that is required under law. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your adult children.

Right to Request Confidential Communications. You have the right to make a written request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Object or Opt-out. You have the right to object to or opt-out of the following:

- Directory: You may object to our inclusion of your name in a Practice Directory that is made available for persons who inquire about you by name.
- Immunization: You may object to our disclosure or immunization information about you or your child to a state immunization registry.
- Family and friends: You may object to or request that we do not share your information with family, friends or a specific person involved in your care or present with you during treatment.
- Email or text: You may object to and request that we do not communicate with you by email or text.
- Fundraising: You may opt-out of fundraising communications.

Right to a Paper Copy of This Notice. You have the right to object to receive a paper copy of this Notice at any time even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice at our website at www.TNoncology.com or a paper copy from your provider.

Right to Receive a Notice of a Breach of Unsecured PHI/Billing Information. You have the right to receive a notice in writing of a breach of your unsecured Protected Health Information (PHI) or billing or financial information. TENNESSEE ONCOLOGY will be responsible for notifying you of any breaches that result from our staff's or a Business Associate's actions or inactions.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you, as well as for any information we receive in the future. We will post the current Notice in the Practice locations and on our website at www.TNoncology.com

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with TENNESSEE ONCOLOGY'S Privacy Officer at 615-514-3035 or Privacy@TNonc.com or by writing to TENNESSEE ONCOLOGY, 2004 Hayes Street, Suite 800, Office of Compliance, Nashville, TN 37203; the Secretary of the Department of Health and Human Services or HHS or with the Office for Civil Rights (OCR). Their contact information is in this Notice. Generally, a complaint must be filed with HHS or OCR before 180 days after the act or omission occurred, or within 180 days of when you knew or should have know of the action or omission. You will not be denied care or discriminated against by TENNESSEE ONCOLOGY for filing a complaint.

OTHER USES AND DISCLOSURES OF MEDICAL OR BILLING INFORMATION REQUIRE YOUR AUTHORIZATION

Disclosures that are not referenced in this Notice of Privacy Practices or are not otherwise allowed or required by federal and/or state law or our policies and procedures, will require your authorization. Uses and disclosure of your medical information not generally covered by this Notice or the laws and regulations that apple to the Practice will be made only with your written permission or authorization. For example, unless otherwise allowed by law, most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes and disclosures that constitute the sale of medical information require an authorization.

If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your medical information for the reasons covered by your written authorization, but the revocation will not affect actions we have taken in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, we still must continue to comply with laws that require certain disclosures, and we are required to retain our records of the care that we provided to you.

If you have any questions about this Notice, please contact the Privacy Officer at 615-514-3035 or Privacy@TNonc.com.

Effective Date: January 1, 2003, Revised August 23, 2013
Revised March 31, 2019

Notice About Nondiscrimination and Accessibility Requirements

DISCRIMINATION IS AGAINST THE LAW

TENNESSEE ONCOLOGY does not discriminate against any person on the ground of race, color, national origin, age, disability (physical or mental) or sex or gender identity in admission to, participating in, or receipt of the service and benefits under any of its programs and activities, and in staff and employee assignments to patients.

TENNESSEE ONCOLOGY provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information in other languages

If you need these services, contact your nearest TENNESSEE ONCOLOGY office.

If you believe that TENNESSEE ONCOLOGY has failed to protect your health information or to provide these services or discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Compliance Office at 615-514-3035, 2004 Hayes Street, Suite 800, Office of Compliance, or by email at Compliance@TNonc.com.

You can also file a civil rights or patient privacy complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 2021

Telephone: 1-800-368-1019, or TTD Number 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html

Southeast Region – Atlanta (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)

Timothy Noonan, Regional Manager Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Customer Response Center:
(800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

A Copy of this Notice is Available at the Front Desk.

NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

www.nashvillebreastcenter.com

Notice of Privacy Practices Acknowledgement Form

HIPAA Code

By typing or signing your name below, **you acknowledge receiving the Notice of Privacy Practices**. You understand that you can get signed copies of the completed documents and a copy of the Notice of Privacy Practices at the front desk at any Tennessee Oncology location. You agree that your typed or electronic signature is the equivalent of a manual signature and that Tennessee Oncology may rely on it, as such, in connection with all documents electronically signed and dated by you.

Communication with Caregivers with a HIPAA Code

Tennessee Oncology knows it's essential for your loved ones and other caregivers to communicate with your providers and clinic team members.

We prefer you use our Patient Engagement Portal and assign "delegates" when sharing your information.

Also, Tennessee Oncology allows patients to select a passcode **(HIPAA Code)** to share with their loved ones to make getting appointments, results, and billing information more accessible. Your emergency contacts should have this code if you want Tennessee Oncology to share limited information with them.

Tennessee Oncology team members will ask for the HIPAA Code when someone calls and requests information. We will use our professional knowledge and judgment before disclosing protected health information. At times, it may be necessary for team members to speak directly with the patient to verify the caller's identity.

Patients can cancel or change the HIPAA Code, but this task must be done in person during an office visit.

Please choose a HIPAA Code between 4 to 6 characters. It can be all numbers or letters or a combination of the two.

_____ _____ _____ _____ _____ _____

Patients are not required to have a HIPAA Code.

_____ _____

Typed Name or Signature **Date**

_____

SELF or **Patient Representative** (choose one)

NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance and any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

The Non-Medicare Patient

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to *Physician/Clinic*. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

The Medicare Patient

I request the payment of authorized Medicare benefits be made to me or on my behalf to *Physician/Clinic* for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Financial Assistance Authorization

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

Patient X _____ Date _____

Responsible Party _____ Date _____

NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

www.nashvillebreastcenter.com

Financial Counselor Services

Dear Patient,

At Tennessee Oncology, we understand you may have questions regarding the cost of treatment, the benefits provided by your insurance coverage, and whether financial assistance is available to help with these costs. We would like to introduce you to our Financial Counselor(s) who can assist you in understanding your insurance benefits, provide estimated treatment costs, introduce you to Patient Co-pay Assistance Foundations and make payment arrangements, if necessary.

Patient Co-pay Assistance Foundations are non-profit foundations designed to assist qualified patients in meeting their financial obligations. These foundations are typically funded for the treatment of a specific disease. While qualifications and funding vary, most have income limitations. Eligibility is determined on an individual basis so that program qualification and funding can be provided to as many patients as possible.

Our Financial Counselor(s) may reach out to you prior to your treatment/appointment to schedule a financial counseling session to discuss our services and available financial options.

Thank you for entrusting Tennessee Oncology with your care. We look forward to assisting you and ensuring your access to the best options for your treatment.

Sincerely,

Your Financial Counseling Team
"Caring for cancer patients is a PRIVILEGE"

NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

EXPLANATION OF TELEMEDICINE SERVICES, PATIENT SCREENING & CONSENT

There may be an opportunity while receiving care at Tennessee Oncology that you could be eligible to engage with your provider by a telemedicine visit instead of a traditional on-site office visit.

What is a telemedicine visit and how is it different from a regular office visit?

- Telemedicine involves the use of electronic communications to allow a patient to visit with his or her healthcare provider(s) from anywhere.
- A patient does not have to go to a clinic or hospital for a telemedicine visit.
- Unlike a traditional office visit, a telemedicine visit may be conducted over the phone and/or through an approved audiovisual website over the internet, making reliable access to your Tennessee Oncology healthcare provider(s) simple and efficient, regarless of your location.

What are the benefits of telemedicine visits?

- Telemedicine allows your healthcare provider to evaluate you from a place you choose, such as your home.
- Avoiding public spaces helps prevent people from exposing each other to illnesses that are spread from one person to another.

What are the risks associated with telemedicine visits?

- You and your provider will not be in the same room which may feel different from a regular office visit.
- Your provider may be unable to examine you as closely as at an office visit. We do not know if telemedicine leads to more errors in healthcare.
- Your provider may decide you still need an office visit.
- Telemedicine visits are not guaranteed and are subject to insurance plan determinations.
- The same rates apply to telemedicine visits as regular office visits.
- Technical problems, such as Internet outages or poor connection quality, may interrupt or stop your visit before you are done. If this occurs, we will try to reconnect, but we may need to reschedule your telemedicine visit.

Will my telemedicine visit be private?

- The privacy laws and rights of patients that apply to office visits also generally apply to telemedicine visits.
- Your telemedicine visits will not be recorded. To keep your visit private, we recommend that you have telemedicine visit in a private place, such as a room in your home, so other people cannot hear you or your healthcare provider.
- Your provider will tell you if someone else from their office can hear or see you and will ask for your verbal consent to proceed with the visit with that person present.
- We use telemedicine technology that is designed to protect your privacy.
- If you use the Internet for a telemedicine visit, we recommend using a private secure network.
- Although we use an encrypted telemedicine technology provider, there is a small change that someone, such as a hacker or other criminal, could use technology (or other means) to hear or see your telemedicine visit, especially if you don't take reasonable precautions to protect the privacy/security of your visit (such as using a secure internet connection, etc.)

Would you be interested in participating in a future telemedicine visit if considered appropriate by your provder(s)?

☐ Yes, I am interested in telemedicine visits.

☐ No, I am not interested in telemedicine visits.

What kind of equipment do I need for telemedicine visits?

- You will need a device that has video and an Internet connection. This could be a smartphone, tablet, laptop, or computer with a webcam and microphone. You will need this device for every telemedicine visit.

Do you have the needed equipment to participate in a telemedicine visit?

☐ Yes, I have the appropriate equipment to participate in a telemedicine visit.

☐ No, I do not have the appropriate equipment to participate in a telemedicine visit.

Print Patient Name _____ **Date** _____

NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

EXPLANATION OF TELEMEDICINE SERVICES, PATIENT SCREENING & CONSENT

I, _____, understand and consent to the following. I understand that I can revoke this consent at any time by contacting Tennessee Oncology privacy officer at 615-514-3035.

1. I understand that the potential benefits and risks of engaging in telemedicine visits. Some of these risks may include but are not limited to an inability to thoroughly assess your condition given the diagnostic limitations of the equipment used, absence of diagnostic testing, the inability to touch or smell or physically examine specific areas of the body; limitations in equipment or connection which may render the visit inadequate for remote consultation; a privacy breach; and the possibility that you cannot be adequately assessed by telemedicine, necessitating a referral for in-person treatment.

2. I understand that I am not guaranteed a telemedicine appointment. Appointments are determined by insurance coverage and provider discretion.

3. I understand that I will not be in the same location or room as my provider.

4. I understand that it is my obligation to notify my provider of any other persons in the location, either on or off came who can hear or see the session. I understand that I am responsible to ensure privacy at my location. I will notify my provider at the outset of each session and am aware that confidential information may be discussed.

5. I agree that I will not record either through audio or video any of the session

6. I understand that Tennessee Oncology is not responsible for any technological problems and cannot guarantee that technology will be available or work as expected.

7. I understand that Tennessee Oncology is not responsible for additional data or Internet surcharges incurred by my participation in a telemedicine appointment.

8. I understand that I am responsible for information security on my device, including but not limited to, computer, tablet, or phone, and in my own location.

9. I understand that the same rates will apply for telehealth as in-person office visits. This includes all co-pays and co-insurance fees that apply to the visit.

Patient Initials

I have read this document carefully and understand that potential limitations and risks of receiving services by telemedicine.

Print Patient Name _____ Date _____

Patient or Personal Representative Signature _____ Date _____

Relationship to Patient _____

Breast Health and Risk Reduction Program
Nashville Breast Center (NBC)

To minimize unnecessary waiting times for our patients we have established the NBC Breast Health and Risk Reduction Program.

For all conditions you will begin with one of our **expert breast Nurse Practitioners or Physician's Assistant (Lynn "Be" Alt, APN, MSN, FNP; Jess Baker, PA, Emily Manning, PA),** who will evaluate your history, symptoms, physical findings perform an ultrasound examination, as needed, and calculate your Lifetime Breast Cancer Risk as needed.

If you have received a recommendation for biopsy on mammogram, ultrasound or MRI, or a new diagnosis of breast cancer, you will then see the breast surgeon (Dr Lawson or Dr Dias) with the Nurse Practitioner or Physician's Assistant.

If you have any of the following conditions you will not have to wait for the breast surgeon (Dr Lawson or Dr Dias) to begin your care plan:

1. A family history of breast cancer or other history indicating above-average risk for breast cancer.
2. Breast pain, tenderness, redness, swelling or an unusual sensation.
3. A Breast (or nipple) Lump or Mass or Thickening or Change - if your Mammogram recommends a follow-up diagnostic or screening mammogram (not a biopsy)
4. An Abnormal Mammogram or Ultrasound or MRI with a recommendation for another mammogram or ultrasound or MRI in the future ("BIRADS 3" category)

In some cases the Nurse Practitioner or Physician's Assistant will order additional follow-up, testing and/or imaging. If indicated, she wil design an **Individualized Breast Health and Risk Reduction Care Plan** for you. If no sign of breast cancer or present need for biopsy is detected, your follow-up appointments and imaging studies will be scheduled without waiting for the surgeon. Your care plan will be started and will be delivered to your referring provider to carry out.

This program allows us to provide comprehensive, expert care with the greatest safety at Nashville Breast Center. Thank you for trusting your care to our team.

NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

NASHVILLE BREAST CENTER | TENNESSEE ONCOLOGY

www.nashvillebreastcenter.com

Patient Name: _____ MRN_____

General Consent to Treatment

As a patient of Tennessee Oncology, including our other specialties, you have the right to be informed about your condition and the medical and diagnostic recommendations so you can make an informed decision about the recommended treatment plan after knowing the possible risks involved.

No specific treatment plan has been recommended at this point in your care. This consent form is simply an effort to obtain your permission to perform tests, evaluations, and assessments to identify the appropriate treatment plan for the identified condition(s), including surgery.

You voluntarily consent to allow Tennessee Oncology providers, including our speciality providers and/or mid-level providers (i.e., Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist, collectively referred to as provider), to perform reasonable and necessary medical examinations and diagnostic testing, to treat my health conditions. You understand that if additional testing and/or invasive or interventional procedures are recommended, you will be asked to read and sign additional consent forms before the test(s) or procedure(s).

I have the right to request that a clinic-appointed chaperone or my caretaker be present in the exam room when my provider is conducting examinations. I understand that healthcare students may be involved in my care.

I authorize my provider(s) to perform other additional or extended services in emergencies if necessary or advisable to preserve my health or life. I understand that my care is directed by my provider(s) and that other personal rendering care and services to me follow the instructions of my provider(s).

You consent to use of clinical photography, if applicable, for diagnosis and treatment.

You can deny consent now or at anytime during your care at Tennessee Oncology or our other speciality providers. However, if you choose to do so, you understand that the physicians and/or healthcare professionals of Tennessee Oncology may not be able to provide the necessary evaluations, tests, and other assessments for continued healthcare services.

You can discontinue services at any time and revoke this consent in writing or by contaction the Tennessee Oncology Compliance Office at 615-514-3035.

I certify that I have read and fully understand the above and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed Name of Patient or Representative Date of Birth