AZCCC Arizona Center for Cancer Care

New Patient Information

The information you provide will help us give you better care. All information is confidential and protected.

Your Name: ______________________ DOB: __________ Today's Date: ________________

Medical History

Are any of these conditions part of your medical history? Explain "YES" answers in space below.

❑ Yes	❑ No	Prior Radiation Therapy	❑ Yes	❑ No	MRSA or other "Hospital" Infections
❑ Yes	❑ No	OTHER CANCER now or in the past	❑ Yes	❑ No	Lupus, scleroderma, or dermatomyositis
❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No	Hyper / Hypo Thyroid
❑ Yes	❑ No	Rheumatic Disease or Valve Replacement	❑ Yes	❑ No	Tuberculosis
❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Infection with HIV or AIDS
❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Infection with any Hepatitis Virus
❑ Yes	❑ No	Blood Clot or Pulmonary Embolism	❑ Yes	❑ No	Pacemaker or Defibrillator

List other MEDICAL CONDITIONS, PAST ILLNESSES and PAST SURGERIES

For example, any conditions or diseases for which you routinely see a physician or take medications

****Heart surgery, joint replacement, abdominal surgery, brain surgery, lung surgery, etc.**

____

____

____

____

Disease Prevention History

Have you ever had a colonoscopy? ❑ Yes (Date: ________) ❑ No

Have you had a mammogram within the last 2 years? ❑ Yes (Date: ________) ❑ No

Women's Health History

Last pelvic exam and/or pap smear? ❑ None ❑ No ❑ In the last 12 months ❑ >1 year ago (date: ________)

Number of pregnancies	________	Ever take birth control pills?	❑ Yes ❑ No
Number of deliveries	________	If Yes, how many years total?	________
Your age at first childbirth	________	Ever take estrogen after menopause?	❑ Yes ❑ No
Your age at first period	________	If Yes, how many years total?	________
Age or date of last period	________	Did you breast feed?	❑ Yes ❑ No
Could you be pregnant?	❑ Yes ❑ No	If Yes, how long (mths or yrs)	________

Medication and Allergy History

❑ Yes ❑ No Do you take **Aspirin, Plavix** (Clopidrogel), **Coumadin** (Warfarin), **Elaquis** (Apixaban), **Xarelto** (Rivaroxaban), or other **blood thinners?**

If Yes, please list below under CURRENT MEDICATIONS

❑ Yes ❑ No Do you have an ALLERGY or INTOLERANCE to any medication or substance?

****If Yes, please list drug(s) and the allergic reactions:**

____

****Preferred Pharmacy Name:** ______________________________ **Pharmacy Phone:** ____________________

Please list your CURRENT MEDICATIONS

Drug Name	Dose	Taken How Often?	Reason?

Lifestyle Profile

Occupation or Primary Activity ____

❑ Yes ❑ No Do you have a life partner or spouse? Name: ______________________________

❑ Yes ❑ No Does anyone live with you? Who? ______________________________

❑ Yes ❑ No Have you ever used tobacco? Please indicate the type of tobacco

❑ Smokeless ❑ Vapor ❑ Chew Start Date: __________________

❑ Cigarettes _________ packs/day for ________years

❑ Yes ❑ No Do you **currently** drink alcohol? If Yes, how many drinks per day? ____________/day

If you do NOT drink now, did you in the past? ❑ Yes ❑ No Year quit: ________

❑ Yes ❑ No Do you have a history of Hepatitis A, B, or C?

❑ Yes ❑ No Have you ever used illicit street drugs?

❑ Marijuana ❑ Other ________________________________

How often? _________________ for ___________years

❑ Yes ❑ No Do you **currently** drive a motor vehicle?

Family Medical History

❑ Yes	❑ No	Any relatives diagnosed with Breast Cancer?	If Yes, list below
❑ Yes	❑ No	Any relatives diagnosed with Ovarian Cancer?	If Yes, list below
❑ Yes	❑ No	Any relatives diagnosed with Colon Cancer?	If Yes, list below
❑ Yes	❑ No	Any other cancers in Parents, Siblings, or Children?	If Yes, list below
❑ Yes	❑ No	Any relatives with Blood Clots or Pulmonary Embolism?	
❑ Yes	❑ No	Are you of Ashkenazi Jewish decent?	

Relative	Type of Cancer	Age at Diagnosis

Have you experienced any of these problems during the past several months?
You can write in additional information about these symptoms below

General

Unexplained Fevers	❑ Yes	❑ No
Weight Gain _______ lb	❑ Yes	❑ No
Weight Loss _______lb	❑ Yes	❑ No
Night Sweats	❑ Yes	❑ No

Eyes

New Vision Problems	❑ Yes	❑ No
New Double Vision	❑ Yes	❑ No

Ears/Nose/Mouth/Throat

Pain or Problems Swallowing	❑ Yes	❑ No
New Hearing Loss	❑ Yes	❑ No
New Dizziness	❑ Yes	❑ No

Heart-Related

Chest Pain	❑ Yes	❑ No
Leg Swelling	❑ Yes	❑ No
Lightheadedness with Activity	❑ Yes	❑ No

Lung-Related

New Cough	❑ Yes	❑ No
Pain with Breathing	❑ Yes	❑ No
New Shortness of Breath	❑ Yes	❑ No

Bone and Muscle-Related

New Back Pain	❑ Yes	❑ No
New Bone Pain	❑ Yes	❑ No

Endocrine

Unusual Thirst	❑ Yes	❑ No
Temperature Sensitivity	❑ Yes	❑ No

Psychiatric

Trouble Sleeping	❑ Yes	❑ No
Disabling Feelings of Anxiety	❑ Yes	❑ No

Gastro-Intestinal

Rectal Bleeding	❑ Yes	❑ No
New Diarrhea	❑ Yes	❑ No
New Constipation	❑ Yes	❑ No
Heartburn or severe indigestion	❑ Yes	❑ No

Genito-Urinary

Excessively frequent urination	❑ Yes	❑ No
Pain with Urination	❑ Yes	❑ No
Blood in Urine	❑ Yes	❑ No
Urinary Incontinence	❑ Yes	❑ No
Abnormal/New Vaginal Bleeding	❑ Yes	❑ No
Pain with Pelvic Exams	❑ Yes	❑ No

Skin

New Rash	❑ Yes	❑ No
New Skin Spots of Concern	❑ Yes	❑ No

Brain and Nerve-Related

New headaches	❑ Yes	❑ No
Seizures or Unexplained Fainting	❑ Yes	❑ No
Arm or Leg Numbness or Weakness	❑ Yes	❑ No
New Bladder or Bowel Incontinence	❑ Yes	❑ No

Hematologic/Lymphatic

New Easy Bruising	❑ Yes	❑ No
New Swollen Glands	❑ Yes	❑ No

Allergies and Immune System

Recurrent Infections	❑ Yes	❑ No
Life-Threatening Allergies	❑ Yes	❑ No

Please list any other specific concerns for today's visit

____

____

____

____

____

____

____

Consent for Treatment/Care

I consent to treatment and care by AZCCC and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications. I understand that my treatment and care may include routine care, such as assessments, medications, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care from my health care provider. I understand that my care team at AZCCC may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, payments, examinations, or procedures

Patient Signature: This is true to the best of my knowledge

Patient Signature: ____ Date: ____________________

For Physician Use Only: I have reviewed this information with the patient

Physician Signature: ____ Date: ____________________

AZCCC
Arizona Center for Cancer Care

Patient Registration

Patient Name: ______________________________ Birth Date: ______________ Gender: ❑M ❑F

Home Address: ____
Street City State Zip

Mailing Address: ____
Street City State Zip

Home Phone: ______________ Work Phone: ______________ Email Adress: ______________________

Social Security Number: ______________ Mobile Phone: ______________ Mobile Phone Provider: ______________

How would you like to receive appointment reminders? ❑Text Message ❑ Email

Marital Status: ❑Single ❑Married ❑ Divorced ❑ Widowed ❑ Other: ______________

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino

Race: ❑American Indian or Alaska Native ❑Asian ❑ African American ❑ Caucasian ❑ Other: ______________

Preferred Language: ❑English ❑ Spanish ❑ French ❑ Chinese ❑ Other: ______________

Patient Employer: ______________________________ Occupation: ______________________

Employer Address: ____
Street City State Zip

Primary Insurance: ______________________________ Subscriber Name: ______________________
Subscriber Date of Birth: ______________________ Relationship to Subscriber: ______________________
Member ID: ______________________________ Group Number: ______________________
Billing Address: ____
Street City State Zip

Secondary Insurance: ______________________________ Subscriber Name: ______________________
Subscriber Date of Birth: ______________________ Relationship to Subscriber: ______________________
Member ID: ______________________________ Group Number: ______________________
Billing Address: ____
Street City State Zip

Referring Physician: ______________________________ Phone: ______________ Fax: ______________
Address: ____
Street City State Zip

Primary Care Physician: ______________________________ Phone: ______________ Fax: ______________
Address: ____
Street City State Zip

Do you have a living will? ❑Yes ❑No Do you have a DNR? ❑Yes ❑No If Yes, please provide a copy for our records

Authorization, Assignment, and Release

I authorize Arizona Center for Cancer Care to perform, evaluate and treat, as they deem necessary. I further authorize my insurance company ______________________ to pay Arizona Center for Cancer Care all medical benefits. I understand that ultimately, I am responsible for all charges not covered by my insurance as well as all deductibles; co-insurance and co pay amounts as determined by my insurance company. I understand that I will be responsible for all collection fees and all legal fees, if my account is placed with an outside collection agency. I hereby authorize Arizona Center for Cancer Care to release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient Signature: ____ Date: ______________

Notice of Privacy Practices and Communication Consent

This form is to identify who may or may not have access to oral communication in regards to the patient's protected health information while the patient is under treatment.

List the full name of family or friends that Arizona Center for Cancer Care can share your protected health information

Name	Phone Number	Relationship

Patient Home Phone: ______________________ Cell Phone: ______________________

May we leave a message? ❑ Yes ❑ No Please select preference for voice message: ❑ Home Phone ❑ Cell Phone

Emergency Contact: ______________________ Relationship to Patient: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Please list Physicians to receive correspondences for our office

Physician: ______________________ Specialty: ______________________

Phone: ______________________ Fax: ______________________

Address: ______________________

Street City State Zip

Physician: ______________________ Specialty: ______________________

Phone: ______________________ Fax: ______________________

Address: ______________________

Street City State Zip

Physician: ______________________ Specialty: ______________________

Phone: ______________________ Fax: ______________________

Address: ______________________

Street City State Zip

I ______________________ acknowledge that I have received a copy of Arizona Center for Cancer Care's Notice of Privacy

Patient Name (please print)

Practices and Patient Rights and Responsibilities. I have identified who may or may not have access to my protected health information while under treatment at Arizona Center for Cancer Care. I understand that this release is valid for the time period of my diagnosis, but may revoke authorization at any time by informing Arizona Center for Cancer Care and my physician.

Patient Signature: ______________________ Date: ______________________

AZCCC
Arizona Center for Cancer Care

Financial Policy

Ashley Albert MD, Christopher Biggs MD, Rezwan Chowdhury MD, Justin Famoso MD, Apar Gupta MD,
Cory Heal MD, Elizabeth Jeans MD, Terry Lee MD, Gerald Lucas MD, Gregory Maggass MD, Subhakar Mutyala MD,
Anushka Patel MD, Daniel Reed DO, Jason Samuelian DO, Steven Sckolnik MD, Scott Tannehill MD

Thank you for choosing Arizona Center for Cancer Care to meet your specialized medical needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. All new patients must complete and sign the Patient Registration and our Financial Policy forms before seeing the physician.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE FOR CO-PAYS UNLESS A PAYMENT ARRANGEMNT AGREEMENT HAS BEEN INITIATED. *PAYMENT PLANS ARE ACCEPTED UPON APPROVAL*

WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS.

Regarding Insurance: Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We will bill your insurance plan for you, as long as you provide us with correct information. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, are ultimately responsible for payment of all services provided by Arizona Center for Cancer Care. While payment is your responsibility, we will assist you in negotiating settlement with your insurance company for any disputed claim. Our billing department is available to discuss any questions you may have regarding your insurance or your account 480- 270-5306 or via email found on your physician’s business card.

Regarding insurance plans where we are a participating or preferred provider: All co pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating, or preferred providers refer to the above paragraph. If you have a secondary insurance, we will bill it for you, as a courtesy, as long as you have provided us with the appropriate information.

Usual and Customary: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

Medical Necessary Care: We will only provide you with a service if we consider it medically necessary. Therefore, if your insurance company arbitrarily determines that a service, we have rendered to you is unnecessary, you will be responsible for the bill.

Credit Policy: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days.

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our billing department as soon as possible by calling 480-270-5306.

If an account becomes past due with no valid reason, necessary action will be taken to recover the account balance due. If your account is placed with an outside collection agency, you will be responsible for all collection fees and all legal fees.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient Signature: ____________________ Date: ____________

Arizona Center for Cancer Care Patient Financial Services is pleased to assist patients in understanding our billing process. AZCCC makes every effort to ensure that your care comes first.

The Billing Process

As a courtesy, AZCCC obtains the referral, required authorizations and bills your insurance company for all medical services provided. Co-pays, co-insurances, and deductibles may accrue as patient balance based on your plan benefits. Upon request, we may provide a quote of the estimated treatment cost based on your plan benefits.

Contact Information

If you have general questions about your insurance benefits, potential future balances, or payment options please call our Patient Account Representative at 480-270-5306.

Frequently Asked Questions

How much will I owe?

The amount owed can vary significantly depending on your benefits. You will not receive a statement from AZCCC until your insurance has started processing your claims. A complete final statement is issued after treatment that includes total patient responsibility.

I met my maximum out-of-pocket with my insurance, why am I being asked to pay a co-pay or other patient balance?

If you are being asked to pay a copay or other patient balance and feel you have met your maximum out of pocket, please contact our billing office at 480-270-5306 for assistance. Refunds can be requested by calling the billing department if needed. A refund will be issued electronically back to the card/bank account used for payment within two (2) business days. In the event that the original payment card and/or account is invalid, a refund will be issued via mailed check after your address has been verified. Mailed checks may be expected within two (2) weeks of the refund request.

What if I have insurance and cannot afford to pay my portion of the bill?

If you receive a statement reflecting a patient balance during your course of treatment and are concerned about the balance, please call our Patient Accounts Representative at 480-270-5306 to discuss assistance options.

Why is a doctor mentioned on my bill or explanation of benefits that I did not see or recognize?

Over a course of treatment, you will be visiting our office frequently, and some visits may only require interaction with a therapist, nurse, or physician assistant. During those visits, your specific doctor may not be at the office, but another radiation oncologist is on-site and they become the “covering doctor” for your treatment that day. In these cases, correct billing requires services on that date be billed under the “covering doctor” instead of your specific doctor.

How do I obtain treatment information so I can file a cancer policy claim?

At the end of treatment, please call our patient Accounts Representative at (480) 270-5306 to obtain a detailed ledger with needed dates of service, procedure and diagnosis information to file your claim.

Why do I have a balance for a date that I did not receive services?

Radiation treatment requires detailed planning by our radiation oncologists and their team. After a consultation, and prior to the start of treatment, our oncologists will perform several treatment planning tasks that are billed to the insurance on dates that you may not actually be at our office. Based on your plan benefits, the insurance may apply a patient balance for those claims.

AZCCC
Arizona Center for Cancer Care

Patient Rights and Responsibilities

You have the right to:

- Be treated with dignity, respect, and consideration.
- Not be discriminated against base on race, age, gender, national origin, religion, sexual orientation, disability, marital status or diagnosis.
- To receive privacy in treatment and care for personal needs
- To receive treatment that supports and respects your individuality, choices, strengths and abilities
- Not be subjected to misappropriation of personal and private property by your provider or its staff
- To review upon written request, your medical record
- Safe care and not be subjected to neglect, exploitation, coercion, manipulation, abuse (physical, sexual, emotional) or sexual assault.
- Know the identity of those professionals that are treating you.
- Participate or have your representative participate in the development of, or decisions concerning, treatment
- Have access to an interpreter, free of charge.
- To receive a referral to another provider if our clinic cannot provide services needed
- Refuse treatment to the extent permitted by law including research or experimental treatment.
- Receive explanation for prior to any transfer of care.
- Have assistance from a family member, representative or other individual in understanding, protecting, or exercising your rights.
- File a complaint with a manager, the Department of Health Services, or your provider without retaliation
- Understand why someone is involved or observing care
- Not be restrained or secluded.
- Receive, on request, information about schedule of rates, charges, explanation of bill, regardless of source of payment.
- Have an advanced directive concerning treatment.

You have the responsibility to:

- Provide accurate & complete information concerning present complaints, past Medical history and other matters relating to his/her health.
- Make it known whether you clearly comprehend the course of treatment and what is expected of him/her.
- Follow the treatment plan established by his/her physician, including the instructions of nurses and other health care professionals, as they carry out the physician's orders.
- Keep appointments; notify Arizona Center for Cancer Care or physician when unable to do so.
- Accept responsibility of your actions should you refuse treatment or not follow physician's orders
- Assure that financial obligations of your care are fulfilled as promptly as possible.
- Follow AZCCC policies and procedures.
- Be considerate of the rights and property of other patients and facility personnel.
- Notify the AZCCC staff of request for interpreter services.

If you have any comments or concerns regarding services provided by Arizona Center for Cancer Care, please contact our Practice Administrator at (623) 773-2873 or write our Practice Administrator, 14155 N. 83rd Avenue, Suite 127 Peoria, AZ 85381.

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

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with Arizona Center for Cancer Care. This information is called protected health information, specifically "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services. Arizona Center for Cancer Care is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law. If you have any questions about this notice please contact our Privacy Manager at 480-278-8300.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information- This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record.

You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.

You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability - This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

Complaints - You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

How We May Use or Disclose Protected Health Information - Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive but do describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results for exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Moreover, we may contact you to provide information about health-related benefits and services offered by our office.

For Payment- Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care

services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations- We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identification information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, **that you identify**, your protected health information that directly relates to that person's involvement in your health care. If you are to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law- We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

For Public Health- We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases- We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight- We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Case of Abuse or Neglect- We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration- We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products: to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings- We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

To Law Enforcement- we may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation- We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

In Cases of Criminal Activity- consistent with applicable federal and state laws, we may disclose protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security- When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities: (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or: (3) to foreign military authority if you are a member of that foreign military services.

For Worker Compensation – Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.

When an Inmate- We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures- Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Authorization to Use, Disclose and Request Protected Health Information

To Our Patient:

There are times when Arizona Center for Cancer Care (AZCCC) will need to request reports and health information from your other physicians and/or medical centers for your care at AZCCC. We also keep your other physicians notified of your treatment outcomes by sending all treatment reports and information to their facilities. In order to do so, your authorization is required.

Patient Name: ____ Date of Birth:____________________

Phone: ____________________________ Address:_________________________ City: ___State:________Zip:_____

I authorize the use, request and/or disclosure of my protected health information as described below. I understand that the information used or disclosed as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or disclosed to persons or organizations receiving it without obtaining my authorization. I have the right to revoke this Authorization by providing written notice to Arizona Center for Cancer Care. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

Arizona Center for Cancer Care (Circle your location)

Gilbert	Shea	Osborn	Biltmore
3645 South Rome St. Suite 116 Gilbert, AZ 85297 Phone: 480-278-8300 Fax: 480-634-2311	10460 N 92nd St, Suite 101 Scottsdale, AZ Phone: 480-278-8300 Fax: 480-922-5231	7337 East 2nd St Scottsdale, AZ 85251 Phone: 480-278-8300 Fax: 480-704-3647	2222 E Highland Ave, Ste 130 Phoenix, AZ 85016 Phone: 480-601-4025 Fax: 602-957-3601
Deer Valley	**Peoria**	**Surprise**	**Tempe**
19646 N 27th Ave Suite 108 Phoenix, AZ 85027 Phone: 480-278-8300 Fax: 623-223-1196	14155 N 83rd Ave Suite 127 Peoria, AZ 85381 Phone: 623-773-2873 Fax: 623-414-4922	14674 W Mountain View Blvd Suite 104 Surprise, AZ 85374 Phone: 623-466-7469 Fax: 623-455-3194	7695 S Research Dr, Suite B Tempe, AZ 85284 Phone: 480-350-7072 Fax: 480-839-0394

- I understand that this release is valid for the timeframe of my diagnosis through treatment, but I may revoke this authorization at any time by informing AZCCC and my physician.

Health information to release includes the following (as checked):

- Entire Health Record including consultation and follow-up notes, radiology results, physics/dosimetry data, and complete treatment record.
- Records from outside physicians that are sent to a physician at AZCCC.
- I give special permission to release any information regarding: (Initial on applicable line(s) only)
  __________ Substance Abuse ________Genetic Testing ________ HIV Information

Purpose: (Check applicable categories)

□ Further Medical Care □ Request □ Insurance Eligibility/Benefits
□ Disability Determination □ Legal Investigation □ Other: ______________________________

Records to be released from or to

Clinic Name: ____

Address: ____

City/State/Zip: ____

Phone: ________________________________Fax: ____________________________________

Expiration Date and Other Information:
This authorization will expire after the completion of my treatment at Arizona Center for Cancer Care. A photocopy of this authorization is as valid as the original. I understand this authorization is voluntary. I am confirming my authorization that the health care provider may use, request and/or disclose to the persons and/or organizations named in this form the protected health information described above. I understand that no person or entity authorized to use, disclose or request health care information may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Patient Signature: ____ Date: ____________________

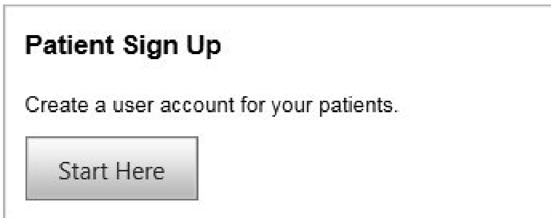
Patient Portal Instructions

AZCCC is excited to share our patient portal with you where you can access your treatment summary, patient education information, view your next appointment, send a secure message to your physician and more!

To get started:

We will provide you with a letter that has a unique PIN. This PIN will expire in 30 days so please go on and set up your access within 30 days of receiving your welcome letter.

Go to: //pat-port.arizonaccc.com Click on Star Here:



Enter your account details (all the fields on the screen) then click “Next”

Review and agree to the Terms of Use and select “Finish”

Then click on “go Login” and enter your username and password to login.

You will receive an email from the portal. It is important that you click on the link sent to you in that email that will be from Active Patient Portal. You will need to confirm your email address so that you can update your password, should it be forgotten.

This is what your portal experience will look like. Please take the opportunity to register and view your treatment summary, look up educational material, communicate with us and more. We are here to help or answer any questions you may have about the portal!!

Shea Office

10460 North 92nd St

Suite 101

Scottsdale, AZ 85258

Office 480 -278-8300

From the 101 Freeway Take Exit 41 for Shea Blvd.

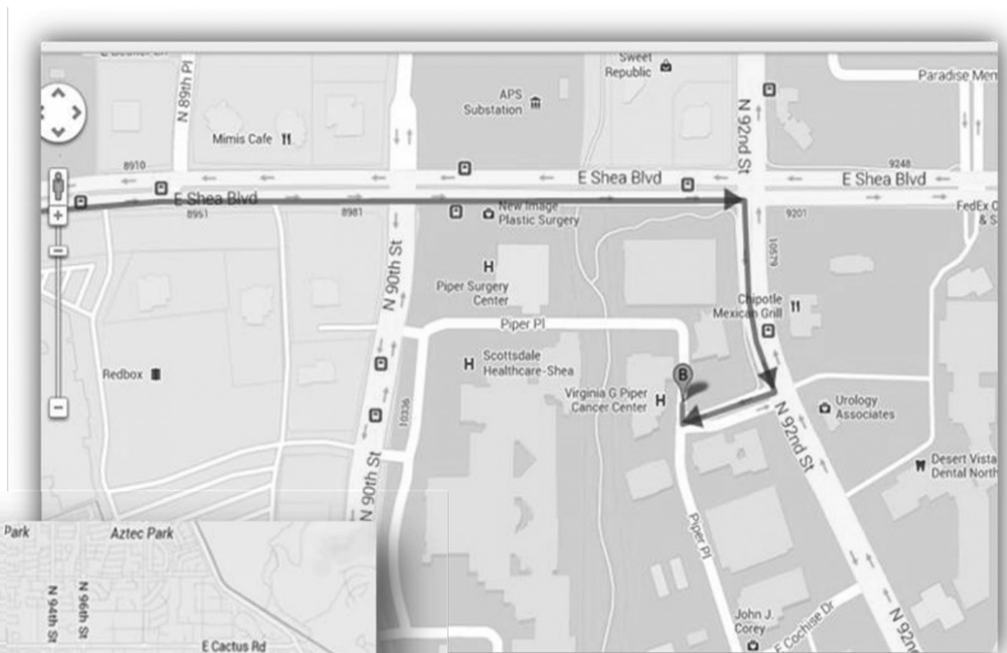
Go east on Shea Blvd.

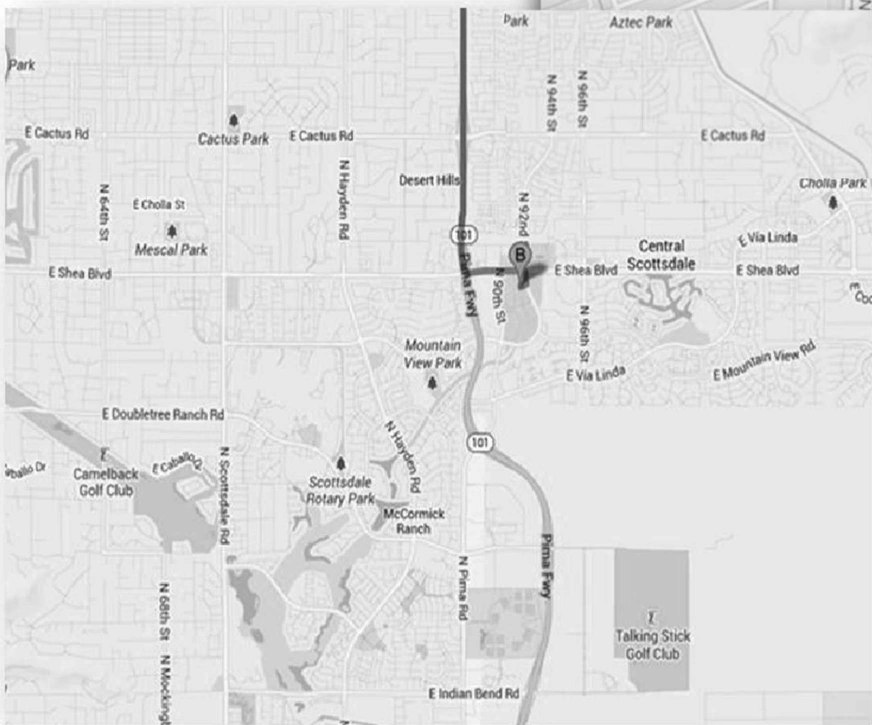
Turn right onto North 92nd St.

Turn Right onto North Lane

Turn Right on Piper Place at the first stop sign and make a quick right into our parking lot located directly across from the office.

Our office is located in the Virginia G Piper Cancer Center on the 1st floor, just past Tina's treasures.





Osborn Office

7337 E. 2nd St
Scottsdale, AZ 85251
Office 480 -278-8300

From the 101 Freeway
Take Exit 47 for Indian School Rd.
Turn right (west) on Indian School Rd and drive 1.9 miles Turn left onto North Drinkwater Blvd
Turn right onto E 2nd St
The 1st street on the left is North Wells Fargo Ave
Our building is Located on the corner of 2nd St and N Wells Fargo Ave
Turn left onto North Wells Fargo Ave and our parking lot is the 1st to the right

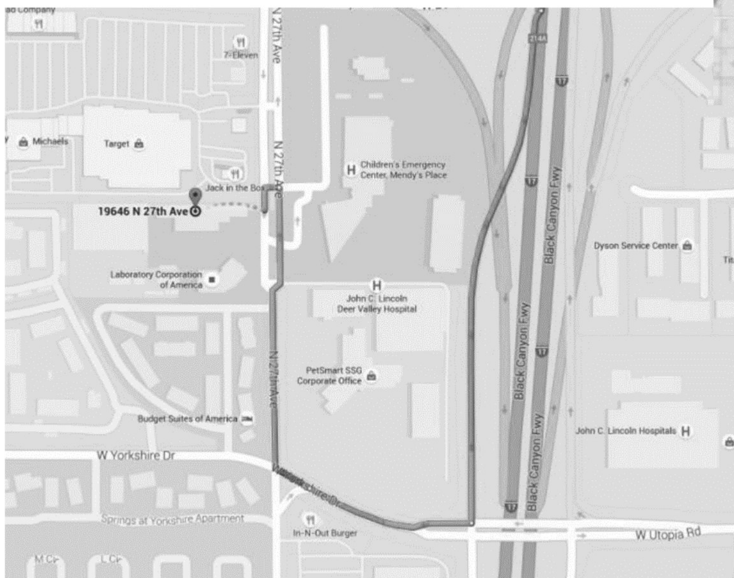
Deer Valley Office

19646 N. 27th Avenue Suite 108
Phoenix, AZ 85027
Office 480 -278-8300

From the 101 Freeway

Take exit 23A for 27th Ave Go South on North 27th Ave
We are located on the Honor Health campus in building 3
Patient parking is located just past our building in the parking garage

From the 17 Freeway
Take Exit 214A-214B for Yorkshire Dr. toward Union Hills Dr
Go west onto Utopia Rd (Utopia Rd. turns into Yorkshire Dr)
Go North on North 27th Ave
We are located on the Honor Health campus in building 3
Patient parking is located just past our building in the parking garage



Gilbert Office

3645 South Rome St. Suite 116

Gilbert, AZ 85297

Office 480 -278-8300

From the 101 Freeway

Head south on the 101 Freeway toward Tucson

Take the exit on the left for the 202 east Santan Freeway

Take exit 42 for Val Vista Dr

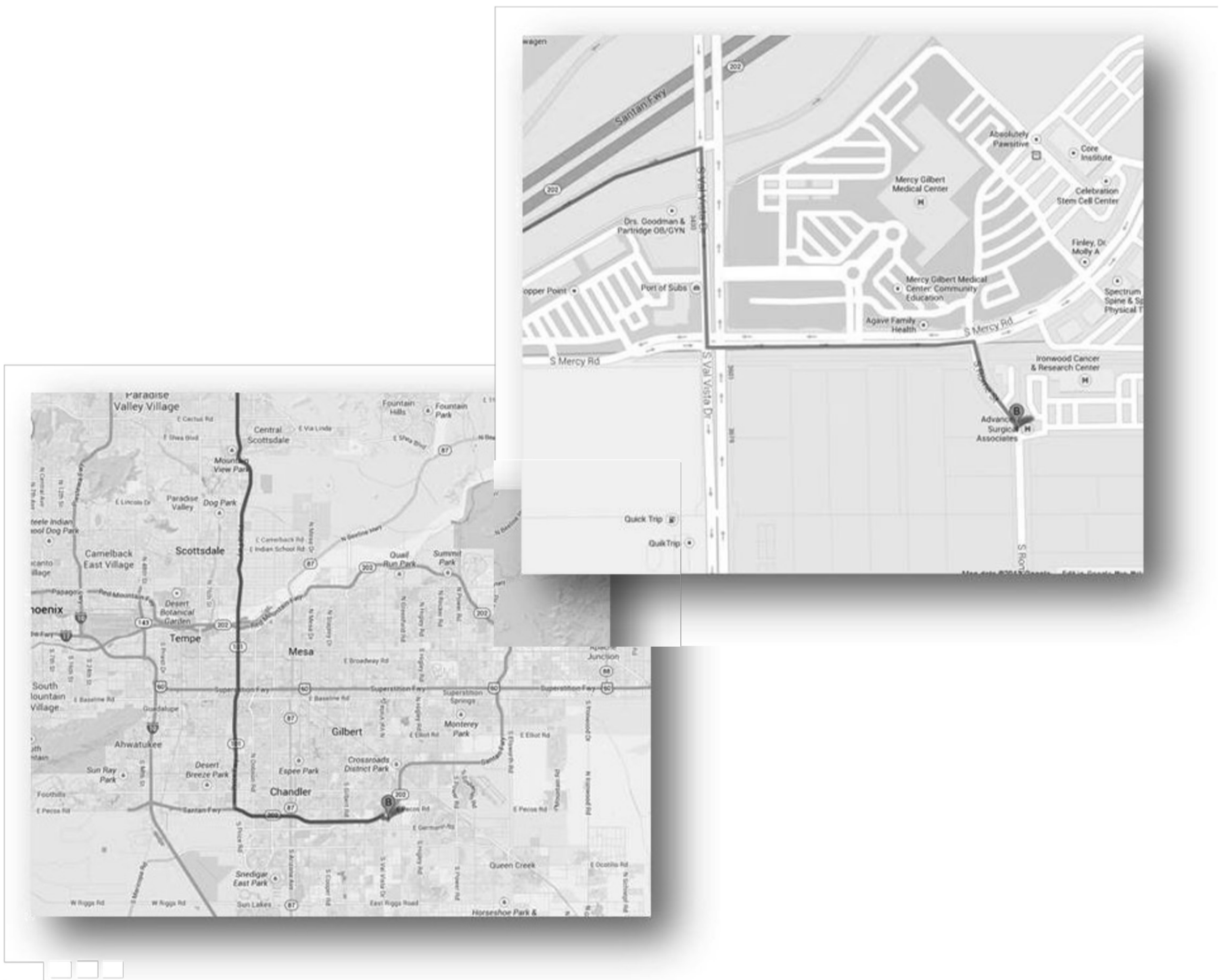
Go south on South Val Vista Dr

Take the 1st left onto South Mercy Rd

Take the 1st right onto South Rome St

Take your 2nd left toward the two-story glass building; our parking lot is located directly in front of the building.

When you come into the front door of the building, our main entrance is to your left.



Peoria Office

14155 N 83rd Ave, Suite 127
Peoria, AZ 85381
Office 623-773-2873

From the 101 Freeway

Take exit 12 for Thunderbird Rd

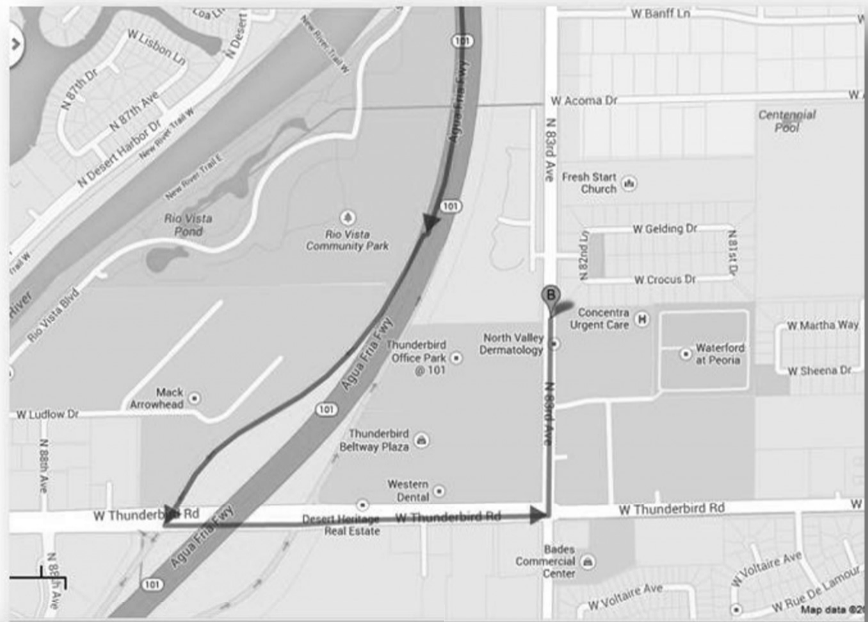
Go east on Thunderbird Rd

Turn Left onto North 83rd Ave

The office is located on the Northeast corner of 83rd Ave and Thunderbird

One block north of Thunderbird Rd

Turn Right into Stonegate Office Park and drive straight back to our building



Surprise Office

14674 W Mountain View Blvd, Suite 104

Surprise, AZ 85374

Office 623-466-7469

From the 101 Freeway

Take exit 14 toward Bell Rd

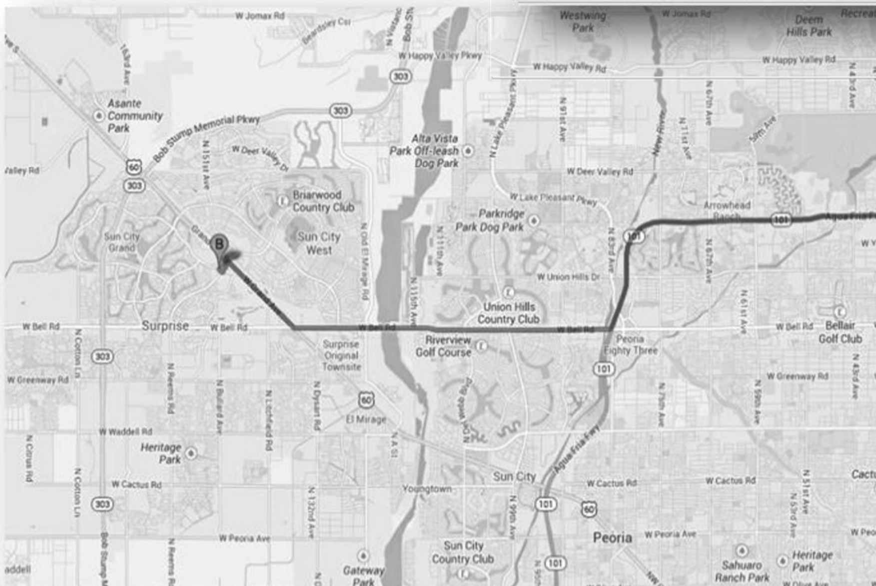
Go west on Bell Rd

Turn Right onto W Grand Ave and drive 1.8 miles

Turn Left onto N Reems Rd

Take the 3rd Right onto Mountain View Blvd

Our office is on the Right



Biltmore Office

2222 E Highland Ave, Suite 130

Phoenix, AZ 85016

Office 602-601-4025

From AZ-51 South

Take Exit 4A toward Camelback Rd

Use right lane to merge onto E Colter St

Use right lanes to turn slightly right onto N 17th Pl/N 18th St

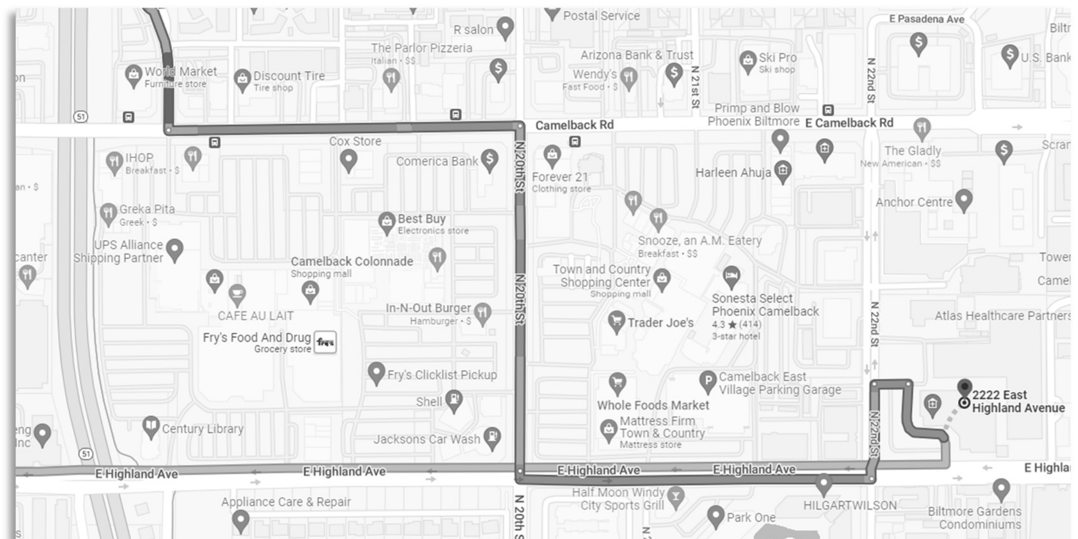
Turn Left onto E Camelback Rd

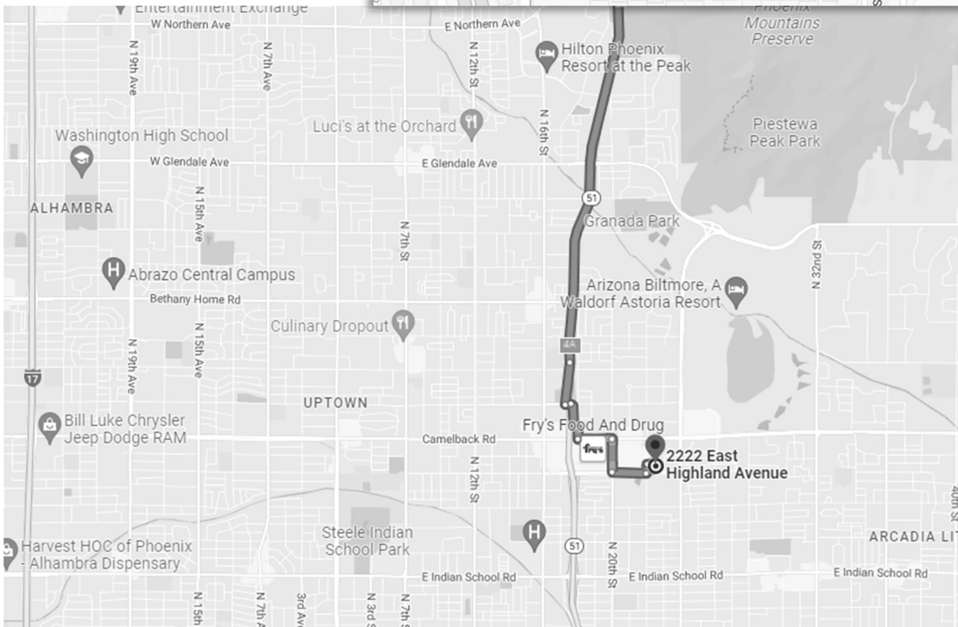
Turn Right onto N 20th St

Turn Left onto E Highland Ave

Turn Left onto N 22nd St

Office is on the Right Side in the Biltmore Medical Mall





Tempe Office

7695 S Research Dr, Suite B

Tempe, AZ 85284

Office 480-350-7197

From the 101 Freeway

Take AZ-101 Loop E and take exit 57 toward Elliot Rd

Use Right lane to merge onto S Price Rd

Turn Right onto E Conference Rd

Turn Right at the 1st cross street onto S River Pkwy

Turn Right onto Research Dr

Follow parking lot around to our building