NORTHWEST ONCOLOGY & HEMATOLOGY

Your center of excellence for personalized cancer care

BRUCE B. BANK, MD
GARY S. GORDON, MD
GARY I. GRAD, MD
STEVEN L. KANTER, MD
GARY E. KAY, MD
SUZANNE LAFOLLETTE, MD
STEVEN J. LEIBACH, MD
KEVIN P. MCKIAN, MD
ROBINSON ORTIZ, MD
EDWIN R. PRIEST, MD
HERBERT J. REISEL, MD
RONALD J. SHADE, MD
ALKARIM TAJUDDIN, MD, MBA
EROL YORUKMAZOGLU, MD

ADVANCED CARE & TREATMENT FOR:

- Lung cancer
- Prostate cancer
- Breast cancer
- Gynecologic cancers
- Colon cancer
- Bladder cancer
- Kidney cancer
- Liver cancer
- Head & neck cancers
- Esophageal cancer
- Leukemia & blood cancer
- Lymphoma
- Sarcoma
- Anemia & blood diseases/disorders

YOUR COMFORT & CONVENIENCE

- Serene, comfortable environment
- Same-day & next-day appointments
- Early morning appointments
- Infusion therapy
- Most insurance accepted & filed
- Payment plans available
- Oral dispensing service for chemotherapy & supportive drugs

3701 Algonquin Rd., Crossroads Center, Ste. 900
Rolling Meadows, IL 60008
Call: 847.870.4100 • Fax: 847.870.0866

800 Biesterfield Rd., Cancer Institute, Ste. 210
Elk Grove Village, IL 60007
Call: 847.437.3312 • Fax: 847.956.5107

1555 Barrington Rd., Doctors Bldg. 3, Ste. 1200
Hoffman Estates, IL 60169
Call: 847.885.4100 • Fax: 847.885.4199

27750 West Hwy. 22, Ste. G70
Barrington, IL 60010
Call: 847.842.0180 • Fax: 847.842.9877

www.NorthwestOncology.com

Welcome to Northwest Oncology and Hematology and thank you for choosing us for your care.

To expedite the check in process for your first visit, please complete the attached new patient packet. The completed forms should be brought with you to your first appointment.

Please arrive at least **20 minutes prior** to your scheduled appointment to complete the registration process.

If you have any questions prior to your first visit, please do not hesitate to contact the **New Patient Coordinator at 847.577.0620 x7112.**

Visit us on our Website: NorthwestOncology.com where you will find:

Physicians and Services Information

Locations with maps

You will receive login information for ***See Your Chart*** at your first visit.

See Your Chart is found on our website and gives our patients online access to limited portions of their ***Northwest Oncology and Hematology*** patient chart. Accessible information includes:

- Certain lab results from blood that is drawn in our office
- Your current demographic information including your address and phone numbers, insurance information, and other physicians included in your care
- A summary page that includes current allergies, oncology and hematology diagnoses, and current medication list
- A calendar showing your scheduled visits
- A list of recorded vital signs
- A resource page including educational sites for different diagnoses

Patient Satisfaction Survey - We value your opinion. After your visit, please complete our Patient Satisfaction Survey, found on our website.

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ASSIGNMENT OF BENEFITS FORM

Patient Name _____

I hereby authorize the release of any medical and other information necessary to insurance companies or associations, employee groups, government agencies or their third party payers and their agents/employees, adjusters and/or attorney's involved in my case, either electronically, by mail, fax or courier, as pertaining to my care in order to process my claims.

I also hereby authorize payment of medical / hospital benefits provided to me and submitted to my insurance company(ies) on my behalf to be paid directly to Northwest Oncology & Hematology, S.C.

If my insurance policy prohibits direct payment to doctor, I hereby instruct and direct my insurance company to do the following for any allowable benefit amounts billed by Northwest Oncology & Hematology and submitted on my behalf: Make the benefit check payable to "my name," and mail it to attention of my name "in care of," to the address as follows:

c/o **Northwest Oncology and Hematology, S.C.**
3701 Algonquin Road, Suite 900
Rolling Meadows, IL 60008

This is a direct assignment of my rights and benefits under this policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
Signature of Policyholder *Date*

_____ _____
*Signature of Claimant (**if other than Policyholder**)* *Witness Signature*

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Notice of Privacy Practices

NOTICE TO INDIVIDUALS OF INFORMATION 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.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal program that requires strict confidentiality for all your personal health information. That includes all your medical and dental information used or disclosed by us in any form, whether electronic, written or verbal. The Act gives you significant rights to understand and control how your health information is used. The Act also provides penalties for the misuse of Protected Health Information (PHI).

PHI is any information about you, including demographic data that identifies you and your past, present or future physical or mental health condition, as well as related healthcare services. This Privacy Policy describes how we may use or disclose your PHI to provide treatment, payment or healthcare operations or other purposes that are permitted or required by law. This policy also describes your rights to access and control your PHI.

Uses and Disclosures of Protected Health Information

Your PHI may be used or disclosed by our physician, office staff or others involved in your care and treatment, whether providing healthcare services to you, paying your healthcare bills, supporting the operation of our practice or any other lawful use.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your healthcare and related services. This includes the coordination or management of your healthcare by a third party. For example, your PHI may be given to a physician you have been referred to in order to ensure that he or she has the necessary information to diagnose or treat you.

Healthcare Operations: We may use or disclose your PHI to support our business activities. These activities may include quality assessment, employee review and conducting or arranging other business activities. We may also use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may call you by name in our reception area when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may phone your home and leave a message (on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder or letter to your home address. Please tell us if you prefer that we call or contact you at another phone number or location.

We may use or disclose your PHI under the following circumstances without your authorization. These include, as required by law:

- Public health issues
- Communicable diseases
- Health oversight
- Abuse or neglect
- Food and Drug Administration requirements
- Legal proceedings
- Law enforcement
- Coroners, funeral directors and organ donation
- Medical research
- Criminal activity; prison inmates
- Military activity and national security
- Workers' Compensation

Required Uses and Disclosures: The law requires us to disclose to you when we are investigated by the Secretary of the Department of Health and Human Services to determine our compliance with HIPAA. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization in writing at any time except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in your authorization.

Payment: Your PHI will be used, as needed, to obtain payment for healthcare services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to your health insurance plan to obtain approval for a hospital admission or a health-related procedure.

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www.NorthwestOncology.com

Your Rights

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records:

- Psychotherapy notes
- Information compiled in reasonable anticipation of, or use in civil, criminal or administrative actions or proceedings
- PHI that is subject to law prohibiting access to said PHI

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request nondisclosure of any part of your PHI to family members or friends who may be involved in your care or for notification purposes described in these Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to your requested restriction. If your physician believes it is in your best interests to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

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

You have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint by notifying our privacy officer at the contact information below. We will not retaliate against you for exercising your right to file a complaint.

Northwest Oncology & Hematology
Attention: Privacy Officer
3701 Algonquin Rd.
Crossroads Center, Ste. 900
Rolling Meadows, IL 60008
Call: 847.577.0620

This Notice was published and is effective on or before 6/1/2010.

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NOTICE OF PRIVACY PRACTICES FORM
ACKNOWLEDGEMENT OF RECEIPT

Patient Name: _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Northwest Oncology and Hematology, S.C.

_____ _____
Print Name of Patient or Personal Representative *Signature of Patient or Personal Representative*

_____ _____
Date *Description of Personal Representative's Authority*

CONTACT INFORMATION
The contact information of the patient or personal representative who signed this form should be filled in below.

Address _____

Telephone: (Daytime)_____ (Evening) _____

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Financial/Authorization Policy

Our Mission: The physicians, nurses and staff at Northwest Oncology & Hematology strive to provide the highest quality, individualized care for our patients in a compassionate, attentive manner. It is our mission to provide up to date care in an environment that comforts our patients and their families, respects their individual needs and wishes, and preserves their dignity.

We understand this may be a difficult and stressful time for you and your family. Our well-experienced staff will help to answer any questions you have regarding your insurance. Should you require chemotherapy treatment or require imaging services or tests, we will verify your insurance benefits and review the information obtained from your insurance carrier with you. A statement of estimate of financial liability, if any, will be discussed with you at this time.

Please take the time and carefully review how we will partner with you in understanding your financial responsibility, authorization policy and other information you may find helpful. A signature and date is required at the end of this form to serve as acknowledgement and authorization of our policies and procedures described herein.

INSURANCE

Claim Submissions
As a service to our patients, we will file claims to your primary and secondary insurance, on your behalf. However, the insurance contracts are between you and your insurance company and you are ultimately responsible to see that your claims are paid in a timely manner.

Insurance Changes
It is your responsibility to notify us immediately regarding any changes in your insurance coverage. This is imperative because most insurance companies have "timely filing" rules, which if missed, will result in denial and non-payment of submitted claims. If this should happen, the full amount billed will become your responsibility to pay. In order to avoid this situation and other similar situations, please contact us as soon as possible with any changes and or updates to your coverage. If your insurance application is pending with Illinois Department of Public Aid (IDPA) for example, please let us know, so we can work with you to expedite the processing of this application.

Medicare – Our physicians are participating providers with Medicare and accept assignment on all covered claims. Medicare requires you to pay the 20% co-insurance and your annual deductible. If you have a secondary (supplemental) insurance, we will file claims to them on your behalf. Medicare reimburses for chemotherapy drugs based on patient diagnosis. If we suspect that Medicare may not cover part of your treatment for your diagnosis, you will be asked to sign an ABN (Advanced Beneficiary Notification) form, which will indicate acknowledgement that you have been informed that part of your treatment may not be covered. We will also work with you to find alternate sources of reimbursement for that part of your treatment that is not covered; for example, the use of a secondary insurance prescription plan or a drug company's patient assistance program.

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Medicaid – Our physicians are participating providers with the Illinois Department of Public Aid (IDPA). Claims will be filed on your behalf with a valid IDPA card that shows your eligibility. A valid IDPA card must be presented at the time of service. Services not covered by IDPA, such as spend down amounts, are your responsibility and payment is expected at the time of service.

Managed Care – Our physicians participate in many different plans and although our staff is knowledgeable about many of these, it is ultimately your responsibility to know. Well before you come in for your appointment, please contact your insurance company and verify that your particular plan is one in which we participate. Insurance company websites do not always contain accurate, up to date information, so please contact them by telephone instead. Also, please be sure to verify that diagnostic testing will be covered and what facility tests should be directed to (ie: Quest Labs).

Commercial/Indemnity Plans– Our physicians participate in all of these plans. These plans generally have an annual deductible and an out-of-pocket expense up to a certain dollar amount. These expenses and deductibles are the patient responsibility and are expected at the time of statement.

Co-payments – A co-payment is a fixed amount of money you are required to pay to the provider, facility, pharmacy, etc., when you receive certain services. Co-payments must be paid at the time of service. Your HMO/PPO/POS plan will require that you pay a co-payment when you see your physician, when you have chemotherapy, when you have a port flush, when you have blood drawn, injections, and/or other imaging services/procedures. Please consult your insurance plan for specific coverage information and be prepared to pay this co-payment at the time of service.

Deductibles – A deductible is a fixed amount of expenses you must pay for certain covered services and supplies before your insurance company starts paying benefits for them. Co-payments & coinsurances do not count toward your deductible. If we verify that a deductible or a portion of your deductible has not been met and we verify that your insurance will cover and allow for payment of services rendered, we will ask for the appropriate portion of your deductible to be paid at the time of service. We can make exceptions to this policy if you can provide us with proof from your insurance company that your deductible has been met for the appropriate calendar year.

Coinsurance – A coinsurance is the percentage of your insurance plan allowance that you are responsible to pay for care. Coinsurance amounts are due and payable at time of statement.

Co-payments, Deductibles & Coinsurance – To summarize, co-payments, deductibles & coinsurance represent your contracted portion and financial obligation for services rendered to you. Routine waiver of co-payments, deductibles & coinsurance is considered “misstating the fee for services rendered” and may violate federal, state and local laws and regulations such as the False Claims Act, Anti Kick-back Statues and compliance guidelines for individual and small group physician practices as well as insurance company/participating physician contracts.

Pharmacy Cards – Please inform us if you have a pharmacy card. Certain insurance carriers require certain injectables (drugs) to be obtained from outside sources as opposed to being obtained directly through our office. Therefore, in order to prevent any unnecessary patient financial responsibility, please provide us with this information.

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Referrals – Your Insurance Plan may have specific requirements for referrals to see a physician, for diagnostic testing and/or treatments. Please review your particular insurance plan or call your insurance for those requirements. It is your responsibility to ensure that a referral is in place prior to your visit. Patients must present with a valid referral for covered services. Patients will not be seen without the referral. If a patient comes in without a referral, it may be necessary to reschedule the appointment. We will be happy to assist you with obtaining the referral. If the referral is for a series of treatments, which require numerous visits, it is your responsibility to ensure that the referral covers the appropriate number of visits to and it is your responsibility to keep track of the number of visits used and the expiration date of the referral. Should you have any questions about this information, please speak with the receptionist at the front desk.

Laboratory – Your Insurance plan may have specific rules about where your labs can be drawn. Most plans will only allow a drawing of a CBC (complete blood count) in our office. Some plans only allow CBC draws on days when chemotherapy treatment is also given. Some policies require your labs to be drawn at your PCP (Primary Care Physician) office or at a designated hospital or drawing facility. We hold a contract with Quest Laboratory, which allows us to draw and send out other lab tests, however, the types of tests allowed via this process vary depending on the particular insurance policy. Therefore, please review your policy and obtain accurate information by calling your insurance plan. ***We will not be responsible for lab tests processed in an incorrect facility and you will be held accountable for any monies due as a result***.

Hospital Admissions – In the event a hospital stay is needed, please let your physician know which hospital is in your insurance plan network. Your insurance policy will most likely require pre-certification prior to your admission and this information will speed up that process.

Billing and Statements – Any questions concerning your billing statement can be answered by our staff at our Central Billing Office at 847-577-0620, Monday through Friday from 9:00am – 4:00pm. Each patient account is assigned and managed by one staff member according to the physician that patient sees. This ensures that you will always speak with the same highly competent specialist regarding your account. This design emphasizes our mission goal, to serve each person individually and to the best of our ability by allowing one particular specialist to familiarize themselves with your account and circumstance. Our staff may need to contact you regarding your account for various reasons, therefore by signing the acknowledgement of receipt of this Financial/Authorization Policy form, you hereby authorize the staff at Northwest Oncology & Hematology to contact you and/or leave a message on voice mail, answering machine or other electronic device or with a person who answers the phone in regards to your appointments, administrative and/or financial obligations to this practice. You will sign a separate form regarding authorization to contact you and/or others regarding your health and any other health- related issues. We reserve the right to charge an administrative fee to help cover costs incurred in the effort to collect on delinquent accounts and also reserve the right to forward delinquent accounts to an outside collection agency should in-house attempts prove unsuccessful. Therefore, we encourage you to make every effort to keep in touch with us regarding the status of your outstanding account.

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FINANCIAL/AUTHORIZATION POLICY FORM

ACKNOWLEDGEMENT OF RECEIPT

Patient Name _____

I hereby certify that I have received a copy of the Financial/Authorization Form of Northwest Oncology & Hematology, S.C.

I also hereby certify that I have read and understand the information and policies contained therein and duly authorize Northwest Oncology & Hematology, S.C. to execute the enclosed policies and its' terms.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

Address:

_____

_____

Telephone:

_____ (Daytime)

_____ (Evening)

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Medication List

Patient Name _____ Doctor _____

DATE	DRUG/PRESCRIPTION	DOSE	DR. WHO PRESCRIBED THE MEDICATION	DATE MEDICATION BEGAN

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Communication Policy and Waiver

Communication is a very important part of providing quality health care. In an effort to provide you with information regarding your health care, we ask that you complete this waiver. **This form will remain active until a request by the patient is made to have information changed or removed.**

We normally contact our patients between 8:00 am and 5:00 pm. Please provide the phone number that we should use to contact you during this period.

_____ Home Work Cell (please circle one)

If we need to reach you outside these hours, what is the phone number that we should use to contact you?

_____ Home Work Cell (please circle one)

Please list any additional phone numbers we may use to contact you.

_____ Home Work Cell (please circle one)

_____ Home Work Cell (please circle one)

I authorize the following people to receive medical information regarding my care:

Name	Relationship	Contact Number

I authorize the following person to discuss financial information regarding my account:

Name	Relationship	Contact Number

Do you have voicemail or an answering machine? Yes No (please circle)
May we leave **medical information** on your voicemail or answering machine? Yes No (please circle)

_____
Print Name

_____ _____
Signature *Date*

Recently enacted Federal laws protecting a patient's privacy prevent us from sharing any information about your medical condition without your authorization. If you would like us to release information to anyone other than your physicians that are treating you or your insurance company, please ask to sign a separate authorization.

FAMILY AND PERSONAL HEALTH HISTORY

Note: Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission

Name_____Age_____Birth Date_____Todays Date_____ Occupation_____Last Physical Exam_____Phone #_____

Medication List

Drugs/Prescriptions	Dose	Refill

OPERATIONS	Yes	**No**	**Date**
Tonsils			
Appendix			
Gall Bladder			
Stomach			
Kidney			
Colon			
Thyroid			
Hernia			
Breast (woman)			
Uterus (woman)			
Ovaries (woman)			
Prostate (men)			
Other - if yes what:			

Do You: (if yes, daily consumption)			
	Yes	No	How Much
Smoke Pkgs.			
Drink Coffee Cups			
Beer ozs.			
Hard liquor ozs.			
Wine ozs			

Family Record Check condition(s) and relationship of any blood relative who has or has had any of the conditions listed below	YES	NO	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER
Alcoholism								
Allergies								
Arthritis								
Asthma								
Birth Defects								
Bleeding Tendency								
Cancer, Tumor								
Colitis								
Congenital Heart								
Diabetes								
Emphysema								
Epilepsy								
Glaucoma								
Goiter								
Hay Fever								
Heart Attack								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Leukemia								
Liver Disease								
Mental Illness								
Migraine								
Nervous Breakdown								
Obesity								
Rheumatism								
Rheumatic Fever								
Sickle Cell Anemia								
Stomach Ulcer								
Stroke								
Suicide								
Tuberculosis								

Family Members Living Age and Health

	AGE	GOOD	FAIR	POOR
Father				
Mother				
Brother(s)				
Sister(s)				

Family Members Deceased

	Cause of Death	Age
Father		
Mother		
Brother(s)		
Sister(s)		

PAST AND PRESENT MEDICAL PROBLEMS

Check all items either yes or no and give approximate date if past	No	Yes Now	Yes Past	If Past date
Asthma				
Abnormal Electrocardiogram				
Angina				
Anemia (type)				
Arthritis				
Blindness Either Eye				
Broken Bones				
Cataracts				
Chronic Bronchitis/Lung Disease				
Cirrhosis of Liver				
Colon or Bowel Trouble				
Deafness				
Dysentery				
Ear Infections				
Diabetes				
Emphysema				
Enlarged Heart				
Glaucoma				
Gall Stones				
Gout				
Goiter				
Gonorrhea				
Hay Fever				
Heart Murmur as Adult				
Heart Attack				
High Blood Pressure				
Hepatitis				
Hemorrhoids				
Kidney Infection				
Kidney Stones				
Nervous Breakdown				
Poor Blood Clotting				
Polio				
Phlebitis				
Rheumatic Fever				
Rectal Trouble				
Recurrent Boils				
Stroke				
Stomach or Duodenal Ulcer				
Syphilis				

Check all items either yes or no and give approximate date if	No	Yes Now	Yes Past	If Past Date
Skin Disease				
Serious Depression				
Serious Emotional Prob				
Tuberculosis				
Thyroid (overactive)				
Thyroid (under active)				
Varicose Veins				
Men				
Prostate Problems				
Women				
Menstrual Difficulties				
Cystitis				
Mastitis				
Ovarian Cyst				
Breast Cancer				
Other Breast Disease				
Still Menstruating?				

Age Period Started:_____
Age Periods Stopped_____
Why Periods Stopped_____
Number of Pregnancies_____
Number of Children_____
Number of Miscarriages_____
Explain:_____

X-Rays

When was your last Mammogram?

Please list any recent scans you have had done.

	Yes	**No**	**Date**
IMMUNIZATIONS			
Pneumonia Vaccine			
Tetanus			
Booster			
Measles			
Influenza			
German Measles/Mumps			

Do you have any Allergies, if yes please list _____

Please list Hospitalizations/Reasons and Dates _____

Northwest Oncology and Hematology, S.C.

Patient Name:_____ Date of Birth:_____

We are mandated by the government and the Health Information Technology for Economic and Clinical Health (HITECH) Act to ask certain questions and have the information available in our Electronic Medical Records System (EMR). The HITECH Act provides The Department of Health and Human Services (HHS) with the authority to establish programs to improve health care quality, safety, and efficiency through the promotion of health information technology (HIT), including electronic health records and private and secure electronic health information exchange. Please fill out the following form and return it to the front desk so your answers can be entered into our EMR system.

Ethnicity (please circle any that apply)

Not Hispanic or Latino Hispanic or Latino

Race (please circle any that apply)

American Indian or Alaska Native Native Hawaiian or Other Pacific Islander

Asian Caucasian

Black or African American Other

Preferred Language (please circle any that apply)

English Vietnamese

Chinese Spanish

French Russian

Italian Portuguese

Japanese Polish

Korean

Preferred Method of Contact (please circle one)

Mail Telephone: Home Work Cell