TENNESSEE PLATEAU ONCOLOGY

I_____ give Tennessee Plateau Oncology

permission to **share my protected health information and account financial information to**

_____ **(relationship)** _____

My protected health and account financial information may be given only by either my verbal or written consent to the parties listed above.

Signature: _____Date:_____

Emergency Contact Information:

Person: _____Relationship:_____

Phone Number: Home: _____

Cell Phone: _____

I understand and recognize that the Medical Insurance I possess, may not completely cover the fee(s) for Professional Services rendered to me. I hereby agree that I, my spouse, family and estate are responsible for said fee(s). I authorize payment directly to and assign to any/all medical payments, if any, otherwise payable to me, to Tennessee Plateau Oncology for their services. I hereby state that all information provided is true and complete to the best of my knowledge. I agree that I, my spouse, family and estate will be responsible for all collection fee(s) incurred if an outside collection agency is used to recover past due balances.

I acknowledge and understand the payment policies of Tennessee Plateau Oncology and authorize the release of medical information necessary to process claims made by Tennessee Plateau Oncology.

Patient Signature: _____ Date: _____

Signature of Spouse/Guarantor: _____Date: _____

I acknowledge that I have received the Tennessee Plateau Oncology Notice of Privacy Practices.

Signature: _____ Date: _____

Tennessee Plateau Oncology
Dirk C. Davidson, M.D.
33 West Adams St
Crossville, TN. 38555
Phone: 931-484-7596
Fax: 931-484-7597

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.

WHO WILL FOLLOW THIS NOTICE:

This notice describes our practice and that of:
Any healthcare professional authorized to enter information into your chart:
All departments and units of this practice:
Any member of a volunteer group we allow to help you while you are in this office:
Any medical student, intern, or fellow that we allow to help you while you are in the office:
Any representative of an insurance carrier, managed care organization, clinical research organization, data analysis organization, or quality improvement that is participating in a review of your medical care:
All employees, staff and other office personnel:
All other entities, sites and locations may share medical information with each other for treatment, payment or operations purposes as described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at this office. We need this information to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the cords of your care generated by this office, whether made by office personnel or your personal doctor.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

WE ARE REQUIRED BY LAW TO:

Make sure that medical information that identifies you is kept private.
Give you this notice of our legal duties and privacy practices with respect to medical information about you.
Follow the terms of this notice and that is currently in effect.

HOW MAY WE USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we may use and disclose medical information.

Treatment: We may disclose medical information about you to provide with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other office personnel that are involved in taking care of you at this office. Different departments of the office may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We may also disclose medical information about you to people outside the office who may be involved in your care after you leave the office, such as family members, clergy or other we use to provide services that are part of your care.

Payment: We may use and disclose medical information about you so that treatment and services you receive at this office may be billed to and payment be collected from you, an insurance company or a third party.

Health care operations: We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing medical review, legal services and insurance.

Appointment reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at this office.

Individuals involved in your care or payment for your care: We may release medical information about you to a family member who is involved in your medical care.

As required by Law: We may disclose medical information about you when required to do so by federal, state or local law.

To avert a serious threat to health or safety: We may use and disclose medial information about you when necessary to prevent a serious threat to your health or safety or that of the public or another person.

SPECIAL SITUATIONS:

Worker's compensation/Disability: We may release medical information about you for these purposes.

Lawsuits and disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order or a subpoena.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

Right to inspect and copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy such information about you: You must submit your request in writing to Tennessee Plateau Oncology, PLLC, Dr. Dirk C. Davidson, 49 Cleveland Street, Suite 270 Crossville, TN. 38555. If you request a copy of such information, we may charge a fee as permitted by state law for the costs of copying, mailing or other supplies associated with your request.

Right to amend: If you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is by or for the office.

Right to request restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to family members or anyone involved in your care. If we do agree, we will comply with your request unless the information is needed to provide you with emergency care. Any such request will have to be presented in writing in our office.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We will post a copy of the current notice and the effective date of such notice will be on the first. Page.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with theoffice, contact our Privacy Officer, Linda W. Barnwell, Tennessee Plateau Oncology, PLLC, 49 Cleveland Street, Suite 270 Crossville, TN. 38555. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OR MEDICAL INFORMATION:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records that we have provided to you.