Paoli Hematology-Oncology Associates, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
&
CONSENT TO USE AND DISCLOSE HEALTH INFORMAITON

READ BEFORE SIGNING THE ACKNOWLEDGEMENT AND CONSENT

This acknowledgement of notice and consent authorizes Paoli Hematology-Oncology Associates, P.C. (PHOA) to use and disclose health information about you for treatment, payment, and health care operations purposes.

- **Notice of Privacy Practices. PHOA** has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review and or receive at your request our current notice prior to signing this acknowledgement and consent.

- **Amendments.** We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:

Michel C. Hoessly, MD
2 Industrial Boulevard Suite 110, Paoli, Pa 19301
610-725-0650 Fax: 610-725-9583

Acknowledgement and Consent

I have reviewed and or received by request the Notice of Privacy Practices for PHOA. PHOA is authorized to use and disclose health information about

_____

For treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of Patient Date
(or patient's personal representative)

****

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented.

Date:	Initials:	Reason:

PAOLI HEMATOLOGY ONCOLOGY ASSOCIATES P.C.

The practice is instituting electronic medical records. Thank you for your patience during this transition.

Name _____

Address _____

City _____ State _____ Zip _____

** Phone: *(Circle preferred method of contact)*

Home _____ Work _____ Cell _____

**Email address _____

**Date of Birth _____ Age _____ Sex ____ SS# _____

Race _____ **Language_ _____ Ethnicity (circle) Latino / Not Latino

Marital Status: S M W D Spouse's Name _____

Occupation _____ Employer _____

In Case of Emergency Call _____ Phone # _____

Are you presently in a Skilled Nursing Facility? Yes _____ No _____

**Have you ever smoked? _____ If yes, do you smoke currently?_____

**Preferred Pharmacy: _____ *Phone _____

**Pharmacy Address_____

Referred to this office by _____

- **Please give the front desk receptionist your insurance card(s) so we may make a copy.** -

Please list any doctors that should receive information about your visit here. If the doctor is not a part of the Paoli Main Line Health system, please provide address and phone if available.

_____

_____

I request that payment of authorized benefits be made to Paoli Hematology Oncology Associates P.C. for any services furnished to me. I authorize the release of medical information to determine these benefits. If I request copies of my medical records, I understand that an additional fee will be charged.

**Signature _____ *Date: _____

PAOLI HEMATOLOGY ONCOLOGY ASSOCIATES P.C.

Patient Name_____ DOB_____ Today's Date_____

****CURRENT MEDICATIONS** (Including over the counter)

DRUG	***DOSE***	***FREQUENCY***
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

****LIST ANY ALLERGIES OR DRUG SENSITIVITIES:** _____

_____

_____

_____

_____