# 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:

Jennifer L.A. Armstrong, MD
2 Industrial Blvd Suite 110 Paoli, Pa 19301
610-725-0650 Fax: 610-725-9583

### HIPAA 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

_____

**Additional Parties to whom we may release your HIPAA Information:**

**Name:** _____ **Relationship:**_____

**Name:** _____ **Relationship:**_____

**Name:** _____ **Relationship:**_____

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

_____
**PRINTED NAME of PATIENT**

_____ _____
**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.**

Name _____

Address _____

City _____ State _____ Zip _____

Preferred Phone Number: _____-_____-_____ Cell /Home/Work

Additional Phone Numbers: _____-_____-_____ Cell/Home/Work _____-_____-_____ Cell/Home/Work

**Email address _____

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

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

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

Patient Occupation _____ Employer_____

In Case of Emergency Call _____Relationship_____ Phone #_____-_____-_____

Name of any additional persons with whom we are permitted to discuss your Medical Information:

Name:_____ Relationship to you:_____

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

**Do you currently smoke? _____ If **NO** have you ever smoked? _____

**Preferred Pharmacy: _____ *Phone _____

**Pharmacy Address_____

Referred to this office by _____

Please give us your Primary Care Provider's Name and Address_____

**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.

_____

**Payment/Medical Release of Information**

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: _____**

**Patient Name_____ DOB _____ Today's Date_____**

**PAOLI HEMATOLOGY ONCOLOGY ASSOCIATES P.C.**

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

| DRUG | DOSE | FREQUENCY |
|---|---|---|

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

11) _____

12) _____

13) _____

14) _____

15) _____

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

_____

| DRUG | REACTION |
|---|---|

_____

_____

_____

_____

**REVISED 11/2019**