ARCH CANCER CARE

Prostate Health Experts

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth: _____ Social Security #:_____ Gender:_____

Ethnicity:_____ Race **(Optional)**_____ Language Preference: _____

Home Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Employed: ☐ FT ☐ PT ☐ Retired ☐ Disabled ☐ Not Employed; Employer Name:_____

Marital Status:_____ Spouse Name:_____ Spouse DOB*:_____
(*We MUST have for insurance filing)

Emergency Contact:_____ Phone:_____ Relation:_____

Email Address:_____ Contact Preference: phone ☐ email ☐ mail ☐

Pharmacy preference/location:_____

Primary Care Physician:_____ Phone:_____

Referring Physician:_____ Phone:_____

INSURANCE INFORMATION

Primary Insurance Company's Name: _____ Name of Policy Holder:_____

Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company's Name: _____ Name of Policy Holder:_____

Insurance ID Number: _____ Group Number: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to St. Louis Urological Surgeons Inc., DBA Arch Cancer Care.
3. My right to payment for all treatments, pharmaceuticals, procedures, test, medical equipment rentals, supplies and nursing/physician services including major medical benefits are herby assigned to St. Louis Urological Surgeons Inc., DBA Arch Cancer Care. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to St. Louis Urological Surgeons Inc., DBA Arch Cancer Care.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from St. Louis Urological Surgeons Inc., DBA Arch Cancer Care.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as an original.

_____ _____

Patient Signature Date

ARCH CANCER CARE
Prostate Health Experts

12855 N. Forty Dr., Lower Level 1
St. Louis, MO 63141
Phone: (314) 523-5444 Fax: (314)523-5550

AUTHORIZATION FOR RELEASE OF INFORMATION

1. **I_____, authorize any provider of my medical care and treatment including, but not limited to, the physician's office, hospital, and any other medical care institution to discuss, release and obtain copies of the Protected Health Information of:**

   _____

   Date of Birth: _____

2. **Obtain/Release Information To/From:** _____

3. Information to be released:
   ☐ Record of Visits ☐ Progress Notes ☐ Consultation Reports ☐ Diagnostic

   ☐ Billing Records ☐ Radiology Reports/Films ☐ Lab Results ☐ H&P

   ☐ EKG ☐ Operative Report ☐ Discharge Summary ☐ Other_____

4. I consent to have my medications history retrieved electronically from pharmacy records. By enrolling in the ePrescribe Program, it allows my healthcare provider to assess medications I am currently taking or have taken to avoid duplication and minimize adverse drug interactions. This program is designed to improve the quality of patient care and safety as defined by the Medicare Modernization Act of 2003.

5. I understand I may have a copy of this authorization and this consent may be revoked in writing at anytime.

6. PLEASE INITIAL ANY OF THE FOLLOWING THAT APPLY:

   ____No, I DO NOT authorize you to release information concerning mental health problems such as phobias, depression, anxiety, attention deficit disorders, etc.
   ____No, I DO NOT authorize you to release any and all medical records in your possession relating to the testing, diagnosis or treatment of HIV or AIDS.
   ____No, I DO NOT authorize you to release information concerning alcohol and/or drug abuse treatment.

7. Family Members that are not allowed release of information:
   _____

8 I understand that the information used to disclose pursuant to this authorization re-disclosure by the recipient and may no longer be protected by Federal Law.

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

RELATIONSHIP TO PATIENT: _____
(If patient is a minor, or if legal representative, next of kin or guardian)

ARCH CANCER CARE
Prostate Health Experts

ST. LOUIS UROLOGICAL SURGEONS
est. 1935

Notice of Privacy Practices

Effective April 14, 2003

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.

We will not disclose your protected health information to third parties without your written authorization or other authority under the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Regulations"). We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We understand that medical information about you is personal. We are committed to protecting information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of your records of care that we maintain. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We reserve the right to change the terms of our privacy notice and to make the new notice provisions effective for all protected health information we maintain. In the event we should make a significant change to our privacy notice, we will provide you with a revised notice at your next visit. The following uses and disclosures will be made only with explicit authorization from you, (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications, (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice.

Your written authorization and specific provisions of the Privacy Regulations govern disclosure of your protected health information. Disclosures not described in this and the next paragraph may be made only with your written authorization, which you may revoke in writing as provided in the Privacy Regulations. The practice is permitted under the Privacy Regulations to use and disclose protected health information for treatment, payment and health care operations. For example, protected health information may be disclosed from one physician to another within the practice for consultation. The practice uses an outside agency to process payment and reimbursement requests, subject to a confidentiality agreement and the governing law under the Privacy Regulations.

Subject to requirements of the Privacy Regulations, we may use and disclose protected health information for purposes of complying with legal requirements; public health activities; reporting abuse; neglect and domestic violence; cooperation with health oversight by government agencies and as required by the Secretary of Health and Human Services for compliance with the Privacy Regulations; for judicial and administrative procedures; for law enforcement; with respect to decedents; regarding cadaveric organ, eye and tissue donation; for certain research conducted by our staff; serious threats to health or safety; specialized government functions; and incident to a use or disclosure otherwise permitted or required by the Privacy Regulations, as provided under the Privacy Regulations. We may also disclose protected health information about you for treatment (such as sending medical information about you to a specialist as part of a referral).

Missouri state laws with respect to genetic information and to human immunodeficiency virus infection status are more stringent that the Privacy Regulations and protected health information regarding these matters will be disclosed only in accordance with the governing Missouri statutes.

You have certain rights with regard to the handling of your protected health information, as provided in the Privacy Regulations. These are as follows: You may request restrictions on certain uses and disclosures of protected health information; however, we are not required to agree to a requested restriction. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. You may receive confidential communications of protected health information as provided by the Privacy Regulations. You may inspect and copy your protected health information, pursuant to a written request, subject to certain restrictions in the Privacy Regulations. You have a right to appeal a denial of access to your records. You may request an amendment of protected health information and demographic information, pursuant to written request, subject to certain limitations in the Privacy Regulations. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply. You have a right to contest a denial of an amendment. You may receive an accounting of certain disclosures of protected health information. You may obtain a paper copy of this notice upon request and a copy of your written acknowledgement of receipt of this notice. You have a right to receive notification if affected by a breach of unsecured PHI.

ARCH CANCER CARE
Prostate Health Experts

**Acknowledgement of Receipt
of Notice of Privacy Practices**

ST. LOUIS UROLOGICAL SURGEONS
est. 1935

ST. LOUIS UROLOGICAL SURGEONS
d.b.a.
ARCH CANCER CARE

Patient Name: ______________________________ **Patient ID #:** ____________________

I hereby acknowledge that I have received a copy of St. Louis Urological Surgeons' , d.b.a. Arch Cancer Care, Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

______________________ but acknowledgment could not be obtained because:

☐ Patient/representative refused to sign
☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____
____
____
____
____

☐ Other (Specify)

____
____
____
____

<u>Arch Cancer Care</u>
Walker Medical Building
12855 North Outer 40
St Louis, MO 63141
(314) 523-5444

Entrance is ground level, 100 feet to the left of the North Tower in the Walker Medical Building.

Driving Eastbound Hwy 40/64
(from Chesterfield)

1. Take Mason Road Exit and follow outer road to overpass.

2. At light, turn left over highway. Stay in right hand lane.

3. Turn right on North Forty Drive, driving eastbound on the north outer road.

4. Pass AAA and Center Oil. Just past the Lutheran Hour Ministry Building, turn left onto the driveway of the Walker Medical Building. (It's at the bottom of the hill and just before you go past the large tower with the high voltage power lines).

Driving Westbound Hwy 40/64
(from Hwy 270)

1. Mason Road is the first exit west of Hwy 270 . Go up ramp, stay in far right lane.

2.Make sharp right turn onto North Forty Drive, driving eastbound on the north outer road.

3. Pass AAA and Center Oil. Just past the Lutheran Hour Ministry Building, turn left onto the driveway of the Walker Medical Building. (It's at the bottom of the hill and just before you go past the large tower with the high voltage power lines).

Google


N
Map
Traffic
North Tower
Arch Cancer Care
Ground Level
Entrance
Brick
Circle Drive
DaVita Dialysis
South Tower
20 ft
10 m
Imagery ©2013 Google
Edit in Google Map Maker
Report a problem