W-

300 ASHVILLE AVE Ste 310
CARY NC 27518-8682
919-233-8585
919-233-8566 Fax

Today's Date________________

PATIENT INFORMATION

FIRST NAME:	M.I.:	LAST NAME:
ADDRESS:		
CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	
EMAIL:		
BEST PHONE FOR CONTACTING YOU ON A WEEKDAY:		

%%%

DATE OF BIRTH:	SEX: Male Female
SOCIAL SECURITY #:	MARITAL STATUS: S M D W
If married, name of spouse:	Spouse's Social Security #:

%%%

EMPLOYMENT STATUS: Full-time Part-time Retired No Current Employment		
WORKPLACE:		
ADDRESS:		
CITY:	STATE:	ZIP:
WORK PHONE:		

%%%

EMERGENCY CONTACT INFORMATION

NAME OF CONTACT:	
HOME PHONE:	CELL PHONE:
RELATIONSHIP TO PATIENT:	

%%%

INSURANCE INFORMATION: Please present card(s) for photocopying

PRIMARY INSURANCE – Name of insurance company:		
Policyholder: Self Spouse Dependent	If spouse, Spouse's SSN:	
Name of Insured:	Name of Employer:	
DOB of Insured:	Group ID:	
Co-Pay:	Plan ID:	
Address:		
City:	State:	Zip:
SECONDARY INSURANCE – Name of insurance company:		
Policyholder: Self Spouse Dependent	If spouse, Spouse's SSN:	
Name of Insured:	Name of Employer:	
DOB of Insured:	Group ID:	
Co-Pay:	Plan ID:	
Address:		
City:	State:	Zip:

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Rev 8-31-2006

How did you find us? Website Patient Physician Referral Other

Acknowledgement of Receipt of Notice

WAVERLY HEMATOLOGY ONCOLOGY

300 Ashville Avenue, Suite 180

Cary, NC 27511

Privacy Officer- Meghan Kelly, RN

919-233-8585

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: ______________________.

Signed: ______________________ Date: ______________________

Print Name: ______________________ Telephone: ______________________

If not signed by the patient, please indicate.

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: ______________________________

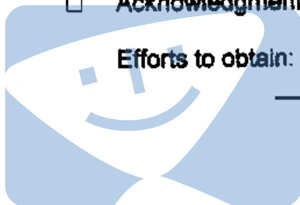
For Office Use Only:

☐ Signed form received by: ______________________

☐ Acknowledgment refused:

Efforts to obtain:

____



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Waverly Hematology Oncology
Mark Graham M.D.
300 Ashville Ave., Suite 180, Cary, NC 27511
Phone: (919) 233-8585

SIGNATURES OF PATIENT OR AUTHORIZED PERSON

I. RELEASE OF MEDICAL INFORMATION NECESSARY TO REPORT A CLAIM

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO REPORT A CLAIM TO MY INSURANCE PLAN(S). A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

SIGNATURE______________________________________ DATE____________________

II. ASSIGNMENT OF PAYMENT TO THE TREATING PHYSICIAN AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

THE SIGNATURE OF THE INSURED OR AN AUTHORIZED PERSON TO ASSIGN BENEFITS OTHERWISE PAYABLE TO THE INSURED TO THE PHYSICIAN INDICATED ON THE CLAIM. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR BENEFITS NOT COVERED BY MY INSURANCE PLAN. A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

SIGNATURE________________________________ DATE____________________

III. FOR MEDICARE PATIENTS ONLY

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I HEREBY AUTHORIZE MEDICARE TO FURNISH TO DR. GRAHAM ANY INFORMATION REGARDING MY MEDICARE CLAIMS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT.

I REQUEST THAT MEDICARE PAYMENTS AND PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE PAYABLE TO DR. MARK GRAHAM FOR ANY SERVICES FURNISHED ME BY DR. MARK GRAHAM.

SIGNATURE________________________________ DATE_________________

IV. CONSENT TO ALLOW PROVISION OF SERVICES AND TREATMENT

I HEREBY AUTHORIZE DR. MARK GRAHAM, AND SUCH ASSISTANTS AS HE MAY DESIGNATE, TO PROVIDE MEDICAL SERVICES WHICH MAY INCLUDE THE ADMINISTRATION OF CHEMOTHERAPY AND OTHER APPROPRIATE TREATMENTS TO:

____________________________ (NAME OF PATIENT) AND CONTINUE SUCH TREATMENT FROM TIME TO TIME AS HE MAY DEEM ADVISABLE. THE EFFECT AND NATURE OF THIS TREATMENT, AND THE RISKS OF INJURY DESPITE PRECAUTIONS, HAVE BEEN EXPLAINED TO ME. NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN BY ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED. THIS CONSENT IS VALID THROUGHT THE COURSE OF TREATMENT UNTIL OR UNLESS REVOKED BY ME.

SIGNED: ____ DATE____________
(PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT)

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V. Complaints

Complaints about this Notice of Privacy Practices or how Waverly Hematology Oncology handles your health information should be directed to:

Meghan Kelly, RN
919-233-8585

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You may also address your compliant to one of the regional Offices for Civil Rights. A list of these offices can be found online at http://www.hhs.gov/ocr/regmail.html.

VI. On-going Access to Privacy Policy

Waverly Hematology Oncology will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to:

Meghan Kelly, RN
300 Ashville Ave., Suite 180
Cary, NC 27511
919-233-8585

Or at the following website address: mkelly@waverlyhemeonc.com.

For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer, Meghan Kelly, RN at the address, telephone number, or e-mail address listed above.

Patient signature____

Date____

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MEDICAL RELEASE OF INFORMATION

Waverly Hematology Oncology
300 Ashville Avenue
Suite 310
Cary, North Carolina 27511
919-233-8585 Fax: 919-233-8566

Mark Graham, II, MD **Suzanne Kirby, MD**
Evan Dropkin, PA-C **Anne Shine, MSN**

I authorize:

Waverly Hematology Oncology ______
Or
Others:
Name: ______________________________Address: ____________________

City: ____________________State: __________Zip: ______

Release to:

Name: _________________________Address: ________________________

City: ____________________State: __________Zip: ______

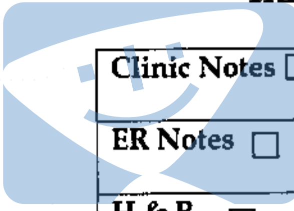
THE MEDICAL RECORDS OF:

Name: ____DOB: ____________

Address: _________________City: ___________State: _______Zip: ________

Phone #: ( ) _________________ SSN #: _______________________

Information to be released: (check appropriate box)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Clinic Notes ☐ Text	Operative Notes ☐	Discharge Summary ☐	Phys.Consult ☐
ER Notes ☐	Pathology Reports ☐	Labs ☐	Others: ☐
H & P ☐	Phys. Orders ☐	Radiology Reports ☐	
Progress Notes ☐	Nurse Notes ☐	EKG, EEG, EMG ☐	

Signature of Patient or Legal Representative: ______________________date: _______
Relationship to Patient: ___________________________

Notice of Privacy 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.

Waverly Hematology Oncology is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at Waverly Hematology Oncology please contact:

Meghan Kelly
919-233-8585

Effective Date of This Notice: October 11, 2004

I. How Waverly Hematology Oncology may Use or Disclose Your Health Information

Waverly Hematology Oncology collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of Waverly Hematology Oncology, but the information in the medical record belongs to you. Waverly Hematology Oncology protects the privacy of your health information. The law permits Waverly Hematology Oncology to use or disclose your health information for the following purposes:

1. Treatment. Treatment activities include a) the provision, coordination, or management of health care and related services by health care providers; b) consultation between health care providers relating to a patient; or c) the referral of a patient for health care from one health care provider to another.

2. Payment. Payment activities include a) billing and collection activities and related data processing; b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; c) medical necessity, and appropriateness of care reviews, utilization review activities; and d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

3. Regular Health Care Operations. Health care operations include a) development of clinical guidelines; b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; c) reviewing the qualifications of and training health care professionals; d) underwriting and premium rating; e) medical review, legal services, and auditing functions; and f) general administrative activities such as customer service and data analysis.

4. Information provided to you.

5. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

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6. Required by law. As required by law, we may use and disclose your health information.

7. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

8. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

9. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

10. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

11. Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.

12. Organ donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

13. Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or <this organization's> privacy board.

14. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. Specialized government functions. We may disclose your health information for military, national security, prisoner and government benefits.

16. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

II. When Waverly Hematology Oncology May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Waverly Hematology Oncology will not use or disclose your health information without your written authorization. If you do authorize Waverly Hematology Oncology to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

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III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Waverly Hematology Oncology is not required to agree to the restriction that you requested.

2. You have the right to receive your health information through a reasonable alternative means or at an alternative location.

3. You have the right to inspect and copy your health information.

4. You have a right to request that Waverly Hematology Oncology amend your health information that is incorrect or incomplete. Waverly Hematology Oncology is not required to change your health information and will provide you with information about Waverly Hematology Oncology's denial and how you can disagree with the denial.

5. You have a right to receive an accounting of disclosures of your health information made by Waverly Hematology Oncology except that Waverly Hematolgy Oncology does not have to account for the disclosures described in parts 1 (treatment), 2 (payment), 3 (health care operations), 4 (information provided to you), and 15 (certain government functions) of section I of this Notice of Privacy Practices.

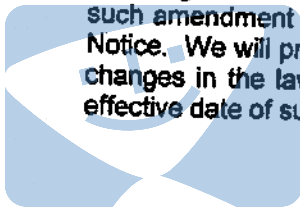
6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact:

Meghan Kelly, RN
919-233-8585

IV. Changes to this Notice of Privacy Practices

Waverly Hematology Oncology reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, Waverly Hematology Oncology is required by law to comply with this Notice. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.



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