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TENNESSEE CANCER SPECIALISTS

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Anil V. Tumkur, MD

Dear Patient,

Welcome to Tennessee Cancer Specialists. Our physicians specialize in the care and treatment of both hematology and oncology diagnoses, and our mission is to provide the highest quality of compassionate care to each of our patients. Your physician has referred you to our practice for consultation. We have attached several forms for you to complete prior to your office visit. Completing these forms in advance will help to save time during the check-in process.

You will receive a text or email from 1-866-540-4548 asking you to confirm your appointment and a link to complete any forms needed for your visit. If you do not complete the paperwork, we will have tablets available for you in the office. Please arrive 30 minutes prior to your appointment to avoid delays.

We will also need you to bring the following information with you to your visit:

- ☐ All medical and pharmacy insurance cards and information
- ☐ A driver's license or any form of photo ID
- ☐ Your actual medication bottles or a detailed list of all medications you are currently taking
- ☐ Any co-pay that is required by your insurance company at the time of your visit
- ☐ Copy of living will or power of attorney

We do not require fasting labs for your initial visit to our office. It is very important that you keep your appointment. If for any reason you are unable to keep your appointment, please call as soon as possible so we may reschedule you in a timely manner.

Our clinic hours vary by location so please ask your Tennessee Cancer Specialists staff about the business hours of your clinic. There will always be personnel available after hours and on the weekend for any emergency that may arise. Be assured that no matter who you are treated by during non-office hours, the continuity of your care is always maintained under the direct supervision of your personal physician.

Our goal is to provide you with professional and courteous service. We look forward to meeting you and assisting you with all your healthcare needs. Thank you for choosing Tennessee Cancer Specialists.

Sincerely,

Your physicians and staff at Tennessee Cancer Specialists

TENNESSEE CANCER SPECIALISTS

HIPAA PATIENT ACKNOWLEDGEMENT FORM
RECEIPT OF NOTICE OF PRIVACY PRACTICES AUTHORIZATION & RELEASE

You may refuse to sign this acknowledgement & authorization. In refusing *we may not be allowed* to process your insurance claims.

Date:_____ Patient Name: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents, any care takers, etc. who can have access to this patient's records):

Name:_____ Relationship:_____ Phone#: _____

Name: _____ Relationship:_____ Phone#: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Home Phone Confirmation
☐ Email Confirmation ☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Home Phone Confirmation
☐ Email Confirmation ☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ Text Message ☐ Email
☐ **Any of the Above** ☐ **None of the Above (opt out)**

I, the undersigned, am the patient or the patient's duly authorized representative, and do herby voluntarily consent to and authorize medical care and treatment by Tennessee Cancer Specialists, through its individual physicians, employees, and or agents. This care and treatment encompass all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician and provided by Tennessee Cancer Specialists.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or Tennessee Cancer Specialists.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

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OFFICE USE ONLY

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

☐ It was emergency treatment ☐ Could not communicate with patient
☐ Patient refused to sign ☐ **Other (please describe):**

Signature: _____

TENNESSEE CANCER
SPECIALISTS

Appointment Cancellation and Rescheduling

Tennessee Cancer Specialists is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

If any appointment that is scheduled by the recommendation of your physician is canceled or altered without notification, be advised this may affect your treatment and overall outcome.

We understand that situations arise in which you must cancel your appointment and that emergencies do happen. We will be happy to work with you to get your appointment rescheduled as soon as possible.

Please call your local clinic **24-hours in advance of your scheduled appointment** to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call your local clinic by 2:00 p.m. on *Friday*.**

Dowell Springs	(865) 934-5800
Greeneville	(423) 639-0243
Johnson City	(423)-588-7130
Morristown	(423) 587-0491
Powell	(865) 637-9330
Parkwest	(865) 693-2255
Athens	(865) 693-2255
Downtown Regional	(865) 862-3561
Harrogate	(423) 869-5893
Jefferson City Memorial Hospital	(865) 934-5800
Jefferson City-Summit	(865) 934-5800
LaFollette	(865) 934-5800
Newport	(865) 934-5800
Oak Ridge	(865) 444-3050
Sweetwater	(865) 934-5800

TENNESSEE CANCER
SPECIALISTS

INSURANCE/BILLING INFORMATION

- We provide verification and review of your insurance benefits.
- If your plan requires an initial referral from a Primary Care Physician (PCP), we will assist in obtaining that referral prior to your visit. The referral will contain the dates of service and number of visits authorized. We will also request any follow-up referrals needed.
- If your plan requires prior authorization for special services and/or treatments (i.e. chemotherapy), we will obtain these authorizations on your behalf. The timeframe to obtain an approval can vary by insurance plan. Despite our best efforts, rescheduling of your appointment may be necessary if an authorization hasn't been approved.
- We will provide you with an estimate of your financial responsibility.
- We will give you information on financial assistance options that may be available from a wide variety of local and national resources.
- For your convenience you can pay online through our website. We accept Visa, MasterCard, Discover and American Express.
- A monthly statement is sent detailing any balance activity (new charges, adjustments, and payments from insurance, etc). We accept check, Visa and MasterCard as well as Discover and American Express.
- With a signed Assignment of Benefits (AOB) in place, we will bill your primary insurance carrier. As a courtesy, we will also bill your secondary carrier.

How You Work With TCS

- Please bring your current health insurance identification card to all appointments.
- You are responsible for ensuring we have your most current health insurance and billing information. We ask that you notify us either in person, via phone or via mail anytime you have a change in your information. If you lose insurance coverage, please notify us immediately.
- Co-pays are expected at each office visit and may also apply to chemotherapy treatments. We accept cash, check, Visa, MasterCard, Discover and American Express.
- Payments for deductibles and balances not paid by insurance are your responsibility. We accept cash, check, Visa, MasterCard, Discover and American Express.

INSURANCE TERMS

CO-PAY: A fixed amount that you pay upfront when you receive specific healthcare services

DEDUCTIBLE: The amount you are required to pay out of pocket before the insurance starts paying your covered health expenses.

COINSURANCE: The percentage of cost you pay after you have met your deductible.

OUT OF POCKET MAXIMUM: The maximum you will have to pay each year for covered health care services.

CO-PAY CARDS: Some drug companies will assist with co-pays if you meet certain criteria. We will assist in finding those services for eligible patients to help reduce expenses. Co-pay cards are drug specific and will only apply to the cost of the drug.

FOUNDATION PROGRAMS: Private foundations that provide assistance based on diagnosis. An application must be submitted and approved for assistance. If funding is exhausted or the foundation closes, outstanding charges will be billed to you.

FINANCIAL COUNSELING

Our Patient Advocates are experts on the resources available through Patient Co-pay Assistance Foundations and pharmaceutical manufacturer programs that may help to offset out-of-pocket treatment costs.

Patient Co-pay Assistance Foundations are non-profit foundations designed to assist qualified patients in meeting their financial obligations. These foundations are typically funded for the treatment of a specific disease state. While qualifications and funding vary, most have income limitations. Eligibility criteria works on an individual basis so that program qualification and funding can be provided to as many patients as possible.

Evaluating every available financial assistance option will require the submission of your personal financial information. We recognize the sensitivity of this information and will request only what is required by each individual program. Please be assured that all information provided will remain completely confidential, except as required for program enrollment.

A member of our Patient Advocate team may reach out to you prior to your scheduled treatment/appointment to schedule a financial counseling session. This service is free of charge. Please bring the following 3 essential documents with you for the appointment:

1. A copy of your most recent federal tax return.
2. If you receive Social Security;
   ___a. A copy of your Social Security card
   ___b. Social Security Disability Award Letter, or
   ___c. A copy of your SSA-1099.
3. 3 most recent, consecutive pay stubs.

If other individuals live in your household and contribute to household expenses, their income information may also be required.

TENNESSEE CANCER SPECIALISTS

Date of Birth: _____

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, (Name of Patient making Request), hereby authorize Tennessee Cancer Specialists, PLLC, (hereafter collectively referred to as the "Practice") to use and disclose:

☐ My entire medical record

☐ Portions of my Medical Record, specifically: ☐ History & Physical ☐ Consultation and/or Progress Reports ☐ Final Diagnosis and/or Discharge Summary ☐ Operative and/or Pathology Reports ☐ Laboratory Reports ☐ X-Ray, CT, MRI, and/or PET Scan Reports ☐ Other: _____

☐ Date specific Portions of my Medical Record, From Date: _____ To Date: _____

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Practice to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***super-confidential information*** as stated in the NOPP (initial where appropriate):

☐ HIV records (including HIV test results) and sexually transmissible diseases
☐ Alcohol and substance abuse diagnosis and treatment records
☐ Psychotherapy records
☐ Not Applicable

REQUIRED TO COMPLETE:
In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request:

1. Date of this Request: _____
2. Please Release my records to: _____ (Name of person or entity)
3. The Records will be obtained by:

   Please allow _____ to pick up a copy of my records

   ☐ Will pick up a copy of my records on or after this date: _____

   ☐ Send a copy of my records to this address or fax number: _____

   _____

   _____

   _____

Signature of Patient: _____ Date: _____

Name of Personal Representative (if applicable): _____

Signature of Personal Representative: _____ Date: _____

Relationship to Patient: _____