David Aljadir, MD
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Devapiran Jaishankar, MD

TENNESSEE CANCER SPECIALISTS

A proud member of the: The US Oncology Network

Ashima Kapoor, MD
Ross E. Kerns, MD
Richard T. Lee, MD
Mitchell D. Martin, MD
Dharmen Patel, MD
R. David Schumaker, MD
Anil V. Tumkur, MD
Felicia Wheeler, MD

Patient Appointment _____ Time _____ Physician _____

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 enclosed several forms that we ask you to complete and bring to your first visit. Completing these forms in advance will help save you time during the check-in process. We will also need you to bring the following with you to your visit:

- ❑ The included forms completely filled out
- ❑ All medical and pharmacy insurance cards and information
- ❑ A driver's license or any form of a photo ID
- ❑ Your actual medication bottles (*not just a list*) of the 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
- ❑ Copy of your Covid-19 Vaccination Card (If you received the vaccine)

We also ask that you try to arrive at least thirty minutes prior to your scheduled appointment time so that we can process your information and answer any questions you might have regarding our facility. **NO fasting labs are required 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. Your cooperation is greatly appreciated.

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 medical personnel available after hours and on weekends for any emergency that may arise. Be assured that no matter whom 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 always to provide you with professional and courteous service. We look forward to meeting 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

---

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: _____

For TCS use only: **Appt. Date and Time:** _____ **Account #** _____ **Physician** _____

Tennessee Cancer Specialists
Patient Information

How did you hear about our practice? _____

Email Address: _____

Name: _____
First Middle Initial Last

Date of Birth: _____ Social Security #: _____ Sex: (circle): M F

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work/Cell: (____) _____ May we leave a message on this number? Y N

Employer: _____ Employer Phone Number: (____) _____

Primary Care Physician: _____ Physician That Referred You to TCS: _____

Primary Language (circle): English Spanish Other _____ Marital Status (circle): M S W D

Ethnicity (circle): Caucasian Hispanic Black Unknown Other: _____

Race (circle): White Hispanic or Latino African American Asian Other: _____

Emergency Contact Information (if different than HIPAA contacts on previous page)

1. Name: _____ Relationship: _____ Phone Number: _____

2. Name: _____ Relationship: _____ Phone Number: _____

Do you have a living will? Yes____ No____

Do you have a medical power of attorney? Yes____ No____

Do you have a DNR? Yes____ No____

Insurance Information

Primary Insurance

Insurance Co. _____

Insurance ID # _____

Group # _____ Effective Date _____

Policy Holder's Name _____

Relationship to Policy Holder _____

Policy Holder's Date of Birth _____

Policy Holder's SS# _____

Policy Holder's Employer _____

Secondary Insurance

Insurance Co. _____

Insurance ID # _____

Group # _____ Effective Date _____

Policy Holder's Name _____

Relationship to Policy Holder _____

Policy Holder's Date of Birth _____

Policy Holder's SS# _____

Policy Holder's Employer _____

Pharmacy Insurance

Insurance Co. _____

Insurance ID # _____

Group # _____ Effective Date _____

Annual Authorization ***Please Initial All Four Lines***

I authorize the release of any medical information necessary to process insurance claims filed on my behalf _____

I authorize payment of medical benefits to be made directly to the supplier or physician for services performed _____

I acknowledge that I will be responsible for any balance after insurance(s) has paid _____

I understand that it is my responsibility to notify the office of any changes or deletions to my insurance(s) policy _____

TENNESSEE CANCER SPECIALISTS

New Patient Medical History Form

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Reason for Referral: _____

Allergies:	**Type of Reaction:**
_____	_____
_____	_____
_____	_____

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Current Medications and Supplements:	**Strength:**	**How Often Taken:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History (Check all that apply):

____ Asthma	____ Diabetes	____ Hepatitis	____ Anxiety
____ Depression	____ Atrial Fibrillation	____ COPD	____ Gallstones
____ Congestive Heart Failure	____ Coronary Artery Disease	____ Reflux Disease	____ Hyperlipidemia
____ Hypertension	____ Thyroid Disease	____ Kidney Stones	____Osteoporosis
____ Peripheral Neuropathy	____ Seizure	____ Stroke	____ Bleeding Disorders
____ Kidney Disease	____ Glaucoma	____ Cancer (please specify) _____	
____ Arthritis			

Other:

_____

_____

Past Surgical History - List all prior surgeries and date of occurrence:

_____	_____
_____	_____
_____	_____

GYN History:

Number of pregnancies_____ Number of live births_____ Number of miscarriages_____ Age at first birth_____

Age at first period_____ Date of last period (mm/dd/yyyy)_____

Any Hormone use?_____ If yes, for contraception or post-menopausal?_____ How many years?_____

_____Last Mammogram (mm/dd/yyyy)_____ Last PAP (mm/dd/yyyy)_____

TENNESSEE CANCER
SPECIALISTS

Patient Name: _____

Social History

Marital Status: (Circle One) Single Married Divorced Widowed

Occupation: _____

Tobacco Use: _____ **Never**

_____ **Yes, but quit**

How long did you smoke? _____

What form of tobacco did you use? Please mark all that apply:

___Cigarettes ___Cigars ___Chewing Tobacco ___Pipe ___Snuff

How many packs per day? _____

When did you quit? _____

_____**Yes, Active**

How long have you smoked? _____

What form of tobacco do you use? Please mark all that apply:

___Cigarettes ___Cigars ___Chewing Tobacco ___Pipe ___Snuff

How many packs per day? _____

Alcohol Use: _____ **Never**

_____ **Yes, Occasional**

_____ **Yes, Active**

How many days per week do you drink? _____

How many drinks per day? _____

_____ **Yes, but quit**

How many days per week do you drink? _____

How many drinks per day? _____

How many years since you quit? _____

Have you ever used any recreational or illicit drugs? ___Yes ___No

Hazardous Materials: Check if you have been exposed to any of the following:

_____ Asbestos _____ Benzene _____Lead _____Radiation

_____Other Petroleum Products _____Other (please specify): _____

TENNESSEE CANCER
SPECIALISTS

Patient Name: _____

Family History

Please list any major medical problems and/or causes of death in your immediate family:

Family Member		Current Age	Age at Death	Major Medical Problems
Mother:	___Alive ___Deceased	_____	_____	_____
Maternal Grandmother	___Alive ___Deceased	_____	_____	_____
Maternal Grandfather	___Alive ___Deceased	_____	_____	_____
Father	___Alive ___Deceased	_____	_____	_____
Paternal Grandmother	___Alive ___Deceased	_____	_____	_____
Paternal Grandfather	___Alive ___Deceased	_____	_____	_____
Brother Sister (circle)	___Alive ___Deceased	_____	_____	_____
Brother Sister (circle)	___Alive ___Deceased	_____	_____	_____

Use back if additional room needed.

Children / Age(s)_____

Any major medical problems?_____

_____

Any additional information that your doctor may need to know:

_____

_____

_____

_____

_____ Date: _____

Patient Signature Date of visit

Date: _____ Name: _____

New Patient Review Of Systems

Chief Complaint: Why are you here **today**? _____

Have you had a **Flu shot** this year? (circle one) YES NO If yes, when? _____

Have you had a **COVID-19 vaccine**? (circle one) YES NO If yes, when? _____

Have you had a pneumococcal vaccine? (circle one) YES NO If yes, when? _____

Have you had any recent **CT scans, MRI's, PET scans, X-Rays, ER Visits**, etc.? (circle one) YES NO

Have you had a **Colonoscopy** or a Flexible Sigmoidoscopy before? (circle one) YES NO If yes, when? _____

Have you received hospice care in the last 60 days? (circle one) YES NO If yes, when? _____

Please mark if you are having any of the following symptoms:

Constitutional	**Eyes**	**ENMT**	**Endocrine**
☐ Appetite Good ☐ Appetite Poor ☐ Fatigue ☐ Night Sweats ☐ Rigors/Chills ☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ >10 lbs ☐ <10 lbs ☐ Weakness ☐ Sleep Disturbance	☐ Blurred Vision ☐ Double Vision ☐ Eye Pain	☐ Trouble Swallowing ☐ Ear Pain ☐ Nose Bleeds ☐ Hearing Loss ☐ Dry Mouth ☐ Oral Bleeding ☐ Sinusitis ☐ Mouth Sores ☐ Altered Taste ☐ Ringing In Ears	☐ Hot Flashes ☐ Cold Intolerance
Hematologic/Lymphatic	**Breast**	**Respiratory**	**Cardiovascular**
☐ Prolonged Bleeding or Bruising ☐ Swollen Lymph Nodes or Glands	☐ Breast Mass L or R ☐ Breast Pain L or R ☐ Nipple Discharge L or R ☐ Skin Changes L or R	☐ Dry Cough ☐ Productive Cough ☐ Shortness Of Breath ☐ At Rest ☐ With Activity ☐ Coughing Up Blood ☐ Hiccups ☐ Wheezing	☐ Chest Pain ☐ Palpitations ☐ Leg or Ankle Swelling ☐ Left ☐ Right
Gastrointestinal	**Genitourinary** **Female**	**Genitourinary** **Male**	**Musculoskeletal**
☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Blood in Stool	☐ Painful Urination ☐ Frequency-Increased Urination ☐ Blood in Urine ☐ Urine Color Change ☐ Vaginal Discharge/ Bleeding	☐ Painful Urination ☐ Frequency-Increased Urination ☐ Blood in Urine ☐ Urine Color Change	☐ Joint Pain ☐ Muscle Weakness ☐ Joint Swelling ☐ Bone Pain
Integumentary	**Neurologic**	**Psychiatric**	**Are you having any pain today? Please check:**
☐ Blisters ☐ Dry Skin ☐ Itching ☐ Rash ☐ Hair Loss	☐ Dizziness ☐ Headache ☐ Insomnia ☐ Memory loss ☐ Paralysis ☐ Seizures ☐ Numbness/Tingling **Location** _____	☐ Hallucinations ☐ Depression ☐ Anxiety	**__ 0 (no pain)** **__ 1** **__ 6** **__ 2** **__ 7** **__ 3** **__ 8** **__ 4** **__ 9** **__ 5** **__ 10** **Location** _____

At **Tennessee Cancer Specialists**, we are committed to alleviating the financial burden on our patients. Our dedicated team will diligently work to review and enroll eligible patients in various patient assistance programs. These programs are designed to provide financial relief by offering free or reduced-cost treatments. We strive to ensure that our patients have access to the necessary resources and support, allowing them to focus on their health and well-being without the added stress of financial concerns. Rest assured; we will explore all available options to assist you in managing your healthcare expenses.

AUTHORIZATION AND ATTESTATION FOR FINANCIAL ASSISTANCE

I understand that **Tennessee Cancer Specialists** and its affiliates (including *The US Oncology Network and Annexus Health*) are acting solely as agents to help me find and apply for appropriate financial assistance, either in the form of free or reduced-cost treatment. In order for **Tennessee Cancer Specialists** and its affiliates to provide me with financial assistance, I understand that they will need to obtain, review, use, and/or disclose my personal health information (PHI), information relating to my medical condition, and information that I otherwise provide to **Tennessee Cancer Specialists** and its affiliates, including my name, address, and other personal identifying information.

I authorize **Tennessee Cancer Specialists** to use my personal health information to complete phone, electronic or hardcopy applications and to sign online applications on my behalf to determine my eligibility. I also authorize my physician, pharmacy, insurance companies, and health plan(s) to disclose my personal health information to **Tennessee Cancer Specialists** and its affiliates as necessary to complete applications on my behalf or to verify information on my application.

I understand that my physician and **Tennessee Cancer Specialists** do not determine my eligibility for assistance. Eligibility for assistance is determined by the sponsors of the charitable foundations or product manufacturers ("Programs") and is contingent upon the eligibility criteria set forth by the program. I understand that the charitable foundations and product manufacturers ("Programs") may perform a "soft credit check" to obtain confirmation of household reported income.

By authorizing **Tennessee Cancer Specialists** to submit my application, I attest that I understand and agree to the below statements:

- I understand **Tennessee Cancer Specialists** and/or their affiliates may contact me to obtain any additional information needed to complete an application.
- I understand that the Program sponsor may request documentation to verify the accuracy of any information that I may provide for the application, including verification of my household income.
- If I do not provide documentation or information as requested by the Program, or if the Program determines I do not meet the Program eligibility requirements, my participation and all assistance may be terminated.
- I understand that all assistance from Programs is subject to availability of funds at the time funds are requested and that this Authorization is not a guarantee that I will receive or obtain any financial assistance.
- I agree that all information I provide to **Tennessee Cancer Specialists** and applicable Programs, to the best of my knowledge, is true, accurate, and complete, and I will notify **Tennessee Cancer Specialists** and any relevant Program of any changes to the information I provide.
- I agree and authorize **Tennessee Cancer Specialists** and the Assistance Program Sponsor(s) to disclose, obtain, and discuss my medical, treatment, therapy, financial, and other personal information relating to my application with my providers, pharmacy, insurance company, and other organizations working on my behalf to obtain eligible treatment.

Patient Initials_____

- I understand that my protected health information disclosed to **Tennessee Cancer Specialists**, to a Program, or under an applicable application for my financial assistance may be re-disclosed by recipients of my health information for the purposes described in this Authorization and may no longer be protected by privacy laws, such as HIPAA.
- I understand that if I have applied for assistance elsewhere, I must disclose this to any other Foundation or Patient Assistance Program that approves me for funds or drug product.
- I understand that there is no fee or charge for this support service.
- I understand that the Program can at any time, and without notice, modify or discontinue all or any part of the Program and/or any assistance provided to me. The financial assistance or free product provided by any Program may not cover my entire liability for treatment. Some Programs limit assistance to the specific drugs that treat or cover only certain conditions. Should additional assistance be needed for continuity of treatment, I understand that **Tennessee Cancer Specialists** will complete and submit applications to secondary Programs or submit renewal applications on my behalf.
- I understand and acknowledge that if I do not sign or provide this Authorization, my physician or **Tennessee Cancer Specialists** cannot withhold or condition my healthcare or treatment based on my decision to not sign or provide this Authorization.
- I understand that this authorization is valid for 12 months. I (or my legally authorized representative) may cancel this Authorization at any time by mailing a written request for such cancellation to **Tennessee Cancer Specialists**. However, I understand that any cancellation will not apply to any information already used or disclosed pursuant to this Authorization. I understand that I may request a copy of this Authorization once it has been signed.
- If applicable, I consent to the use of electronic signatures to complete, sign, and deliver this Authorization and agree that my electronic signature is as valid as if I signed the document in writing.

Patient Name (*print*): _____

Patient DOB: _____

PLEASE SIGN ONE OF THE SECTIONS BELOW

I agree and certify that I have read, understood, and will abide by the above attestation and authorize Tennessee Cancer Specialists to proceed with applying for assistance on my behalf.

Effective Date: _____

Signature of Patient/Legally Authorized Representative: _____

Relationship to Patient (if Patient is not signing): _____

I choose to decline and/or retract my authorization for Tennessee Cancer Specialists and the above listed affiliates to proceed with applying for assistance on my behalf.

Effective Date: _____

Signature of Patient/Legally Authorized Representative: _____

Relationship to Patient (if Patient is not signing):_____

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TENNESSEE CANCER SPECIALISTS

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Anil V. Tumkur, MD
Felicia Wheeler, MD

We are committed to the best possible care for you and are always looking for ways to enhance our services. Your provider may use a voice-enabled technology that acts as a scribe and assists with documentation in your medical record. This allows your physician to focus on your conversation instead of the computer during your visit. The technology is HIPAA-compliant, and your conversation remains confidential, which is consistent with Tennessee Cancer Specialists commitment to data privacy and security. Your authorization to use this technology may be withdrawn at any time.

Please select only one option below to either consent or decline. Please do not select both options.

☐ I hereby CONSENT for my provider to use this technology during office visits.

☐ I hereby DECLINE for my provider to use this technology during office visits.

Print Name: _____

Sign Name: _____

Date of Birth:_____

Date: _____

NAME: _____ DATE: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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: _____

Revised 2.19.18

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

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 mail anytime you have a change in your information. If you lose insurance coverage, please notify us immediately.
- Copays are expected at each office visit and may also apply to chemotherapy treatments. We accept Checks, Visa, MasterCard, Discover, and American Express.
- Payments for deductibles and balances not paid by insurance are your responsibility. We accept Checks, 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.
- **OUTOF POCKET MAXIMUM:** The maximum you will have to pay each year for covered health care services.
- **CO-PAYCARDS:** 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.

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.