Eastern Connecticut Hematology and Oncology

330 Washington Street, Suite 220, Norwich, CT 06360
860-886-8362 Fax 860-886-9262
www.echoassociates.org

Patient Demographics and Registration

CONTACT INFORMATION **Todays Date** _____

Legal First Name _____ Last Name _____

Preferred Name _____ D.O.B _____

Home Address _____
Street City State Zip

Mailing Address
(if different than above) _____
Street City State Zip

Currently in a Skilled Nursing Facility? No ☐ Yes ☐ If yes, please advise location: _____

Phone Numbers (H) _____ (C)_____ (W)_____

Email Address _____

Sex Assigned at Birth ☐ Male ☐ Female ☐ Intersex ☐ Other please specify: _____ ☐ I wish not to disclose

Gender Identity ☐ Male ☐ Female ☐ Non-binary ☐ Trans-Male ☐ Trans-Female ☐ Other _____

Preferred pronouns ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other_____

Race (Select all that apply) ☐ Asian ☐ Black or African American ☐ Latino/ Latina/Latinx ☐ Native American or First American

☐ Native Hawaiian and Pacific Islander ☐ White ☐ Other Race _____ ☐ I wish not to disclose

Ethnicity _____ Preferred Language _____

Health Care Providers

Referring Provider _____
Primary Care Physician _____
OB/GYN Physician _____
Pain Management or Other _____

Please List any other physicians you would like to receive copies of information:

	Name	Problem Cared for
1.	_____	_____
2.	_____	_____
3.	_____	_____

Do you have Advance Directives ☐ No ☐ Yes If yes please provide a copy of these directives

☐ Living Will ☐ Healthcare Proxy ☐ POA Healthcare/Financial ☐ Conservatorship
☐ DNR ☐ Organ Donor Card

Advance Care Planning (ACP) is an ongoing process of learning about the choices we have for our future medical care.
Would you like more information on Advance Care Planning? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance: _____ ID#_____

Subscriber Name:_____ D.O.B: _____ Group #: _____ Relationship: _____

Secondary Insurance: _____ID#_____

Subscriber Name:_____ D.O.B: _____ Group #: _____ Relationship: _____

PLEASE PROVIDE YOUR INSURANCE CARD(S) AND VALID PHOTO ID

SOCIAL HISTORY

Emergency Contact _____ Phone _____
Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner
Living arrangement: ☐ Alone ☐ With Spouse ☐ With significant other or roommate
☐ Supervised Living ☐ Other _____
Do you have children? ☐ No ☐ Yes If yes how many?_____ Are your children: ☐ Biological ☐ Adopted
Are you currently employed? ☐ Yes ☐ No Retired Occupation (previous if retired)
Are you a Veteran? ☐ Yes ☐ No
If yes Branch _____ Years Served_____ Active Combat? ☐ Yes ☐ No Discharge Year_____

MEDICAL HISTORY

Eastern Connecticut Hematology and Oncology operates an in-office dispensary for patients to have their medications prescribed by ECHO conveniently filled at ECHO. If we are unable to fill in our office, please list your preferred pharmacy:

Pharmacy name: _____ Pharmacy Phone number: _____

Pharmacy Address: _____

Are you currently on Oxygen? ☐ Yes ☐ No

Do you have any allergies, including medication, dyes, latex or contrast? ☐ No ☐ Yes If yes please list the medication and type of reaction:

Allergen	Reaction

Hospitalizations

Have you been hospitalized since your last visit? No ☐ Yes ☐

Please list any recent hospitalizations including surgeries:

Date	Reason	Where	Doctor

Do you have any surgical hardware/implants (please check all that apply)?

☐ Hip Valves ☐ Pacemaker ☐ Defibrillator ☐ Aneurysm Clip ☐ Mechanical Stimulating Device ☐ Breast Implants

Vaccine History

Last month/year you last had:

Flu Vaccine _____ Pneumonia Shot _____ Covid-19 Vaccine _____ Shingles _____ Tetanus Shot _____

Exam History

Last month/year you last had:

TB Test _____ Eye Exam _____ Dental Visit _____ Rectal Exam _____ Colonoscopy/Sigmoid Exam _____

Stool Blood Test _____

Have you ever had polyps? ☐ No ☐ Yes If yes when? _____

Are you under the care of a cardiologist? ☐ No ☐ Yes Doctor Name _____

MEDICATION LIST

Please list all current prescriptions and over-the-counter medications. Please include herbals, supplements and vitamins below:

Medication	Dosage	How often?	When prescribed?

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HIPAA DISCLOSURE RELEASE FORM AND COMMUNICATION PREFERENCES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner(s) (Check All That Apply):

Cell Telephone (ph #_____)
- ☐ Leave Message with detailed information
- ☐ Only leave message with call back detail

Work Telephone (ph #_____)
- ☐ Leave message with detailed information
- ☐ Only leave message with call back details

Home Telephone (ph #_____)
- ☐ Leave Message with detailed information
- ☐ Only leave message with call back details

Written Correspondence
- ☐ Mail to my home address on file
- ☐ Mail to address listed below

_____

_____

I hereby authorize the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand the identity of designers must be verified before the release of PHI.

Authorized Designees:

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

Your signature below affirms your authorization above and acknowledges the following:

- You understand you have the right to revoke this authorization, in writing, at any time.
- You understand that information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.

_____	_____	_____	_____
Print Name Patient/Legal Representative	Patient/Legal Representative Signature	D.O.B	Date

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CONSENT TO BILL

My signature indicates that I agree with all the information below, or as it has been explained to me.

- I authorize the use of this form on all insurance submissions.
- I authorize the release of information to all my insurance companies.
- I understand that I am responsible for my bills and office copays.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.

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Patient Rights & Responsibilities & Code of Conduct

PATIENT RIGHTS

At **Eastern Connecticut Hematology and Oncology**, we believe that the protection and support of the basic human rights of freedom of expression, decision and action are important to the healing and well-being of our patients. Therefore, we strive to treat patients with respect and with full recognition of human dignity. Decisions regarding health care treatment will not be based on race, creed, sex, national origin, age, disability, or sources of payment. As a patient of **Eastern Connecticut Hematology and Oncology**, you have the right to:

- Be fully informed in advance about care/services to be provided to you, including the scope of planned
- care/services and any specific limitations, the expected frequency of visits.
- Be informed of your financial responsibility for any care/services.
- Participate in the development and periodic revision or modification of your plan of care.
- Refuse care, services or treatment after being fully presented with the consequences of refusing care, services or treatment.
- Receive information about the creation of Advanced Directives upon request.
- Be treated with respect, consideration, and recognition of your dignity and individuality.
- Be able to identify personnel members through proper identification.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse.
- Voice grievances/complaints regarding treatment or care or lack of respect to your property, or recommend changes in policy, personnel, or care/service without discrimination, or reprisal.
- Have your records and communications treated as confidential. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.
- Receive appropriate care without discrimination in accordance with your providers' orders.
- To have your family take part in your care decisions with your express permission.
- To request and/or be provided with language assistance i.e., interpreter services, if you have a language barrier or hearing impairment. This will be provided at no cost to you to help you actively participate in your care.
- Be fully informed of your responsibilities.

PATIENT RESPONSIBILITIES

Your contribution to your health care is vital, and you can be involved in the health care process by fulfilling certain responsibilities. As a patient, you, or your designated representative (if you have one) have a responsibility to:

- Submit forms, insurance cards or other documents that are necessary to receive services or care from Practice.
- Keep appointments scheduled with your healthcare provider. If you need to cancel an appointment, you should do so promptly with at least 24 hours before your appointment time when possible. If an appointment is missed or cancelled with less than 24 hours' notice, you may be charged a $50 fee.
- Provide accurate medical, pharmacy and contact information and any changes to such information:
    - Provide, to the best of your ability, accurate and complete information about your present condition,
    - past illnesses, hospitalizations, medications, and other matters related to your health, including
    - information about home and work that may impact your ability to follow the proposed treatment.
    - Tell your care team if you have an Advanced Directive and the intent it contains.
    - Notify your care team of any potential side effects and/or complications that you experience.
    - Tell your caregivers about any changes in your health.
- Maintain any equipment provided to you by **Eastern Connecticut Hematology and Oncology**, if applicable.
- Notify **Eastern Connecticut Hematology and Oncology** staff of any concerns about the care or services provided.
    - Ask questions so that you may understand your health problems and what to reasonably expect during
    - your treatment.
    - Ask questions if you do not understand or need more information.
- Make Informed Decisions
    - If you are unable to make decisions about your care, your legally appointed decision-maker has a responsibility to make healthcare decisions that are consistent with your values and life goals.
- Participate in your care and follow the instructions for taking medication as directed.
- Follow the mutually agreed to treatment plan developed with your provider.
    - Express any concerns about your ability to understand or comply with a proposed course of treatment.

- You are responsible for the outcomes if you refuse treatment or do not follow your care provider's
- instructions.
- Remain adherent to your treatment plan, and work with your **Eastern Connecticut Hematology and**
- **Oncology** care team to address any obstacles that may prevent you from following your care plan.

- Accept Financial Responsibilities
  - Provide information necessary for claims processing and maintain personal and financial integrity with respect to healthcare services provided on your behalf.
  - You are responsible for meeting your financial responsibility for any amounts required by your insurance carrier, or any care or services not covered by your insurance.
- Support **Eastern Connecticut Hematology and Oncology** policies that apply to patient care and conduct:
  - Treat all **Eastern Connecticut Hematology and Oncology** staff, other patients, and visitors with courtesy and respect.
  - Follow all **Eastern Connecticut Hematology and Oncology** rules and safety regulations, and be mindful of noise levels, privacy, and the number of visitors.
  - Respect the privacy and confidentiality of other patients.
  - Refrain from using a smart device to record your experience in audio, video, or photography format in the practice without the consent of everyone involved including **Eastern Connecticut Hematology and Oncology** physicians, nurses, and other staff.
  - Express any needs you may have, so we can provide reasonable accommodation.
  - Inform the healthcare team when you have issues or concerns related to your safety

PATIENT AND GUEST CODE OF CONDUCT

Exceptional patient care requires a safe, supportive, inclusive, equitable, and respectful environment that involves a commitment by patients, providers, employees, families, caregivers and visitors to maintain such an environment. Behavior that interferes with the delivery of healthcare or creates an unsafe and disrespectful environment is unacceptable. Utilizing our services, there is an expectation of mutual respect among our colleagues and the patients we serve.

Expected behavior includes:

- Treat employees, volunteers and other patients with kindness, respect and dignity through your language and actions.
- Respect patient privacy.

Unacceptable behavior includes:

- Making threats of harm or violence against an employee, provider, volunteer, patient or guest of the practice.
- Throwing objects and/or destruction of property.
- Making offensive, disrespectful or discriminatory comments.
- Verbal or physical abuse. Yelling, using profanity or other actions that disrupt the care and treatment of patients. This includes abuse of a sexual nature.
- Intimidating or harassing employees, providers, volunteers or other patients/family members/caregivers.
- Use of profanity, discriminatory or hateful language.
- Possession of a weapon of any kind.
- Disrupting other patients' care of experiences.
- Photographing, videotaping or audio recording without the consent of all parties.

Eastern CT Hematology and Oncology reserves the right to take action to protect its staff, providers, volunteers and patients. Behaving in a manner causes staff, providers, volunteers or patients to feel unsafe may result in:

- Being asked to leave ECHO.
- The discontinuation of our patient/provider relationship.
- Involvement of local authorities.

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Patient Rights & Responsibilities & Code of Conduct Acknowledgement

By signing below, you attest that you have received a copy of and are aware of the Eastern Connecticut Hematology and Oncology, Patient Rights and Responsibilities and Code of Conduct. You agree to abide by the parameters detailed in these documents.

Print Name Patient/Legal Representative	Patient/Legal Representative Signature	Date

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AUTHORIZATION TO OBTAIN HEALTH INFORMATION

I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Patient Name: _____ **D.O.B:** _____

I authorize _____ to disclose by health information to:

Eastern Connecticut Hematology and Oncology by fax to **860-886-9262** or by mail to **330 Washington Street #220, Norwich, CT 06360.**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Eastern Connecticut Hematology and Oncology may release by health information to: _____

_____

The dates of service and the type(s) of information to be used or disclosed are as follows:

Date(s) of Treatment: _____

☐ History & Physical ☐ Discharge Summary ☐ ED Record ☐ Operative Reports ☐ Consultation

☐ Lab Reports ☐ Radiology Reports ☐ Radiology Films ☐ Pathology Reports

☐ Progress Reports ☐ Billing Records ☐ ENTIRE RECORD ☐ Other: _____

- This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying Eastern Connecticut Hematology and Oncology in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable lab, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal or state privacy laws.
- I understand that my treatment or continued treatment by ECHO is in no way conditions on whether I sign this authorization, and that I may refuse to sign it.

_____	_____	_____
Print Name Patient/Legal Representative	Patient/Legal Representative Signature	Date

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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.**

You have the right to:	
Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can file a complaint if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	**Example:** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary	**Example:** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

The Practice may use and disclose health information about you for purposes of treatment, payment, healthcare operations, public health and other purposes permitted by applicable law. The Practice participates, or may in the future participate, in Health Information Exchanges (HIEs) or other organizations with healthcare providers, insurers, and/or other health care industry participants and their subcontractors to share health information for treatment, payment, health care operations and other purposes permitted by law. Unless you notify the Practice, in writing, that you desire to opt-out of participation, your health information may be shared with participants in HIEs and other organizations as described above.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you The new notice will be available upon request, in our office, and on our web site

This Notice of Privacy Practices applies to the following organizations.

All Eastern Connecticut Hematology & Oncology locations and/or affiliates

Compliance and Privacy Officer: Andra Hinz, CHPC, CHG Telephone: 1-844-473-5115

Email: CompliancePrivacyandEthics@OneOncology.com

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Nondiscrimination and Accessibility Policy

Discrimination is Against the Law

Eastern Connecticut Hematology & Oncology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Eastern Connecticut Hematology & Oncology does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Eastern Connecticut Hematology & Oncology:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services please let a member of your care team know.

If you believe that Eastern Connecticut Hematology & Oncology has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Rebecca Moore, Compliance Coordinator, Mailing address:

330 Washington Street, Suite 220
Norwich, CT 06360
Phone: 1-860-886-836 ext 249
Fax: 1-860-886-9262, Email
RMoore@echoct.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our Compliance Coordinator, Rebecca Moore is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. This notice is available at Eastern Connecticut Hematology and Oncology's website: https://echoassociates.org

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Print Name Patient/Legal Representative	Patient/Legal Representative Signature	D.O.B	Date

Health Information Exchange
Notice of Privacy Practices Language

Your Rights Regarding Electronic Health Information Exchange

We participate in the electronic sharing of health information with other health care providers, health plans, and other health care-related entities through CTHealthLink, a health information exchange (HIE). Your electronic health records, including certain sensitive health information, e.g., mental health information, HIV/AIDS, genetic information, some alcohol and drug abuse treatment information, communicable diseases, and developmental and intellectual disability treatment, may be accessible through the HIE to properly authorized users for purposes of treatment, payment, and health care operations, as well as other purposes permitted or required by law unless you submit a completed CTHealthLink Opt-Out Form to this practice/facility or unless you submit an opt-out request online through www.CTHealthLink.com.

> If you do not want your electronic health records shared and used through the HIE, you can opt-out of the HIE by submitting a completed CTHealthLink Opt-Out Form to this practice/facility or by submitting your opt-out request online at www.CTHealthLink.com.

Even if you opt-out of having your health information used and disclosed through the HIE, some of your information may still be available through the HIE to properly authorized individuals as necessary in an emergency, Prescription Drug Monitoring Program or to report specific information to a government agency as required by law (for example, reporting of certain communicable diseases or suspected incidents of abuse).