NOVACURE CONSULTANTS, PC

8101 Hinson Farm road, Suite 211, Alexandria, VA, 22306 . Ph: 703-780-2216 . F: 703-780-9487

Hematology & Oncology Specialists

nova-cure.com

NovaCure consultants is a practice of Hematology and Oncology originally established in 1991. We believe in precision and personalized medical care and fortunate to have highly skilled staff and specialized nurses providing state-of –the-art care for our patients.

We are passionate about our profession and confident that the medical care received will follow the highest levels of up-to-date modern standard of care.

We also take pride of many positive outcomes seen in our patients who were accepted as second opinions and have seen unique results outperforming the highest expectations.

All treatments and infusions are administered in our onsite infusion suite under the direct supervision of our specialized team.

Patients are seen by appointment only, however urgent visits are worked in on an as needed basis.

Insurance requirements vary greatly and it is your responsibility to obtain any necessary referrals before coming to see the doctor. If a referral is not presented at the time of the visit, you may be asked to reschedule. Co-payments are collected at the time of all visits and any billing questions will be directed to our billing service.

Medical records will be kept for up to 6 years from the date of last visit and will then be discarded in a confidential manner.

We would like to thank you for choosing our practice and look forward to serving you.

Soren Caffey, MD, FACP

President

NovaCure Consultants, PC

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8101 Hinson Farm Road . Ste 211 . Alexandria, VA 22306
Phone (703)780-2216 . Fax (703)780-9487
Soren Caffey, MD . Yin Wu, MD

PHARMACY: _____

PATIENT INFORMATION

NAME: (FIRST) _____ (MIDDLE) _____ (LAST) _____

DATE OF BIRTH:_____ SEX: MALE____ FEMALE____ MARITAL STATUS: _____

SOCIAL SECURITY #: _____ RACE: _____ ETHNICITY: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ **EMAIL ADDRESS:** _____

HOME PHONE: (___)_____WORK PHONE: (___)_____CELL PHONE: (___)_____

OCCUPATION: _____ APPT. REMINDER: TEXT_____ EMAIL_____

REFFERING OR PRIMARY DOCTOR: _____ PHYSICIAN'S PHONE: (___)_____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____

STREET ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: (___)_____ WORK PHONE: (___)_____ CELL PHONE: (___)_____

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN INFORMATION (MUST BE COMPLETED)

PLAN NAME: _____ PHONE NUMBER: (___)_____

GROUP #: _____ POLICY #: _____

POLICY HOLDER: _____ SS# OF POLICY HOLDER: _____

HOLDER'S DATE OF BIRTH: _____ RELATIONSHIP: _____

EMPLOYER'S NAME: _____ EMPLOYER'S PHONE: (___)_____

COPAY (YES) _____ (NO) _____ REFERRAL NEEDED: _____

SECONDARY INSURANCE PLAN INFORMATION

PLAN NAME: _____ PHONE NUMBER: (___)_____

GROUP #: _____ POLICY #: _____

POLICY HOLDER: _____HOLDER'S DOB: _____ RELATIONSHIP: _____

This is authorization for *NovaCure Consultants*, to apply for benefits on my behalf and receive any payments for medical services rendered to me by employees of this organization through all insurance plans indicated above or any other plans through which I may receive coverage. I further authorize the release of any necessary medical information for any claim to my insurance carrier or any medical facility to ensure continuity of care. I herby acknowledge that I am fully responsible for payment or the total bill incurred and warrant that I shall comply with all insurance plan guidelines to insure liability for reimbursement of services provided by *NovaCure Consultants*.
In the event that a collection agency becomes involved due to non-payment, I understand that I am responsible for any and all collection and/or legal fees.

SIGNATURE_____ DATE: _____

NovaCure Consultants, PC

Date:

(703)780-2216

NAME:_____ DOB:_____ AGE:_____

HEIGHT:_____ WEIGHT:_____

REASON FOR VISIT:_____

HPI:

Past Medical History:

Hypertension [ ]	Stroke [ ]	Lung disease [ ]
Diabetes [ ]	Stomach ulcer [ ]	Liver Disease [ ]
Heart Disease [ ]	High cholesterol [ ]	Kidney Disease [ ]
Arthritis [ ]	Other: _____	

Past Operations:

Name of operation: Name of surgeon: Month/Year:

Family History: Father- Mother-

Brother- Sister-

Other Family Members-

Social History: Live Alone [ ] With Spouse [ ] With Other family [ ] With Friend [ ]

Smoking: [ ] Packs per day:_____ for_____ years

Alcohol: [ ] Social [ ] Moderate [ ] Heavy [ ] For _____ Year

Other drugs used in the past or present-_____

Type of work most of your life- _____

Ob/Gyn History (Women only): Menstrual Cycle regular- YES NO

Menopause- YES NO If yes, age of menopause___

No. of Children _____

No. of Miscarriages- _____

NAME:_____DOB:_____

Review of systems: Please write the duration of following symptoms after the [ ] in weeks or months or years.

General:

Fever [ ] _____
Chills [ ] _____
Night sweats [ ] _____
Lumps or Bumps [ ]_____
Loss of appetite [ ]_____
Weight [ ] _____
Fatigue [ ] _____
Pain [ ] _____ Location_____

Cardiopulmonary:

Cough [ ]_____
Chest Pain [ ]_____
Blood in Sputum [ ]_____
Swelling of Legs [ ]_____
Shortness of Breath [ ]_____
Phlegm [ ]_____ Color of Sputum_____
Palpitation [ ]_____

Gastro-intestinal:

Nausea [ ]_____
Vomiting [ ]_____
Heartburn [ ]_____
Difficulty swallowing [ ]_____
Gaseousness [ ]_____
Blood in stool [ ]_____
Abdominal pain [ ]_____
Constipation [ ]_____
Diarrhea [ ]_____
Abdominal Distension [ ]_____
Dark stool [ ]_____
Pain in B.M [ ]_____

Genito- urinary:

Burning with urination [ ]_____
Difficulty urinating [ ]_____
Incontinence [ ]_____
Blood in urine [ ]_____
Frequent urination [ ]_____
Discharge [ ] _____

Nervous System:

Headache [ ]_____
Dizziness [ ]_____
Numbness [ ]_____
Weakness [ ]_____
Impaired vision [ ]_____
Impaired hearing [ ]_____
Impaired memory [ ]_____

Musculoskeletal:

Backache [ ]_____
Muscle ache [ ]_____
Joint pains [ ]_____
Joint Swelling [ ]_____
Joint stiffness [ ]_____

Skin:

Rash [ ]_____
Itching [ ]_____
Bruises [ ]_____
Ulcers [ ]_____

Other:

Nose Bleed [ ]_____
Fainting [ ]_____
Bleeding gums [ ]_____

Medication:

NAME: DOSE HOW OFTEN

ALLERGIES:

**** Notice of Privacy Practices ****

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY
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State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. This notice will take effect on (insert date) and will remain in effect until it is amended or replaced by us.
It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our notice effective for all health information maintained, created and/or received by us before the date changes were made.
You may request a copy of our privacy notice at any time by contacting our privacy officer, (insert name). information on contacting us can be found at the end of this notice.

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TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION
We will keep your health information confidential, using it only for the following purposes:
Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentially statement.
Disclosure: we may disclose and/or share your health information with health care professionals who provide treatment and/ or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.
Payment: We may use and disclose your health information to seek payment for services we provided to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.
Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible of your care, in cases of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgement to disclose only that information directly relevant to your care. We will also use our professional judgement to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.
Healthcare operations: We will use and disclose your health information to keep our practice operable. Examples of personal who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar actives.
Require by law: We may use or disclose your health information when we are required to do so by law. [Court or administrative orders, subpoena, discovery requestor other lawful process.] we will use and disclose your information when requested by national security, intelligence and other state and federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
Abuse or neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to extent necessary to prevent a serious threat to your health or safety or that of others.
Public health Responsibilities: We will disclose your health care information to report problems with products, reactions to medication, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.
Marketing Health-Related Services: we will not use your health information for marketing purposed unless we have your written authorization to do so.
National security: the health information of armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activates, we may disclose e it to authorized federal officials.
Appointment Reminders: we may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail message, postcards, letters.

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YOUR PRIVACY RIGHTS AS OUT PATIENT

Access: Upon written request you have the right to inspect and get copies of your health information (and that of and individual for whom you are legal guardian.) there will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our privacy officer for a copy of the Request form. You may also request access by sending us a letter to the address at the end of this notice Once approved, an appointment can be made to review your records. Copies, if requested, will be (insert fee) for each page and the staff time charged will be (insert fee) per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our privacy officer for a fee and/or for an explanation of our fee structure.

Amendment: you have the right to amend your health information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include and explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: you have the right to receive a list of non-routine disclosures we have made of your health care information. (when we make a routine disclosure of your information to a professional for treatment of payment purposes, we do not keep a record of routine disclosures: therefore, these are not available.) you have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request Non-routine disclosures going back 6 years starting April 14, 2003. Information prior to that date would not have to be released. (Example: if you request information on May 15,2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: you have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do we will abide by agreement. (except in emergencies.) Please contact our privacy officer if you want to further restrict to your health care information. This request must be submitted in writing.

QUESTIONS ANDCOMPLAINTS

You have the right to file a complaint with us if you feel we have not compiled with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have Violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a complaint form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of health and human Services.

HOW TO CONTACT US

Practice Name: NovaCure Consulants, PC
President: Soren Caffey, MD, FACP

Office Manager: Lois Convery

Telephone: 703-780-2216
Fax: 703-780-9487

Address: 8101 Hinson Farm Road, Ste. #211
Alexandria, VA 22306

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ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to patient:

We are required to provide you with a copy of out Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this officer's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtainedbecause:

- ○ The patient refused to sign.
- ○ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ○ We weren't able to communicate with patient.
- ○ Other(please provide specific details

Employee signature

Date

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HIPAA Acknowledgement of receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

NOVACURE CONSULTANTS, PC

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my healthcare, *N*ova*C*ure *C*onsultants, pc originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosure. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that my Medical Records will be kept for up to 6 years from the date of last visit and will then be discarded in a confidential manner in accordance with State of Virginia Law.

I understand that *N*ova*C*ure *C*onsultants, pc is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations.

I further understand that *N*ova*C*ure *C*onsultants, pc reserves the right to change this notice and practices and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations. Should *N*ova*C*ure *C*onsultants, pc change this notice, a copy of any revised notice will be sent to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____

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Hematology & Oncology Specialists

Financial Responsibility Agreement

I hereby acknowledge that I am responsible for the cost of any and all services provided to me by the office of Dr. Soren Caffey (*N*ova*C*ure *C*onsultants, pc). I understand that I will be financially responsible for the cost of any services not covered by my insurance(s). I understand that I am responsible for the cost remainder if any services or charges are only partially covered by my insurance(s). I agree to verify all benefits with my insurance(s). I understand that I am responsible for all copayments and deductibles and coinsurances and for the payment of any non-covered services.

I hereby acknowledge that the contract I have with my insurance company (ies) is my individual responsibility. If I change my insurance coverage, I am responsible for notifying *N*ova*C*ure *C*onsultants of such change(s) prior to the effective date of the change(s). I will be held responsible for any cost incurred by my failure to do so.

In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible. **Balances due that are greater than $500 and remain unpaid for more than 30days after the monthly statement date will accrue interest at a rate of 18% APR. Any balance that remains unpaid for more than 6 months may be subject to collections agency action.** In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorney's fees and other collection costs.

Any balances greater than $500 must be paid in full by December 31st of each calendar year. Failure to comply with office financial policy may result in interruption of treatment at NovaCure.

The undersigned certifies that he or she has read this form and understands its terms. The undersigned certifies that he/she may request a copy of it and that the undersigned is either the patient or is duly authorized to sign this form and accept its terms.

_____

Patient (Guardian/Responsible Party)

_____

Date

NOVACURE CONSULTANTS, PC

Hematology & Oncology Specialists

FORMS & COPIES POLICY FOR OUR PRACTICE

REQUESTING COPIES:

Since the cost of supplies and paper is going up we are obligated to implement the following charges:

1 page = $0.50 each for copy of labs, radiology reports and any other paper

RECORDS TO BE COPIED –

$0.50 per page up to 50 pages and $0.25 a page thereafter
Plus $10 fee for search & handling

Please allow 7-10 business days for the records to be copied and mailed once payment and signed consent form has been received.

MISSING AN APPOINTMENT:

It is our policy to require appointment cancellations no later than 48 hours in advance in order to avoid a no show charge. Failure to notify our office within this time limit or failure to show up for scheduled appointment will result in a $75 charge to your account. IT IS YOUR RESPONSIBILITY. You will receive a bill for this and payment is expected prior to your next appointment.

REQUESTING FORMS TO BE FILLED OUT BY THE DOCTOR:

Following forms will be charged with corresponding fees:
Disability forms - $ 50.00
Insurance forms - $ 50.00
FMLA forms - $ 50.00
DMV forms - $ 35.00
MISCELENIOUS FORMS & LETTERS: $35.00 - $50.00

RETENTION OF RECORDS:

Our practice retains records for 6 years following your last visit with our physicians. If you have not been seen for 6 years your records will be discarded in a confidential manner without further notice.