

PATIENT REGISTRATION

Associated Medical Specialists, P.A. d/b/a Coastal Cancer Center ("CCC")

Office Use Only Date: _____ Chart # _____ Initial _____

Name _____ Sex (circle) M F

Date of Birth _____ Age _____ Social Security # _____

Marital Status (circle) Married Single Widowed Divorced Ethnicity (circle) Hispanic/Latino NOT Hispanic/Latino

Race (circle) American Indian or Alaska Native Asian Black or African American White

Preferred Language English _____ Other _____

Permanent/Primary Address _____

City/State/Zip + 4 _____

Temporary/Alternate Address _____

City/State/Zip + 4 _____

Preferred Mailing Address Permanent/Primary Address Temporary/Alternate Address

Phone: Home () _____ Cell () _____ Work () _____

Email Address _____ Or Not Applicable

Employment Status (Circle) 1-Full-time 2-Part-time 3-Not Employed 4-Self 5-Retired 6-Active Duty

Occupation _____ Employer Name _____ Phone () _____

Employer Address _____ City/State/Zip + 4 _____

Disabled? _____ Year _____ Due To _____

Guarantor Information

Guarantor Name _____ Phone: Home () _____ Work () _____

Address (if different from Patient's) _____ City/State/Zip + 4 _____

Social Security Number _____ Date of Birth _____

Insurance Information

Primary Insurance _____ Name of Subscriber *(if not patient) _____

Secondary Insurance _____ Name of Subscriber *(if not patient) _____

Please complete only if subscriber on any policy is other than you, the patient

Subscriber Name _____ Subscriber Date of Birth _____ Subscriber Social Security # _____

Relationship of Patient to Subscriber (please circle) Self Spouse Child Other: _____

Subscriber Occupation _____ Subscriber Employer _____

Subscriber Employer Address _____ City/State/Zip + 4 _____

Subscriber Work Phone () _____ Full-time Part-time Not Employed Self Retired

Emergency Contacts/Who May We Notify?

Name _____ Relationship _____

Phone: Home () _____ Cell () _____ Work () _____

Address _____ City/State/Zip + 4 _____

Name of Relative NOT Living with You _____ Relationship _____

Address _____ City/State/Zip + 4 _____

Phone: Home () _____ Cell () _____ Work () _____

Name _____

Chart number: _____

CCC charges the Patient for all services it renders, regardless of insurance coverage. Please provide all insurance cards to the registrar upon arrival. A copy of insurance cards will be kept which makes it imperative for you, as the Patient, to inform us of a change in your coverage, work or other financial matters, as soon as it becomes known to you. Medicare, Medicaid and contracted insurers claims will be filed by this office. All other insurance claims are the responsibility of the Patient. Any assistance completing the forms may be offered as needed. Payment is expected for all services when rendered, unless previous arrangements in writing have been agreed upon.

GUARANTEE OF PAYMENT

In consideration for services, the patient and any Guarantor individually guarantee payment of all services provided to the Patient by CCC. This obligation of payment extends to all charges not paid by the Patient's insurance company or, if available, Medicare as stated below. By voluntarily signing this Guarantee, the Patient and Guarantor each agree to the payment of any outstanding charges and expenses arising from all services provided to the Patient. If the applicable insurance company does not pay within 30 days after any payment is due, payment is due from the Patient or Guarantor.

SIGNATURE

DATE

SPOUSE

DATE

MEDICARE PATIENTS

Medicare policies have a coinsurance and deductible. If Patient does not have supplemental coverage that covers coinsurance and deductible or if Patient has signed an Advance Beneficiary Notice, Patient agrees to be personally and fully responsible for payment. Patient requests that payment of authorized Medicare benefits be paid to CCC for services furnished. Patient authorizes CCC to release to the Centers for Medicare and Medicaid services or its agents, any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE

DATE

SPOUSE

DATE

INSURANCE ASSIGNMENT AND AUTHORIZATION AND RELEASE AUTHORIZATION

In order to submit a claim for payment for services covered by a policy or program, such as Medicare, we must have your authorization to release medical information. I (Patient) authorize the release of any medical information relating to my charges with CCC. I authorize CCC to act in my behalf as authorized representative: (1) in the collection of benefits from any responsible third party through whatever means may be deemed necessary; and (2) in the endorsement of benefit checks made payable to myself and/or participant or insured. I request and authorize that benefit payment be made directly to CCC. Furthermore, I designate CCC as my authorized representative and authorize CCC to act on my behalf to (1) request and receive a copy of the summary plan description; (2) pursue a benefit claim and/or (3) appeal an adverse benefit determination. I understand that I am responsible for payment of my medical charges regardless of the status of any claim.

SIGNATURE (Patient)

DATE

SIGNATURE (Guarantor)

DATE

CONSENT TO TREAT

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I authorize the use and disclosure of my personal health information for the purposes of treatment and healthcare operations. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

SIGNATURE

DATE

COASTAL CANCER CENTER WITNESS

DATE

8121 ROURK STREET
MYRTLE BEACH, SC 29572
(843) 692-5000

COASTAL CANCER CENTER
A DIVISION OF ASSOCIATED MEDICAL SPECIALISTS, PA

Chart#: _____
817 FARRAR DR
CONWAY, SC 29526
(843) 234-1660

3008 BAYBORO ST
LORIS, SC 29569
(843) 756-0932

4620 HIGHWAY 17
MURRELLS INLET, SC 29576
(843) 357-7357

PATIENT MEDICAL HISTORY FORM

LAST NAME _____ FIRST NAME: _____ MI: _____ DATE OF BIRTH: ____/____/____ AGE: _____

NOTIFY IN EMERGENCY: _____

NAME _____ RELATIONSHIP _____
STREET _____ PHONE NUMBER _____
CITY/STATE/ZIP +4 _____

DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)? Yes _____ No _____ IF YES, PLEASE PROVIDE A COPY.

LOCAL PHARMACY: _____ PHONE NUMBER: _____

FAMILY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS: What is the main reason for your visit today? (Describe your problem in detail)

Please answer the following questions about your present medical problem as it applies to you.

CANCER PAIN SEVERITY (IF APPLIES)

If pain is present, circle the number that best describes the level of pain with 4 being the most severe.

- 0 None
- 1 Mild pain not interfering with function.
- 2 Moderate pain; pain or analgesics interfering with function, but not interfering with activities of daily living.
- 3 Severe pain; pain or analgesics severely interfering activities of daily living.
- 4 Disabling pain.

LOCATION

- Abdomen Back Breast Extremity
 - Chest Head/Neck
- Other _____

DURATION

When did you first notice the problem?
Other _____

MODIFYING FACTORS

Does anything help or make the problem worse?
Moving around? Standing up? Lying on my side?
Other _____

TIMING

How long does the problem last?

ASSOCIATED SIGNS/SYMPTOMS

Is anything else occurring at the same time? Please explain.

CONTEXT

Is the problem constant or variable?
Dull then Sharp? Very sharp then leaves? Always there?

QUALITY

Does the problem interfere with your normal functions?
Yes No If yes, please explain

PAST MEDICAL HISTORY: Please circle and list dates if you have had any of the following:

		Date:	
Cancer	Y	N	_____
Lymphoma	Y	N	_____
Leukemia	Y	N	_____
Blood Problem	Y	N	_____
Connective Tissue Disease	Y	N	_____
Arthritis	Y	N	_____
Thyroid Problem	Y	N	_____
High Cholesterol	Y	N	_____
Other			_____

		Date:	
Diabetes	Y	N	_____
Kidney Disease	Y	N	_____
Tuberculosis	Y	N	_____
Appendix Removal	Y	N	_____
Asthma	Y	N	_____
Heart Disease	Y	N	_____
High Blood Pressure	Y	N	_____
Lung Disease	Y	N	_____
Other			_____

Patient Name: _____ Chart # _____

Please list all prior hospitalization and surgery. Please do not list any pregnancies and/or births

	#1	#2	#3
Reason for admission (Medical reasons or diagnosis)	_____	_____	_____
Month and year hospitalized	_____	_____	_____
Type of Surgery (if one was done)	_____	_____	_____

Have you EVER received radiation treatment for any illness? Yes No

If yes, for what illness? _____

When was the treatment received? _____

Have you EVER received chemotherapy treatment for any illness? Yes No

If yes, for what illness? _____

When was the treatment received? _____

MEDICATIONS:

List all medications, or drugs you currently use or have used at home within the last three months. Include those with a prescription from a doctor, those you bought over the counter in a store, any you received from a friend, any vitamins, home remedies, laxatives or any other product you take to improve your health. If you do not know all this information, please bring all the bottles or boxes with you to your next office visit. (Please attach an additional page if you need more space)

	Name & Strength of Medication	Amount taken	Approximate date started
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

ALLERGIES:

List anything (drugs, food, insects, pollens, etc.) you are allergic to:

	Item	Describe reaction you had
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

FOR WOMEN ONLY

Are you currently menstruating? Yes No

If yes, when did your last menstrual period begin? DATE ____/____/____

If you are post-menopausal, give approximate date. DATE ____/____/____

Please provide the following information:

Number of children born alive _____

Number of miscarriages _____

Are you on hormone replacement therapy? Yes No

Do you have abnormal vaginal bleeding? Yes No

The following questions are about your **FAMILY**, you may not know all the information asked. Please answer to the best of your ability.

Please add additional information on the last page.

	NAME	LIVING	DEAD	PRESENT AGE OR AGE AT DEATH	HEALTH PROBLEMS	CAUSE OF DEATH IF DECEASED
Mother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Father	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Brother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Brother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Brother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sister	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sister	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Sister	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

CHILDREN:	NAME	LIVING	DEAD	PRESENT AGE OR AGE AT DEATH	HEALTH PROBLEMS	CAUSE OF DEATH IF DECEASED
First	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Second	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Third	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Fourth	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Fifth	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Any history of cancer, leukemia or lymphoma in your family? If so, give details: _____

SOCIAL HISTORY:

MARITAL STATUS: Single Divorced
 Married Separated
 Widowed

What is/was your job position? _____

What was your last grade completed in school? _____

What are your hobbies? _____

Have you EVER smoked? Yes No

Do you now smoke? Yes No

If yes, average number of packs/day _____

Number of years smoked _____

Date stopped _____

Do you desire counselling for smoking cessation? Yes No
 If yes, please speak with your nursing staff.

Do you consume alcoholic drinks? Yes No

- Amount:
- Never
 - Rarely
 - Moderately
 - Socially
 - Frequently
 - Excessively

Do you now or have you ever had a problem with alcoholism or drug addiction? _____

If you are of reproductive age (generally females age 18-40 and males age 18-50), do you desire to address fertility in regard to your diagnosis and treatment options? Yes No
 If yes, please speak with your nursing staff.

Patient Name: _____ Chart #: _____

Review of Systems: Do you **CURRENTLY** have or are you **NOW** bothered with the following symptoms? Circle Yes or No

Constitutional Symptoms Fever Y N Chills Y N Fatigue/Excessively tired Y N Weight loss Y N	Cardiovascular Heart pain (Angina) Y N Irregular heart rhythm Y N Congestive heart failure Y N Varicose veins Y N Extremity swelling Y N
Allergic/Immunologic Seasonal allergies Y N Food allergies Y N IV contrast allergies Y N Drug allergies Y N	Gastrointestinal Nausea Y N Vomiting Y N Diarrhea Y N Constipation Y N Abdominal pain Y N Abdominal swelling Y N Loss of appetite Y N Indigestion/heartburn Y N Blood in bowel movement Y N
Eyes Sudden visual changes Y N Excessive tearing Y N Eye irritation Y N Double vision/Blurred vision Y N	Genitourinary Blood in urine Y N Painful urination Y N Frequent urination Y N Hesitation on urination Y N Incontinence Y N Sexual dysfunction Y N Genital Mass/tenderness Y N
Ear/Nose/Throat/Mouth Hearing difficulty Y N Dry mouth Y N Mouth irritation Y N Sore throat/Hoarseness Y N Difficulty Swallowing Y N Ear discomfort Y N Sinus problem Y N Ringing in the ears Y N	Musculoskeletal Joint pain Y N Swelling/edema Y N Muscle aches Y N Bone pain Y N Decreased range of motion Y N
Endocrine Hot flashes Y N Sweats Y N Heat intolerance Y N Cold intolerance Y N Excessive Thirst Y N	Integumentary Skin rash Y N Lesions Y N Skin breakdown Y N Persistent itch Y N
Hematological/Lymphatic Easy bruising Y N Easy bleeding Y N Tender lymph nodes Y N Swollen lymph nodes Y N	Neurological Headaches Y N Dizzy spells Y N Numbness/tingling Y N Weakness Y N Unsteady balance when walking Y N Tremor Y N
Breasts Abnormal breast mass Y N Nipple Discharge Y N Nipple pain Y N	Psychological Are you generally satisfied with your life? Y N Do you feel nervous or anxious? Y N Do you have trouble sleeping? Y N Do you have periods of extreme sadness or crying? Y N
Respiratory Wheezing Y N Persistent cough Y N Sputum production Y N Shortness of breath Y N Chest pain on breathing Y N Coughing up blood Y N	

Patient Signature

Date

Physician Signature

Date



Attention Patients & Guests

To best serve our practice,
Coastal Cancer Center
does not allow
guests and/or visitors
under fifteen (15) years of age
in the clinical areas
(e.g. laboratory, mixing center,
treatment room, shot area).

Thank you,
Your CCC Care Team

**Associated Medical Specialists, PA, d/b/a Coastal Cancer Center
Authorization for Release of Information to Family and/or Friends**

Patient Name: _____ Chart No.: _____

Associated Medical Specialists, PA, d/b/a/ Coastal Cancer Center is authorized to release protected health information about the above named patient to the authorized people named below. This will enable Coastal Cancer Center to best coordinate your healthcare.

<u>Print name</u>	<u>Relationship/Phone #</u>	Please circle the information each person may receive:		
_____	_____	CLINICAL	APPOINTMENT	FINANCIAL
_____	_____	CLINICAL	APPOINTMENT	FINANCIAL
_____	_____	CLINICAL	APPOINTMENT	FINANCIAL

If you have an answering machine or voice mail, may we leave a message regarding the following? **Y N**

Please circle each one signifying your consent **CLINICAL** **APPOINTMENT** **FINANCIAL**

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by contacting Coastal Cancer Center, and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in effect until revoked by the patient or the patient's representative.

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation)

Coastal Cancer Center Witness Date

**Associated Medical Specialists, PA
d/b/a Coastal Cancer Center**

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.

If you have any questions about this Notice, please contact our Privacy Officer at:
Coastal Cancer Center – Privacy Officer
8121 Rourke Street
Myrtle Beach, South Carolina 29572
(843) 692-5000

Effective date: April 1, 2003

Revised: September 23, 2013

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or healthcare operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: www.coastalcancercenter.com.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide healthcare treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or healthcare provider (e.g., a hospital) who, at the request of your physician, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if a service will be paid.

PHI may be shared with the following:

- Billing companies and collection agencies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services, such as labs, to your insurance company so that we can get paid for the procedure. We may at times contact your healthcare plan to receive approval PRIOR to performing certain procedures. This will require sharing of your PII.

We may use or disclose as needed, your PHI in order to support the business activities of this practice which are called healthcare operations.

EXAMPLES:

- Training students, other healthcare providers, or ancillary staff such as billing personnel, to help them learn or improve their skills.
- Quality improvement processes which look at delivery of healthcare and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.
- We may use a sign-in sheet at the registration desk where you will be asked to sign your name and we may call you by name in the waiting room.
- Our patients are treated in common settings such as the laboratory and chemotherapy area.

We may use and disclosure your PII in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.

- **Police or other law enforcement purposes:** The release of PHI will meet all applicable legal requirements for release.
- **Coroners, funeral directors:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- **Medical research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- **Special government purposes:** Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- **Health and Safety of Others:** Information may be shared which is necessary for your health or the health and safety of other individuals.
- **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information:

Business Associates: Some services are provided through the use of contracted entities called "business associates." We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include our electronic medical record vendor and transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options, or other health related services, that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post treatment instructions with the person who drove you to the facility unless you tell us specifically not to share the information.

- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing.
- Disclosures of any purposes which require the sale of your information.
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time but must be made in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. If you would like to make a written request, please ask for the HIPAA Privacy Officer or the Location Supervisor.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request an alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Coastal Cancer Center – Privacy Officer
8121 Rourk Street
Myrtle Beach, South Carolina 29572
(843) 692-5000

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and became effective April 1, 2003, Revised September 23, 2013

**Associated Medical Specialists, PA
d/b/a Coastal Cancer Center**

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Chart No. _____

I have received a copy of the Notice of Privacy Practices from the above named practice.

Patient or Personal Representative Signature

Date

Coastal Cancer Center Witness

Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

____ An emergency existed & a signature was not possible at the time.

____ The individual refused to sign.

____ A copy was mailed with a request for a signature by return mail.

____ Unable to communicate with the patient for the following reason: _____

____ Other: _____

Coastal Cancer Center printed name: _____

Signature: _____

Date: _____