Valor Oncology
New Patient Information

The information you provide will help us give you better care. All information is confidential and protected.

Your Name: _____DOB: _____ Today's Date: _____

Medical History

Are any of these conditions part of your history? Explain "YES" answers in space below.

❑ Yes	❑ No	Prior Radiation Therapy?	❑ Yes	❑ No	MRSA or other 'Hospital' Infections?
❑ Yes	❑ No	OTHER CANCER now or in past?	❑ Yes	❑ No	Lupus, scleroderma, or dermatomyositis?
❑ Yes	❑ No	Rheumatic Fever?	❑ Yes	❑ No	Hyper / Hypo Thyroid?
❑ Yes	❑ No	Rheumatic Disease or Valve Replacement?	❑ Yes	❑ No	Tuberculosis?
❑ Yes	❑ No	Diabetes?	❑ Yes	❑ No	Infection with HIV, or AIDS?
❑ Yes	❑ No	High Blood Pressure?	❑ Yes	❑ No	Infection with any Hepatitis Virus?
❑ Yes	❑ No	Blood Clot or Pulmonary Embolism?	❑ Yes	❑ No	Pacemaker or Defibrillator?

List other MEDICAL CONDITIONS, PAST ILLNESSES, and PAST SURGERIES
For example, any conditions or diseases for which you routinely see a physician or take medicines
****Heart surgery, joint replacement, abdominal surgery, brain surgery, lung surgery, etc.**

_____

_____

_____

_____

_____

Disease Prevention History

Have you ever had a colonoscopy? ❑ Yes (date:_____) ❑ No

Have you had a mammogram within the last 2 years? ❑ Yes (date:_____) ❑ No

Women's Health History

Last pelvic exam and/or Pap smear? ❑ None ❑ In last 12 months ❑ >1 year ago (date:_____)

Number of pregnancies _____

Number of deliveries _____

Your age at first childbirth _____

Your age at first period _____

Age or date of last period _____

Could you be pregnant? ❑ Yes ❑ No

Ever take birth control pills? ❑ Yes ❑ No

If Yes, how many years total? _____

Ever take estrogen after menopause? ❑ Yes ❑ No

If Yes, how may years total?

Did you breast feed? ❑ Yes ❑ No

If Yes, how long (mths or yrs)? _____

Medication and Allergy History

❑ Yes ❑ No Do you take **aspirin**, **Plavix** (Clopidrogel), **Coumadin (**Warfarin**)**, **Elaquis** (Apixaban), **Xarelto** (Rivaroxaban), or other **blood thinner?**
If YES, please list below under CURRENT MEDICATIONS.

❑ Yes ❑ No Do you have an **ALLERGY** or **INTOLERANCE** to any medication or substance?

****If YES**, please list the drug(s) and the **allergic reactions:**

_____

****Preferred Pharmacy Name**: _____Pharmacy Phone:_____

Please list your CURRENT MEDICATIONS

Drug Name	Dose	Taken how often?	Reason?

Lifestyle Profile

Occupation or Primary Activity _____

❑ Yes ❑ No Do you have a life partner or spouse? Name: _____

❑ Yes ❑ No Does anyone live with you? Who? _____

❑ Yes ❑ No Do you feel safe in your home? _____

❑ Yes ❑ No Have you ever used tobacco? Please indicate the type of tobacco:
Smokeless ❑ Vapor ❑ Chew
Cigarettes_____ packs/day for _____years
Still smoking? If not, when did you quit? _____

❑ Yes ❑ No Do you **currently** drink alcohol? If "Yes" how many drinks per day? _____ / day
If you do NOT drink now, did you in the past? ❑ Yes ❑ No Year quit:_____

❑ Yes ❑ No Do you have history of Hepatitis A, B, or C?

❑ Yes ❑ No Have you ever used elicit street drugs? ❑ Marijuana ❑
Other_____
How often: _____ for _____ years

❑ Yes ❑ No Do you **currently** drive a motor vehicle?

Family Medical History

❑ Yes ❑ No	Any relatives diagnosed with Breast Cancer?	If YES, list below
❑ Yes ❑ No	Any relatives diagnosed with Ovarian Cancer?	If YES, list below
❑ Yes ❑ No	Any relatives diagnosed with Colon Cancer?	If YES, list below
❑ Yes ❑ No	Any other cancers in Parents, Siblings, or Children?	If YES, list below
❑ Yes ❑ No	Any relatives with Blood Clots or Pulmonary Embolism?	
❑ Yes ❑ No	Are you of Ashkenazi Jewish decent?	

Relative	Type of Cancer	Age at Diagnosis

Have you experienced any of these problems during the past several months?
You can write in additional information about these symptoms below.

General

- Unexplained fevers ❑ Yes ❑ No
- Weight gain _____lbs ❑ Yes ❑ No
- Weight loss _____lbs ❑ Yes ❑ No
- Night sweats ❑ Yes ❑ No

Eyes

- New vision problems ❑ Yes ❑ No
- New double vision ❑ Yes ❑ No

Ear/Nose/Mouth/Throat

- Pain or problems swallowing ❑ Yes ❑ No
- New hearing loss ❑ Yes ❑ No
- New dizziness ❑ Yes ❑ No

Heart-Related

- Chest pain ❑ Yes ❑ No
- Leg swelling ❑ Yes ❑ No
- Lightheadedness with activity ❑ Yes ❑ No

Lung-Related

- New cough ❑ Yes ❑ No
- Pain with breathing ❑ Yes ❑ No
- New shortness of breath ❑ Yes ❑ No

Bone and Muscle-Related

- New back pain ❑ Yes ❑ No
- New bone pain ❑ Yes ❑ No

Endocrine

- Unusual thirst ❑ Yes ❑ No
- Temperature sensitivity ❑ Yes ❑ No

Gastro-Intestinal

- Rectal bleeding ❑ Yes ❑ No
- New diarrhea ❑ Yes ❑ No
- New constipation ❑ Yes ❑ No
- Heartburn or severe indigestion ❑ Yes ❑ No

Genito-Urinary

- Excessively frequent urination ❑ Yes ❑ No
- Pain with urination ❑ Yes ❑ No
- Blood in urine ❑ Yes ❑ No
- Urinary Incontinence ❑ Yes ❑ No
- Abnormal/new vaginal bleeding ❑ Yes ❑ No
- Pain with pelvic exams ❑ Yes ❑ No

Skin

- New rash ❑ Yes ❑ No
- New skin spots of concern ❑ Yes ❑ No

Brain and Nerve-Related

- New headaches ❑ Yes ❑ No
- Seizures or unexplained fainting ❑ Yes ❑ No
- Arm or leg numbness or weakness ❑ Yes ❑ No
- New bladder or bowel incontinence ❑ Yes ❑ No

Hematologic/Lymphatic

- New easy bruising ❑ Yes ❑ No
- New swollen glands ❑ Yes ❑ No

Allergies and Immune System

- Recurrent infections ❑ Yes ❑ No
- Life-threatening allergies ❑ Yes ❑ No

Psychiatric

- Trouble sleeping ❑ Yes ❑ No
- Disabling feelings of anxiety ❑ Yes ❑ No

Please list any other specific concerns for today's visit.

_____

_____

_____

_____

_____

_____

_____

Patient Signature: This is true to the best of my knowledge

Patient Signature _____Date _____

For Physician Use Only I have reviewed this information with the patient.

Physician Signature _____Date _____

Valor Oncology
Patient Registration

Patient Name:_____Birth Date:_____ Gender: □ M □ F

Home Address:_____
Street City State Zip

Mailing Address:_____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we leave a message? ❑ Yes ❑ NO Preferred Number: ❑ Home ❑ Work ❑ Cell

Social Security Number: _____ Email Address: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other: _____

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ African American ❑ Caucasian ❑ Other:_____

Preferred Language: ❑ English ❑ Spanish ❑ French ❑ Chinese ❑ Other:_____

Patient Employer:_____Occupation:_____

Employer's Address:_____
Street City State Zip

Primary Insurance: _____ Subscriber: ❑ Self ❑ Spouse ❑ Parent ❑ Other: _____

Subscriber Name (***if not patient***): _____Subscriber DOB: _____

Secondary Insurance: _____ Subscriber: ❑ Self ❑ Spouse ❑ Parent ❑ Other: _____

Subscriber Name (***if not patient***): _____Subscriber DOB: _____

Referring Physician:_____Phone:_____Fax:_____

Primary Care Physician:_____Phone:_____Fax:_____

Authorization, Assignment, and Release

I authorize Valor Oncology to perform, evaluate and treat, as they deem necessary. I further authorize my insurance company to pay Valor Oncology all medical benefits. I understand that ultimately, I am responsible for all charges not covered by my insurance as well as all deductibles, co-insurance and co pay amounts as determined by my insurance company. I understand that I will be responsible for all collection fees and all legal fees, if my account is placed with an outside collection agency. I hereby authorize Valor Oncology to release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient Signature:_____ Date:_____

Notice of Privacy Practices and Communication Consent

This form is to identify who may or may not have access to oral communication in regards to the patients protected health information while the patient is under treatment.

List the full name of **family or friends** that Valor Oncology can share your protected health information.

Name Phone Number Relationship

_____

_____

_____

_____

Emergency Contact:_____ Relationship to patient:_____

Home Phone:_____ Cell Phone:_____

Please list Physicians to receive correspondences from our office

Physician:_____Specialty:_____

Physician:_____Specialty:_____

Physician:_____Specialty:_____

Do you have a Living Will?	❑ Yes ❑ No	*If yes, please provide us with a copy for our records*
Do you have a DNR?	❑ Yes ❑ No	*If yes, please provide us with a copy for our records*
Do you have a Power of Attorney?	❑ Yes ❑ No	*If yes, please provide us with a copy for our records*

I acknowledge that I have received a copy of Valor Oncology's Notice of Privacy Practices and Patient Rights and Responsibilities. I have identified who may or may not have access to my protected health information while under treatment at Valor Oncology. I understand that this release is valid for the time period of my diagnosis but may revoke authorization at any time by informing Valor Oncology and my physician.

Patient Signature:_____ Date:_____

Financial Policy

Thank you for choosing Valor Oncology to meet your specialized medical needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. All new patients must complete and sign the Patient Registration and our Financial Policy forms before seeing the physician.

Payment in full is due at time of service for co-payments unless a payment arrangement has been initiated.

Payment plans are accepted upon approval.

We accept cash, check, Visa, Mastercard, Discover, and American Express.

Regarding Insurance: Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We will bill your insurance plan for you, as long as you provide us with correct information. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, are ultimately responsible for payment of all services provided by Valor Oncology. While payment is your responsibility, we will assist you in negotiating settlement with your insurance company for any disputed claim. Our billing department is available to discuss any questions you may have regarding your insurance or your account 760-688-0819 or via email found on your physician's business card.

Regarding insurance plans where we are a participating or preferred provider: All co pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating, or preferred providers refer to the above paragraph. If you have a secondary insurance, we will bill it for you, as a courtesy, as long as you have provided us with the appropriate information.

Usual and Customary: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Medical Necessary Care: We will only provide you with a service if we consider it medically necessary. Therefore, if your insurance company arbitrarily determines that a service, we have rendered to you is unnecessary, you will be responsible for the bill.

Credit Policy: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days.

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our billing department as soon as possible by calling 760-688-0819.

If an account becomes past due with no valid reason, necessary action will be taken to recover the account balance due. If your account is placed with an outside collection agency, you will be responsible for all collection fees and all legal fees.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient Signature:_____ Date:_____

Patient Billing Process, Important Billing Contact Information, Frequently Asked Questions

Valor Oncology Patient Financial Services is pleased to assist patients in understanding our billing process. Valor Oncology makes every effort to ensure that your care comes first.

The Billing Process

As a courtesy, Valor Oncology obtains the referral, required authorizations and bills your insurance company for all medical services provided. Co-pays, co-insurances, and deductibles may accrue as patient balance based on your plan benefits. Upon request, we may provide a quote of the estimated treatment cost based on your plan benefits.

Contact Information

If you have general questions about your insurance benefits, potential future balances, or payment options please call our Patient Account Representative at 760-688-0819.

Frequently Asked Questions

How much will I owe?
The amount owed can vary significantly depending on your benefits. You will not receive a statement from Valor Oncology until your insurance has started processing your claims. A complete final statement is issued after treatment that includes total patient responsibility.

I met my maximum out-of-pocket with my insurance, why am I being asked to pay a co-pay or other patient balance?
If you are being asked to pay a copay or other patient balance and feel you have met your maximum out of pocket, please contact our billing office at 760-688-0819 for assistance. Refunds can be requested by calling the billing department if needed. A refund will be issued electronically back to the card/bank account used for payment within two (2) business days. In the event that the original payment card and/or account is invalid, a refund will be issued via mailed check after your address has been verified. Mailed checks may be expected within two (2) weeks of the refund request.

What if I have insurance and cannot afford to pay my portion of the bill?
If you receive a statement reflecting a patient balance during your course of treatment and are concerned about the balance, please call our Patient Accounts Representative at 760-688-0819 to discuss assistance options.

Why is a doctor mentioned on my bill or explanation of benefits that I did not see or recognize?
Over a course of treatment, you will be visiting our office frequently, and some visits may only require interaction with a therapist, nurse or other member of the clinical team. During those visits, your specific doctor may not be at the office, but another radiation oncologist is on-site, and they become the "**covering doctor"** for your treatment that day. In these cases, correct billing requires services on that date be billed under the "covering doctor" instead of your specific doctor.

How do I obtain treatment information so I can file a cancer policy claim?
At the end of treatment, please call our patient Accounts Representative at 760-688-0819 to obtain a detailed ledger with needed dates of service, procedure and diagnosis information to file your claim.

Why do I have a balance for a date that I did not receive services?
Radiation treatment requires detailed planning by our radiation oncologists and their team. After a consultation, and prior to the start of treatment, our oncologists will perform several treatment planning tasks that are billed to the insurance on dates that you may not actually be at our office. Based on your plan benefits, the insurance may apply a patient balance for those claims.

Patient Rights and Responsibilities

You have the right to:

- Be treated with dignity, respect, and consideration.
- Not to be discriminated against based on race, age, gender, national origin, religion, sexual orientation, disability, marital status or diagnosis.
- To receive privacy in treatment and care for personal needs
- To receive treatment that supports and respects your individuality, choices, strengths and abilities
- Not be subjected to misappropriation of personal and private property by your provider or its staff
- To review upon written request, your medical record
- Safe care and not be subjected to neglect, exploitation, coercion, manipulation, abuse (physical, sexual, emotional) or sexual assault.
- Know the identity of those professionals that are treating you.
- Participate or have your representative participate in the development of, or decisions concerning, treatment
- Have access to an interpreter, free of charge.
- To receive a referral to another provider if our clinic cannot provide services needed
- Refuse treatment to the extent permitted by law including research or experimental treatment.
- Receive explanation for prior to any transfer of care.
- Have assistance from a family member, representative or other individual in understanding, protecting, or exercising your rights.
- File a complaint with a manager, the Department of Health Services, or your provider without retaliation
- Understand why someone is involved or observing care
- Not be restrained or secluded.
- Receive, on request, information about schedule of rates, charges, explanation of bill, regardless of source of payment.
- Have an advanced directive concerning treatment.

You have the responsibility to:

- Provide accurate & complete information concerning present complaints, past
- Medical history and other matters relating to his/her health.
- Make it known whether you clearly comprehend the course of treatment and what is expected of him/her.
- Follow the treatment plan established by his/her physician, including the instructions of nurses and other health care professionals, as they carry out the physician's orders.
- Keep appointments; notify Valor Oncology or physician when unable to do so.
- Accept responsibility of your actions should you refuse treatment or not follow physician's orders.
- Assure that financial obligations of your care are fulfilled as promptly as possible.
- Follow Valor Oncology's policies and procedures.
- Be considerate of the rights and property of other patients and facility personnel.
- Notify the Valor Oncology staff of request for interpreter services.

Patient Signature:_____ Date:_____

If you have any comments or concerns regarding services provided by Valor Oncology, please contact our Practice Administrator at 530-691-5920 or write our Practice Administrator at: Valor Oncology, 1700 Esplanade, Chico, CA 95926

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

Protected health information (PHI) about you, is obtained as a record of your contacts or visits for healthcare services with Valor Oncology. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services. Valor Oncology is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law. If you have any questions about this notice, please contact our Privacy Manager at 530-691-5920.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

- **You have the right to receive, and we are required to provide you with a copy of this Notice of Privacy Practices-** We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.
- **You have the right to authorize other use and disclosure-** This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.
- **You have the right to designate a personal representative-** This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.
- You have the right to inspect and copy your protected health information- This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record.
- **You have the right to request a restriction of your protected health information-** This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.
- **You may have the right to have us amend your protected health information-** This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.
- **You have the right to request a disclosure accountability-** This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive but do describe the types of uses and disclosures that may be made by our office.

- **For Treatment**- We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results for exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Moreover, we may contact you to provide information about health-related benefits and services offered by our office.
- **For Payment-** Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.
- **For Healthcare Operation**s- We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets and creating de-identification information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

- **To Others Involved in Your Healthcare**- Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, **that you identify**, your protected health information that directly relates to that person's involvement in your health care. If you are to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. 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, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.
- **As Required by Law**- We may use or disclose your protected health information to the extent that the use or disclosure is required by law.
- **For Public Health**- We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

- **For Communicable Diseases**- We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **For Health Oversight**- We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- **In Case of Abuse or Neglect**- We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **To the Food and Drug Administration**- We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products: to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.
- **For Legal Proceedings**- We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- **To Law Enforcement**- we may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.
- **To Coroners, Funeral Directors, and Organ Donation**- 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. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
- **In Cases of Criminal Activity**- consistent with applicable federal and state laws, we may disclose protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **For Military Activity and National Security**- When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities: (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or: (3) to foreign military authority if you are a member of that foreign military services.
- **For Worker's Compensation**- Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.
- **When an Inmate**- We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.
- **Required Uses and Disclosures**- Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.
- **E-Prescribe Consent, RX History-** I authorize, Paragon Chico Medical Group dba Valor Oncology, and its affiliated providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here.

Patient Signature:_____ Date:_____

Authorization to Use, Disclose and Request Protected Health Information

To Our Patient:

There are times when Paragon Medical Management Group dba Valor Oncology will need to request reports and health information from your other physicians and/or medical centers for your care at Valor Oncology. We also keep your other physicians notified of your treatment outcomes by sending all treatment reports and information to their facilities. In order to do so, your authorization is required.

Patient Name: _____Date of Birth:_____

Phone:_____Address:_____

City: _____State:_____ Zip:_____

I authorize the use, request and/or disclosure of my protected health information as described below. I understand that the information used or disclosed as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or disclosed to persons or organizations receiving it without obtaining my authorization. I have the right to revoke this Authorization by providing written notice to Valor Oncology. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

Valor Oncology Locations

Chico Office	**Redding Office**	**Palm Desert Office**
1700 Esplanade	923 Dana Drive	74000 Country Club Dr. Ste. D
Chico, CA 95926	Redding, CA 96003	Palm Desert, CA 92260
Phone: 530-691-5920	Phone: 530-900-4000	Phone: 760-368-2000
Fax: 530-691-5922	Fax: 530-900-4444	Fax : 760-368-2222

□ I understand that this release is valid for the timeframe of my diagnosis through treatment, but I may revoke this authorization at any time by informing Valor Oncology and my physician.

Health information to release includes the following (as checked):

□ Entire Health Record including consultation and follow-up notes, radiology results, physics/dosimetry data, and complete treatment record.
□ Records from outside physicians that are sent to a physician at Valor Oncology
□ I give special permission to release any information regarding: (Initial on applicable line(s) only)

_____Substance Abuse _____Genetic Testing _____HIV Information

Purpose: (Check applicable categories)

□ Further Medical Care □ Patient's Request □ Insurance Eligibility/Benefits
□ Disability Determination □ Legal Investigation □ Other: _____

Records to be released from or to:

Clinic Name: _____

Phone: _____Fax: _____

Expiration Date and Other Information:

This authorization will expire after the completion of my treatment at Valor Oncology. A photocopy of this authorization is as valid as the original. I understand this authorization is voluntary. I am confirming my authorization that the health care provider may use, request and/or disclose to the persons and/or organizations named in this form the protected health information described above. I understand that no person or entity authorized to use, disclose or request health care information may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Patient Signature:_____ Date:_____