Advance Directives

Your Right to Make Health Care

Decisions at

Nebraska Hematology Oncology PC

Advance Directives

In 1990, Congress passed the Patient Self-Determination Act. It requires health care institutions to tell adult patients and the people in their communities about their rights under Nebraska law to make decisions about medical care. These rights include the right to accept or refuse medical treatments and the right to make Advance Directives about their care. In Nebraska these rights apply to competent adults who are 19 years or older. In Iowa these rights apply to adults who are 18 years or older.

What is an Advance Directive?

An Advance Directive is a written statement in which you state your choices for health care, or name someone to make such choices for you, if you become unable to make your own decisions about medical treatment. The two most common forms are:

- Living Will
- Power of Attorney for Health Care

What is a Living Will?

In a Living Will document you state the kinds of medical treatments you want, or do not want, when you are terminally ill and unable to make your own decisions. It is called "Living Will" because it takes effect while you are still living but unable to communicate your choices. It is important to understand that a Living Will is authoritative; that means that it cannot be overridden by the wishes of family members who might not agree with everything you have decided about your medical care.

What is a Power of Attorney for Health Care?

In a Power of Attorney for Health Care document you name another person to act as your "attorney in fact" or your "representative". This person will make medical decisions for you, if you become unable to make them for yourself.

Your representative <u>can be</u>:

- a family member or
- a close friend.

Your representative <u>cannot be</u>:

- your doctor
- an employee of your doctor or your health care provider (unless he/she is your relative) or
- any person already serving as Power of Attorney for Health Care for 10 or more people (unless he/she is your relative).

Your representative is guided by your instruction about any medical treatment you want or do not want.

Can I appoint more than one person to share the responsibility of being my Power of Attorney for Health Care?

You should appoint only ONE person to be your attorney in fact, but you may appoint others as your alternates.

When do Advance Directives take effect?

Your Advance Directive takes effect only after you can no longer make personal decisions about medical treatment. As long as you can make your own decision, your healthcare providers will rely on your judgment about what to do.

Can I have both?

Yes. In fact, it is often a good idea to have both written instructions about what medical care you do and do not want provided to you if you are terminally ill (a Living Will) and the name of a person to make decisions on your behalf about care when you are unable to do so (Power of Attorney for Health Care).

Do I have to make an Advance Directive?

No. It is entirely up to you whether you want to prepare an Advance Directive. The main advantage of an Advance Directive is to express your wishes if you become unable to state them yourself.

What if I change my mind after I sign an Advance Directive?

You can revoke it. At any time, if you want, you can make a new one. If you are a patient; tell your doctor or nurse that you want to change your Advance Directive. It is best to destroy the old one.

What choices should I make in my Advance Directive?

You decide what to include in your Advance Directive. You should consider the circumstances in which you want life-prolonging medical treatments started, continued or stopped. You may wish to discuss this decision with your family, close friends, health care providers, clergy and others.

Does an Advance Directive have to be signed and witnessed?

Yes, you sign and date both a Living Will and a Power of Attorney for Health Care in order for them to be legally valid.

Your signature on a **Living Will** can be witnessed by either:

1) two qualified adults
   - cannot be your life or health insurance provider
   - only one witness may be an employee of your health care provider or
2) a notary public

Your signature on a **Power of Attorney for Health Care** can be witnessed by either:

1) two qualified adults
- cannot be:
   - your spouse, parent, child, grand- child, brother or sister
   -any person entitled to your estate
   - your doctor
   - your Power of Attorney for Health Care or their alternates
   - an employee of your life insurance or health insurance provider and- only one witness may be an employee of your health care provider

Or

2) a notary public

If I have an Advance Directive in one state, will it be followed in a different state?

Yes. Under Nebraska law an Advance Directive that is properly prepared according to another state's laws may be honored in Nebraska.

What do Advance Directives NOT include?

1) A Living Will is not the same as a Last Will and Testament.
2) Power of Attorney for Health Care is not the same as Power of Attorney for financial issues.
3) A Living Will is not the same as "Do Not Resuscitate" (DNR) order. A DNR is generated only by a physician order at your request.

How do I make my wishes known regarding organ and tissue donation?

You may request a donor card and make your wishes known to your family.

What should I do with my Advance Directive if I choose to have one?

If you have a Living Will or Power of Attorney for Health Care, give a copy to a family member, your doctor, and your representative, if you have named one.

Tell your doctor to make the Advance Directive part of your permanent record. Keep the original of your Advance Directive in a safe place where it can easily be found by others if it is needed. If you ever need to go into the hospital, you should bring a copy of your Advance Directive with you.

Additional Resources

Nebraska Department of Health & Human Services
State Unit on Aging
P. O. Box 95026
Lincoln NE 68509-5026

Toll Free Phone: (800) 942-7830
Local Phone: : (402) 471-2307
Email: DHHS.Aging@Nebraska.gov
Facebook: https://www.facebook.com/NebraskaSUA

http://dhhs.ne.gov/medicaid/Aging/Pages/ElderRights.aspx

Nebraska Hospice and Palliative Care Association

http://www.nehospice.org/

NEBRASKA Advance Directive
Planning for Important Health Care Decisions

www.caringinfo.org

Nebraska Hematology Oncology NHO

Dear New Patient,

In an effort to ease some of the administrative requirements associated with your first visit in our office, we have enclosed a packet of forms to fill out at home. After completed, please return these forms in the envelope provided. Here is a checklist of the forms and a short explanation:

- ❑ **Registration form:** Please complete all items. Please bring your insurance cards as we will need to photocopy them.

- ❑ **Health History Questionnaire:** Please fill out completely as this will assist us in your total care. Please provide all medications you are taking and be sure to include any herbs and vitamins as well. If you are unsure about any of the medications, please bring them with you.

- ❑ **My Care Plus Patient Portal Information and Consent Form.** Please complete the Email Authorization Form for the patient portal. Sign and return.

- ❑ **Financial Policy:** This is your acknowledgment that you understand our billing procedures and that you are ultimately responsible for any balance due on your account.

- ❑ **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 and retain for your records.

- ❑ **Acknowledgement of Receipt of Notice of Privacy Practices**
  Please sign and return.

Thank you for taking the time to review and complete these forms prior to your appointment.

Sincerely,

Physicians and Staff

Nebraska Hematology Oncology NHO

Financial Policy

At Nebraska Hematology-Oncology, P.C., our experienced administrative support staff will help you manage your insurance and other paperwork details. Please understand that payment of your bill is part of your treatment. The following is a statement of our Financial Policy, of which we require that you read and sign.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will submit claims to your insurance plan for you, as long as the most current and accurate information is provided. Please be aware that some of the services provided may be non-covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, ultimately are responsible for payment of all services provided by our Care Center. Please note that copays specified by your insurance plan are due at time of service.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the most appropriate 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.

CREDIT POLICY: Accounts are due and payable as of the date billed. We realize it may be necessary on occasion to make payment arrangements. If financial difficulties arise, please contact our Patient Accounts department as soon as possible.

If an account becomes past due with no valid reason or communication from you, or if your statements are returned to us in the mail with no forwarding information, necessary action will be taken to recover the account balance due.

Our patient Account department is available to discuss any questions you may have regarding your insurance or your account. They can be reached through our main number at 402-484-4900.

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

_____ Date: _____

Signature of Patient or Responsible Party

For your convenience we accept cash, checks, Visa, MasterCard and Discover

Nebraska Hematology Oncology NHO
4004 Pioneer Woods Drive Lincoln, NE 68506
YourCancerCare.com
Phone: 402.484.4900
Fax: 402.484.6456

PATIENT INFORMATION DATA SHEET

Today's Date: _____

ALL INFORMATION IS ESSENTIAL PLEASE DO NOT LEAVE ANY FIELDS BLANK

Name: _____ DOB: ___/___/_____ SS#: _____-_____-_____

Gender: **M / F** **Email Address:** _____ Marital Status: _____

Please print: (*Email needed for test results and important information*)

What is your Preferred Language: _____

What is your Race: _____ ☐ Declined

What is your Ethnicity: Are you of Hispanic or Latino origin? ☐ Yes ☐ No ☐ Declined or Unknown

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: Home: [ ] _____ Work: [ ] _____ Cell: [ ] _____

May we leave a message regarding appointment information? Y / N

Preferred Method of Contact: [ ]Home Phone [ ]Cell Phone [ ]Work Phone

Your Employer: _____ If Retired, Date of Retirement: _____

Primary Care Physician: _____ Referring Physician: _____

EMERGENCY CONTACT	Phone	Relationship	OK to release information to?
_____	( ) _____	Spouse Child Other_____	Y / N
_____	( ) _____	Child Other _____	Y / N
_____	( ) _____	Child Other _____	Y / N

HEALTH INSURANCE INFORMATION

Please provide us with your insurance card so we can make copies for your chart.

	Employee Name		SS#	DOB	Employer		Relationship
Primary:	_____	_____	___/___/_____	___/___/_____	_____	Self	Spouse / Parent
Secondary:	_____	_____	___/___/_____	___/___/_____	_____	Self	Spouse / Parent
Tertiary:	_____	_____	___/___/_____	___/___/_____	_____	Self	Spouse / Parent

ATTN: Medicare Patients: If you are covered with Group Insurance through an employer that you or your spouse are NOW RETIRED FROM, then list Medicare as Primary and the Group Plan as Secondary. If you're employed full-time, then the group plan would be Primary and Medicare would be Secondary.

****Do you have Prescription Coverage: Y/N: Please provide us with a copy of your prescription insurance card**

Is it: _____ Medicare Part D or _____ Group or Individual Plan or _____ VA only or _____None

I realize that the responsibility for all medical expenses is mine and any dispute with the insurance company is not reason for nonpayment of this account. My signature below will authorize the release of any medical or other information necessary to process my claims. I also authorize all payment of medical benefits to Nebraska Hematology-Oncology, P.C. for all claims on my behalf.

Signature: _____ Date: _____

It is mutually agreed that a photographic copy of this signature shall be as valid as the original.

REQUIRED QUESTIONS TO BE ANSWERED BY ALL MEDICARE PATIENTS

ARE YOU A VETERAN?	Y / N	IS THIS MEDICAL CONDITION DUE TO AN ACCIDENT OF ANY KIND?	Y / N
DID THE VA REFER YOU HERE FOR TREATMENT?	Y / N	IF YES, WAS IT RELATED TO: ☒WORK ☒AUTO ☒HOME ☒OTHER	
DO YOU HAVE A VA FEE BASIS ID CARD?	Y / N	ARE YOU COVERED BY AN EMPLOYER'S HEALTH INSURANCE PLAN	
DO YOU HAVE A FEDERAL BLACK LUNG CARD?	Y / N	THROUGH YOUR OWN EMPLOYMENT OR THAT OF A FAMILY MEMBER (NOT RETIREE COVERAGE)?	Y / N

Nebraska Hematology Oncology NHO

4004 Pioneer Woods Drive
Lincoln NE 68506
Phone: (402) 484-4900

www.YourCancerCare.com
Fax: (402) 484-6456

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____ **ETHNICITY:** _____ **GENDER:** M F

OCCUPATION: _____ **REASON FOR VISIT TODAY:** _____

PRIMARY CARE PHYSICIAN: _____ **REFERRING PHYSICIAN:** _____

PREFERRED PHARMACY: _____

Please list all medications (including prescription, non-prescription, vitamins and herbal) you are currently taking (if your list is lengthy, you may provide us with a copy of all of your medications):

Name of Drug	Drug Dosage	Reason for use	Prescribed by:	Date Drug started

Please list any drug/food allergies you have and the type of reaction you have to that medication/food:

Name of Drug/food Allergy	Type of Reaction

Please list any operations and/or procedures you have had and the year that you had them:

Type of Operation/Procedure	Year of Operation/Procedure

Please list any diseases/conditions you currently have or have had in the past:

Disease/condition	Current condition or Resolved	Type of Treatment

Date of last mammogram (if applicable): _____

Date of last colonoscopy (if applicable): _____

Date of last Pap Smear/Pelvic Exam (if applicable): _____

Date of last Bone Density (if applicable): _____

Immunizations: please fill in the year: Influenza: _____ Pneumovax: _____ Tetanus/TDAP: _____

Patient Name: _____

SOCIAL HISTORY:

SUBSTANCE	CURRENT USE	TYPE	AMOUNT/DAY	YEAR/AGE STARTED	YEAR/AGE QUIT
Tobacco Use	YES/NO	Smoke/chew	Packs:		
Alcohol Use	YES/NO	Beer/wine/ hard alcohol	Drinks:		
Drug Use	YES/NO	Ex: marijuana, heroin, cocaine, etc.			
Caffeine Use	YES/NO		Drinks:		

FAMILY HISTORY: In the section, "other significant diseases," include the following diseases/conditions if the family member has/had the disease/condition: Alzheimer's, Anemia, Arthritis, Asthma, Birth defect, bleeding disorder, Diabetes, Down's syndrome, Heart disease, Hypertension, Kidney Disease, Mental condition, Muscle disease, Neurologic Disorder, Respiratory disorder, Seizures/epilepsy, or skin disorder.

FAMILY	GENDER	L-Living or D-Deceased	Current Age or birthdate	Age at death	Cancer Diagnosis	Age at Diagnosis	Other significant diseases
Father							
Mother							
Sibling	M F						
Sibling	M F						
Sibling	M F						
Sibling	M F						
Maternal Grandmother	M F						
Maternal Grandfather	M F						
Maternal Aunt	M F						
Maternal Uncle	M F						
Paternal Grandmother	M F						
Paternal Grandfather	M F						
Paternal Aunt	M F						
Paternal Uncle	M F						
Niece/Nephew	M F						
Niece/Nephew	M F						
Child	M F						
Child	M F						
Child	M F						
Child	M F						
Child	M F						

Patient Name: _____

HAVE YOU EXPERIENCED THE FOLLOWING?

GENERAL:		Yes/No	COMMENTS/DESCRIPTION:
	Fatigue		
	Fever/night sweats		
	Difficulty with bathing/showering		
	Difficulty with dressing		
	Difficulty with walking/stair climbing		
	Difficulty with meal preparation		
	Confined to bed/chair more than 50% of day		
EYES:			
	Visual changes/double vision		
	Eyes yellow		
ENT:			
	Decreased hearing		
	Ringing in ears		
	Nose bleeds/nasal discharge		
	Hoarseness		
	Sores/white patches in mouth		
	Dental Problems		
	Thyroid Problems		
HEART:			
	Chest pain		
	Ankle swelling		
	Heart problems		
	Blood Clots		
	Irregularity/skipped beats		
LUNGS:			
	Shortness of breath		
	Cough with or without blood		
	Wheezing		
	Pulmonary Embolus		
GI-GASTROINTESTINAL:			
	Constipation		
	Diarrhea		
	Dietary Intake changes		
	Dietary restrictions		
	Fluid Intake changes		
	Heartburn		
	Nausea/vomiting		
	Trouble swallowing		
	Vomit blood		
	Weight changes (loss/gain)		
	Weight changes (intentional/non-intentional)		
PAIN			
	Currently experiencing pain		
	Pain Intensity 1-10		
	Pain Location		

PATIENT NAME: _____

HAVE YOU EXPERIENCED THE FOLLOWING?

GU-GENITOURINARY		Yes/No	COMMENTS/DESCRIPTION:
	Blood in urine		
	Up at night to urinate		
	Loss of bladder control		
	Kidney stones		
SKIN			
	Rash		
	Skin itching		
	Yellow skin (jaundice)		
	Bruising		
NEUROLOGICAL			
	Numbness/tingling		
	Headache		
	Dizziness		
	Weakness		
	Seizure		
PSYCHIATRIC			
	Anxiety		
	Depression		
	Insomnia		
	Mental Health Disorder		
ENDOCRINE			
	Diabetes		
	Heat/cold intolerance		
	Thyroid problems		
LYMPH			
	Lumps or bumps		
HEMATOLOGY			
	Bleeding problems		
	Anemia		
	Blood Transfusion history		
MUSCULOSKELETAL			
	Muscle Weakness		
	Gait (walking) problems		
REPRODUCTIVE/SEXUAL			
	Changes in sexual desire		
	Painful Intercourse		
	Erectile dysfunction (males)		
	Capable of Reproduction		
	Fertility Preservation concerns		
	Birth control (if yes-what method)		Method:
WOMEN:	Vaginal Discharge or bleeding		
	Hot flashes		
	Breast- lumps		
	Menstrual Period-date of LMP		
	Post-menopausal		
	Hysterectomy		

Nebraska Hematology Oncology NHO

Cancer Insurance Policies:

We will send your cancer insurance carrier the itemized statement detailing the charges for the date(s) of treatment. Cancer policy statements are sent on a monthly schedule after the close of the billing cycle. If you would prefer to send in your own statements, we will print it for you and you will be able to pick it up at your convenience.

In order to file your claims we need you to provide our office with your cancer insurance company's information, including:

Name:
Mailing Address:
Phone number:
Fax number:
Policy Number:

Work Release/Return to Work Note

Please check with your employer to determine if you will need a work release for the time taken off for your appointments. If so, please check to see if there is a specific form required for your place of employment. We can provide a basic work release/return to work note for you upon request, but please give us prior notice as this cannot be completed the same day as requested.

FMLA

When a Family Medical Leave Act (FMLA) form is required by your employer, a signed release of records authorization needs to be executed and on file before the information can be released. We request 7-10 business days to complete these forms. **Please note: there is a $5 pre-paid fee for completion of all FMLA, Disability and Cancer forms.**

Disability Insurance

When a disability insurance form is required from your employer or through their disability insurance company, a signed release of records authorization needs to be executed and on file before the information can be released. We request 7-10 business days to complete these forms. **Please note: there is a $5 pre-paid fee for completion of all FMLA, Disability and Cancer forms.**

Cancer Insurance Forms

Cancer insurance forms can be brought into our office after you have received a confirmed diagnosis. We will fill out the physician section and provide you with the necessary notes, itemized statements HCFA 1500 forms, and pathology reports. A signed release of records authorization needs to be executed and on file before the information can be released. We request 7-10 business days to complete these forms. **Please note: there is a $5 pre-paid fee for completion of all FMLA, Disability and Cancer forms.**

Effective Date: April 14, 2003. Revised: 2010 2011 2013 2015

PATIENT 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.

A. How This Medical Practice May Use or Disclose Your Health Information:

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describe your rights and our obligations regarding the use and disclosure of that information. A copy of our current notice will always be posted in our reception area. You will also be able to obtain your own copies by accessing our website at YourCancerCare.com, calling our office at 402.484.4900 or asking for one at the time of your next visit.
If you have any questions about this notice, please contact Amy King, Privacy Officer at 402.484.4900.

IMPORTANT SUMMARY INFORMATION:
Requirement for Acknowledgment of Notice of Privacy Practices. We will ask you to sign a form that will serve as an acknowledgment that you have received this Notice of Privacy Practices.

This medical practice collects health information about you and stores it in a in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our Business Software Vendor, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Identification for services. We may use and disclose medical information about you by having you wear a patient name badge when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your

did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

1. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes To This Notice Of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment: We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Office of Civil Rights OCRMail@hhs.gov

The complaint form may be found at: www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.

Nebraska Hematology Oncology NHO

Thank you for choosing our office to provide you with your specialized medical needs. Your concerns are very important to us and we want to assure you that it is our intent to give you the best care possible for your medical condition. In an effort to assist you with questions that you may have once you return home, we are providing you with this informative tool.

- Our office hours are Monday through Thursday, 8:00am to 5:00pm and on Fridays from 8:00am to 3:00 pm.

- If you are in need of medical advice after our office is closed, dial **484-4900** and our answering service will pick up your call. They in turn will take your message and contact the physician on call for that day. Please be aware that after hours a physician other than the one you normally see in our office may return your call.

- **FOR ALL LIFE THREATENING EMERGENCIES, DIAL 911.**

- To make an appointment or to inquire about an existing appointment, please call our office at **484-4900** and ask to speak to someone in scheduling.

- When arriving for an appointment, please arrive 15-20 minutes early if you are also scheduled to have lab drawn.

  The Physicians and Staff will do all that we can to stay on schedule. At times, however, there are patients that need to be worked into the schedule on an emergent basis or who come in for a regularly scheduled appointment, and have developed complications that require more of the physicians' time than we allowed for. We ask for your patience in these situations and we will do our best to communicate these delays. We also appreciate the frustration of excessive waiting times, so if you have waited more than 20 minutes for your scheduled appointment, and have not had communication with our staff, please check with the front desk.

- If you have had routine labs drawn, it is not our policy to call you with the results unless they are abnormal. Therefore, if you do not hear from us, do not worry.

- Prescription refills should be done through your pharmacy, Monday through Thursday. It is best not to wait until Friday, as it is very difficult to fill prescriptions over the weekend. The pharmacy will call us with the proper information that we need in order to authorize your refill. If your refill requires a written prescription each time, you will need to call our pharmacy line at **484-4902** and leave a message. This voice mail is checked frequently throughout the day.

  ALL REFILLS REQUIRE A MINIMUM OF 24 HOURS NOTICE. We do not want anyone to go without their necessary medication, so please allow 24 hours for our office to take care of your refill needs. It takes time for your pharmacy to contact our office, for our staff to discuss your request with the physician and for us to call your pharmacy back or to have the signed, written prescription ready for you to pick up.

In addition, please be aware that our office is closed for the following holidays: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving, and Christmas Day. Please make sure you have enough of your prescriptions to get through the holiday.

- Our nurses receive a large volume of phone calls each day. If you call our office for a non-urgent matter and the nurse is not available, we ask that you leave a message on their voicemail. They check this at least every hour and return ALL calls by the end the day. It is very important you provide us with the most appropriate phone number to reach you and if you give your permission, we can leave routine information about refills and appointments, on your voice mail for your convenience. Any messages left for our staff or physicians after 4:00 pm may not be returned until the following day.

- For urgent calls, dial **484-4900** and make sure you convey the urgency of your call to the receptionist. **FOR ALL LIFE THREATENING EMERGENCIES, DIAL 911**.

- We will make every attempt to assist you with insurance requirements prior to services being rendered. Ultimately however, it is your responsibility to verify that referrals and authorizations have been taken care of. Consequently, it is in your best interest to apprise us of all insurance changes promptly.

- If you have insurance forms, such as for disability, that requires some portion of it be completed and signed by your physician, please bring them with you to your next appointment. Make sure all information required by the patient has been completed. We receive many requests of this nature and will do our very best to return them to you in a timely fashion. *There may be a fee associated with this service.*

- Some insurance companies have restrictions on the brand of medication prescribed. If you have any formulary guidelines imposed by your insurance coverage, it is your responsibility to bring that list of accepted drugs at the time of your appointment.

- You will need to check in with the Front Desk each visit so that we may verify that you have not had any changes since your last visit, i.e. address, phone, insurance changes etc. From time to time we will ask you to complete updated demographic information sheets and obtain current copies of your insurance cards. We appreciate your cooperation with this request.

- Co-pays are required to be paid at the time of service.

If you find that other information would have been helpful to you, please let us know so that we may consider adding that information to future printings.

Mark R. Hutchins, MD • Eric J. Avery, MD • Joni A. Tilford, MD • Madhu V. Midathada, MD • Kailash Mosalpuria, MD
4004 Pioneer Woods Drive • Lincoln, NE 68506 • 402.484.4900 • Fax 402.484.6456 • www.YourCancerCare.com

Nebraska Hematology Oncology
NHO
4004 Pioneer Woods Dr., Lincoln, NE 68506 | 402.484.4900 | toll free: 877.436.3662 | www.YourCancerCare.com

NOTICE OF NONDISCRIMINATION

Nebraska Hematology-Oncology, P.C. (NHO), complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Nebraska Hematology-Oncology, P.C., does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Nebraska Hematology-Oncology, P.C.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters

If you need these services, contact NHO's Compliance Officer:

If you believe that Nebraska Hematology-Oncology, P.C., 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:

Compliance Officer, Administrator:
4004 Pioneer Woods Drive Lincoln NE 68506,
Phone:(402) 484-4900 ,
Fax: (402) 484-6456, or
Email: AKing@yourcancercare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, NHO's Compliance Officer, 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.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-402-484-4900

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-402-484-4900

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-402-484-4900

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-402-484-4900.

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 402-484-4900

unD (Karen)
ဟ်သူဉ်ဟ်သး- နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ် ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စုၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး
1-402-484-4900

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-402-484-4900

Oroomiffa (Oromo)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-402-484-4900

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-402-484-4900

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-402-484-4900

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-402-484-4900

नेपाली (Nepali)
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-402-484-4900

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-402-484-4900

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫ ຼືອ ດ້ານພາສາ, ໂດຍບໍ່ເສັ ຽຄ່າ, ແມ່ ນມີ ພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1-402-484-4900

کوردی (Kurdish)
ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1- 402-484-4900

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-402-484-4900تماس بگیرید.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-402-484-4900

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Nebraska Hematology-Oncology, P.C.

Patient Name: _____ _____

Patient DOB

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name Personal Representative (*if signing for patient)*

_____

Description of Personal Representative's Authority