ELHAMY D. ESKANDER, M.D., F.A.C.P. MARK G. GOLDSTEIN, M.D. BRIAN M. O'CONNOR, M.D.
MICHELLE MILLER, R.N. PATRICIA A. RICE, C.R.N.P., O.C.N.
(301) 662-8477 FAX (301) 662-4293

Dear Patient:

We have attached several forms to this letter, which you will need to complete. They are:

OCC Registration Form, pages 1 & 2
Authorizations for Release of Information and Benefits Assignment
Acknowledgement of Receipt of Privacy Practices Notice

Please bring the completed forms and your **Insurance Cards** with you on the day of your appointment.

Please arrive for your appointment 30 minutes early, so that we can complete the registration process.

Please have your medical records forwarded to our office 3 days prior to your appointment. **In addition, please bring all your medications in their original containers.**

If you are a member of an **HMO** that requires a **referral** from your primary care doctor, **please bring the completed referral form** with you to your appointment**.** Without an appropriate referral, we may have to reschedule your appointment.

If you have any questions about your appointment, or if we can be of any further assistance, please do not hesitate to call the Receptionist at **(301) 662-8477.**

Welcome to Oncology Care Consultants. We look forward to meeting you soon.

FMH REGIONAL CANCER THERAPY CENTER 501 WEST SEVENTH STREET SUITE 1A FREDERICK, MD 21701

WELCOME

TO

ONCOLOGY CARE CONSULTANTS

SPECIALIZING IN

MEDICAL ONCOLOGY

AND

HEMATOLOGY

Clinical Staff:

Elhamy D. Eskander, M.D., F.A.C.P.
Mark G. Goldstein, M.D.
Brian M. O'Connor, M.D.
Michelle Miller, R.N.
Patricia A. Rice, MSN, C.R.N.P., O.C.N.

Location:

Frederick Memorial Hospital
Regional Cancer Therapy Center
501 West 7th Street, Suite 1A
Frederick, MD 21701-4507
(301) 662-8477
(301) 662-4293 FAX
www.cancercarefrederick.com

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Oncology Care Consultants is located in Frederick, Maryland, and specializes in Medical Oncology (cancer care) and Hematology (blood disorders). Its President, P. Gregory Rausch, M.D., F.A.C.P., founded the practice in 1979. Dr. Brian O'Connor joined the practice in 1991. Dr. Elhamy Eskander and our nurse practitioner, Patricia Rice, both joined the practice in 1996. Dr. Mark G. Goldstein, our newest physician, joined the practice in 2009.

Dr. Brian M. O'Connor **was born in Washington, D.C., received a Bachelor of Arts from the University of Notre Dame, and performed his premedical studies at George Washington University in Washington, D.C. He attended medical school at the University of Chile and served a Family Medicine internship and residency at the Deaconess Hospital in Buffalo, N.Y., an Internal Medicine residency at the State University of N.Y., and a Hematology/Medical Oncology fellowship at State University of N.Y. Institutions including the Roswell Park Cancer Institute. Dr. O'Connor is a member of the American College of Physicians, the American Society of Hematology, and the American Society of Clinical Oncology. He is board certified by the American Board of Internal Medicine in Medical Oncology, Hematology, and Internal Medicine.**

Dr. Elhamy D. Eskander **received his medical degree from Cairo University. He is a Clinical Assistant Professor of Medicine at the Penn State University College of Medicine. He completed his fellowship training in Hematology/Medical Oncology at Penn State University College of Medicine. He completed his residency in Internal Medicine at Conemaugh Memorial Hospital in affiliation with Temple University School of Medicine. Prior to that, he did cancer research and a residency in Pathology at the University of Pittsburgh. He is a Fellow of the American College of Physicians, and he is a member of the American Society of Clinical Oncology and the American Society of Hematology. He is board certified by the American Board of Internal Medicine in Medical Oncology, Hematology, and Internal Medicine.**

Dr. Mark G. Goldstein **was born in Atlanta, Georgia and received his Bachelor of Science in Genetics at the University of Georgia. He completed medical school at St. George's University. He then completed internship and residency in Internal Medicine at the University of Connecticut where he received commendations for excellence in patient care. Dr. Goldstein stayed at the University of Connecticut for fellowship training in Hematology and Oncology. During this time he also received additional training in bone marrow transplantation at Yale University.**

Dr. Goldstein is a registered investigator with the National Cancer Institute. He is Board Certified by the American Board of Internal Medicine in Internal Medicine, Hematology,

and Medical Oncology. Dr. Goldstein is a member of the European Society of Medical Oncology, the American Society of Clinical Oncology, the American Society of Hematology, the American College of Physicians, and the Maryland/DC Society of Clinical Oncology.

Our *Nurse Practitioner, Patricia Rice*, was born in Detroit, Michigan. She received a Bachelor of Science degree in nursing from Catholic University of America in Washington, D.C., and a Masters of Science in nursing from the University of Maryland at Baltimore. She is certified as an adult nurse practitioner, a certified oncology nurse, and a certified clinical research professional. Ms. Rice has a special interest in genetics and hereditary cancers and heads up our Cancer Risk Assessment Program. She is a member of the Nurse Practitioner Association of Maryland and the Oncology Nursing Society.

LOCATION

Oncology Care Consultants is located at 501 West Seventh Street in the Frederick Memorial Hospital Regional Cancer Therapy Center. The office complex comprises 12,000 square feet, contains five private consultation offices, and fourteen examination rooms. The office is fully handicapped accessible and English, Spanish, Arabic, and American Sign Language are spoken.

TREATMENT

Chemotherapy treatments are delivered in the Intravenous Therapy Center of the Regional Cancer Therapy Center. This is an outpatient clinic sponsored by Frederick Memorial Hospital, which provides a full range of chemotherapy services, as well as outpatient antibiotic therapy, blood product support, continuous infusion chemotherapy, and sophisticated pain control modalities with continuous infusion of morphine and other agents. Dr. Rausch serves as the Medical Director of this program, and third party payers are billed directly by the hospital for the cost of drug administration and drug formulation.

CLINICAL TRIALS

Oncology Care Consultants participates with the National Surgical Adjuvant Breast Program (NSABP) and the Eastern Cooperative Oncology Group (ECOG) – two major research organizations. Because of these affiliations, the practice offers its patients state-of-the-art therapy through participation in various clinical trials for cancer. In recognition of this work, Oncology Care Consultants was awarded the prestigious Clinical Trials Award by the American Society of Clinical Oncology in 2003. The practice is one of only nine practices in the United States so honored. Shelley Francella is the Research Nurse and can be reached at (301) 668-7043 or via email at *clinicaltrials@fmh.org*

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I hereby acknowledge that I have received a copy of Frederick Memorial Healthcare Systems' Notice of Privacy Practices. I have also received a copy of Oncology Care Consultants' Medical Record Policy.

Signed: ____ **Date:** ____________

Printed Name: __________________________________**Telephone:** ___________

If not signed by the patient, please indicate:

Relationship:

_____ Parent or guardian of minor patient
_____ Guardian or conservator of an incompetent patient
_____ Beneficiary or personal representative of deceased patient

Name of Patient: ____

****

For Office Use Only:

_____ Signed form received by: _____________________________________

_____ Acknowledgement refused: ___________________________________

Efforts to obtain: ____

____

Reasons for refusal: ____

____

____

Staff Signature: ____

FMH Regional Cancer Therapy Center 501 West Seventh Street Suite 1A Frederick, MD 21701

Frederick Memorial Healthcare System
Affiliated Physician Groups:

Parkview Medical Group
Oncology Care Consultants
Union Bridge

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.

Effective Date: April 14th, 2003

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal and are committed to protecting your medical information. We create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or received by us.

We are required by law to:

- Make sure that medical information that identifies you is kept private, and will be used or disclosed only as described by this Notice or applicable law;
- Make this Notice available to you; and
- Follow the terms of the Notice that is currently in effect.

2. CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our offices and on our website: www.fmh.org.

3. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose your medical information. For each category of uses or disclosures, we will give some examples. Not every use or disclosure in a category will be listed.

a. For Treatment. We will use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other office personnel who are involved in taking care of you. For example, we would disclose your health information, as necessary, to a home health agency that provides care to you. We also may disclose medical information about you to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

b. For Payment. We will use and disclose medical information about you so that the treatment and services we provide may be billed to and payment may be collected from you, an insurance company, a governmental entity such as Medicare or Medicaid, or a third party. For example, we may need to give your health plan information about treatment we provide so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment or hospital admission. We may also have to send your information to more than one health plan in circumstances where it is not clear which health plan has the responsibility to pay for your care.

c. For Healthcare Operations. We will use and disclose medical information about you for our operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other office personnel for review and learning purposes. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

d. Treatment Alternatives. We may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

e. Health-Related Benefits and Services. We may use and disclose your medical information to tell you about health-related benefits or services that may be of interest to you.

f. Reminders. We may use and disclose medical information about you to contact you in an effort to provide appointment reminders for medical care.

g. Research. Under certain circumstances, we will use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process that takes into account patients' need for privacy.

h. Business Associates. We contract with business associates to provide some services. Examples may include medical billing and transcription services. When these services are contracted, we may/will disclose your health information to our business associate so that they may perform the job we have asked them to do. To protect your health information however, we require the business associate to appropriately safeguard your information.

i. As Required By Law. We will disclose medical information about you when required to do so by federal, state, or local law.

j. To Avert a Serious Threat to Health or Safety. We will use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

k. Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. *Except in emergency situations, you may object to the uses and disclosures described in this Section k, either in general or to any specific person or persons to whom your medical information might otherwise be disclosed.*

l. Special Situations. We will use and disclose medical information about you:

- To facilitate organ and tissue donation.
- For specialized governmental functions, including the military and veterans, national security, criminal corrections and public benefit purposes.
- For Workers' Compensation or similar programs, as permitted by law.
- For public health activities.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.
- For health oversight activities including, for example, audits, investigations, inspections, and licensure.
- For lawsuits and disputes, we will disclose medical information about you in response to a valid court or administrative order or in the course of defending ourselves.
- For law enforcement purposes when asked to do so by a law enforcement official.
- To coroners, medical examiners, and funeral directors as necessary to assist them to carry out their duties.
- To correctional institutions or law enforcement officials with respect to inmates.

m. Written Authorization. Except as described above, we will disclose your medical information only with your prior written authorization. You may revoke that authorization, in writing, at any time, unless we have taken action relying on your prior authorization or if you signed the authorization as a condition of obtaining insurance coverage.

4. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

a. Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes and other mental health records under certain circumstances.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy medical information in certain very limited circumstances, including requests by an inmate at a correctional institution, requests for information we obtained from someone else subject to certain confidentiality agreements, and some requests concerning ongoing research projects. If you are denied access to medical information for any other reason, you may request that the denial be reviewed. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

b. Request to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, please submit a written request to our Privacy Officer with a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by us;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

If we deny your request, you may submit a written statement disagreeing with the denial. We will keep your statement on file and distribute it with all future disclosures of the information to which it relates.

c. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures of medical information about you, with exceptions. We do not need to account for disclosures made: (i) to you; (ii) pursuant to your written authorization; (iii) for the purpose of carrying out treatment, payment or operations; (iv) to persons involved in your care, or to notify your family or friends about your whereabouts; (v) that are incidental to another permissible use or disclosure; (vi) for national security or intelligence purposes; (vii) to correctional institutions or law enforcement officers who had you in custody at the time of the disclosure; (viii) as part of a limited data set; or (ix) to a health oversight agency or law enforcement official if they so request. The accounting will include the date of each disclosure, the name of the entity or person to whom the disclosure was made and that person's address (if known), and a brief description of the information disclosed together with the purpose of the disclosure.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example: on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

d. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us (i) what information you want to limit; (ii) whether you want to limit our use, disclosure, or both; and (iii) to whom you want the limits to apply, for example, disclosures to your spouse.

e. Right to Confidential Communications. You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. All reasonable requests will be granted. Contact our Privacy Officer if you require such confidential communications.

f. Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice by requesting a paper copy from our Privacy Officer in writing.

5. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint to:

Health Information and Privacy Office
400 West 7th Street
Frederick, Maryland 21701
240.566-3884

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights, Huber H. Humphrey Bldg.
200 Independence Ave., S.W. Room, 509F HHH Bldg.
Washington, DC 20201
or
www.os.dhhs.gov/ocr/contact.html

You will not be penalized for filing a complaint.

REGISTRATION FORM

PATIENT INFORMATION:

Name: ____

Age: _____ **Date of Birth:** ___________ **Soc Sec #:** ____________________ **Sex:** ___ M ___F

Race: ____ African American ____ Asian ____Caucasian ____ Hispanic ____Other

Address: ____
Street City St Zip

Home Phone: _________________ **Work Phone:** ________________ **Cell Phone:** ________________

Employed: ____ Fulltime ____ Part-time _____ Self-employed _____ Active Military

____ Not Employed ____ Disabled _____ Retired **Student:** ____ Fulltime ____Part-time

Employer Name & Address: ____

SPOUSE INFORMATION:

Name: ___________________________ **Date of Birth:** ________ **Soc Sec #:** _________________

Address: ____

Home Phone: ________________ **Work Phone:** _________________ **Cell Phone:** ______________

Employed: ____ Fulltime ____ Part-time _____ Self-employed _____ Active Military

____ Not Employed ____ Disabled _____ Retired **Student:** ____ Fulltime ____Part-time

Employer Name& Address: ____

NEXT OF KIN OR OTHER PERSON TO CALL IN CASE OF EMERGENCY:

Name: ______________________________________**Relationship to Patient:** ____________________
Address: ____
Home Phone: _________________________**Work Phone:** ____________________________________

PHYSICIAN INFORMATION:

Family Doctor: ___________________________
Address: ___________________________________
Phone: ____________________________________

Surgeon: __________________________________
Address: ___________________________________
Phone: ____________________________________

Other Physicians: ____
____

PLEASE LIST ALL ALLERGIES YOU MAY HAVE:

____
____

INSURANCE INFORMATION

Primary Insurance Carrier:

Name of Ins Co: ____

Claims Address: ____

Name of Policyholder: ____________________________ Policyholder's Date of Birth: ________

Policy Identification #: __________________ Group Name and/or #: _____________________

Policyholder's Soc Sec number:___________________________ Copay Amount:____________

Secondary Insurance Carrier:

Name of Ins Co: ____

Claims Address: ____

Name of Policyholder: ___________________________ Policyholder's Date of Birth: _________

Policy Identification #: ___________________ Group Name and/or # :____________________

Policyholder's Soc Sec number:_________________________ Copay Amount:______________

Third Insurance Carrier:

Name of Ins Co:____

Claims Address:____

Name of Policyholder:__________________________Policyholder's Date of Birth:_________

Policy Identification #:______________________ Group Name and/or #:__________________

Policyholder's Soc Sec number:_________________________ Copay Amount:_____________

Coordination of Benefits:

1. Are you currently actively employed? ______ Yes ______ No
2. If employed, does your employer have fewer than 20 employees? ______ Yes ______ No
3. If you are not actively employed, are you disabled? ______ Yes ______ No
4. On what date did your disability commence? ___________________________________
5. If you are disabled and you are covered by a group health plan, does the employer have fewer than 100 employees? ______ Yes _____ No

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AUTHORIZATIONS FOR RELEASE OF INFORMATION AND BENEFITS ASSIGNMENT

MEDICARE PATIENT'S AUTHORIZATION:
I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration/HCFA or its intermediaries or carriers any information needed to determine benefits payable for this or a related Medicare claim. I assign the benefits payable to Frederick Memorial Hospital d.b.a. Oncology Care Consultants or authorize Frederick Memorial Hospital d.b.a. Oncology Care Consultants to submit a claim to Medicare for payment to me. I understand that I may be responsible for the Part B deductible each year, the remaining 20% of reasonable charges, and any personal charges incurred.

____

Patient's or Authorized Representative's Signature **Medicare #** **Date**

PATIENT AUTHORIZATION:
I authorize Oncology Care Consultants to release any medical or other information necessary to process this claim. I also authorize payment of health insurance benefits be made either to me or on my behalf to Frederick Memorial Hospital d.b.a. Oncology Care Consultants.

____

Patient's Signature (if minor-parent or legal guardian) **Date**

INSURED'S AUTHORIZATION:
I authorize payment of medical benefits directly to Frederick Memorial Hospital d.b.a. Oncology Care Consultants for services rendered by Oncology Care Consultants to the patient listed above.

____

Signature Primary Insured/Policyholder **Date**

____

Signature Secondary Insured/Policyholder **Date**

FINANCIAL AGREEMENT:
I agree that, in consideration of the services to be rendered to myself, the patient, I will pay my outstanding account. In addition, if Frederick Memorial Hospital d.b.a. Oncology Care Consultants is not under contract with my insurer or payer, the bill may be applied to my out-of-network benefits, in which case I will be responsible for deductibles and/or coinsurance payments.
Pre-certification: If pre-certification is required and not obtained by the physician or myself, I understand that I am responsible for the bill for services rendered by Frederick Memorial Hospital d.b.a. Oncology Care Consultants.

____

Patient/Guarantor Signature (If minor-parent or legal guardian) **Date**

____

Witness (FMH/OCC Employee) **Date**