Heartland Hematology & Oncology, P.C.
412 West 42nd Street Kearney, NE 68845
ph - 308-865-2303 fax – 308-865-2304

Patient: _____

Appointment Date and Time: _____

Please arrive 15 minutes early.

The physicians and staff of **Heartland Hematology & Oncology, P.C.** welcome you to our clinic. Your health and well-being are our primary concern. We hope the information provided here answers your questions about our services, policies, and procedures.

Physicians

Dr. Cynthia M. Lewis, **MD**, is a Board Certified Hematologist/Oncologist. She received her undergraduate degree from the University of Nebraska, Lincoln, and received her medical degree from the University of Nebraska Medical Center, Omaha. She completed her Hematology/Oncology Fellowship at the University of Nebraska Medical Center, Omaha.

Dr. Nick J. Hartl, MD, is a Board Certified Hematologist/Oncologist. He received his undergraduate degree from the University of Nebraska, Kearney, and received his medical degree from the University of Nebraska Medical Center, Omaha. He completed his Hematology/Oncology Fellowship at the University of Iowa Hospitals and Clinics, Iowa City, Iowa.

General Information

The clinic is open to serve you, answer your questions, or schedule an appointment **Monday through Friday from 8:00 am until 5:00 pm.** After hours, an on-call staff member is always available should you need care when the clinic is closed. By calling the main number, you will be given information regarding on-call staff.

Appointments

We will do our best to keep our appointment schedule. However, please understand that not all patients require the same amount of time with the doctor and that emergencies do occur, so some delays are unavoidable. We will do our best to keep you informed of delays. Your patience in these situations will be greatly appreciated.

History Information

Enclosed you will find forms that we ask you to complete. Please **return before/bring to** your appointment. If you are to return the forms, we have enclosed a return envelope for your convenience. This will enable our clinic to establish your file and gather necessary information to facilitate the appointment. Please fill out each form as completely as possible. Some forms do have questions on both the front and the back of the page.

Registration

On your first visit to **Heartland Hematology & Oncology, P.C.**, you will be asked for verification of basic information to complete your medical record and business account. **Please bring your current insurance cards and a photo ID at that time**. We also ask that you notify our office of any changes in name, address, phone number, or insurance coverage as soon as any change occurs.

Fees

Our charges for services are based on the severity and complexity of your illness or service need as required under federal guidelines. After discussion with you and a complete review of your medical records, a plan of care will be determined to best treat your individual needs. A financial representative will be pleased to discuss our fees with you. Please do not hesitate to inquire about the charges for our services.

Insurance
Our financial representative will submit primary and secondary insurance claims for you--subject to your having given us current insurance information prior to the service being provided. Policy coverage varies from one insurance plan to another, as do the "usual, customary and reasonable" fees that various insurance plans have established. Our fees are accepted by most plans, but occasionally one of our patients is notified that the amount for our service exceeds "UCR FEES". To avoid disappointment, we strongly suggest that patients contact their insurance company to make certain their medical insurance assumptions are correct. Pre-certification of any services, if required by the insurance company, is the responsibility of the patient. Contact our financial representative if you have any questions regarding pre-certification. Some patients have cancer insurance policies that will help to cover services provided. Please notify us with information regarding any cancer policy you may have so we can help facilitate these amounts toward payment of your bill. If at any time you are in need of a billing statement to send to a cancer insurance plan, please contact our financial representative.

Our contractual arrangement for payment of all services is with you, our patient, not your insurance company. Should there be a dispute related to the service provided or the charge for that service, the settlement of that dispute is between you and your insurance carrier. Our office is not involved in the settlement of such disputes. The final responsibility for payment of the services provided to you is yours.

Financial Arrangements
Charges are payable at the time of treatment or when service is provided. Regardless of your medical insurance coverage, our office relies on you to settle your account. In order that we may have a definite understanding regarding the payment of fees, please review the following:

A. Cash Payment Plan. Payment of the portion of the medical services your insurance will not cover (co-payment or deductible) is due and payable on the day the service is provided. Payment for these services may be paid by cash, personal check, debit or credit card (VISA or MasterCard).

B. Statement Plan. Payment of the balance **in full** upon receipt of your statement. Payment may be paid by cash, personal check, debit or credit card (VISA or MasterCard). Please contact a financial representative if you would like to authorize that monthly balances be charged to your credit card.

C. Personal Loan. For balance amounts you are unable to pay in full upon receipt of your statement, we ask that you make arrangements with a lending institution for a payment plan. After credit is approved, the lending institution will pay the balance due, and you may repay their loan over a period of months at prevailing bank rates.

D. Monthly Payment Plan. Arrangements can be made to have an automatic payment withdrawn from your checking account on the 28th of each month and sent directly to **Heartland Hematology & Oncology, P.C.** Please contact our financial representative to complete the paperwork.

If other arrangements are needed please talk to a financial representative PRIOR TO receiving service.

Patient Assistance
Several Foundations and drug companies are available to provide help to patients that qualify for assistance. This can include assistance with medications and insurance copays. Before treatment, our staff will check if you qualify for assistance and we help our patients through the process. If you have questions, please talk to our staff.

Workers Compensation
As a courtesy to our patients, our financial representative will file workers compensation claims. However, if the claim is denied, unsettled, or is not paid within 60 days from date of service, we request that you file a personal health insurance claim or pay the charges in full. You should always notify your company if there is any delay or problem in resolving your workers compensation claim. Unreasonable delays or the use of delaying tactics should be reported to the office of the Insurance Commissioner of Nebraska.

Thank You
We appreciate your selection of **Heartland Hematology & Oncology, P.C.** to meet your health care needs. We are committed to you to do the very best we can to provide you with the very best of care. Our staff—practitioners, nurses, technicians, clerical, and administrative—work as a team. We take great pride in our training, abilities, and dedication and hope you will soon share in our confidence. Your suggestions and comments are always welcome, and should you have any concerns, PLEASE give us a chance to discuss them with you.

Heartland Hematology & Oncology
412 West 42nd Street Kearney, NE 68845
Phone: (308) 865-2303 Fax: (308) 865-2304

Patient's Name _____ Primary Care Physician: _____
(first) (middle initial) (last)

Patient Address: _____ Referring Physician: _____
(st/rt#/box#)

_____ _____
(city) (state) (zip) (EMAIL ADDRESS)

Patient Home Phone: _____ Patient Cell Phone: _____

Date of Birth: _____ Sex: Male Female

Social Security Number: _____ Marital Status: S M W D Other_____

Preferred Language: English Spanish Other_____

Race: _____ Ethnicity: Hispanic/Latino Not Hispanic Latino Refuse to report

Employment Status: Full Time Part Time Retired Disabled Homemaker Student

Employer: _____ Job Title: _____ Employer Phone _____

Employer Address: _____
(st/rt#/box#) (city) (state) (zip)

Spouse Name: _____ Spouse Cell Phone: _____

Spouse Employer: _____ Spouse Job Title: _____ Employer Phone _____

Employer Address: _____
(st/rt#/box#) (city) (state) (zip)

Responsible Party (if Minor or Other Reason): _____

Relationship (circle one) Parent Guardian Power of Attorney Other _____

Responsible Party Address: _____
(st/rt#/box#) (city) (state) (zip)

Home Phone: _____ Cell Phone: _____

Insurance Information

Medicare Number: _____ Medicaid Number: _____

Primary Insurance Company Name: _____

Policy #: _____ Group ID #: _____

Subscriber Name (person who carries the insurance) _____
Subscriber's date of birth: _____ SSN: _____

Please complete information on reverse side.

Heartland Hematology & Oncology

Name _____

Secondary Insurance Company Name_____

Policy # _____ Group ID # _____

Subscriber Name (person who carries the insurance) _____

Do you have a cancer policy? Yes No If yes, ask about help to get the claim processing information.

If you do not have insurance, how to you intend to pay for your services? Cash Check Credit Card

Advance Directive

Do you have a Living Will? Yes No **Power of Attorney for Health Care?** Yes No **DNR** Yes No
If you do, please bring to the clinic to be scanned and kept on your chart.

Pharmacy Information

Preferred Local Pharmacy: _____ Location: _____
(city) (state) (zip)

Mail Order/Specialty/Medicare Part D Pharmacy: _____
(If Medicare Part D, will need to scan card)

Nearest Friend or Relative Not Living with You (Emergency Contact)

Name: _____ Home Phone Number: _____

Relationship to Patient: _____ Cell Phone Number:_____

Address: _____
(st/rt#/box#) (city) (state) (zip)

Are you a Veteran?
Yes ☐ No ☐

Did the VA refer you here for treatment?
Yes ☐ No ☐

Do you have a VA "Fee Basis ID Card"?
Yes ☐ No ☐

Do you have a Federal Black Lung Card?
Yes ☐ No ☐

Are you covered by an employer's health insurance plan through your employment or that of a family member? (Not Retiree Coverage)
Yes ☐ No ☐

Is this medical Condition due to an accident of any kind? Yes ☐ No ☐
(If you answer yes please complete the following) Work Related ☐ Injured in your home ☐ Auto ☐ Other ☐

Your physician may request your permission for a healthcare provider not associated with the practice, (i.e. a physician resident in training) to accompany them during the office visit. If you deny the request, your physician will comply with the denial.

I authorize the release of my medical records from this office, as well as records obtained from other facilities pertinent to my treatment plan, to other medical facilities as necessary for continued care. I authorize Heartland Hematology & Oncology to take a photograph of me and keep this photograph in my file for identification purposes.

I authorize disclosure of portions of my medical record to my insurance provider to determine liability and to obtain reimbursement. I assign all medical/surgical benefits for which I am entitled to Heartland Hematology and Oncology, PC. I understand that CHARGES ARE PAYABLE AT THE TIME OF TREATMENT. I further understand that I am financially responsible for all charges whether or not paid by said insurance.

I hereby authorize Heartland Hematology and Oncology, P.C. to render medical services to me.

DATE _____ SIGNATURE _____

Heartland Hematology/Oncology
412 West 42nd Street
Kearney, NE 68845

Patient Name _____

REVIEW OF SYSTEMS

Circle a Y or N or n/a for each line.

GENERAL

Appetite Loss	Y	N	n/a
Weight Loss	Y	N	n/a
Weight Gain	Y	N	n/a
Fever	Y	N	n/a
Chills	Y	N	n/a
Fatigue	Y	N	n/a
Hot Flashes	Y	N	n/a
Night Sweats	Y	N	n/a
Pain	Y	N	n/a
Location			

SKIN

Bruising	Y	N	n/a
New Lesions	Y	N	n/a
Dryness	Y	N	n/a
Rash	Y	N	n/a

HEENT

Headache	Y	N	n/a
Visual Disturbances	Y	N	n/a
Hearing Loss	Y	N	n/a
Nasal Congestion	Y	N	n/a
Seasonal Allergies	Y	N	n/a
Mouth Sores	Y	N	n/a
Sore Throat	Y	N	n/a
Bleeding Gums	Y	N	n/a
Double Vision	Y	N	n/a
Dry Eyes	Y	N	n/a
Nose Bleeds	Y	N	n/a

RESPIRATORY

Shortness of Breath	Y	N	n/a
Cough	Y	N	n/a
Sputum Production	Y	N	n/a
Coughing up Blood	Y	N	n/a

CARDIOVASCULAR

Irregular Heart Rhythm	Y	N	n/a
Chest Pain	Y	N	n/a
Edema	Y	N	n/a
Elevated BP	Y	N	n/a
Palpitations	Y	N	n/a

GASTROINTESTINAL

Heartburn	Y	N	n/a
Abdominal Pain	Y	N	n/a
Blood in Stools	Y	N	n/a
Constipation	Y	N	n/a
Diarrhea	Y	N	n/a
Difficulty Swallowing	Y	N	n/a
Nausea	Y	N	n/a
Vomiting	Y	N	n/a

MUSCULOSKELETAL

Back Pain	Y	N	n/a
Bone Pain	Y	N	n/a
Joint Pain	Y	N	n/a
Joint Stiffness	Y	N	n/a
Muscle Pain	Y	N	n/a
Muscle Cramps	Y	N	n/a

NEUROLOGICAL

Numbness/Tingling	Y	N	n/a
Location			
Dizziness	Y	N	n/a
Fainting	Y	N	n/a
Unsteadiness	Y	N	n/a
Weakness	Y	N	n/a

PSYCHIATRIC

Mood Swings	Y	N	n/a
Anxiety	Y	N	n/a
Depression	Y	N	n/a
Unable to Concentrate	Y	N	n/a
Difficulty Sleeping	Y	N	n/a

HEMATOLOGY

Abnormal Bleeding	Y	N	n/a
History of Blood Clots	Y	N	n/a
Enlarged Lymph Nodes	Y	N	n/a
Easy Bruising	Y	N	n/a

IMMUNOLOGY

History of:

Sinus Infection	Y	N	n/a
Bladder Infection	Y	N	n/a
Pneumonia	Y	N	n/a
Bronchitis	Y	N	n/a

GENITOURINARY

All

Incontinence	Y	N	n/a
Blood in Urine	Y	N	n/a
Void Frequently	Y	N	n/a
Times Voiding at Night			

Women

Age of 1st Period:			
Age of 1st Live Birth:			
Age of Menopause:			
Menstruation # of Days:			
Length of Cycle:			

Men

Hesitancy	Y	N	n/a
Trouble Starting Stream	Y	N	n/a

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Patient History Form

Name:_____ **Date**_____
Reason for Visit:_____

Past Medical History (all health diagnosis & pertinent illnesses):

Pneumonia Vaccine: Y/N Date:_____ **Influenza Vaccine**: Y/N Date:_____
Colonoscopy: Y/N Date:_____ **Recent Fall(s):** Y/N Date:_____
Facility location:_____

Past Surgical History (with approx. dates):

Family Medical History:

Family Member:	**Diagnosis:**	**Living or Deceased:**

Social History:

Smoke or Tobacco Use: Y/N # of years?____ Pack/s per day:___ When did you quit?_____
Alcohol Use: Y/N # of drinks per: Day:_____ Week:_____ Month:_____ Year:_____
Married / Single / Widowed / Divorced Number of Children_____
Occupation: _____

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Patient Medication List

Medications (Including over the counter and herbals):

Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day
Drug	Dosage	Times per day

Allergies:

Drug or Type	reaction	Drug or Type	reaction
Drug or Type	reaction	Drug or Type	reaction
Drug or Type	reaction	Drug or Type	reaction
Drug or Type	reaction	Drug or Type	reaction

REQUEST FOR RELEASE OF MEDICAL RECORDS

From: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PLEASE INCLUDE THE FOLLOWING:

_____ HISTORY AND PHYSICAL

_____ DISCHARGE SUMMARY

_____ LAB/X-RAY REPORTS

_____ OTHER: _____

_____

_____

_____

_____ ALL MEDICAL RECORDS

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

Heartland Hematology & Oncology, PC
412 West 42nd Street
Kearney, NE 68845

PHONE: (308) 865-2303
FAX: (308) 865-2304

_____ _____

PATIENT PRINTED NAME DATE OF BIRTH

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

_____ _____

PATIENT SIGNATURE DATE

_____ _____

or AUTHORIZED REPRESENTATIVE SIGNATURE Reason

Heartland Hematology & Oncology P. C.
412 West 42nd Street Kearney, NE 68845
Phone: (308) 865-2303 Fax: (308) 865-2304

Receipt of Notice of Privacy Practices (HIPAA)
Written Acknowledgement Form

I, _____, have received a copy of Heartland Hematology & Oncology P.C.'s Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative Date

Recipient. Heartland Hematology & Oncology, P.C., takes patient privacy seriously. HHO personnel use and disclose patient health information only as permitted by HHO policies and applicable law. Such polices and law permit HHO personnel to disclose a patient's health information to friends and family members designated by the patient. This voluntary form allows you to designate the friends and family members to who HHO personnel may disclose information about your health care, as well as the information that may be disclosed. The following persons or organization are to *receive* the personal health information:

Name	Relationship	Phone Number

Explanation of Rights. I understand that:

- I can revoke this authorization at any time by giving my written revocation to the Disclosing Provider. My revocation is not effective as to disclosure already made and actions already taken in reliance upon this Authorization.
- The disclosing provider may NOT condition treatment, enrollment in the health plan or eligibility for benefits on whether I sign this Authorization.
- I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Representative's Relationship to Patient (if applicable) Date

Renewal of Privacy Practice Policy

- I have read and understand the above information and I reauthorize the above people to *receive* health information.

_____ _____ _____ _____
Date/Initials Date/Initials Date/Initials Date/Initials

Heartland
Hematology& Oncology P.C.

Cynthia M. Lewis, MD
Nicholas J. Hartl, MD
George K. Bascom, MD

412 W. 42nd St.
Kearney, NE 68845

Phone 308-865-2303
Fax 308-865-2304

Nurse Navigator Program

Heartland Hematology & Oncology has started a nurse navigator program for our patients diagnosed with cancer and blood disorders. This navigator service is to help you and your loved ones as you go through this journey by offering support and information. The goal of navigation services is to provide assistance to assure you receive timely, quality treatment for your disease. The navigator works with all health care professionals to remove barriers that stand in the way of effective, comprehensive cancer and hematology care. Our nurse navigators are experienced oncology nurses who are there to help you understand and adhere to your treatment plan and changes in your life it may require. These services are available to you from the time of diagnosis through treatment and into survivorship.

The nurse navigator can help you accomplish any of the following:

1) Provide information needed to make decisions.
2) Give information on what to expect during appointments and treatments.
3) Help arrange appointments with other physicians and support services such as physical therapy, transportation services
4) Assist with translation/interpreter services.
5) Identify sources of financial support and insurance issues.
6) Share information about clinical research trials available.
7) Provide support and understanding through treatment.

Heartland Hematology & Oncology's Nurse Navigators

HEARTLAND HEMATOLOGY & ONCOLOGY, P.C.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Heartland Hematology & Oncology, P.C.
412 West 42nd Street
Kearney, NE 68845
308-865-2303

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice-including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entitles to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

    - maintaining vital records, such as births and deaths
    - reporting child abuse or neglect
    - preventing or controlling disease, injury or disability
    - notifying a person regarding potential exposure to a communicable disease
    - notifying a person regarding a potential risk for spreading or contracting a disease or condition
    - reporting reactions to drugs or problems with products or devices
    - notifying individuals if a product or device they may be using has been recalled
    - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
    - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general

3. **Lawsuits and Similar Proceedings**. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit of similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement**. We may release IIHI if asked to do so by a law enforcement official:

    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - Concerning a death we believe has resulted from criminal conduct
    - Regarding criminal conduct at our offices
    - In response to a warrant summons, court order, subpoena or similar legal process
    - To identify/locate a suspect, material witness, fugitive or missing person
    - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Deceased Patients**. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Organ and Tissue Donation**. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Research**. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI (Protected Health Information) will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. **Serious Threats to Health or Safety**. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military**. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security**. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates**. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation**. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. Additionally, **Heartland Hematology & Oncology, P.C.,** may leave a message on your answering machine regarding appointment dates and times, test results, and information requests. In order to request a specific type of confidential communication, you must make a written request to **Heartland Hematology & Oncology, P.C., 412 West 42nd Street, Kearney, NE 68845, 308-865-2303** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Financial Communications.** You have the right to request that our practice communicate with you regarding your insurance coverage, insurance payments, or financial obligations in a particular manner or at a certain location as outlined above. Additionally, **Heartland Hematology & Oncology, P.C.,** may leave a message on your answering machine requesting certain information, or that you contact our office. In order to request a specific type of financial communication, you must make a written request to **Heartland Hematology & Oncology, P.C., 412 West 42nd Street, Kearney, NE 68845, 308-865-2303** specifying the requested method of contact, or the location where you wish to be contacted.

3. **Requesting Restrietions.** You have the right to request a restriction in our use or disclosure of you IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Heartland Hematology & Oncology, P.C., 412 West 42nd Street, Kearney, NE 68845, 308-865-2303.** Your request must describe in a clear and concise fashion:

    a) the information you wish restricted;
    b) whether you are requesting to limit our practice's use, disclosure or both; and
    c) to whom you want the limits to apply.

4. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Heartland Hematology & Oncology, P.C., 412 West 42nd Street, Kearney, NE 68845, 308-865-2303** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

5. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Heartland Hematology & Oncology, P.C., 412 West 42nd Street, Kearney, NE 68845, 308-865-2303.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

6. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse, or the billing department using your information to file your insurance clam. In order to maintain an accounting of disclosures, you must submit your request in writing to **Heartland Hematology & Oncology, P.C., 412 West 42nd Street, Kearney, NE 68845, 308-865-2303.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

7. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Heartland Hematology & Oncology, P.C., 412 West 42nd Street, Kearney, NE 68845, 308-865-2303.**

8. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Heartland Hematology & Oncology, P.C., 412 West 42nd Street, Kearney, NE 68845, 308-865-2303.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

9. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Heartland Hematology & Oncology, P.C., 412 West 42nd Street, Kearney, NE 68845, 308-865-2303.**

Header images:
Clouds - Hospice
House - home care main and home health page
Country road - Private Duty