Pacific Cancer Care
Advanced Treatment. Personalized Care.

Patient Information

ACCT # DATE

PATIENT

FIRST NAME MIDDLE LAST NAME

DATE OF BIRTH AGE SEX RACE MARITAL STATUS SSN

PHYSICAL ADDRESS

MAILING ADDRESS

HOME PHONE MOBILE WORK EMAIL ADDRESS

EMPLOYMENT & REFERRAL

CURRENT EMPLOYMENT STATUS EMPLOYER

EMPLOYER ADDRESS CITY ZIP

NAME OF DOCTOR OR PERSON WHO REFERRED YOU TO DR.

EMERGENCY CONTACTS

1. NAME RELATIONSHIP PHONE

2. NAME RELATIONSHIP PHONE

ADVANCE DIRECTIVES

Living Will ☐ Yes ☐ No **Durable Power of Attorney** ☐ Yes ☐ No

DNR ☐ Yes ☐ No

Please bring a copy with you!

Monterey *Medical Oncology & Hematology*
5 Harris Court, Bldg. T, Suite 201
Monterey, CA 93940
P (831) 375-4105 · F (831) 372-5722

Los Gatos *Radiation & Medical Oncology*
15400 National Ave., Los Gatos, CA 95032
Radiation: Ste. 100 · P (408) 358-8400
Medical: Ste. 201 · P (408) 358-8415

Gilroy *Medical Oncology*
8060 Santa Teresa Blvd, Suite 100
Gilroy, CA 95020
P (408) 665-3283 · F (408) 358-8438

I give Pacific Cancer Care permission to electronically obtain my medication history

☐ Yes ☐ No

INSURANCE INFORMATION

We will need your current insurance & prescription cards, and your driver's license. Please give them to the receptionist to make copies.

Primary Insurance

COMPANY

COMPANY ADDRESS

MEMBER ID # GROUP #

Subscriber ☐ Self ☐ Spouse ☐ Guardian

SUBSCRIBER'S NAME DOB

SUBSCRIBER'S ADDRESS

Secondary Insurance

COMPANY

COMPANY ADDRESS

MEMBER ID # GROUP #

Subscriber ☐ Self ☐ Spouse ☐ Guardian

SUBSCRIBER'S NAME DOB

SUBSCRIBER'S ADDRESS

COMMUNICATION & VISIT CONSENTS

It is our standard practice to enroll all patients in assistance programs. By signing below, you agree to allow our office to sign and submit your assistance application electronically.

Text & Email Messages

To provide our patients with the best possible care, we occasionally send relevant and convenient text messages and emails. Message and data rates may apply. Reply STOP at any time to opt out.

☐ I consent to be contacted via email and text by Pacific Cancer Care.

☐ I do not consent to be contacted via email and text by Pacific Cancer Care.

DeepScribe Medical Documentation

To help your provider focus on you during your visit, Pacific Cancer Care uses DeepScribe to assist with medical documentation. If you choose to participate, DeepScribe will securely capture and process information discussed during your appointment so your provider can review and finalize your medical record.

☐ I have read the information above and consent to the use of DeepScribe during my visit.

☐ I do not consent to the use of DeepScribe during my visit.

PATIENT CERTIFICATION

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by myself/patient and agree to pay my copays and deductibles at time of service. I authorize physician and clinic to release any medical information necessary to process claims. I also authorize my insurance claims/Medical Benefits to be paid directly to Pacific Cancer Care. In the event that my medical claim is denied, I authorize Pacific Cancer Care to initiate and file a complaint with the insurance commissioner.

PATIENT SIGNATURE	DATE	PROVIDER REP. INITIALS

Pacific Cancer Care
Advanced Treatment. Personalized Care.

Authorization for Use or Disclosure of Protected Health Information

Privacy Officer: Nicole Billingsley · (831) 375-4105

PATIENT NAME | DATE OF BIRTH

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

RELATIVES OR INDIVIDUALS WE MAY DISCLOSE PROTECTED HEALTH INFORMATION TO

	NAME	RELATIONSHIP	PHONE NUMBER
1.			
2.			
3.			

HEALTH INFORMATION TO BE USED OR DISCLOSED (check all that you are requesting)

☐ **Verbal** discussion of any and all of my health information, including but not limited to, my diagnosis, lab reports, tests and evaluation results, treatment health status and prescriptions.

☐ **Printed** copies of any and all of my health information, including but not limited to, my diagnosis, lab reports, tests and evaluation results, treatment health status and prescriptions.

I UNDERSTAND

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

- I have the right to inspect the health information to be released, unless prohibited by law and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.
- HIPAA permits Pacific Cancer Care to use and provide to third parties de-identified data from your medical record for clinical improvement processes.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF PERSONAL REPRESENTATIVE _____ DATE _____

DESCRIPTION OF REPRESENTATIVE AUTHORITY TO ACT FOR THE PATIENT _____

This form supersedes any previously signed HIPAA documents.

Notice of Rights: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by and order of the court or the Department of Health or by law.

PROCESSED BY (PRINT NAME & DEPT) _____

Rev. 11-2025

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. The privacy of your medical information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice has been updated effective August 1, 2009 and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice, post the revised notice at each of our service delivery sites, and make the new notice available to our patients and others upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information at the end of this notice.

Uses and Disclosures of Medical Information

Treatment: We may use your medical information, without your permission, to treat you. We may disclose your medical information, without your permission, to a physician or other health care provider for your treatment. When we transport you to a hospital, we may disclose your health information for treatment purposes.

Payment: We may use and disclose your medical information, without your permission, to obtain or provide reimbursement for health care we provide to you. If we bill Medicaid or Medicare for reimbursement, we will submit an electronic claim that includes your name and other personal information.

Health Care Operations: We may use and disclose your medical information for certain services of our health care operations. Health care operations include:

- health care quality assessment and improvement activities;

- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, de-identifying medical information, and creating limited data sets for health care operation, public health activities, and research.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Patient Contact: We may use your medical information to contact you or your authorized representative via telephone or mail to discuss billing or appointment information. If you are not available, we may leave this information on your answering machine.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and in the following situations:

- for public health, including to report communicable disease, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state licensing and peer review authorities, and fraud prevention enforcement agencies;
- to coroners, medical examiners and funeral directors;
- as authorized by state worker's compensation laws;
- in response to court and certain administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- to the military, to federal official for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody.

You may be able to opt out of use or disclosure of your medical information pursuant to a written request from a government agency, unless the disclosure is required by law.

We may not disclose HIV test results, certain confidential medical information or mental health treatment records for certain of these purposes without your written permission,

unless required by law. Your HIV test results, if any, may be disclosed as set forth in California Statutes §121015(b).

Individual Rights

Contact Information: If you have any questions about your rights under this privacy notice, please contact the Privacy Officer. Specific contact information is located at the end of this notice.

Forms: You may obtain necessary forms to exercise your rights from the Privacy Officer. Specific contact information is located at the end of this notice.

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You must make a written request to obtain access to your medical information.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact us using the information at the end of this notice for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

Within 60 days of your request, we will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information and mental health treatment records. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request for specified reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the un-amended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law.

Confidential Communications: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternate locations

that you specify. You must make your request in writing. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communication. We will not ask you to explain the reason for your request.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact the Privacy Officer using the information at the end of this notice.

If you are concerned that we may have violated your Privacy rights, or you disagree with a decision we made about access to your medical information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services. You may contact the Office for Civil Rights Hotline at 1-800-368-1019. We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer, Pacific Cancer Care, 5 Harris Court, Bldg. T, 2nd Floor, Monterey, CA 93940 · (831) 375-4105

Acknowledgement of Notice of Privacy Practices

Under the federal privacy laws we are required to provide you with our Notice of Privacy Practices. This Notice provides information about how we may use and disclose your protected health information. You are not required to sign and return an acknowledgement. We are required to give you this Notice. If you would like to acknowledge receipt of this Notice, please sign the acknowledgement form and return it to: Privacy Officer, Pacific Cancer Care, 5 Harris Court, Bldg. T, 2nd Floor, Monterey, CA 93940. If you have any questions regarding this acknowledgement, please contact the Privacy Officer as listed above.

Pacific Cancer Care
Advanced Treatment. Personalized Care.

Acknowledgement of Receipt

Notice of Privacy Practices
Privacy Officer · (831) 375-4105

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Pacific Cancer Care. Our "Notice of Privacy Practices" provides information about how we may use and disclose your Protected Health Information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at (831) 375-4105. If you have any questions about our "Notice of Privacy Practices", please contact our Privacy Officer.

I hereby acknowledge receipt of a copy of the Notice of Privacy Practices of Pacific Cancer Care.

SIGNED (PATIENT / LEGAL REPRESENTATIVE) _____ DATE _____

PRINT NAME _____ TELEPHONE _____

IF SIGNED BY SOMEONE OTHER THAN 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

PRINT NAME (LEGAL REPRESENTATIVE) _____

OFFICE USE ONLY — INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and explain the reasons why the acknowledgement was not obtained.

PATIENT NAME

_____

Reasons why the acknowledgement was not obtained:

☐ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.

☐ Other: _____

DATE _____ TIME (AM/PM) _____

SIGNATURE (PROVIDER REPRESENTATIVE) _____ PRINT NAME (PROVIDER REPRESENTATIVE) _____

Rev. 11-2025

Pacific Cancer Care
Advanced Treatment. Personalized Care.

Prescription & Lab Disclosure

PATIENT RX DISCLOSURE

To better meet our patients' needs, we can now dispense many of the prescriptions as prescribed by our physicians. We will bill your pharmacy insurance and charge the applicable co-pay. Please understand that you are not obligated to have prescriptions filled here and you have the option of receiving your medications from the pharmacy of your choice. We would be happy to facilitate this for you.

LAB DISCLOSURE

We will process your labs in the PCC lab whenever possible. Some tests may need to be sent out. Please notify our Laboratory personnel if your lab tests need to go to a specific laboratory that's covered under your insurance plan. Also, if there are any changes with your insurance plan, please let the phlebotomist know so they'll send it to the correct laboratory.

- Labs will be processed at: **PCC**
- If we (PCC) cannot process a particular test — which lab would you like us to send it to?

☐ **CHOMP** ☐ **Quest Lab** ☐ **LabCorp** ☐ **Other** — please specify:

_____

Please sign on the line below indicating you understand this policy.

PATIENT'S NAME

_____

PATIENT'S SIGNATURE _____ DATE _____

NOTICE TO CONSUMERS

Medical Doctors are licensed and regulated by
The Medical Board of California
(800) 633-2333 · www.mbc.ca.gov

I understand that my physician is licensed and regulated by the Medical Board of California.

PATIENT'S SIGNATURE _____ DATE _____

Pacific Cancer Care
Advanced Treatment. Personalized Care.

Patient Intake Form

NAME

DATE OF BIRTH

CONTACT INFORMATION (PLEASE MARK YOUR PREFERENCE)

☐ HOME ☐ CELL ☐ WORK

REFERRING PHYSICIAN

REASON FOR REFERRAL

PRIMARY CARE PHYSICIAN

OTHER PHYSICIANS YOU SEE

MEDICAL HISTORY

SURGICAL HISTORY

SURGERY	SURGEON	DATE

FAMILY HISTORY

If any blood relative has had any of the following conditions, please check and specify.

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Cancer (see separate form)
- ☐ Diabetes
- ☐ Emphysema / COPD
- ☐ Epilepsy / seizure disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Other conditions:

SOCIAL HISTORY

PLACE OF BIRTH

WHERE DO YOU LIVE CURRENTLY (AND WITH WHOM?)

OCCUPATION

RETIRED ☐ Yes ☐ No

VOLUNTEER ACTIVITIES

Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Children ☐ Yes ☐ No Ages (if applicable)

Alcohol use ☐ Never ☐ Current — drinks/day _____

☐ Former — drinks/day, quit date _____

Have you ever been treated for alcohol abuse? ☐ Yes ☐ No

Tobacco use ☐ Never ☐ Current — packs/day _____

☐ Former — packs/day, quit date _____

Drug use ☐ Never ☐ Former — type / frequency _____

MEDICATIONS

NAME	DOSE	INDICATION	ORDERING PHYSICIAN

SUPPLEMENTS / ALTERNATIVE MEDICINES

ALLERGIES (AND REACTION)

REVIEW OF SYSTEMS

Please check if you have had any of the following.

General

- ☐ Fevers
- ☐ Recent weight change
- ☐ Fatigue
- ☐ Night sweats
- ☐ Other _____

Eye, Ear, Nose & Throat

- ☐ Eye pain
- ☐ Wear glasses/contacts
- ☐ Blurry or double vision
- ☐ Loss of vision
- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Ear infection
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Sore throat

- [ ] Hoarseness or voice change
- [ ] Swollen neck glands
- [ ] Other _____

Gastrointestinal

- [ ] Loss of appetite
- [ ] Bloating
- [ ] Abdominal pain
- [ ] Constipation
- [ ] Diarrhea
- [ ] Change in bowel habits
- [ ] Nausea
- [ ] Vomiting
- [ ] Vomiting blood
- [ ] Red blood in stool
- [ ] Black/tarry stools
- [ ] Liver disease
- [ ] Other _____

Heart

- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Chest pain/angina
- [ ] Heart murmur
- [ ] Heart failure
- [ ] Palpitations/skipped beats
- [ ] Rapid heart beat
- [ ] Swelling of ankles
- [ ] Other _____

Lung

- [ ] Chronic cough
- [ ] Asthma or wheezing
- [ ] Bronchitis
- [ ] Shortness of breath
- [ ] Difficulty breathing
- [ ] Coughing up blood
- [ ] Home oxygen
- [ ] Other _____

Genitourinary

- [ ] Urinary infections
- [ ] Frequent urination
- [ ] Difficulty urinating
- [ ] Burning/painful urination
- [ ] Bloody or pink urine
- [ ] Kidney problems/failure
- [ ] Kidney stones
- [ ] Prostate enlargement
- [ ] Impotence
- [ ] Sexual difficulty
- [ ] Other _____

Skin

- [ ] Itching
- [ ] Rash
- [ ] Prior skin cancer
- [ ] Removal of skin lesions
- [ ] Other _____

Neurological

- [ ] Migraines
- [ ] Headaches
- [ ] Stroke
- [ ] Seizures
- [ ] Dizziness
- [ ] Head injury
- [ ] Falling
- [ ] Other _____

Blood Disorders

- [ ] Bruising
- [ ] Anemia
- [ ] Prior transfusions
- [ ] Blood clots
- [ ] HIV/AIDS
- [ ] Other _____

Muscle & Joint

- [ ] Arthritis
- [ ] Chronic neck pain
- [ ] Chronic back pain
- [ ] Broken bones/fractures
- [ ] Muscle weakness
- [ ] Difficulty walking
- [ ] Joint pain
- [ ] Other _____

Endocrine

- [ ] Thyroid disease
- [ ] Diabetes
- [ ] Hormone problem
- [ ] Other _____

Women Only

☐ Breast lump ☐ Breast pain ☐ Prior breast biopsy ☐ Nipple discharge

☐ Hot flashes ☐ Vaginal discharge ☐ Heavy periods ☐ Frequent periods

Age at first period _____ Date of last period _____

Date of last PAP _____ ☐ Normal ☐ Abnormal

# of pregnancies _____ # of children _____ Age at first delivery _____

VACCINATION HISTORY

VACCINE	RECEIVED?	DATE
Flu vaccine	☐ Yes ☐ No	
Pneumovax (pneumonia) vaccine	☐ Yes ☐ No	
Zostavax (shingles) vaccine	☐ Yes ☐ No	

PHARMACY INFORMATION

NAME OF LOCAL PHARMACY AND ADDRESS

YOUR MAIL ORDER PHARMACY (IF APPLICABLE) — SUBSCRIBER NAME

SUBSCRIBER ID

YOUR HOME CARE AGENCY (IF APPLICABLE)

ANY OTHER HEALTH ISSUES OR CONCERNS THAT OUR STAFF SHOULD BE MADE AWARE OF?

Thank you for completing this form.

SIGNATURE

DATE

Monterey *Medical Oncology & Hematology*
5 Harris Court, Bldg. T, Suite 201
Monterey, CA 93940
P (831) 375-4105 · F (831) 372-5722

Los Gatos *Radiation & Medical Oncology*
15400 National Ave., Los Gatos, CA 95032
Radiation: Ste. 100 · P (408) 358-8400
Medical: Ste. 201 · P (408) 358-8415

Gilroy *Medical Oncology*
8060 Santa Teresa Blvd, Suite 100
Gilroy, CA 95020
P (408) 665-3283 · F (408) 358-8438

Pacific Cancer Care
Advanced Treatment. Personalized Care.

Medical Records Release Form and Authorization for Use or Disclosure of PHI

PATIENT

PATIENT NAME

DATE OF BIRTH

ADDRESS

PHONE

SSN

AUTHORIZATION

I AUTHORIZE THE CUSTODIAN OF MEDICAL RECORDS

OR OTHER PERSON/ENTITY (SPECIFICALLY DESCRIBE)

to disclose/release the following information (check all applicable):

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing records
- ☐ Abstract/summary
- ☐ Pharmacy/prescription records
- ☐ Other (describe specifically)

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of information.

THESE RECORDS ARE FOR SERVICES PROVIDED ON THE FOLLOWING DATE(S)

PLEASE SEND THE RECORDS LISTED ABOVE TO

NAME

PHONE

ADDRESS

FAX

THIS AUTHORIZATION SHALL EXPIRE NO LATER THAN (DATE)

OR UPON THE FOLLOWING EVENT

(whichever is sooner), and may not be valid for greater than one year from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

SIGNATURE OF PATIENT (OR PATIENT'S PERSONAL REPRESENTATIVE)

DATE

PRINTED NAME OF PATIENT REPRESENTATIVE

REPRESENTATIVE'S AUTHORITY TO SIGN FOR PATIENT

(i.e. parent, guardian, power of attorney for healthcare, executor)

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Administrator at any Pacific Cancer Care location:

Monterey
5 Harris Ct., Bldg. T, Suite 201, Monterey, CA 93940

Los Gatos
15400 National Ave., Suite 100 / 201, Los Gatos, CA 95032

Gilroy
8060 Santa Teresa Blvd, Suite 100, Gilroy, CA 95020

Pacific Cancer Care
Advanced Treatment. Personalized Care.

Appointment Cancellation & No-Show Policy

Thank you for trusting your medical care to Pacific Cancer Care. When you schedule an appointment with PCC, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who are waiting for an appointment.

OUR APPOINTMENT CANCELLATION / NO-SHOW POLICY

- Effective January 1, 2023, any established patient who fails to show or cancels/ reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$50 fee**.
- Any **established patient** who fails to show or cancels/reschedules an appointment with no 24 hours' notice a second time will be charged a $50.00 fee and may be dismissed from Pacific Cancer Care.
- Any **new patient** who fails to show for their initial visit will be charged a $50 fee.
- Any **new patient** who fails to call or show for a second time will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager. You may contact Pacific Cancer Care 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Friday or over the weekend, you may leave a message with our answering service.

PACIFIC CANCER CARE
831-375-4105

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

SIGNATURE

DATE

PRINTED NAME

Monterey *Medical Oncology & Hematology*
5 Harris Court, Bldg. T, Suite 201
Monterey, CA 93940
P (831) 375-4105 · F (831) 372-5722

Los Gatos *Radiation & Medical Oncology*
15400 National Ave., Los Gatos, CA 95032
Radiation: Ste. 100 · P (408) 358-8400
Medical: Ste. 201 · P (408) 358-8415

Gilroy *Medical Oncology*
8060 Santa Teresa Blvd, Suite 100
Gilroy, CA 95020
P (408) 665-3283 · F (408) 358-8438

Pacific Cancer Care
Advanced Treatment. Personalized Care.

Informed Consent for Outpatient Referral Lab Molecular/Genetic Testing

PATIENT NAME

I, _____

request and permit an approved, licensed Reference Lab to perform the following molecular/genetic testing on my blood/tissue/bone marrow sample, if ordered by my clinician:

- Genomic testing
- Cytogenetic testing
- Fluorescence in situ hybridization (FISH)
- Genetic testing
- Biomarker testing
- Flow cytometry

I UNDERSTAND THAT

1. A single test or a panel of tests may involve out-of-pocket expenses depending on the reference lab selected, the test(s) requested by my clinician, and my insurance provider and/or coverage.
2. The reference lab selected for this testing may contact me regarding insurance coverage and to discuss payment options for this testing.
3. I am responsible for verifying whether the reference lab accepts my insurance, whether my insurance covers the tests ordered, and any financial responsibility I may have for reference lab testing.
4. I may receive invoices from a reference lab that is not affiliated with Pacific Cancer Care, for services performed.
5. No molecular testing apart from that which is ordered will be performed, and any additional testing requires my additional, express consent.
6. Molecular genetic tests may not be diagnostic for the selected condition(s) in all individuals. This test may or may not provide actionable information or have an implication on my medical management.
7. Some types of DNA changes that could cause a specific disorder or disease may not be detected by this test. As with most molecular genetic tests, they have technical limitations that may prevent detection of rare variants, poor sample quality, current limits of medical knowledge and technology.

8. There may be possible sources of error including, but not limited to, contamination, technical error in the laboratory, rare DNA variants that compromise data analysis, inconsistent scientific classification systems, and inaccurate or insufficient reporting of family relationships or clinical diagnosis information.
9. Clinical reports are released only to the certified healthcare professional(s) listed on the test requisition form. Clinical reports are confidential and will only be released to other medical professionals with my explicit consent. It has been explained to me that my clinical report is available to me after it has been reviewed and released by my healthcare professional(s). Alternatively, my clinical report can be made immediately available upon completion of the test with the prior approval of my healthcare professional, as indicated on the test requisition form.

By signing below, I attest to the following: I have read and understand the information provided on this form, I have discussed the recommended testing with my physician, and I have had an opportunity to have any questions answered by my healthcare provider. I have a good understanding of the concepts of the specific testing ordered and have elected to proceed.

SIGNATURE OF PATIENT / LEGAL GUARDIAN

DATE