MISSOURI CANCER ASSOCIATES

There for you, every step of the way.

Dear Patient:

This letter is also to provide you with the paperwork required for your patient registration. Please complete these forms and bring them with you to the appointment. Please also bring your insurance cards along with your photo identification and we will make a copy of them for our records. ***We also need you to bring a list of your current medications with you to the appointment including prescription and over the counter medications.***

Instructions for the demographic form:

1. Please fill out each line of the form.
2. If you are employed, please list it on the form next to Patient's Employer, if you are retired, you can list retired.
3. For the emergency contact, please list someone outside of your home, not a spouse. List either a family member or a friend that has a different phone number than you.
4. Please sign and date the form on the second page.

Instructions for the Medical History and Current Medicines and Symptoms:

1. Fill out all information regarding you and your family history.
2. Make sure and complete all pages of both forms.

Instructions for the Patient Portal: My Care Plus form:

1. Please fill out each line of the form.

Missouri Cancer Associates has knowledgeable and courteous Patient Benefit Representatives who will verify your insurance benefits prior to your appointment. Co-pays, deductibles and/or co-insurance amounts are expected on the dates services are provided. You will meet with our patient benefit representatives on the day of your appointment to discuss any estimated out of pocket costs associated with your treatment plan. Missouri Cancer Associates does offer financial assistance for patients who are in need. Please contact a Patient Benefit Representative with questions.

Completion of forms - $25 fee for all FMLA/disability forms requiring a physician/nurse to fill out and sign.

Thank you for your cooperation. If you have any questions or concerns, you may contact our office at 573-874-7800 or toll free at 1-866-724-2413 and select "O" for the operator. You can also visit our website at www.missouricancer.com. We look forward to meeting you.

Sincerely,

MO Cancer Associates Team

MISSOURI CANCER ASSOCIATES

Legal Name: _____ Name you go by: _____

Social Security#: _____ Date of Birth: _____

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

Home Phone: _____ Cell Ph: _____ Wk Ph: _____

Marital Status (select one): ☐ Single ☐ Married ☐ Divorced ☐ Widow Sex: ☐ Male ☐ Female

Race: _____ Ethnicity: Hispanic/Latino ☐ Yes ☐ No Preferred Language: _____

Email _____

Preferred Contact Method (select one): ☐ home phone ☐ cell phone ☐ work phone ☐ email

Referral Source (select one): ☐ Friend/Relative ☐ Hospital _____ ☐ Insurance ☐ Internet

Referring Physician: _____ Phone: _____

Primary Care Physician (if different from Referring Physician listed above):

Name: _____ Phone: _____

Patient's Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship to Emergency Contact: _____

Insurance Policy Holder Information (if insurance is through spouse or parent)

Primary Insurance Information:

Name: _____ Relationship: _____ Date of Birth: _____ Phone: _____

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

Social Security#: _____ Employer: _____ Work Phone: _____

Secondary Insurance Information:

Name: _____ Relationship: _____ Date of Birth: _____ Phone: _____

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

Social Security#: _____ Employer: _____ Work Phone: _____

Preferred Pharmacy Information

Preferred Pharmacy: _____ Phone: _____

MISSOURI CANCER ASSOCIATES

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE MEDICAL INFORMATION:
I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Missouri Cancer Associates for any services furnished to me by my provider. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services: Division of Family Services, Centers for Medicare and Medicaid Services, insurers and/or agents of these companies, responsible person(s) listed, Name of authorized person (specify relationship) or other healthcare providers assisting in my medical care.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I have been offered a copy of Missouri Cancer Associates' Notice of Privacy Practices.

CONSENT TO TREATMENT:
I authorize Missouri Cancer Associates and/or any physician or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substances that is capable of transmitting disease and I am unable to timely consult with my physician prior to testing, I consent to limited testing to determine the presence , if any, of antibodies to or infectious agents of hepatitis A, B, C and HIV.

I understand that in order for Missouri Cancer Associates to comply with the federally mandated initiative for electronic medication prescribing (e prescribing) software to send prescriptions over the internet to pharmacies. These transmissions are done in a safe manner that protects the privacy of personal information. I agree that Missouri Cancer Associates may request and use my prescription history from other healthcare provides or third party payors for treatment purposes as required by the above mentioned federal initiative.

FINANCIAL AGREEMENT:
I understand that I am financially responsible for any charges regardless of insurance coverage. Should I default, I agree to pay all cost of collections including interest applied by collection agency, court cost and attorney fees. Any suit filed may be brought in the county where services are rendered. I also understand and acknowledge that I am personally responsible to pay Missouri Cancer Associates in full for services that my health insurer will not cover due to non-payment of my health insurance premiums.

I have read and agreed to the provisions on listed on this form and accept the terms. A duplicate of this statement is considered the same as original.

Print Name: _____

_____ _____
Signature of Patient (For patients 17 yrs of age or younger, parent or guardian MUST sign.) Date

_____
If legal representative, relationship to patient

The patient above also authorized the disclosure of health and financial information to:

(This is not permission to release your official medical record)

Names of Individual: _____ Phone #: _____

Names of Individual: _____ Phone #: _____

Patient Portal: My Care Plus

My Care Plus offers convenient and secure access to your personal health record. My Care Plus patient portal is the system that allows access to your Medical Oncology, Chemotherapy, Radiation Oncology and Radiation Therapy records.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Choosing to share your username and password with family members and caregivers is your choice. Please be aware that anyone that has this information can access the information contained in your patient portal.

Please look for an email from My Care Plus after submitting this form. For your protection, the link is designed to expire quickly if not used. Please choose an email address that will not be subject to access by anyone you do not trust. The invitation and enrollment directions will be sent to the email address provided.

If you have any questions, please call Missouri Cancer Associates at 573-874-7800 or toll free at 866-724-2413 and ask for assistance with your patient portal access.

Once your account is established, you will need to save the portal link to your favorites in order to access your information. Links to My Care Plus can be found on our website, www.missouricancer.com.

My Care Plus: https://www.mycareplusonline.com

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Please write legibly.

_____	_____
Patient Name (First Name, Middle Initial, Last Name)	Email Address
_____	_____
Date of Birth of Patient	Missouri Cancer Associates Physician
_____	_____
Patient's Signature	Date

Patient Name: _____

Date of Birth: _____ **Today's Date:** _____

Reason for Visit: _____

MISSOURI CANCER ASSOCIATES

There for you, every step of the way

Health Questionnaire

PAST MEDICAL HISTORY

Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing a check (√) in the appropriate box(es). If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. Circle the appropriate choice when multiple choices are listed in a question.

	Medical Problem	Surgery	Year(s) of Surgery	Describe
Eyes (cataracts, glaucoma)	☐	☐	_____	_____
Ears, nose, sinuses, or tonsils	☐	☐	_____	_____
Thyroid or parathyroid glands	☐	☐	_____	_____
Heart disease	☐	☐	_____	_____
Atrial fibrillation	☐	☐	_____	_____
Coronary (heart) arteries (angina)	☐	☐	_____	_____
Arteries (aorta, arteries to head, arms, legs)	☐	☐	_____	_____
Veins or blood clots in the veins	☐	☐	_____	_____
Lungs	☐	☐	_____	_____
Esophagus or stomach (ulcer)	☐	☐	_____	_____
Bowel (small & large intestine) or appendix	☐	☐	_____	_____
Liver or gallbladder (including hepatitis)	☐	☐	_____	_____
Pancreas	☐	☐	_____	_____
Hernia	☐	☐	_____	_____
Lymph nodes or spleen	☐	☐	_____	_____
Kidneys or bladder	☐	☐	_____	_____
Bones, joints or muscles	☐	☐	_____	_____
Back, neck or spine	☐	☐	_____	_____
Brain	☐	☐	_____	_____
Skin	☐	☐	_____	_____
Breasts	☐	☐	_____	_____
Females: uterus, tubes, ovaries	☐	☐	_____	_____
Males: prostate, penis, testes, vasectomy	☐	☐	_____	_____

Patient Initials/Date of Birth: _____

Female Patients Only:

Have you ever taken birth control pills or hormone replacement? □ No □ Yes

Have you experienced menopause or had a hysterectomy? □ No □ Yes

If no: Are you concerned about your menstrual periods? □ No □ Yes

Might you be pregnant at this time? □ No □ Yes

Date of onset of your last menstrual period: mo: _____ yr: _____

Approximate date of your last Pap smear and pelvic exam: mo: _____ yr: _____ □ Never

Age at first menstrual period: _____ Age at first pregnancy: _____ Number of pregnancies: _____ Live births: _____

PERSONAL HISTORY

Have you ever had any of the following:	**YES**	**Describe the problem when appropriate:**
Anxiety, depression or mental illness	□	_____
Autoimmune disease (Lupus, Rheumatoid arthritis, etc.)	□	_____
Blood problems (abnormal bleeding or anemia)	□	_____
Blood or blood product transfusion	□	_____
Chemotherapy or immunotherapy	□	_____
Diabetes	□	_____
Polyp or tumor removed from colon or rectum	□	_____
High blood pressure	□	_____
High cholesterol or triglycerides	□	_____
Radiation (Cobalt or radioactive implants) therapy	□	_____
Stroke or TIA	□	_____
Treatment of alcohol and/or drug abuse	□	_____
Tuberculosis or positive skin test for TB	□	_____

MEDICATIONS

Please list any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, and cold medications. **Please use a separate piece of paper if necessary.** If you keep your list of medications and wish to provide it separately, you may bring it with you and we will make a copy for your medical chart.

Name of Medication	**Dose**	**How Often Taken**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Initials/Date of Birth: _____

ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions to medications? Please list below.

Name of Medication	**Describe Allergic Reaction**	**Have you had an allergic reaction to:**	
_____	_____	Iodine or shellfish	□ No □ Yes
_____	_____	Latex, rubber or adhesive tape	□ No □ Yes
_____	_____	Bee or wasp stings	□ No □ Yes
_____	_____		

Are there medications, other than those you are allergic to, you would prefer not to take due to prior unpleasant side effects?

□ No □ Yes, please explain → _____

List any food allergies _____ □ None

REVIEW OF SYSTEMS

Please circle any of the following which apply to you.

Category	**Issues**	**No Problems**
General	Appetite change, fatigue, fevers, sweats, weight loss, weight gain, weakness	□
Skin	Itching, rash, mole change	□
Eyes	Vision change, cataracts, glaucoma	□
Ears/Nose/Mouth	Dizziness, ringing in the ears, sore throat, hoarseness	□
Lungs	Cough, chest pain, shortness of breath, wheezing, coughing blood	□
Heart	Chest pain, shortness of breath with exertion, palpitations, fainting episodes, leg pains, sleeping with more than one pillow	□
GI	Abdominal pain, bloating, nausea, vomiting, diarrhea, constipation, jaundice, black stools, blood in stools, difficulty swallowing, hemorrhoids	□
Genitourinary	Painful urination, increased frequency, urgency, leaking urine, blood in urine, kidney stones, urinating at night, incomplete emptying of bladder	□
Breasts	Discharge, mass, pain, tenderness	□
Musculoskeletal	Arthritis, joint stiffness, swelling, back pain, swelling, weakness	□
Neurologic	Headaches, seizure, dizziness, tremors, memory loss, paralysis, numbness, tingling, coordination, muscle strength/tone	□
Psychiatric	Anxiety, depression, personality change, suicidal thoughts	□
Female Reproductive	Pelvic pain, irregular periods, absent periods, bleeding in between periods, bleeding after intercourse, painful intercourse, abnormal vaginal discharge/bleeding, hot flashes	□
Lymphatic	Enlargement, tenderness of lymph nodes	□
Hematologic	Bruising, bleeding, recurrent infections	□

Patient Initials/Date of Birth: _____

FAMILY HISTORY

Father □ Alive (Age ___) □ Deceased (Age ___) Cause of death: _____

Mother □ Alive (Age ___) □ Deceased (Age ___) Cause of death: _____

Brothers # _____ Medical Problems: _____

Sisters # _____ Medical Problems: _____

Children # _____ Medical Problems: _____

Please check below if any blood relative has had any of the following conditions and note which relatives affected.

□ Diabetes □ Kidney disease □ Easy bleeding
□ Heart disease □ Thyroid disease □ Blood clots
□ Stroke □ Autoimmune disease

□ Cancer type: _____ Relationship to you: _____ Age diagnosed: _____
□ Cancer type: _____ Relationship to you: _____ Age diagnosed: _____
□ Cancer type: _____ Relationship to you: _____ Age diagnosed: _____
□ Cancer type: _____ Relationship to you: _____ Age diagnosed: _____
□ Cancer type: _____ Relationship to you: _____ Age diagnosed: _____

Is there a history of the following cancers?

☐ Breast ☐ Ovarian ☐ Uterine ☐ Colon ☐ Prostate ☐ Pancreatic ☐ Melanoma

SOCIAL HISTORY

How many years of school have you completed? _____ Are you married? □ No □ Yes Do you live alone? □ No □ Yes

Your current employment status: □ Employed □ Retired □ Unemployed

Current or previous occupation: _____

Are you disabled? □ No □ Yes, please explain → _____

Do you have a living will or advance directive for healthcare? □ No □ Yes

If you are unable to make your own medical decisions, who will do that for you? _____

Relationship to patient: _____

Have you used any of the following substances?

Substance	Currently Use?	Previously Used?	Type/Amount/Frequency	How Long (years)?	Year stopped?
Cigarettes	□ No □ Yes	□ No □ Yes			
Other Tobacco	□ No □ Yes	□ No □ Yes			
Alcohol (beer/wine)	□ No □ Yes	□ No □ Yes			
Recreational/Street Drugs	□ No □ Yes	□ No □ Yes			

Health Maintenance: Please list the date of last exam and, if abnormal, any findings if known.

Last Mammogram		Location:
Last Colonoscopy		Location:
Last Bone Density Scan		Location:
Last Echocardiogram		Location:
Shingles vaccine		
Influenza vaccine		
Pneumovax vaccine		

Missouri Cancer Associates

NOTICE OF PRIVACY PRACTICES

Effective Date: **September 23, 2013**

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.

About Us

In this Notice, we use terms like “we,” “us,” “our” or "Practice" to refer to Missouri Cancer Associates, its physicians, employees, staff and other personnel. All of the sites and locations of Missouri Cancer Associates follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information without your written authorization:

For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another healthcare provider to be sure they have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of 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 health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

Individuals Involved in Your Care or Payment for Your Care and Notification: If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

We may use or disclose your information to notify or assist in notifying a family member, personal representative or any other person responsible for your care regarding your physical location within the Practice, general condition or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status and location.

We are also allowed to the extent permitted by applicable law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- Activities related to the quality, safety or effectiveness of FDA-regulated products;
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement authorities to identify or apprehend an individual.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation or banking of organs, eyes, or tissues.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.

- Sale of Your Health Information: We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

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

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **In most circumstances, 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 and submit it to the office Privacy Officer. We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to the office Privacy Officer. We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the office Privacy Officer. You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you designate. Your written, signed re-

quest must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the office Privacy Officer.

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the office Privacy Officer. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact staff at the front desk. You may also obtain a paper copy of this Notice at our website, www.missouricancer.com.

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the scheduling area of our office. Each version of the Notice will have an effective date listed

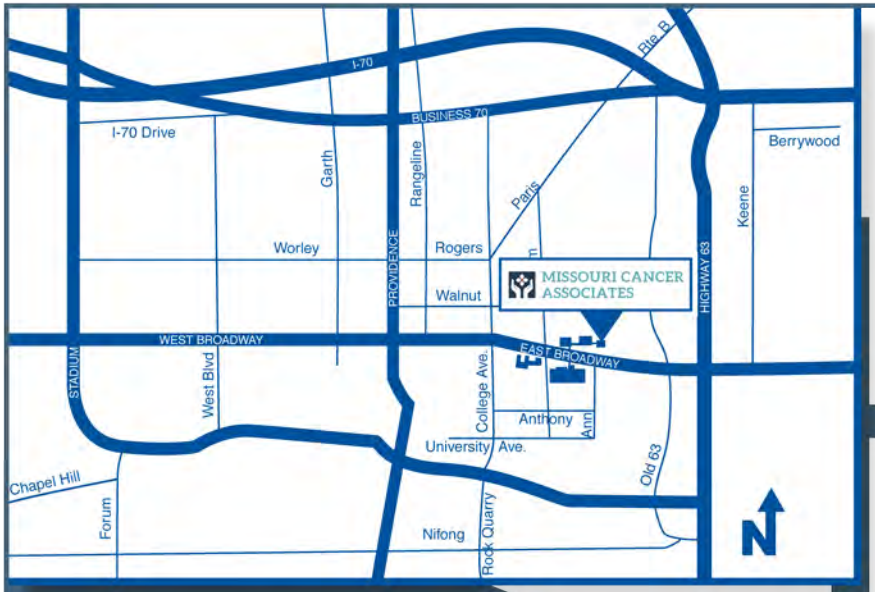
on the first page. Updates to this Notice are also available at our website, www.missouricancer.com.

Complaints

If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: **Privacy Officer, 1705 E Broadway Ste 100 Columbia, MO 65201 or (573) 874-7800**. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

Questions

If you have questions about this Notice, please contact the office Privacy Officer, (573) 874-7800.



Directions

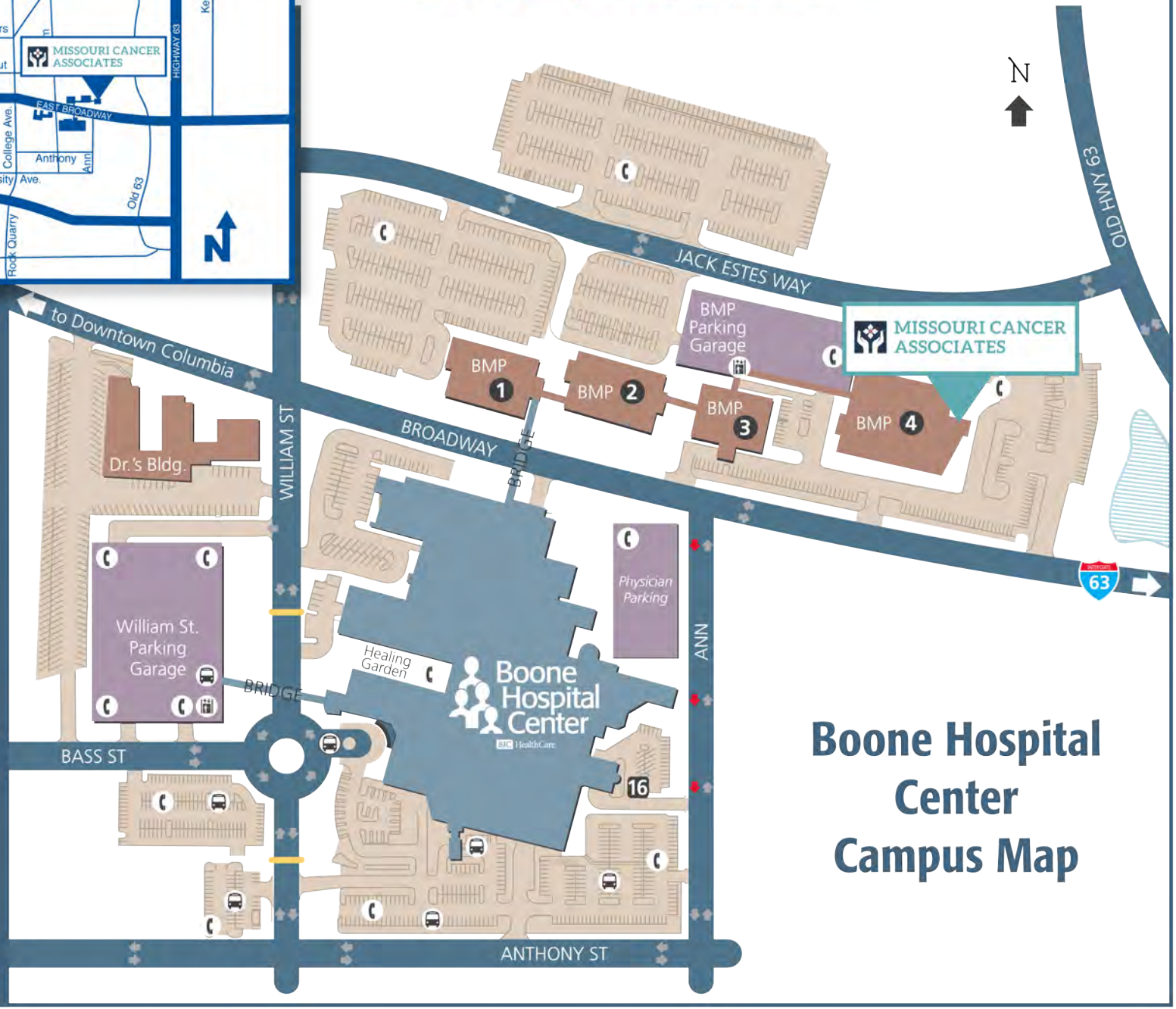
From I-70, exit at Highway 63 South. Turn west on Broadway. Continue for approximately one mile to the first drive past Old Highway 63 on the right.

Our facility is located at:
1705 East Broadway
Broadway Medical Plaza 4
Suite 100

Parking is available in front of the building.

Please feel free to call us at 573.874.7800 or toll-free at 866.724.2413.

MISSOURI CANCER ASSOCIATES



Boone Hospital Center Campus Map

MISSOURI CANCER ASSOCIATES

There for you, every step of the way.

Questions to Ask Your Physician

Patient Name:_____ **Date of Birth**: _____

Please write down any questions you may have regarding your diagnosis, your health, or anything you wish to discuss with the physician.

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

6. _____

_____

7. _____

_____

8. _____

A. Ingles
2/14/2017