Notice of Privacy Practices

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this office, whether made by your personal Social Worker or others working in this office. This notice will inform you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice of Privacy Practices.

How we may use and disclose health information about you:

- For treatment
- For health care operations
- For appointment reminders
- Child Protective reporting requirements (by law)
- As required by law
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- **Law enforcement**
- **Coroners, health examiners and funeral directors**
- **To avert a serious threat to health and safety**
- **As required by the Military or Veterans Administration**
- **National security**
- **Inmates**
- **Worker's Compensation**

Your rights regarding health information about you:

- **Right to inspect and copy**
- Right to amend
- Right to an accounting of disclosures
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this notice

Changes to Notice of Privacy Practices:
We reserve the right to change this notice. We will post a copy of the current notice in our facility with the current effective date on the first page.

Complaints:
If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact Privacy Officer at Community Cancer Services.

Acknowledgement of Receipt of this Notice:
We will request that you sign a separate form acknowledging you have a received a copy of this notice. This acknowledgment will become part of your record.

Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. I understand a longer version is available to me by request. It is also posted at Community Cancer Services.

{ } I have read the Notice of Privacy Practices.

_____ _____

Client's or Guardian's Signature Date

Updated 03/01/2013

1205 Highway 2 Suite 101B
Sandpoint, ID 83864
www.communitycancerservices.com
208-255-2301
208-255-4304 Fax

OFFICE USE ONLY

Approved Initials _____
Date _____
Inactive _____

CLIENT QUESTIONNAIRE

NAME _____ DATE _____

ADDRESS _____CITY, STATE, ZIP _____

COUNTY _____ DATE OF BIRTH _____ M or F (CIRCLE)

EMAIL _____ OK TO CONTACT FOR FUNDRAISERS? Y or N (CIRCLE)

HOME PHONE #: _____ CELL # _____ WORK #_____

SPOUSE/EMERGENECY CONTACT/CAREGIVER _____RELATIONSHIP_____

PHONE# _____ ADDRESS _____CITY, ST, ZIP _____

DO YOU HAVE HEALTH INSURANCE? YES or NO IF YES, CARRIER:_____

Are you currently working? YES or NO Have you ever served in the Military? YES or NO

Have you received assistance from any other local organization? YES or NO

Have you applied for State or Federal Assistance? YES or NO

If Yes Who? _____ When? _____ Current status? _____

SERVICES REQUESTED

□ Transportation/Rides	□ Gas Voucher	□ Mentor
□ Wigs/Hats	□ Post-Mastectomy items	□ Research Info
□ Equipment Loan	□ Assistance with Medications	□ Support Groups
□ Individual/Family Counseling	□ Ensure/Nutritional Supplements	□ Other _____ _____ _____
□ Lodging	□ Childcare Needs	_____

DIAGNOSIS _____ **REFERRED BY** _____

NOTES _____

PHONE # _____ **FAX #** _____

MONTHLY INCOME INFORMATION

Salary or Wages Self $_____ Spouse $_____ Public Assistance $_____
Spousal/Child Support $_____Other $_____

*COMBINED TOTAL MONTHLY INCOME $*_____

✸*Income for grant writing purposes only, does NOT determine eligiblility!*

AVERAGE MONTHLY EXPENSES
Rent/Mortgage: $ _____ Home/Rent Insurance: $ _____ Utilities: $ _____
Car Payments: $_____ Auto Expenses (Ins. Gas, Repairs):$_____
Phone/cell: $_____ Health Insurance: $_____ Prescriptions: $_____
Groceries/Household Expenses: $_____ Other: $_____
Health Care Cost Not Covered by Insurance: $_____

*COMBINED TOTAL MONTHLY EXPENSES $*_____

OF PEOPLE IN HOUSEHOLD: _____ ADULTS _____ CHILDREN UNDER 18 _____

In order to better serve the client's needs, Community Cancer Services (CCS) request the following information: DIAGNOSIS: _____ DATE OF DIAGNOSIS: _____
DATE TREATMENT BEGAN OR WILL BEGIN: _____

Treatments you are currently undergoing: (please check all that are applicable)
☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ Other Oncology

Where are you currently undergoing treatments?
☐ Sandpoint ☐ Spokane ☐ Coeur d'Alene ☐ Post Falls

Do you need transportation assistance to get to your appointments? _____Yes _____No

Please state anything further that you feel will assist CCS in meeting you or your family's needs.
_____
_____
_____

Client Record of Disclosures

I wish to be contacted in the following manner (check all that applies):

☐ Home # _____	☐	***Check the box if it is Ok to leave a message***
☐ Cell # _____	☐	
☐ Message # _____	☐	
☐ Written Communication		

NAME OF PHYSICIAN(S):

1. PRIMARY CARE PROVIDER _____
   ADDRESS _____
   PHONE _____

2. ONCOLOGIST _____
   ADDRESS _____
   PHONE _____

3. PHYSICIAN _____
   ADDRESS _____
   PHONE _____
   ☐ Kootenai Cancer Center (please check to include)

OTHER PHYSICIANS OR COMMUNITY AGENCIES:

- _____
- _____

I have read and understand the above CLIENT QUESTIONNAIRE, and declare the information furnished by me is true and complete to the best of my knowledge. I understand as a client of CCS, Board Members, Volunteers and employees have access to my chart at CCS.I hereby authorize COMMUNITY CANCER SERVICES to contact my physician, oncologist; treatment oncology team to obtain appropriate medical information regarding my care. In addition, I authorize CCS to contact my Pharmacies if I am utilizing the CCS's prescription assistance program. Furthermore I authorize CCS to contact Hospice if at any time I were to become a patient with Hospice. Finally I consent to the exchange of information between CCS and _____,_____,_____ This consent will remain in effect until revoked by me in writing.

_____ _____

Client/Responsible Party Printed Name of Client

_____

Date

Community Cancer Services is a private non-profit organization serving the needs of all cancer patients and their family. Community Cancer Services does not discriminate against any person because of their race, creed, religion, gender or age.