NEW PATIENT REGISTRATION PACKET

Find a digital copy of this New Patient Registration Packet online at cbsclinic.com for your convenience and reference.

CANCER & BLOOD SPECIALITY CLINIC

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P: 323-847-5857
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A LETTER TO OUR NEW PATIENTS

Thank you for choosing our clinic for your healthcare needs. We are honored to have the opportunity to provide you with the highest standard of care and support during this challenging time. At our clinic, we prioritize your safety, comfort, rights, and well-being above all else. Enclosed is your patient welcome packet containing operations and services, patient safety, and other important patient information. Please take a few minutes to read through the information and keep this packet for your future reference.

On behalf of our entire clinic, we extend a warm welcome to you. We are here to walk alongside you on your healthcare journey, providing comprehensive treatment, advanced therapies, and access to copay assistance programs whenever feasible. We are grateful to be a part of your healthcare team, and we look forward to serving you with excellence and compassion.

This packet includes the following information:

- Patient Demographics Form
- Medication and Allergies List
- Authorization to Release Healthcare Information
- Prescription Services
- Copay Assistance Programs
- HIPAA Email Consent
- Advanced Directive Statement
- Acknowledgement of Supplemental Material
- Patient Education
- Patient Complaint/Grievance Form
- Patient Medical Records Request Form

PATIENT DEMOGRAPHICS FORM

Today's Date: _____

Please PRINT

PATIENT INFORMATION			
Last Name	First Name	Middle Initial	Nickname
Date of Birth	Social Security Number	Driver's License Number	Gender ☐ Male ☐ Female
Marital Status (circle one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow			
Home Address			
P.O. Box	City	State	Zip Code
Home Phone	Mobile Phone	Email	
Occupation	Employer	Employer Phone	
Ethnicity	Race	Preferred Language	

REFERRAL INFORMATION	
How did you hear about us? ☐ Referring Doctor ☐ Insurance Referral ☐ Family and Friends ☐ Website ☐ Other: _____	
Primary Care Physician	Physician Phone
Referring Physician	Physician Phone

EMERGENCY CONTACT INFORMATION	
Name of emergency contact (not living at same address)	Relationship to patient
Home Phone	Mobile Phone

METHODS OF COMMUNICATION	
I authorize CBSC's staff to do the following: ☐ Leave a detailed message on my home phone ☐ Leave a detailed message on my mobile phone ☐ Send a text message to my mobile phone ☐ Send mail to my home ☐ Send me an unencrypted email (refer to HIPAA Email Consent section)	The following people are authorized to discuss and receive information about my Personal Health Information: Individual 1: Name: _____ Relationship: _____ Individual 2: Name: _____ Relationship: _____

By signing below, I confirm that the information provided in this demographics form is accurate and complete to the best of my knowledge. I understand that it is my responsibility to promptly inform the healthcare facility of any changes to my personal or insurance information.

Patient/Guardian Signature: _____ Date: _____

RETURN TO CLINIC

MEDICATIONS AND ALLERGIES LIST

Patient Name: _____ DOB: _____

CURRENT MEDICATIONS		
Name of Medication	**Dosage**	**Frequency**
PATIENT ALLERGIES		
PHARMACY INFORMATION		
Pharmacy 1	Phone	Location
Pharmacy 2	Phone	Location

I confirm that the information provided above is filled out accurately to the best of my knowledge.

Patient Signature: _____ Date: _____

RETURN TO CLINIC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ DOB: _____

Phone Number: _____ SSN: _____

At the Cancer and Blood Specialty Clinic, we understand the importance of comprehensive care, which often involves collaboration with other healthcare providers. By signing this authorization to release and receive healthcare information, you empower us to securely exchange your medical records with other medical facilities involved in your care.

This authorization allows us to:

1. **Receive Medical Records**: We can obtain vital information from your previous and current healthcare providers, including medical histories, test results, and treatment plans. This ensures we have a complete understanding of your health status and can tailor our services to meet your needs effectively.
2. **Send Medical Records:** We can share relevant information with other healthcare providers as needed, facilitating seamless coordination of care. Whether you require referrals, consultations, or ongoing treatment, this authorization ensures that essential information is communicated accurately and efficiently.

Your privacy and confidentiality are our top priorities. Rest assured, all information exchanged is done so securely and in compliance with privacy regulations.

To streamline this process, please take a moment to fill out the information below:

I request and authorize the Cancer and Blood Specialty Clinic to:

☐ Receive healthcare information from other healthcare providers involved in my care relating to the following treatment, condition, or dates: _____

☐ Receive all healthcare information from other healthcare providers involved in my care

☐ Send my medical records to other healthcare providers as needed for continuity of my care

☐ Other: _____

I understand that I may refuse to sign this authorization or revoke this authorization at any time by giving written notice to Cancer and Blood Specialty Clinic. I understand that my revocation or refusal to sign this authorization form will not affect my ability to obtain health care services or payment or my eligibility for benefits. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from which disclosure is sought in writing. I understand as a patient I have the right to access my records during business hours. Copies of the records may be obtained with reasonable notice and payment of printing cost. I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations. A photocopy or exact reproduction of this signed authorization shall have the same force and effects as the original.

Patient Signature: _____ **Date:** _____

RETURN TO CLINIC

CBSC PRESCRIPTION SERVICES

Prescription Services Phone Number: (562) 725-4368
Prescription Services Address: 3851 Katella Ave #125, Los Alamitos, CA, 90720
Hours of Operation: Monday through Friday, 9:00 AM-5:00 PM
Website: https://cbsclinic.com/

At the Cancer and Blood Specialty Clinic, our prescription services are tailored to ensure seamless medication management for our patients. We understand the critical role medication plays in your treatment journey, we are committed to providing personalized care and support every step of the way.

Prescription services include, but are not limited to:

- Timely and accurate medication filling
- Personalized plan of care
- Specialized clinical staff for patient support
- Immediate implementation of physician-recommended changes
- Patient counseling, education, and monitoring
- Advocacy for patient access to medications
- Guidance on financial assistance programs
- Adherence reminder calls
- 24/7 access to dispensing physician for consultation
- Referral to other providers if medication cannot be filled

PRESCRIPTION SERVICES ACKNOWLEDGEMENTS:

1. I acknowledge that it is my responsibility to provide accurate and up-to-date information regarding my personal details, contact information, and medical history.
2. I understand that the prescription services provided at the Cancer and Blood Specialty Clinic are an integral part of my treatment and care.
3. I acknowledge that it is my responsibility to inform the clinic's prescription services of any changes in my medications, allergies, or medical conditions.
4. I understand that the prescription services team may need to consult with my healthcare providers to ensure the safe and effective use of medications.
5. I acknowledge that the prescription services team may need to contact me to discuss medication-related matters, including refill requests, dosage adjustments, and potential side effects.
6. I understand that the prescription services team will make every effort to maintain the privacy and confidentiality of my personal and medical information.
7. I acknowledge that it is important for me to follow the instructions provided by the prescription services team regarding medication administration, storage, and potential interactions with other substances.
8. I understand that the prescription services team may provide medication counseling and education to ensure my understanding of the medications prescribed to me.

By signing below, I confirm that I have reviewed the information provided and choose to:

☐ Consent to filling medications with the Cancer and Blood Specialty Clinic prescription services
☐ Opt out of filling medications with the Cancer and Blood Specialty Clinic prescription services

Print Name: _____ **Signature:** _____ **Date:** _____

RETURN TO CLINIC

COPAY ASSISTANCE PROGRAMS

Our copay assistance program is designed to help patients afford their medication costs. It is important to note that this assistance is specifically for medications and may not cover other medical expenses, such as office visit copays.

Drug assistance programs provide financial support to patients who need help affording their medications. These programs can come from pharmaceutical companies, nonprofit organizations, government agencies, and other sources. They often offer discounts, coupons, or direct financial assistance to reduce the out-of-pocket costs of prescription medications.

To ensure that you qualify for copay assistance and to process your application efficiently, we may need certain information from you that verify your identity and eligibility for assistance. Providing accurate and complete information ensures that you receive the maximum benefit from the copay assistance program. We understand the sensitivity of this information and assure you that it will be handled securely and in accordance with privacy laws.

Patient Name: _____

Patient DOB: _____

Social Security Number: _____

Annual Household Income: _____

Number of Dependents: _____

Employment Status: _____

Are you currently enrolled in any copay assistance programs? ☐ Yes ☐ No

CONSENT FOR COPAY ASSISTANCE PROGRAMS

Please check one of the following:

☐ I hereby authorize the Cancer and Blood Specialty Clinic Prescription Services to apply for copay assistance programs on my behalf if such programs are available and if I meet the qualifications. I understand that this information is necessary to determine my eligibility for financial support, which will assist me in accessing the necessary healthcare services. I acknowledge that the clinic will handle my personal and medical information with utmost privacy and confidentiality in accordance with applicable laws.

By signing below, I affirm that the information provided above is accurate and complete to the best of my knowledge. I understand that any false or misleading information may affect my eligibility for copay assistance.

Patient Signature: _____ Date: _____

☐ I do not wish to consent for copay assistance programs at this time.

Patient Signature: _____ Date: _____

RETURN TO CLINIC

HIPAA EMAIL CONSENT

HIPAA is a federal law enacted to safeguard patients' protected health information (PHI) and ensure its confidentiality, integrity, and availability, At the Cancer and Blood Specialty Clinic, we adhere to HIPAA regulations to protect your privacy and maintain the security of your medical information. Email communication is a convenient and popular method for sharing information, including healthcare-related matters. However, it's essential to be aware of the potential risks associated with unencrypted email transmission, particularly when sharing sensitive medical information.

Risks of Unencrypted Email Transmission

When information is transmitted via unencrypted email:

- Data stored on our computer is encrypted, but popular email serviced like Hotmail®, Gmail®, Yahoo® do not utilize encryption.
- Third parties may intercept and access the information while it is transmitted over the internet.
- Once received, someone with access to the patient's email account may also be able to read the information.

HIPAA Guidance on Email Communication

The federal government, through the Department of Health and Human Services (HHS), has provided guidance on email communication and HIPAA. According to these guidelines:

- If a patient has been made aware of the risks associated with unencrypted email transmission and provides consent to receive health information via email, a healthcare entity may send personal medical information to that patient via email.

Accessing the Guidelines

For further information on HIPAA and email communication, you can visit the Department of Health and Human Services website, where you'll find detailed guidelines and resources regarding the transmission of health information via email.

https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providers-to-use-email-to-discuss-health-issues-with-patients/index.html

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Your Consent

By providing your consent, you acknowledge that you understand the risks associated with unencrypted email transmission and agree to receive health information via email. This consent allows us to communicate with you efficiently and effectively while maintaining compliance with HIPAA regulations.

☐ I consent to receive unencrypted email communication from the Cancer and Blood Specialty Clinic for health-related purposes.
☐ I do not consent to receive unencrypted email communication from the Cancer and Blood Specialty Clinic for health-related purposes.

By selecting the appropriate option above, you acknowledge and agree to the terms outlined in our HIPAA Email Consent Policy. Please sign below to confirm your choice.

Patient Print Name: _____

Patient Signature: _____ Date: _____

ADVANCED DIRECTIVE STATEMENT

As part of our commitment to providing comprehensive and compassionate care, we ask all patients to indicate whether they have an advanced directive in place. An advanced directive is a legal document that outlines your healthcare preferences in the event that you are unable to communicate them yourself.

Please indicate below whether you have an advanced directive:

☐ Yes, I have an advanced directive.

☐ No, I do not have an advanced directive.

If you have an advanced directive, would you be willing to provide us with a copy for inclusion in your medical records?

☐ Yes, I am willing to provide a copy.

☐ No, I prefer not to provide a copy at this time.

Please indicate below if you have named a surrogate decision maker

☐ Yes, I have named a surrogate decision maker in my advanced directive.

☐ No, I have not named a surrogate decision maker in my advanced directive.

If you have named a surrogate decision maker, please provide the following information:

Name of Surrogate Decision Maker: _____
Relationship to Patient: _____
Phone Number: _____
Email Address: _____

If you have not yet named a surrogate decision maker in your advanced directive, we encourage you to consider doing so and to discuss your wishes with them.

Please note that completing an advanced directive and designating a surrogate decision maker are voluntary. Your decision will not affect your access to care or treatment at our facility.

Thank you for taking the time to provide this important information. If you have any questions or need assistance, please don't hesitate to ask our staff.

RETURN TO CLINIC

ACKNOWLEDGEMENT OF SUPPLEMENTAL MATERIAL

Before proceeding, please take a moment to review the supplemental materials provided in this packet. These documents are designed to assist you in understanding your rights, responsibilities, and the policies of the Cancer and Blood Specialty Clinic. Our commitment to your well-being extends beyond medical treatment, and we believe that clear communication and mutual understanding are essential for a positive patient experience. Should you have any questions or require further clarification on any aspect of the materials, our staff is here to assist you every step of the way. Your comfort, safety, and satisfaction are our top priorities, and we are dedicated to providing you with the highest quality of care throughout your journey with us.

Please initial next to the following statements to signify that you have read and acknowledge these sections:

_____ **Notice of Privacy Practices:** I understand the policies and procedures regarding the privacy of my health information as outlined in the Notice of Privacy Practices. I understand how my health information is protected and used by the clinic.

_____ **Financial Fees and Responsibilities:** I understand my financial responsibilities for services provided and the clinic's fee structure.

_____ **Patient Rights and Responsibilities:** I am aware of my rights and responsibilities as a patient at the clinic.

_____ **No Show Policy:** I understand the consequences of missing appointments without prior notice.

_____ **Termination Policy:** I understand the circumstances under which the clinic may terminate our professional relationship.

_____ **Patient Complaint/Grievance Form:** I am familiar with the clinic's process for filing a complaint or grievance.

_____ **Patient Medical Records Request Form:** I understand the process for requesting my medical records from the clinic.

By signing below, I confirm that I have reviewed and understand the supplemental materials provided by the clinic, and I agree to abide by the policies and procedures outlined in each document.

Patient Print Name: _____

Patient Signature: _____ Date: _____

RETURN TO CLINIC

PATIENT EDUCATION

Notice of Privacy Practices

At the Cancer and Blood Specialty Clinic, safeguarding your privacy and confidentiality is fundamental to our commitment to providing exceptional healthcare. This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can access this information. We encourage you to review it carefully.

How Your Medical Information May Be Used and Disclosed:

Your medical information may be used and disclosed for purposes such as treatment, payment, and healthcare operations. Additionally, we may use and disclose your information for purposes permitted or required by law, such as public health activities and legal proceedings.

Your Rights Regarding Your Medical Information:

You have the right to:

- Obtain an electronic or paper copy of your medical record
- Correct your health and claims if you believe they are inaccurate or incomplete
- Request confidential communication of your medical information
- Ask us to limit the information we share
- Receive the list of those with whom we've shared your information
- Obtain a copy of this Notice of Privacy Practices
- Designate someone to act on your behalf regarding your privacy rights
- File a complaint if you believe your privacy rights have been violated

Requesting Your Medical Records

To obtain a copy of your medical records, simply fill out a Medical Records Request Form attached to this packet. Once submitted, your treating physician will review and approve the request. This step ensures that any sensitive or confidential information is appropriately reviewed and released in accordance with applicable laws and regulations. Once your request and physician approval are received, we will process your request promptly. Please note that processing times may vary depending on the volume of requests and the complexity of your medical records. Records will be received in a paper format and can be picked up at our clinic. A nominal fee may apply for the processing and duplication of your medical records. Our staff will inform you of any applicable fees prior to processing your request.

Questions and Concerns

If you have any questions or concerns about how your medical information is used or disclosed, please don't hesitate to ask our staff. Your privacy is important to us, and we are here to address any inquiries you may have.

Filing and Complaint

If you believe your privacy rights have been violated, you have the right to file a complaint with our Human Resources and Compliance Specialist, Alison Le. Please direct your complaints to:

Alison Le
HR and Compliance Specialist
3851 Katella Ave Suite #125
Los Alamitos, CA, 90720
Tel: (562) 353-1184
Email: ale@cbsclinic.com

PATIENT EDUCATION

Financial Fees and Responsibilities

At Cancer and Blood Specialty Clinic we believe in transparent communication regarding financial responsibilities to ensure a smooth and stress-free healthcare experience for our patients. Please take a moment to review the following information regarding financial fees and responsibilities.

Patient Financial Responsibility

When you elect to participate in our healthcare services, you assume a financial responsibility for the fees associated with your care. While we strive to provide comprehensive billing services, it's important to understand that you are ultimately responsible for ensuring payment in full of your fees.

Insurance Billing

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, please note that any fees not covered by your insurance, including copayments, deductibles, and coinsurance are your responsibility. If your insurance claim denies any part of the claim or if continued therapy is elected past the approved period, you will be responsible for the account balance in full.

Understanding Our Financial Policies

We consider understanding our financial policies as an integral part of your care and treatment. Our aim is to provide you with the best possible care and service, and clarity regarding financial obligations is an essential aspect of this commitment.

Additional Fees

Please be aware of the following fees that are instituted and are not billable to insurance. Payment will be required prior to your next scheduled visit.

Missed Appointments (No Show Without Notice)	$25.00
Dictated Physician Letter	$25.00
Forms – EDD, FMLA	$25.00
DMV, Jury Duty	$20.00
Short Notice Cancellations (Less Than 24 Hours)	$25.00
Non-Sufficient Funds Check	$40.00

These fees are charged because insurance generally covers medical services aimed at diagnosing, treating, or preventing illness/injury. However, completed forms and associated fees are administrative rather than medical in nature. Insurance typically does not reimburse for these services because they are not considered medically necessary.

Payment Requirements

Copayments, coinsurance, and deductibles are to be paid prior to services being performed. This ensures timely and efficient processing of your appointment and billing.

PATIENT EDUCATION

Patient Rights and Responsibilities

To ensure the finest care possible, all of Cancer and Blood Specialty Clinic patients are entitled to the following:

Patient Rights

- To select those who provide you with clinic and prescription services
- To receive the appropriate or prescribed services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap
- To be treated with friendliness, courtesy and respect by each and every individual representing our organization, who provided treatment or services for you and be free from neglect or abuse, be it physical or mental
- To assist in the development and preparation of your plan of care that is designed to satisfy, as best as possible, your current needs, including management of pain
- To be provided with adequate information from which you can give your informed consent for commencement of services, the continuation of services, the transfer of services to another health care provider, or the termination of services
- To express concerns, grievances, or recommend modifications to your clinic and dispensary services, without fear of discrimination or reprisal and to have grievance followed up by staff
- To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, risk of treatment or care plans
- To receive treatment and services within the scope of your plan of care, promptly and professionally, while being fully informed as to our clinic's policies, procedures and charges
- To request and receive information regarding treatment, scope of services, or costs thereof, privately and with confidentially
- To be given information as it relates to the uses and disclosure of your plan of care
- To have your plan of care remain private and confidential, except as required and permitted by law
- To receive instructions on handling drug recall
- To confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information
- To receive information on how to access support from consumer advocates groups
- To receive clinic and prescription services health and safety information to include consumers' rights and responsibilities
- To identify the staff member of the clinic and their job title, and to speak with a supervisor of the staff member if requested
- To decline participation, refuse treatment and have consequences explained, revoke consent or dis-enroll at any point in time

Patient Responsibilities

- To provide accurate and complete information regarding your past and present medical history
- To give accurate clinical and contact information and to notify the clinic of changes in this information
- To agree to a schedule of services and report any cancellation of scheduled appointments and/or treatments
- To participate in the development and updating of a plan of care
- To communicate whether you clearly comprehend the course of treatment and plan of care
- To comply with the plan of care and clinical instructions
- To accept responsibility for your actions, if refusing treatment or not complying with, the prescribed treatment and services
- To notify your physician, clinic, and prescription services with any potential side effects and/or complications
- To notify CBSC via telephone or in person when medication supply is running low so refill may be completed for you promptly
- To submit any forms that are necessary to participate in the organization to the extent required by law
- To respect the rights of clinic personnel

PATIENT EDUCATION

No Show Policy

At the Cancer and Blood Specialty Clinic, we understand that unexpected circumstances may arise that prevent patients from attending scheduled appointments. However, missed appointments can disrupt out scheduling and prevent other patients form receiving timely care. Therefore, we have implemented the following no-show policy:

1. Patients are expected to arrive on time for scheduled appointments. If unable to attend, we require at least 24 hours' notice to cancel and reschedule appointments.
2. Failure to provide timely notice of cancellation or failure to attend a scheduled appointment without prior notification may be considered a no-show.
3. A patient who accumulated a no-show will be subject to a $25 fee, which will be billed to their account.
4. Patients who anticipate difficulty attending scheduled appointments are encouraged to contact our clinic as soon as possible to discuss alternative options or rescheduling.

Termination Policy

At the Cancer and Blood Specialty Clinic, we strive to maintain a positive and productive patient-provider relationship. However, in certain circumstances, it may become necessary to terminate our professional relationship with a patient. This decision may be made if:

1. The patient engaged in behavior that is disruptive, abusive, or threatening to staff and other patients.
2. There is a threat of legal action against CBSC physicians and employees.
3. The patient fails to comply with physician's order regarding their care, preventing the physician from providing adequate medical care.
4. An individual fails to show for their first appointment without notification or rescheduling.
5. A patient chronically fails to show for appointments, preventing other patients from receiving timely care.
6. The patient engages in misuse or abuse of prescriptions and medications.
7. The physician determines that he or she cannot provide continued, effective care.

In the event of termination, the patient will be notified in writing and provided with information regarding the reason for termination, any outstanding obligations or referrals, and options for seeking alternative care.

Every effort will be made to provide ongoing health care to all patients at CBSC. This medical practice does not discriminate in providing care to a patient due to race, color, sex, religion, national origin, age, handicap, or any other factors prohibited by law.

PATIENT EDUCATION

Emergency Preparedness

In case of a medical emergency at home, your safety is paramount. If you or someone else experiences a life-threatening situation, such as difficulty breathing, chest pain, severe bleeding, or loss of consciousness, please dial 911 immediately for emergency medical assistance. While awaiting help, provide any necessary first aid to the best of your ability and ensure the safety of the individual until paramedics arrive. Remain calm and follow the instructions provided by the 911 dispatcher. Your quick action can make a significant difference in the outcome of the emergency.

Additionally, we encourage you to follow up with our clinic after any emergency situation or if you have any concerns about your health. CBSC is here to support you every step of the way, ensuring you receive the care and assistance you need during your journey with us.

In the event of an emergency related to your medication or if you need to contact our prescription services after hours, our on-call physician can be contacted by calling the prescription services number, (562) 725-4368, and pressing 2. Our dedicated team is available to assist you 24/7, ensuring that you have access to medical support whenever you need it. We understand the importance of timely communication regarding medication, and our on-call physician is ready to address any concerns or emergencies that may arise.

Medication Disposal

Proper disposal of medication is crucial for both environmental and safety reasons. We encourage all patients to dispose of unused or expired medications properly. Here are some dos and don't for medication disposal:

DO:

1. **Use Medication Take-Back Programs:** Many pharmacies, healthcare facilities, and law enforcement agencies offer medication take-back programs. There programs allow you to safely dispose of unused or expired medications at designated drop-off locations.
2. **Follow Disposal Instructions:** Some medications come with specific disposal instructions provided by the dispensing physician. Follow these instructions carefully to ensure proper disposal.
3. **Remove Personal Information:** Before disposing of medication packaging, be sure to remove any personal information to protect your privacy.

DON'T:

1. **Flush Medications Down the Toilet:** Flushing medications down the toilet can contaminate water sources and harm aquatic life. Avoid flushing medications unless specifically instructed to do so by disposal instructions or take-back programs,
2. **Throw Medications in the Trash Whole:** Simply throwing medications in the trash can pose a risk of accidental ingestion, especially for children or pets.
3. **Share Medications**: Never share prescription medications with others, even if they have similar symptoms or conditions. Each medication is prescribed based on individual needs and health factors.

KEEP FOR YOUR RECORDS

PATIENT COMPLAINT/GRIEVANCE FORM

Patient Name: _____ DOB: _____

NATURE OF COMPLAINT/GRIEVANCE:
Please describe the nature of your complaint or grievance in detail.

_____
_____
_____

DATE OF INCIDENT: _____ **LOCATION OF INCIDENT:** _____

NAMES OF INDIVIDUALS INVOLVED: _____

RESOLUTION DESIRED:
Please describe the outcome or resolution you are seeking:

_____
_____
_____

I acknowledge that as a patient of CBSC Clinic, I have the right to voice my concerns and file a complaint or grievance without fear of reprisal. I also understand that it is my responsibility to provide accurate and detailed information regarding my complaint or grievance. By signing this form, I am formally submitting a complaint or grievance to CBS Clinic. I acknowledge that the clinic staff will review and address my concerns in a timely manner.

Signature: _____ Date: _____

Witness Signature (if applicable): _____ Date: _____

Note: We take patient complaints and grievances seriously and are committed to addressing them promptly and effectively. Your feedback is valuable to us and helps us improve our services.

CLINIC STAFF RESPONSE – FOR CLINIC USE ONLY

DATE RECEIVED: _____ **DATE ACKNOWLEDGED:** _____

INVESTIGATION OUTCOME:

_____
_____
_____

RESOLUTION PLAN:

_____
_____
_____

Clinic Staff Representative Signature _____ Date: _____

KEEP FOR YOUR RECORDS

PATIENT MEDICAL RECORDS REQUEST FORM

Our Medical Records Request Form allows you to obtain copies of your medical records from the Cancer and Blood Specialty Clinic. Medical records contain vital information about your health history, diagnoses, treatments, and medications. By completing this form, you can request access to your records for personal review, continuity of care, or to share with other healthcare providers as needed. Your medical records are confidential and protected by privacy laws, and our clinic is committed to ensuring the security and privacy of your health information. Simply fill out the form and our staff will process your request promptly. We understand the importance of having access to your medical history, and we are here to assist you in obtaining the information you need for your continued care.

Please note: Records are available for pick-up in-office only. Processing times may vary.

Full Name:	
DOB:	
Specific Records Requested: *Please ensure that you provide specific dates and specify the exact records required in addition to checking the checkbox options provided. This will help us process your request accurately and efficiently.*	☐ Consultation Notes: _____ ☐ Progress Notes: _____ ☐ Lab Results: _____ ☐ Imaging Results: _____ ☐ Pathology Results: _____ ☐ Medication History: _____ ☐ Other: _____

PURPOSE OF REQUEST

☐ Personal Review
☐ Continuity of Care
☐ Second Opinion
☐ Legal Purposes
☐ Other (Please specify): _____

DESIGNATED INDIVIDUALS (IF APPLICABLE)

If you are designating another individual to receive these records, please provide their contact information and indicate your relationship to them in this section.

Full Name:	
Relationship to Patient:	
Contact Information:	

SIGNATURE

Before signing, please review your selections and ensure that all necessary information is provided to accurately fulfill your medical records request.

Patient Signature:		**Date:**	

KEEP FOR YOUR RECORDS