Seattle Cancer Care Alliance
Fred Hutch · Seattle Children's · UW Medicine
Proton Therapy Center

Dear New Patient,

Welcome to the SCCA Proton Therapy Center. We're committed to helping our patients live healthy, fulfilling lives by providing the best treatment and care possible. Our care team focuses not only on treatment, but also on patients' overall well-being. Please don't hesitate to let any of our staff know if you have any questions or concerns.

Before we can start your treatment, we need to gather some information and signatures from you. This packet includes all the forms we need to ensure that you are properly registered, and our care teams have all the background information pertinent to your care.

Please take a minute to carefully read the instructions.

Once you've completed the forms, please print them out and bring them with you to the Center or ask Concierge to print them for you. We will need these forms before you can begin your first appointment.

- To fill out the forms, please click on a blue box and start typing. Hit the TAB button to move to the next box.
- Boxes with a red border are required.
- Some boxes will auto-fill in the rest of the forms so that you don't have to retype the same information more than once.

SCCA Proton Therapy Center
Registration / Assignment of Benefits

Seattle Cancer Care Alliance
Fred Hutch · Seattle Children's · UW Medicine
Proton Therapy Center

Patient Information:

Patient First Name:_____ MI:_____ Patient Last Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Preferred Number: Alternate:

Email Address:_____
Preferred Method of Contact: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

OK to leave message? ☐ Yes ☐ No

Demographics:

Date of Birth:_____ Gender:_____ Marital Status:_____

Caregiver Name:_____ Languages Spoken:_____ Interpreter Needed? ☐ Yes

Race:_____ Ethnicity:_____

Employer:

Employer Name:_____ Employer Phone:_____

Employer Address:_____

Occupation:_____

Responsible Party:

Responsible Party Name:_____ Relationship to Patient:_____

Responsible Party Phone:_____

Emergency Contact Information:

Emergency Contact Name:_____ Relationship to Patient:_____

Emergency Contact Phone:_____

Insurance Information:

Primary Insurance:_____ Primary Insurance Phone:_____

Insured Name:_____ Insured Date of Birth:_____

Group Number:_____ Patient ID Number:_____

Secondary Insurance:_____ Secondary Insurance Phone:_____

Insured Name (if different from Primary):_____

Insured Date of Birth (if different from Primary):_____

Group Number:_____ Patient ID Number:_____

Physician Information:

Primary Care Physician Name:	Facility:	Phone:
Medical Oncologist :	Facility:	Phone:
Radiation Oncologist:	Facility:	Phone:
Surgeon:	Facility:	Phone:

For Ocular Patients only:

Ocular Oncologist :	Facility:	Phone:
Retinal Specialist:	Facility:	Phone:
Optometrist:	Facility:	Phone:

For Thoracic/Lung Patients only:

Pulmonologist:	Facility:	Phone:

For Brain/CNS Patients only:

NeuroOncologist:	Facility:	Phone:
Neurologist:	Facility:	Phone:

For Gastroenterology Patients only:

Gastroenterologist:	Facility:	Phone:

For Prostate/Genito-urinary Patients only:

Urologist:	Facility:	Phone:

Other Care Provider:	Facility:	Phone:
Other Care Provider:	Facility:	Phone:
Preferred Pharmacy:	Phone:	
Preferred Imaging:	Phone:	
Preferred Labs:	Phone:	

Assignment of Benefits

1. I authorize my insurance company to release information regarding my coverage to SCCA Proton Therapy Center. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits and quality assurance reviews within the SCCA Proton Therapy Center.
2. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing services, including major medical benefits, are hereby assigned to SCCA Proton Therapy Center. This assignment covers any and all benefits under Medicare, other government-sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to SCCA Proton Therapy Center.
3. As a courtesy to you, SCCA Proton Therapy Center will verify your health insurance benefits; however, you, the policy holder, are ultimately responsible for knowing your insurance policy coverage, co-pay, deductible and co-insurance and maximum out-of-pocket. Proton beam therapy is provided in an office setting, not a facility, and you may be responsible for a co-pay for an office visit and a physician visit.
4. I understand that I may be responsible for charges not covered or reimbursed by the above agents. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. It is my responsibility to notify the SCCA Proton Therapy Center of any changes in health care insurance coverage.
5. I understand that my patient information arising out of my medical treatment by physicians and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally-funded registries (which in the case of patients receiving stem cell transplant services may include sharing of patient-identifying information such as name and address) and universities; (e) representatives and agents of my health benefits plan; (f) persons conducting quality or peer review of patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with SCCA Proton Therapy Center.

   This Agreement/Consent will remain in effect unless revoked by me in writing.

   I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original. I agree, and it is my intent, to sign this document by electronically submitting it to SCCA Proton Therapy Center. I understand that my signing and submitting this document in this fashion is the legal equivalent of having placed my hand-written signature on this document. I understand and agree that by electronically signing and submitting this document in this fashion I am affirming to the truth of the information contained therein.

Patient Signature:_____ Date:

Responsible Party Signature:_____ Date:

Seattle Cancer Care Alliance
Fred Hutch · Seattle Children's · UW Medicine
Proton Therapy Center

Electronic Communications Consent

By your electronic signature below, you agree and consent to receive electronically all communications, agreements, documents, notices and disclosures (collectively, "Communications") that Seattle Proton Center, LLC (the "Center" or "we") provides to you in connection with the services rendered by the Center. Communications may include, but are not limited to:

- HIPAA Notice of Privacy Practices
- Acknowledgment of Receipt of HIPAA Notice of Privacy Practices
- Statement of Patient Rights
- Assignment of Benefits
- Medical Records Release

We will provide these Communications to you by posting them on the Center's web site after you log-in, and/or by emailing them to you at your registered email address. It is your responsibility to keep your registered email address up to date so that we can communicate with you electronically. You have the right to request paper copies of any Communication. Paper copies can be requested by calling 206-306-2800.

By signing this Consent, you acknowledge that there may be some level of risk that Communications transmitted over the internet or through e-mail could be read by a third party. The Center is not responsible for any unauthorized access of Communications that the Center transmits to you via the internet or through e-mail.

You may withdraw your consent to receive Communications electronically by calling us at 206-306-2800.

Please indicate your consent to the foregoing by clicking "Accept" below.

Signature: _____

Patient Name: _____

Date: _____

☐ ACCEPT

Seattle Cancer Care Alliance
Fred Hutch · Seattle Children's · UW Medicine
Proton Therapy Center

Authorization to Obtain Protected Health Information

Patient Information:

Patient First Name:_____ MI:_____ Patient Last Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____

Who are we authorized to obtain your protected health information from?

Person/Organization	Phone	Street Address

Information Type(s) to be obtained:

Date range of records to be obtained:_____

☐ All Medical Records ☐ Imaging Reports ☐ Pathology Reports ☐ Laboratory Reports
☐ ED Records ☐ Imaging Films ☐ Pathology Reports ☐ Billing Records
☐ Other:_____

Signature_____ Date:_____

I understand that the information in my health record may include sensitive information related to HIV/AIDS, sexually transmitted diseases, behavioral or mental health services, and/or treatment for alcohol and drug abuse.

☐ *I wish to exclude from disclosure sensitive information related to sexually transmitted diseases, including AIDS, HIV, mental health services and treatment for alcohol and drug abuse.*

Minors: A minor patient's signature is required in order to release the following information: Conditions relating to the minor's reproductive care, sexually transmitted disease (if age 14 and older), alcohol and/or drug abuse, and mental conditions (if age 13 and older).

Minor Signature:_____ Date:_____

By signing this page, I acknowledge that I have read and agree to the terms on both sides of this form.

Signature (Patient or Patient's Authorized Representative):	Print Name	Date
If signed by person other than patient, what is your relationship to the Patient? (*Please attach legal documentation) ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney*		

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Compliance Officer, Seattle Proton Center, 1570 N. 115th Street, Seattle, WA 98133
- Revocation will not apply to information that has already been disclosed in response to this authorization.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this release.
- REDISCLOSURE: Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected with the exception of Alcohol/Drug Abuse records, which are protected by Federal Confidentiality Rules that prohibit the recipient from redisclosure unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part2.

(THE AREA BELOW IS FOR SEATTLE PROTON THERAPY CENTER USE ONLY)

Printed name of employee processing this request: _____

Date received:_____Date processed:_____ Medical Record: _____

Seattle Cancer Care Alliance
Fred Hutch · Seattle Children's · UW Medicine
Proton Therapy Center

Authorization to Disclose Protected Health Information

Patient Information:

Patient First Name:_____ MI:_____ Patient Last Name: _____

Address: _____

City: _____ State:_____ Zip: _____

Date of Birth: _____

Initial Information:

1. Select the purpose of your request to release records from the options below:

☐ Continuing care (Provider/Facility) ☐ Personal Copy ☐ Insurance ☐ Legal
☐ Coordination of Care (Family/Caregivers) Other _____

2. Who are we authorized to release your health information to or discuss your health information with?

Person/Organization	Phone	Preferred Delivery Method (Address, Email address or Fax number)

Information Type(s) to be Released:

☐ End of Treatment Summary ☐ On Treatment Visit Notes ☐ Simulation Notes
☐ Treatment Summary ☐ Other: _____

Authorization Expiration Date (Expires 90 days from date signed if a box is not checked) End of

☐ Treatment
☐ Other: _____

Signature:_____ **Date:**_____

I understand that the information in my health record may include sensitive information related to HIV/AIDS, sexually transmitted diseases, behavioral or mental health services, and/or treatment for alcohol and drug abuse.

☐ *I wish to exclude from disclosure sensitive information related to sexually transmitted diseases, including AIDS, HIV, mental health services and treatment for alcohol and drug abuse.*

Minors: A minor patient's signature is required in order to release the following information: Conditions relating to the minor's reproductive care, sexually transmitted disease (if age 14 and older), alcohol and/or drug abuse, and mental conditions (if age 13 and older).

Minor Signature:_____ **Date:**_____

By signing this page, I acknowledge that I have read and agree to the terms on both sides of this form.

Signature (Patient or Patient's Authorized Representative):	**Print Name**	**Date**
If signed by person other than patient, what is your relationship to the Patient? (*Please attach legal documentation) ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney*		

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Compliance Officer, Seattle Proton Center, 1570 N. 115th Street, Seattle, WA 98133
- Revocation will not apply to information that has already been disclosed in response to this authorization.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this release.
- REDISCLOSURE: Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected with the exception of Alcohol/Drug Abuse records, which are protected by Federal Confidentiality Rules that prohibit the recipient from redisclosure unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part2.

(THE AREA BELOW IS FOR SEATTLE PROTON THERAPY CENTER USE ONLY)

Printed name of employee processing this request: _____

Date received:_____Date processed:_____ Medical Record:_____

Seattle Cancer Care Alliance
Fred Hutch · Seattle Children's · UW Medicine
Proton Therapy Center

SCCA Proton Therapy Center
Health History Questionnaire

Patient Information:

Patient First Name:_____ MI:_____ Patient Last Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone Number: Cell: Work:

Email Address:_____

Date of Birth:_____

EmergencyContactInformation:

Emergency Contact Name:_____ Relationship to Patient:_____

Emergency Contact Phone:_____

Can we disclose medical information to spouse/companion/emergency contact? ☐ Yes ☐ No

Health History:

Do you need help in your home? ☐ Yes ☐ No Do you have transportation needs? ☐ Yes ☐ No

Please list any allergies you have:

Please list any medical problems you have or are concerned about:

Are you currently or have you ever had chemotherapy, radiation, or other treatment for cancer? If yes, please explain:

Surgeries:

If you have had previous surgeries, do you have any implants or hardware that stay in your body? ☐ Yes ☐ No

Year:_____ Reason:_____ Hospital:_____

Year:_____ Reason:_____ Hospital:_____

Other Hospitalizations:

Year:_____ Reason:_____ Hospital:_____

Year:_____ Reason:_____ Hospital:_____

Prescription Drugs/Over-the-Counter Drugs/Vitamins:

Drug Name:_____ Dose:_____ Frequency:_____

Drug Name:_____ Dose:_____ Frequency:_____

Drug Name:_____ Dose:_____ Frequency:_____

Drug Name:_____ Dose:_____ Frequency:_____

Drug Name:_____ Dose:_____ Frequency:_____

Drug Name:_____ Dose:_____ Frequency:_____

Have you ever been exposed to hazardous materials? ☐ Yes ☐ No

Family Health History:

Have any of your family members had a history of any of the following? Please answer Yes or No. If Yes, please explain.

	Yes	No	Explain
Kidney Disorders	☐	☐	
High Blood Pressure	☐	☐	
Heart Disease	☐	☐	
Heart Attack	☐	☐	
High Cholesterol	☐	☐	
Bleeding Disorders	☐	☐	
Birth Defects	☐	☐	
Stroke	☐	☐	
Cancer	☐	☐	

Current Health Assessment:

Have you recently experienced any of the following? Please answer Yes or No. If Yes, please explain.

	Yes	No	Explain
General			
Weight Loss	☐	☐	
Fever	☐	☐	
Chills	☐	☐	
Night Sweats	☐	☐	
Fatigue	☐	☐	
Change in Sleep Habits	☐	☐	
Appetite Changes	☐	☐	
Respiratory			
Cough	☐	☐	
Shortness of Breath	☐	☐	
Asthma	☐	☐	
Chest Pain	☐	☐	
Wheezing	☐	☐	
Pneumonia	☐	☐	
Coughing up Blood	☐	☐	
Intubation	☐	☐	
Cardiovascular			
High Blood Pressure	☐	☐	
Low Blood Pressure	☐	☐	
Bruising	☐	☐	
Irregular Pulse	☐	☐	
Fainting	☐	☐	
Chest Pain	☐	☐	
Pacemaker	☐	☐	
Implantable Cardioverter Defibrillator (ICD)	☐	☐	
Hematology/Immunology			
Bleeding	☐	☐	
Enlarged Glands	☐	☐	
Anemia	☐	☐	
Blood Transfusion	☐	☐	
Fainting	☐	☐	
Neurological			
Headache	☐	☐	
Confusion	☐	☐	
Difficulty with Balance	☐	☐	
Memory Loss	☐	☐	
Dizziness	☐	☐	
Difficulty Walking	☐	☐	
Tremor	☐	☐	
Numbness	☐	☐	
Tingling	☐	☐	
Taste Change	☐	☐	
Seizures	☐	☐	
Difficulty Talking	☐	☐	
Difficulty Swallowing	☐	☐	
Blurred Vision	☐	☐	
Double Vision	☐	☐	
Glaucoma	☐	☐	
Seeing Spots	☐	☐	

	Yes	No	Explain
Ears, Nose and Throat			
Hearing Loss	☐	☐	
Noise Sensitivity	☐	☐	
Lip Sores	☐	☐	
Dental Problems	☐	☐	
Do you have dental fillings?	☐	☐	
Do you have dental implants?	☐	☐	
Do you have a dental bridge?	☐	☐	
Do you have dentures?	☐	☐	
Do you have any removable hardware?	☐	☐	
Allergies			
Do you have an allergy to latex or tape?	☐	☐	
Itching	☐	☐	
Hives	☐	☐	
Hay Fever	☐	☐	
Endocrine			
Excessive Sweating	☐	☐	
Voice Changes	☐	☐	
Goiter	☐	☐	
Thyroid Disease	☐	☐	
Increased Thirst	☐	☐	
Appetite Changes	☐	☐	
Hormone Therapy	☐	☐	
Diabetes	☐	☐	
Musculoskeletal			
Joint Pain	☐	☐	
Muscle Pain/Cramps	☐	☐	
Fracture	☐	☐	
Injuries	☐	☐	
Swelling	☐	☐	
Weakness	☐	☐	
Skin			
Skin sensitivities	☐	☐	
Rash	☐	☐	
Wounds	☐	☐	
Pain	☐	☐	
Are you currently experiencing problems with pain?	☐	☐	
Gastrointestinal			
Loss of Appetite	☐	☐	
Nausea/Vomiting	☐	☐	
Difficulty Chewing	☐	☐	
Difficulty Swallowing	☐	☐	
Mouth or Lip Sores	☐	☐	
Dental Problems	☐	☐	
Abdominal Bloating	☐	☐	
Constipation	☐	☐	
Diarrhea	☐	☐	
Blood in Stool	☐	☐	
Food Allergies/Restrictions	☐	☐	
Are you working with a Dietician?	☐	☐	
Have you had recent weight loss or gain?	☐	☐	
Psychosocial			
Depression	☐	☐	
Anxiety	☐	☐	
Do you drink alcohol?	☐	☐	
Do you smoke?	☐	☐	
Have you ever used recreational drugs?	☐	☐	
Do you feel safe at home?	☐	☐	
Would you like a referral to speak with a Social Worker?	☐	☐	

How do you manage stress? _____

How would you describe your diet? ☐ Normal ☐ Soft ☐ Liquid ☐ Bland ☐ Supplements ☐ TPN ☐ Other: _____

Current Weight: _____

Are you experiencing any of the following during urination?

☐ Dribbling ☐ Burning ☐ Blood in Urine ☐ Incontinence ☐ Pain
☐ Up at night to urinate ☐ Trouble starting to urinate

Usual bowel habits: _____ stools/day

Women Only

Have you recently experienced any of the following? Please answer Yes or No. If Yes, please explain.

	Yes	No	Explain
Painful menstrual cycles	☐	☐	
Irregular menstrual cycles	☐	☐	
Abnormal Vaginal Bleeding	☐	☐	
Pregnancy	☐	☐	
Pain with Intercourse	☐	☐	

Date of last menstruation: _____

Date of last PAP Smear: _____

Date of last rectal exam: _____

Signature: _____ (Patient or Patient's Authorized Representative) **Date:** _____

If signed by person other than patient, specify relationship to patient:

☐ Parent ☐ Spouse ☐ Guardian

☐ Healthcare Power of Attorney ☐ Adult Child ☐ Adult Sibling

SCCA Proton Therapy Center
Patient Bill of Rights & Responsibilities

Patient First Name:_____ MI:_____ Last Name:_____

Patient Bill of Rights

As a patient at Seattle Proton Center LLC (SCCA Proton Therapy Center), you have the right:

- To be informed of these rights, as evidenced by your written acknowledgement, or by documentation by staff in the medical record, that you were offered a written copy of these rights and given a written or verbal explanation of these rights, in terms you could understand. The Seattle Proton Center shall have a means to notify you of any rules and regulations it has adopted governing patient conduct in the Seattle Proton Center;
- To be informed of services available in the Seattle Proton Center, of the names and professional status of the personnel providing and/or responsible for your care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the Center and any charges for services not covered by sources of third-party payment or not covered by the Seattle Proton Center's basic rate;
- To be informed if the Seattle Proton Center has authorized other health care and educational institutions to participate in your treatment. You also have a right to know the identity and function of these institutions, and to refuse to allow their participation in your treatment;
- To receive from your physician(s) or clinical practitioner(s), in terms that you understand, an explanation of your complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to your health, or if you are not capable of understanding the information, the explanation shall be provided to your next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing you directly, shall be documented in your medical record;
- To participate in the planning of your care and treatment, and to refuse medication and treatment. Such refusal shall be documented in your medical record;
- To be included in experimental research only when you give informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. You may refuse to participate in experimental research, including the investigation of new drugs and medical devices;
- To voice grievances or recommend changes in policies and services to Seattle Proton Center personnel, the governing authority, and/or outside representatives of your choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal;
- To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect you or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of Seattle Proton Center personnel;
- To confidential treatment of information about you.
- Information in your medical record shall not be released to anyone outside the Center without your approval, unless another health care Center to which you were transferred requires the information, or unless the release of the information is required and permitted

by law, a third-party payment contract, or a peer review, or unless the information is needed by the Department for statutorily authorized purposes.
    - The Seattle Proton Center may release data about you for studies containing aggregated statistics when your identity is masked;
- To be treated with courtesy, consideration, respect, and recognition of your dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. Your privacy shall also be respected when Center personnel are discussing you;
- To not be required to perform work for the Seattle Proton Center unless the work is part of your treatment and is performed voluntarily by you. Such work shall be in accordance with local, State, and Federal laws and rules;
- To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon you;
- To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the Seattle Proton Center; and

Advance Directives

If you are an adult (at least 18 years of age and have the capacity to make health-care decisions), you have the right to:

- Make your wishes known about the extent of the treatment you would desire if you became unable to communicate those wishes. This communication is called an advance directive. Two commonly used advance directives are:
    - A health-care directive (living will), in which you communicate orally, or in writing, the specific treatment desired if you later cannot communicate these wishes.
    - A durable power of attorney for healthcare, in which you designate another person to make decisions about your healthcare if you become unable to do so.

The Seattle Proton Center staff is available to assist you with advance directives. The Center will respect the intent of your directives to the extent permitted by law and Center policy.

Conflict Resolution

As a patient at Seattle Proton Center LLC (SCCA Proton Therapy Center), you have the right to:

- Investigate any wrongful actions against your rights.
- Address concerns and complaints regarding patient rights. The Seattle Proton Center encourages you, the patient, to talk with your health-care team initially. If this course of action does not meet your needs, we encourage you to speak with the QA and Compliance Manager at (206) 306-2811.

Patient's Responsibilities

The Seattle Proton Center Staff strives to provide you, the patient, with the best health care possible. Below are some things you can do to help us achieve that goal:

- Arrive on time for scheduled appointments. If you will not be able to make a scheduled appointment or will be late, please call and cancel it so that another patient may be scheduled in your place.
- Give your Care Team all the information she or he will need to determine the best treatment for you: fill out any forms completely and accurately; tell your provider about past and current diagnoses and treatments, such as past illnesses, hospitalizations, and medications; and be as clear as you can about current symptoms, including pain and/or psychological stress.
- Provide correct and complete contact information.
- Be open and honest with your Care Team if you do not understand or cannot comply with instructions you are given.
- Call your Care Team promptly if your condition worsens or does not follow the expected course.
- Treat fellow patients and Seattle Proton Center staff and physicians with the same courtesy and respect that you expect from them. Please respect others' right to privacy as you would ask that your own be respected.
- Make use of information available through the materials in our waiting rooms and on our website. You can make your experience at the Seattle Proton Center more satisfying by understanding the way appointments are scheduled and the resources available for after-hours care or emergencies.
- Know the coverage provided by your medical insurance policy, and know what payments you are responsible for regarding applicable co-pays, co-insurance, or deductibles.

Personal Valuables

Seattle Proton Center LLC (SCCA Proton Therapy Center), and its affiliates (including SCCA, Fred Hutchinson Cancer Research Center, UW Medicine, and Seattle Children's) is not responsible for any loss or damage to your personal property including money, jewelry, watches, or other items of value. We strongly recommend that you not bring any of these items with you when you are being treated at Seattle Proton Center LLC (SCCA Proton Therapy Center).

Weapons and Illegal Substances

Weapons and illegal substances are not allowed on Seattle Proton Center LLC (SCCA Proton Therapy Center) property (including SCCA, Fred Hutchinson Cancer Research Center, UW Medicine, and Seattle Children's, Pete Gross House, and SCCA House). To report or request assistance in handling a suspected case or actual observed violation, contact 911. The existence of a concealed weapons permit does not exempt a person from this policy. Please secure weapons prior to entering the Center.

Acknowledgement

Patient
I acknowledge that I have reviewed and understand this document.

Initials: _____ Date: _____

Personal Representative
I acknowledge that I have reviewed and understand this document.

Initials: _____ Date: _____

Name of Personal Representative: _____

Description of Authority of Personal Representative: _____

Notice of Privacy Practices

Of

SCCA Proton Therapy Center

Effective November 3, 2017

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.

Date: _____

Patient First Name: _____ MI:____ Last Name: _____

Date of Birth: _____

UW MR #: _____

Overview

This Notice provides information about the use and disclosure of protected health information (PHI) by Seattle Proton Center, LLC d/b/a SCCA Proton Therapy Center (Center) and members its medical staff who practice at the Center.

This Notice applies when services are provided within Center and/or when Center is acting as part of one or more Organized Healthcare Arrangements described below. This Notice also:

- Describes your rights and our obligations for using your health information.
- Informs you about laws that provide special protections.
- Explains how your PHI is used and how, under certain circumstances, it may be disclosed.
- Tells you how changes to this Notice will be made available to you.

Organized Healthcare Arrangements: An organized healthcare arrangement is characterized by separate healthcare providers participating in joint arrangements, delivering healthcare together, and sharing PHI for clinical care services, payment for clinical care services, and related healthcare operations and activities. The Center is in an organized healthcare arrangement with Seattle Cancer Care Alliance, Children's University Medical Group, and UW Medicine.

Protected Health Information

This Notice applies to protected health information (PHI) created or received by the Center that identifies you; relates to your past, present or future physical or mental condition; relates to the care provided; or relates to the past, present or future payment for your healthcare. For example, PHI includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. This information often contained in your medical record, among other purposes, serves as:

- A means of communication among the many health professionals who contribute to your care.

- The legal record describing the care you received.
- A means by which you or a third-party payer (such as healthcare insurance) can verify that services billed were provided.
- A tool to educate health professionals.
- A source of data for medical research.
- A source of information for public health officials.
- A source of information for facility planning.
- A tool we use to improve the care we give and the outcomes we achieve.

Understanding what is in your record and how your health information is used and disclosed helps you to:

- Ensure accuracy in the record.
- Better understand who, what, when, where, and why others may access your health information.
- Make a more informed decision when authorizing disclosures to others.

Use and Disclosure of Your Protected Health Information Without Your Authorization

We may use and disclose PHI without your written authorization for the following reasons:

To Provide Treatment. For example:

- Your doctor uses your PHI to find out whether certain tests, therapies, and medicines should be ordered.
- Nurses may need to know and/or discuss your health problems to care for you and to understand how to evaluate your response to treatment.
- We may disclose your PHI to another one of your treatment providers in the community.
- We may use and disclose your prescription information with pharmacies and health plans to improve patient safety and reduce healthcare costs.

For Payment Purposes. For example:

- We may use PHI to prepare claims for payment of services you have received.
- If you have health insurance and we bill your insurance directly, we will include information that identifies you, as well as your diagnosis, the procedures performed, and supplies used so that we can be paid for the treatment provided.

For Healthcare Operations. We may use and disclose your PHI to support daily activities related to healthcare, for example, to monitor and improve our health services or for authorized staff to perform administrative activities.

- **To Train Staff and Students**. For example, our teaching physicians review PHI with medical students.

- **To Conduct Research.** An Institutional Review Board (IRB) will review each request to use or disclose your PHI to protect the rights, safety, and welfare of research subjects. In some cases, your PHI might be used or disclosed for research without your consent. For example, we might look at medical charts to see if people who wear bicycle helmets get fewer injuries. We might use some of your PHI to decide if we have enough patients to conduct a cancer research study or include your information in a research database. In these cases, the IRB will determine if using your information without your authorization is justified, and makes sure that steps are taken to limit its use. In all other cases, we must obtain your authorization to use or disclose

your information for a research project. We may share information about you used for research with researchers at other institutions.

To Contact You for Information. Your PHI may be used to call you or send you a letter to remind you about appointments, provide test results, inform you about treatment options, or advise you about other health-related benefits and services.

To Conduct Fundraising. The Center may use basic demographic information limited to your name, date of birth, address, phone number, health insurance status, the dates you received services, department of service information, treating physician information, outcome information to contact you for fundraising activities. We will not prohibit or condition treatment or payment on whether you choose to receive fundraising communications. We raise funds to expand and support healthcare services, educational programs, and research activities related to curing disease. We will not sell, trade, or loan your information to any third parties, but the Center may share it with third parties working directly for the Center. These third parties must agree to protect the confidentiality of your information. If you do not wish to be contacted as part of our fundraising efforts, please notify us at:

SCCA Proton Therapy Center
Compliance Officer
1570 North 115th Street Seattle, WA 98133
206-306-2811

Joint Activities. Your health information may be used and shared by the Center to further its joint activities and with other individuals or organizations that engage in joint treatment, payment or healthcare operational activities with the Center. Health information is shared when necessary to provide clinical care services, secure payment for clinical care services, and perform other joint healthcare operations such as peer review and quality improvement activities, accreditation related activities, and evaluation of trainees.

Business Associates. Your health information may be used by the Center and disclosed to individuals or organizations that assist the Center or to comply with their legal obligations as described in this Notice. For example, we may disclose information to consultants or attorneys who assist us in our business activities. These business associates are required to protect the confidentiality of your information with administrative, technical and physical safeguards.

Other Uses and Disclosures. We also use and disclose your information to enhance healthcare services, protect patient safety, safeguard public health, ensure that our facilities and staff comply with government and accreditation standards, and when otherwise allowed by law. For example, we provide or disclose information:

- About FDA-regulated drugs and devices to the U.S. Food and Drug Administration.
- To government oversight agencies with data for health oversight activities such as auditing or licensure.
- To public health authorities with information on communicable diseases and vital records.
- To your employer, findings relating to the medical surveillance of the workplace or evaluation of work-related illnesses or injuries.
- To workers' compensation agencies and self-insured employers for work-related illness or injuries.
- To appropriate government agencies when we suspect abuse or neglect.
- To appropriate agencies or persons when we believe it necessary to avoid a serious threat to health or safety or to prevent serious harm.
- To organ procurement organizations to coordinate organ donation activities.
- To law enforcement when required or allowed by law.

- For court order or lawful subpoena.
- To coroners, medical examiners, and funeral directors.
- To government officials when required for specifically identified functions such as national security.
- When otherwise required by law, such as to the Secretary of the United States Department of Health and Human Services for purposes of determining compliance with our obligations to protect the privacy of your health information.
- If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Use and Disclosure When You Have the Opportunity to Object

Facility Directory. This information is limited to your name, location in the facility, and general health condition [such as "critical," "poor," "fair," "good," "excellent," or similar statements]. When you are in the Center, we may provide this information to visitors who ask for you by name, unless you object.

Disclosure to and Notification of Family, Friends, or Others. Unless you object, your healthcare provider will use his or her professional judgment to provide relevant protected health information to your family member, friend, or another person. This person would be someone that you indicate has an active interest in your care or the payment for your healthcare or who may need to notify others about your location, general condition, or death.

Disclosure for Disaster Relief Purposes. We may disclose your location and general condition to a public or private entity (such as FEMA or the Red Cross) authorized by its charter or by law to assist in disaster relief efforts.

Use and Disclosure Requiring Your Authorization

Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. The Center requires your written authorization for most uses and disclosures of psychotherapy notes, for marketing (other than a face-to-face communication between you and a Center's workforce member or a promotional gift of nominal value); or before selling your protected health information. If you provide us with written authorization, you may revoke it at any time unless disclosure is required for us to obtain payment for services already provided, we have otherwise relied on the authorization, or the law prohibits revocation.

Additional Protection of Your Patient Health Information

Special state and federal laws apply to certain classes of patient health information. For example, additional protections may apply to information about sexually transmitted diseases, drug and alcohol abuse treatment records, mental health records, and HIV/AIDS information. When required by law, we will obtain your authorization before releasing this type of information.

Your Individual Rights About Patient Health Information

You have rights related to the use and disclosure of your protected health information.
To contact the Center to exercise your rights, you may contact:

SCCA Proton Therapy Center
Compliance Officer

1570 North 115th Street
Seattle, WA 98133
206-306-2811

Your specific rights are listed below:

- The right to request restricted use: You may request in writing that we not use or disclose your information for treatment, payment, and/or operational activities except when authorized by you, when required by law, or in emergency circumstances. We are not legally required to agree to your request, except if your request is to restrict disclosing PHI to a health plan for the purpose of carrying out payment or health care operations, the disclosure is not otherwise required by law, and the PHI pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf. If you make your request to the Center, we will provide you with written notice of our decision about your request.
- The right to receive confidential communications: You have the right to request that we communicate with you about medical matters in a particular way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the address above. We will grant all reasonable requests. Your request must specify how or where you wish to be contacted.
- The right to inspect and receive copies: In most cases, you have the right to inspect and receive a copy of certain healthcare information including certain medical and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- Right to receive notification of a breach: We are required to notify you if we discover a breach of your unsecured PHI, according to requirements under federal law.
- The right to request an amendment to your record: If you believe that information in your record is incorrect or that important information is missing, you have the right to request in writing that we make a correction or add information. In your request for the amendment, you must give a reason for the amendment. We are not required to agree to the amendment of your record, but a copy of your request will be added to your record.
- The right to know about disclosures: You have the right to receive a list of instances when we have disclosed your health information. Certain instances will not appear on the list, such as disclosures for treatment, payment, or healthcare operations or when you have authorized the use or disclosure. Your first accounting of disclosures in a calendar year is free of charge. Any additional request within the same calendar year requires a processing fee.
- The right to make complaints: If you are concerned that we have violated your privacy, or you disagree with a decision we made about access to your records, you may file a complaint with the Center using the contact information above. The Center will not retaliate against anyone for filing a complaint.

If you believe that your privacy rights have been violated, you may also contact the U.S. Department of Health and Human Services, Office for Civil Rights:

Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue — Mail Stop RX-11
Seattle, WA 98121-1831
206.615.2290; 206.615.2296 (TTY)
206.615.2297 (fax)
Toll free: 1.800.362.1710; 1.800.537.7697 (TTY)

Our Legal Duties

We are required by law to protect the privacy of your information, notify affected individuals following a compromise of unsecured protected health information, provide this Notice about our privacy practices, and follow the privacy practices that are described in this Notice.

Privacy Notice Changes

We reserve the right to change the privacy practices described in this Notice. We reserve the right to make the revised or changed Notice effective for protected health information we already have as well as any information we may receive in the future. We will post a copy of the current Notice at the Center's facility. In addition, each time you register at the Center for treatment you may request a copy of the current Notice from the location of your care provider or you may request a copy of this Notice from the Center's Compliance Officer.

Signature of patient or person responsible for patient's care:

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