ONCURA HEALTH

REGISTRATION PACKET

Welcome to Oncura Health. We want to thank you for entrusting us for your care.
Our mission is to provide unparalleled care to each patient that comes through our doors. We offer individualized treatment using the most recent and relevant proven advances in cancer care, curated with deliberation and compassion. Rest assured, your doctor will do everything they can to help you through this process.

Attached please find a New Patient Registration Packet containing the following:

- Explanation of Paperwork (This Page)
- Patient Registration & Demographics
- Review of Systems, Reproductive & Preventative Health History
- Personal Medical History, Social History, Hospitalization History
- Vaccination History, Advance Directives, & PHQ-2
- Family Health History
- Medication & Allergy List
- Authorization for Release of Health Information
- Notice of Privacy Practices

Please complete all forms and bring them with you to your first appointment, along with your current insurance cards and photo ID.

As a service to you, we provide registration and verification of insurance and assistance with payment arrangements, if needed. We work extensively with insurance companies to have claims paid at their maximum benefit to keep your financial burden to a minimum.

You will receive an automated reminder of your scheduled appointment 5 days prior to your first visit. Please listen and respond to the options given to confirm your appointment.

A repeated pattern of no shows and/or canceled appointments may result in termination of the provider/patient relationship. Additionally, we may charge a fee for not showing up to a scheduled appointment. If you need to reschedule, please do so at least 24 hours in advance.

Please arrive at our office 30 minutes early for your first scheduled appointment to allow ample registration time. Please be advised that there could be additional forms that will need to be completed upon your arrival.

Our practice has a patient portal, Navigating Care, that provides you and your caregiver easy access to your health information. Navigating Care allows you to view your medical appointments, review your medical records, and send secure messages to your care team. Please speak with a member of our front desk staff to provide you with the enrollment link.

If you have any questions concerning the above information, please do not hesitate to contact us.

Please indicate that you have read the above information.

Signature: _____ Today's Date: _____

ONCURA HEALTH

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Date: _____ Patient MRN (Office to Complete) _____

Patient's Legal Name (First, Middle, Last): _____

Preferred Name: _____ Email Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Address Street: _____ City: _____

State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Last 4 of SSN (Optional): _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Primary Language: _____ Secondary Language: _____

How did you hear about us: ☐ Google ☐ Social Media ☐ Insurance Referral ☐ Website

☐ Friend / Family ☐ MD Referral (name) _____ ☐ Other _____

Providing the information in the following sections is voluntary and is used to support quality of care, patient safety, language access and comply with non-discrimination.

Sex Assigned at Birth (Choose 1)	
☐ Single	☐ Female
☐ Intersex	☐ Other
☐ Decline to Disclose	

Gender Identity		
☐ Male	☐ Female	☐ Non-Binary
☐ Trans-Male	☐ Trans-Female	☐ Decline to Disclose

Which of the following best describes your race and/or ethnicity?			
☐ Asian	☐ Caucasian	☐ Black/African American	☐ Middle Eastern/ North African
☐ Hispanic	☐ Native Hawaiian/ Pacific Islander	☐ American Indian/ Alaskan Native	☐ Choose Not to Disclose

Do you have any religious or cultural beliefs that may affect your medical care?	
☐ Yes	If yes, explain: _____
☐ No	

Are you still working?	
☐ Yes	If yes: ☐ Full-Time ☐ Part-Time
☐ No	If no: ☐ Retired ☐ Disabled ☐ Unemployed

Did you ever work in an occupation involving exposure to asbestos, carcinogens, hazardous chemicals, or toxic fumes?	
☐ Yes	☐ No

ONCURA HEALTH

NEW PATIENT REGISTRATION

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

PRIMARY CARE PHYSICIAN

MD Name: _____ Phone: _____ Fax: _____

DENTIST

Dentist Name: _____ Phone: _____ Fax: _____

OTHER DOCTORS INVOLVED IN YOUR CARE

MD Name: _____ Specialty: _____ Phone: _____ Fax: _____

Were you referred to us by a doctor other than your primary care physician? ☐ Yes ☐ No

If yes:

Referring MD Name: _____ Phone: _____ Fax: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone: _____

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

INSURANCE INFORMATION

Primary Ins: _____ ID: _____ Group ID: _____

Policy Holder: _____ DOB: _____ Relationship: _____

Secondary Ins: _____ ID: _____ Group ID: _____

Policy Holder: _____ DOB: _____ Relationship: _____

SOCIAL GEOGRAPHIC HISTORY

In which state (or country) were you born? _____

In what area did you live most of your life: _____

PAIN MEASUREMENT SCALE

0 = No Pain → 10 = Worst Pain Imaginable

Rate Your Pain: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

Quality: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐ Cramping ☐ Aching ☐ Stabbing

PAIN MANAGEMENT QUESTIONS

Are you in pain now? _____

When did your pain start? _____

Location of Pain: _____

How long have you been in pain? _____

How is your pain being managed? _____

Anything making it better? _____

Anything making it worse? _____

ONCURA HEALTH

REVIEW OF SYSTEMS

NEW PATIENT QUESTIONNAIRE

Name: _____ D.O.B. _____ Date Completed: _____

Dear patient,
To ensure optimal care for you, we need to understand your complete health status and health history. With this goal in mind, we appreciate you taking the time to complete this comprehensive health questionnaire as accurately as possible.

REVIEW OF SYSTEMS

For the Review of Systems, please indicate "Yes" if you are currently experiencing the symptom or if you have experienced the symptom within the past three months.
Please fill in the appropriate bubble completely. For example ☑ Yes ☐ No

General/Constitutional

Change in Appetite	☐ Yes	☐ No
Fatigue/Weakness	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Weight Loss/Gain	☐ Yes	☐ No
Hot Flashes	☐ Yes	☐ No
Chills	☐ Yes	☐ No

Neurological

Headache	☐ Yes	☐ No
Neuropathy	☐ Yes	☐ No
Dizziness/Fainting	☐ Yes	☐ No
Confusion/Memory Loss	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Numbness/Tingling	☐ Yes	☐ No
Speech Changes	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Difficulty Balancing	☐ Yes	☐ No

Ears, Nose, Throat, Mouth

Hearing Loss	☐ Yes	☐ No
Mouth Sores	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No
Difficulty Swallowing	☐ Yes	☐ No
Voice Changes/Hoarseness	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No
Ear Pain	☐ Yes	☐ No
Hearing Aids	☐ Yes	☐ No
Nose Bleeds	☐ Yes	☐ No

Eyes

Blurred Vision/Double Vision	☐ Yes	☐ No
Excessive Tearing	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Eye Pain	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Contacts/Glasses	☐ Yes	☐ No
Decreased Vision/Changes in Vision	☐ Yes	☐ No
Light Flashes/Halos	☐ Yes	☐ No

Cardiovascular

Chest Pain	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Swelling of Legs/Ankles	☐ Yes	☐ No
Heart Defects	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No

ONCURA HEALTH

REVIEW OF SYSTEMS

Respiratory

- Shortness of Breath ☐ Yes ☐ No
- Wheezing ☐ Yes ☐ No
- Difficulty Breathing ☐ Yes ☐ No
- Cough ☐ Yes ☐ No
- Dry/Productive/Bloody ☐ Yes ☐ No

Gastrointestinal

- Abdominal Pain/Cramps ☐ Yes ☐ No
- Nausea/Vomiting ☐ Yes ☐ No
- Rectal Bleeding ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Blood in Stool ☐ Yes ☐ No
- Heartburn/Indigestion ☐ Yes ☐ No
- Hemorrhoids ☐ Yes ☐ No
- Changes in Bowel Habits ☐ Yes ☐ No

Musculoskeletal

- Bone Pain ☐ Yes ☐ No
- Joint Pain/Swelling ☐ Yes ☐ No
- Back Pain ☐ Yes ☐ No
- Muscle Cramps/Aches ☐ Yes ☐ No

Integumentary (Skin)

- Rash/Acne ☐ Yes ☐ No
- Itching/Irritation/Eczema ☐ Yes ☐ No
- Discoloration ☐ Yes ☐ No
- New Moles ☐ Yes ☐ No
- Open Sores/Slow Wound Healing ☐ Yes ☐ No

Endocrine

- Cold Intolerance ☐ Yes ☐ No
- Heat Intolerance ☐ Yes ☐ No
- Excessive Thirst ☐ Yes ☐ No
- Frequent Urination ☐ Yes ☐ No

Hematologic/Lymphatics

- Excessive or Spontaneous Bruising ☐ Yes ☐ No
- Excessive or Spontaneous Bleeding ☐ Yes ☐ No
- Enlarged Lymph Nodes ☐ Yes ☐ No

Genitourinary

- Incontinence ☐ Yes ☐ No
- Difficulty Urinating ☐ Yes ☐ No
- Blood in Urine ☐ Yes ☐ No
- Discharge/Odor with Urine ☐ Yes ☐ No
- Sexual Difficulties ☐ Yes ☐ No
- Impotence ☐ Yes ☐ No
- Discharge from Penis ☐ Yes ☐ No
- Lump in Testicles ☐ Yes ☐ No

Gynecological

- Odorous Discharge ☐ Yes ☐ No
- Pain ☐ Yes ☐ No
- Sexual Difficulties ☐ Yes ☐ No

Breast

- Breast Pain ☐ Yes ☐ No
- Breast Lumps ☐ Yes ☐ No
- Nipple Discharge ☐ Yes ☐ No
- Nipple Retraction/Inversion ☐ Yes ☐ No
- Breast Dimpling ☐ Yes ☐ No
- Breast Redness or Swelling ☐ Yes ☐ No
- Breast Skin Like an Orange Peel ☐ Yes ☐ No

Fatique Rating

0 1 2 3 4 5 6 7 8 9 10

REPRODUCTIVE HISTORY

(Female)

Age of 1st Menstrual Period: _____ Date of Last Menstrual Period: _____ Age at last Menstrual Period: _____

Birth Control Pills Used? ☐ Y ☐ N Other _____

Injectable Birth Control (that prevents monthly menstrual periods)? ☐ Y ☐ N

Hormone Replacement Therapy Used? ☐ Y ☐ N If Yes, how many years? _____

Total Pregnancies: _____ Age at 1st pregnancy: _____

Number of Live Births: _____ Number of Miscarriages: _____

Number of Abortions: _____

Number of Ectopic Pregnancies: _____

Number of C-Sections: _____

Hysterectomy ☐ Partial ☐ Complete ☐ Bilateral Salpingo-Oophorectomy (removal of ovaries and fallopian tubes)

☐ Tubal Ligation ☐ Other sterilization procedure _____

(Male)

☐ Orchiectomy ☐ Vasectomy ☐ Other sterilization procedure _____

Contraceptives? ☐ Former ☐ Current ☐ Never

☐ Abstinence ☐ Condoms ☐ Rhythm method ☐ Other _____

PREVENTATIVE HEALTH HISTORY – Indicate date of last screening: Month/Year

Pap Smear: _____ Mammogram: _____ Colonoscopy: _____ Bone Density: _____

Cholesterol: _____ Skin Exam: _____ Dental Exam: _____

MEDICAL HISTORY – Please indicate if you have ever been diagnosed with or treated for any of the following conditions

Asthma	☐ Yes	☐ No	Neurologic Disorder	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Anxiety Disorder/Panic Attacks	☐ Yes	☐ No
Hyperthyroidism	☐ Yes	☐ No	Carpal Tunnel	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Thrombosis/Blood Clots	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No	Autoimmune Disorder	☐ Yes	☐ No
Diabetes, Type I {Insulin Dependent)	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
Diabetes, Type II (Non-Insulin Dependent)	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No
Hypercholesterolemia/High Cholesterol	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No
Hypertension/High Blood Pressure	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Coronary Artery Disease/ Angina	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Abnormal Pap Smear	☐ Yes	☐ No	Gout	☐ Yes	☐ No
Abnormal Uterine Bleeding	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Alcohol Abuse	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No	Drug Abuse	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No	Pacemaker/Implanted medical device	☐ Yes	☐ No
Mental health disorders	☐ Yes	☐ No	History of Cancer	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	Infectious Disease	☐ Yes	☐ No
Skin Disorders	☐ Yes	☐ No	Prior biopsies for suspicious areas or tumor	☐ Yes	☐ No
Depression/Mania/Bipolar	☐ Yes	☐ No			

Other Diagnosed Conditions List here: _____

SOCIAL HISTORY

Alcohol Consumption

Frequency:

☐ Never ☐ Less than 1 drink per week ☐ 2-3 drinks per week

☐ 1 drink per day ☐ 2-3 per day ☐ 3+ per day

Tobacco Use

Do you smoke? ☐ Yes ☐ No If yes, how long did you smoke? _____ years

Cigarettes? ☐ Yes ☐ No If yes, how many per day? _____

Pipe? ☐ Yes ☐ No If yes, how much tobacco per day? _____

Vaping? ☐ Yes ☐ No If yes, how much per day? _____

Marijuana? ☐ Yes ☐ No If yes, how much marijuana per day? _____

Chewing Tobacco/other smokeless tobacco products? ☐ Yes ☐ No If yes, how much per day? _____

Substance Use (Cocaine, heroin, fentanyl, methamphetamine)? ☐ Yes ☐ No

If yes, type of substance _____ , how much per day? _____

HOSPITALIZATIONS & SURGERIES

Month & Year	Type of Surgery /Reason for Surgery

VACCINATION HISTORY

Vaccination	Date last received
COVID-19 Vaccine - please indicate which vaccine {J&J, Pfizer, or Moderna)	
Influenza (Flu) Vaccine	
Pneumococcal Vaccine (for pneumonia)	
Hepatitis Vaccine	
HPV Vaccine	
Shingles	
Any other vaccination notes	

ADVANCE DIRECTIVES

Advance Care Planning (ACP) is an ongoing process of learning about the choices we have for our future medical care. An advance directive is optional and not required to receive treatment. Information about advance directives is available upon request.

Do you have any of the following? (Check all that apply).

☐ Healthcare Proxy
☐ Medical Power of Attorney
☐ Living Will
☐ Do Not Resuscitate (DNR)
☐ Organ Donor Card
☐ Power of Attorney
☐ POLST / Advance Directive (California)

Would you like more information about Advance Care Planning?
☐ Yes ☐ No

If you answered "yes" to any of the above, please provide a copy of the document to staff at **check-in.**

ONCURA HEALTH

FAMILY HEALTH HISTORY

FAMILY HISTORY – Age at which family member was diagnosed

	Family Members	Status (A/D/U) Alive, Deceased, Unkown	Breast Cancer	Ovarian Cancer	Uterine Cancer	Colon Cancer	Prostate Cancer	Stomach Cancer	Pancreatic Cancer	Melanoma	Heart Disease	High Blood Pressure	Diabetes	Other
	Example	A	62										51	Lymphoma (68)
Paternal Family	Father			N/A	N/A									
Paternal Family	Grandfather			N/A	N/A									
Paternal Family	Grandmother						N/A							
Paternal Family	Aunt						N/A							
Paternal Family	Uncle			N/A	N/A									
Maternal Family	Mother						N/A							
Maternal Family	Grandfather			N/A	N/A									
Maternal Family	Grandmother						N/A							
Maternal Family	Aunt						N/A							
Maternal Family	Uncle			N/A	N/A									
Personal	Self													
Personal	Sister						N/A							
Personal	Brother			N/A	N/A									

Other family health history notes:

MEDICATION & ALLERGY

CURRENT MEDICATIONS (including over-the-counter meds, vitamins, nutritional supplements, herbal supplements, etc)

Name	Strength	Qty	Frequency (How Often)	Start Date

ALLERGIES

Name of Allergen	Reaction

Any additional notes you would like to share with your doctor:

AUTHORIZATION FOR THIRD PARTY MEDICATION PICK-UP

AUTHORIZATION FOR THIRD-PARTY (INCLUDING FAMILY MEMBERS, FRIENDS, AND/OR CAREGIVERS) MEDICATION PICK-UP

Completion of this document authorizes a third party (family members, friends, and/or caregivers) to pick-up medication(s) prescribed by your Oncura Health provider from a Oncura Health clinic. Many of our patients allow family members (such as their spouse, significant other, parents, or children), friends, and/or caregivers to pick-up medication(s) on their behalf for one of the following reasons:

- The patient does not have means of or access to transportation to a Oncura Health clinic, or
- The patient has an acute illness (such as flu, strep, nausea, vomiting, diarrhea, etc.) that would create a safety /health concern for themselves or others.

If you wish to have your family members, friends, and/or caregivers pick-up your medication(s) on your behalf, you must write their full name and relationship, sign this form, and submit it in person to a Oncura Health clinic, email: iod@oncurahealth.com, or fax: (844) 292-1565.
I hereby authorize the following third party(s) to pick up my medication(s) prescribed by a Oncura Health Provider from a Oncura Health clinic.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

MY RIGHTS

- Filling out and signing this document is completely optional.
- I may obtain a copy of this authorization.
- I may revoke this authorization at any time [except where we have already given the medication(s) to the third party on your prior consent], but I must do so in writing and submit it to the following address, fax, or email:

  1505 Wilson Terrace, Suite 210
  Glendale, CA 91206
  Fax: (844) 292-1565
  Email: iod@oncurahealth.com

- This authorization expires on the following date: _____

SIGNATURE

My signature below authorizes the third-party(s) listed in this form to pick up my medication(s) from a Oncura Health clinic and deliver it to me. I further acknowledge that once my medication is in the possession of the authorized third-party, it is my full responsibility to ensure that such third-party delivers the medication to me.

Print Name: _____

Signature: _____ Date: _____

ONCURA HEALTH

CONDITIONS OF SERVICE

Oncura Health • 541 W. Colorado St, Suite 309 Glendale, CA 91204 • 323.254.0046

In this document, **"Patient"** means the person receiving treatment. **"Patient Representative"** means any person acting on behalf of the Patient. "I," "you," "your," or "me" may include both the Patient and the Patient Representative; with respect to financial obligations, also the "Guarantor."

"Provider" means the practice and may include **Oncura Health** physicians and/or staff, including but not limited to Oncologists, Radiologists, Radiation Oncologists, PAs, NPs, Social Workers, Behavioral Health Practitioners, and any authorized agents, contractors, affiliates, successors, or assignees.

1. CONSENT TO TREATMENT

I consent to medical care and procedures recommended by my Provider, including emergency care, lab tests, x-rays, imaging, diagnostics, and other treatments. I allow residents and supervised trainees to participate in or observe my care. I consent to blood-borne disease testing (hepatitis, HIV, AIDS) if ordered by my Provider; side effects are usually minor. Test results will be kept confidential in my medical record.

2. CONSENT TO TREATMENT USING TELEHEALTH

I consent to receive health care services through telehealth, including audio, video, or other electronic communications for diagnosis, treatment, consultation, follow-up, care management, or patient education. Applicable confidentiality and privacy protections apply equally to telehealth interactions (Cal. Bus. & Prof. Code § 2290.5(f)).

California Telehealth Disclosure — Cal. Bus. & Prof. Code § 2290.5

- Telehealth involves potential limitations and risks: technical failures, interruptions, delays, limitations on physical examination, and the possibility that insufficient information may be transmitted for appropriate medical decision-making.
- Use of telehealth is voluntary; I may withhold or withdraw consent at any time without affecting my right to future care or treatment.
- I may seek in-person care instead of telehealth, where available. My consent will be documented in my medical record.

Additional California Notice for Medi-Cal Beneficiaries (Cal. Welf. & Inst. Code § 14132.725)

I have the right to access covered services through an in-person visit or through telehealth. If I have difficulty accessing in-person services due to transportation, coverage may be available when other resources are reasonably exhausted. Interpretation/translation services are available, as applicable.

3. FINANCIAL AGREEMENT

I (the Patient or Guarantor) agree to pay any balance not covered by insurance, including coinsurance, deductibles, non-covered services, or amounts due to policy limits or exclusions. If I overpay, the extra may be applied to other balances before a refund. I can request a free, itemized billing statement. Patients will not be billed for amounts prohibited by state or federal law, including applicable surprise billing protections.

4. PROFESSIONAL SERVICES BY INDEPENDENT CONTRACTORS

Independent contractors and advanced practice professionals providing services at the practice are not agents or employees of the practice, to the extent permitted by applicable law. I may receive a separate bill for professional services (e.g., radiology, pathology) that is separate from the practice bill.

5. LEGAL RELATIONSHIP BETWEEN PRACTICE AND PHYSICIANS

Independent physicians and advanced practice professionals are responsible for their own actions. The practice shall not be liable for their acts or omissions to the extent permitted by applicable law.

6. ASSIGNMENT OF BENEFITS

I assign my insurance benefits to the Provider and authorize direct payment to the Provider. I agree to help the Provider collect payment from any responsible party, including forwarding any payment I receive directly. I also

authorize the Provider to pursue claims, appeals, or legal remedies for unpaid or underpaid benefits. This assignment is full and unconditional to the extent permitted by applicable law.

Medicare Patient Certification and Assignment of Benefit

I certify that information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) is correct. I request payment of authorized benefits to be made on my behalf to the practice or its physicians.

Outpatient Medicare Patients — Self-Administered Drugs

Medicare generally does not cover self-administered drugs. If you receive such drugs not covered under Part B, we may bill you. If enrolled in a Medicare Part D Drug Plan, those drugs may be covered under Part D benefits.

7. CONSENT TO PHOTOGRAPHS, VIDEO, DIGITAL, AND AUDIO RECORDINGS

The practice's patient care, quality improvement, and risk management activities may involve photographs, video, digital and/or audio recordings of me, including recordings of telephone or virtual communications. Audio recording of conversations will only occur with my knowledge and consent, as required by applicable law. These images and recordings may only be used and disclosed as permitted by applicable law.

☐ I consent to photography ☐ I consent to audio/video recordings

Security Monitoring Notice: For safety and security purposes, video surveillance may be in use in common areas of the facility (entrances, waiting areas, hallways). Audio recording is not used for security monitoring.

8. CONSENT TO USE OF AI-ASSISTED DOCUMENTATION TOOLS

I understand that my provider may use secure, HIPAA-compliant technology, including artificial intelligence (AI) or digital scribe tools, to assist in documenting my care. These tools may process audio of my conversation with my provider to generate clinical documentation for my medical record. I understand that the AI tool is used only to assist with documentation and does not replace the clinical judgment of my provider, and that my provider reviews and finalizes all documentation entered into my medical record. I also understand that my information will be protected and handled in accordance with applicable privacy and security laws, and that audio and/or transcripts may be temporarily processed to support documentation and are maintained, stored, or deleted in accordance with the practice's policies and applicable law. I understand that I may decline or withdraw consent to the use of AI-assisted documentation at any time without affecting my access to care or treatment.

Practice Implementation Note (Remove Before Deployment):
Verify AI vendor's HIPAA-compliant BAA, CMIA compliance (Cal. Civil Code §§ 56 et seq.), and internal policies governing transcript retention and deletion before activating the checkboxes below.

☐ I consent to AI-assisted documentation tools ☐ I decline AI-assisted documentation tools

9. CONSENT TO TELEPHONE CALLS, EMAIL, OR TEXT MESSAGE

I authorize the use of any email address or telephone number I provide (including email addresses or telephone numbers that I provide for my family or designated representatives) (whether wireless or a landline and including email addresses and telephone numbers that are forwarded or transferred from the information provided) for receiving information relating to my healthcare services and financial obligations, including healthcare-related information and financial communications. I expressly agree and consent that you or your customer service personnel and collection agents may contact me by telephone, on a recorded line and/or using automated dialing technology, at any telephone number I have provided or obtained, or any number forwarded or transferred from that number, regarding the services rendered or my related financial obligations. Methods of contact may include pre-recorded/artificial voice messages and/or automated dialing devices. I represent that I am the account holder for any telephone number(s) provided and am responsible for notifying the Provider of any changes or updates. I understand that emails and text messaging are unencrypted and that there is some risk that information included in unencrypted messages may be intercepted or received by unintended third parties and/or stored or archived by service providers

and system operators. Information included in such messages may include name, date/time of appointments, physician/practice name or specialty, patient account number, or other information related to financial obligation or services. Message and data rates may apply. I understand that I may opt out of these communications at any time by notifying Oncura Health in writing.

For assistance: contact **Oncura Health** at **323.254.0046**

☐ I consent to email or text communications for the purpose of treatment, payment, education, or operations

☐ I consent to email or text communications for the purpose of marketing

10. USE AND DISCLOSURE OF INFORMATION

I consent to Providers using and disclosing health information about me for treatment, payment, healthcare operations, public health, and other purposes permitted by applicable law. Covered information includes history and physical records, emergency records, laboratory reports, pharmacy claims, physician and nurse notes, discharge summaries, genetic, psychological, psychiatric, intellectual disability, and substance abuse disorder information, and information about blood-borne diseases such as HIV and AIDS. Certain categories of sensitive information are further protected under California and federal law and will be disclosed only as permitted or required by law. Unless I notify the Provider in writing that I choose to opt-out, I consent to my health information being shared through Health Information Exchanges (HIEs) for permitted purposes.

California SB 81 (eff. September 20, 2025) Immigration Status & Place of Birth | Cal. Civil Code § 56.10
A patient's current or prior immigration status and place of birth are protected "medical information" under the CMIA. This practice is PROHIBITED from disclosing this information for immigration enforcement purposes except: (1) pursuant to a valid search warrant or court order from a California state or federal court; (2) as expressly authorized in writing by the patient; or (3) as otherwise permitted or required by law.

11. OTHER ACKNOWLEDGMENTS

Weapons / Explosives / Controlled Substances

I understand that if the practice believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage on my person or with my belongings, the practice may take appropriate action, including termination of the patient relationship, consistent with applicable law.

ACKNOWLEDGMENTS AND SIGNATURES

Acknowledgment of Notice of Patient Rights and Responsibilities. I have been furnished with a Statement of Patient Rights and Responsibilities, which ensures that I am treated with respect and dignity without discrimination based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source, or any other basis prohibited by federal, state, or local law. I may provide an advance directive to the Provider and may request information about formulating one. I have the right to participate in decisions regarding my care and to voice complaints or grievances without fear of retaliation.

Initials: _____

Notice of Privacy Practices. I acknowledge receipt of the Notice of Privacy Practices, which describes how my health information may be used and disclosed under federal law and applicable California law, including HIPAA (45 CFR Parts 160 & 164), the CMIA (Cal. Civil Code §§ 56 et seq.), SB 81 (eff. 9/20/2025, protecting immigration status and place of birth), and AB 352 (eff. 7/1/2024, EHR segregation of sensitive services records). If I decline or am unable to acknowledge receipt, the practice may document its good faith effort to provide the Notice. I may contact the Privacy Officer designated on the Notice or file a complaint with the U.S. Department of Health and Human Services.

Initials: _____

General Acknowledgment. I have been given the opportunity to read and ask questions about this form, including the financial obligations and assignment of benefit provisions. My questions have been answered to my satisfaction and I am signing voluntarily. Signing does not affect my access to care or treatment.

Initials: _____

I, the undersigned, as the Patient or Patient Representative, or for a minor/incapacitated Patient as the legal guardian, certify I have read and understand these Conditions of Service and have signed knowingly, freely, and voluntarily. No promises, assurances, or guarantees have been made regarding results of medical treatment. If insurance coverage is insufficient, denied, or unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Patient / Patient Representative Signature: **Date:**

Witness Signature and Title: **Time:**

Additional Witness Signature and Title (required for Patients unable to sign without a representative or Patients who refuse to sign)

Additional Signature and Title:

If you are not the Patient, please identify your relationship (check all that apply):

☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Healthcare POA ☐ Guarantor ☐ Other:

Other Relationship (specify):

Legal Authorities: HIPAA Privacy Rule, 45 CFR §§ 160 & 164 • Cal. Civil Code §§ 56–56.37 (CMIA) • SB 81 (2025, eff. 9/20/2025) • Cal. Bus. & Prof. Code § 2290.5 (Telehealth) Cal. Welf. & Inst. Code § 14132.725 (Medi-Cal Telehealth) 42 CFR Part 2 (SUD Records).

ONCURA HEALTH

HIPAA DISCLOSURE RELEASE & COMMUNICATION PREFERENCES

Patient Name: Date of Birth: Phone: MRN / Account #:

PART 1 — COMMUNICATION PREFERENCES

Under HIPAA (45 CFR § 164.522(b)) and the CMIA (Cal. Civil Code § 56.107, AB 1184, eff. July 1, 2022), you have the right to request that communications of your PHI be directed to a specific address, phone, or format. This form also serves as your Confidential Communication Request (CCR) under AB 1184.

California AB 1184 — Sensitive Services Disclosure Prohibition (Cal. Civil Code § 56.107):
This practice is prohibited from disclosing records related to sensitive services to anyone other than you — including the policyholder, primary subscriber, or parent — without your express written authorization. Sensitive services include mental/behavioral health, sexual and reproductive health, STI services, substance use disorder treatment, gender-affirming care, and intimate partner violence services.

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

☐ Cell Phone
- ☐ Leave message with detailed information
- ☐ Leave callback number/details only

☐ Work Telephone
- ☐ Leave message with detailed information
- ☐ Leave callback number/details only

☐ Home Telephone
- ☐ Leave message with detailed information
- ☐ Leave callback number/details only

☐ Written Correspondence
- ☐ Mail to home address on file
- ☐ Mail to alternative address below:

Alternative Mailing Address:

City / State / ZIP:

Confidential Communication Request (CCR) Required under Cal. Civil Code § 56.107 (AB 1184):
If you want ALL communications about your medical information directed to a specific phone, email, or address different from what is on file, provide your preferred contact below. The Practice is required by law to honor this request.

☐ I am requesting a Confidential Communication — use the contact information below for ALL health and treatment communications:

ONCURA HEALTH

Preferred Phone: Preferred Email: Preferred Mailing Address:

California SB 81 (eff. September 20, 2025) Immigration Status & Place of Birth | Cal. Civil Code § 56.10:
Your current or prior immigration status and place of birth are protected medical information under California law. This practice will not disclose this information for immigration enforcement purposes except as required by a valid court order from a California state or federal court, or as expressly authorized by you in writing.

PART 2 — AUTHORIZATION TO RELEASE PHI TO DESIGNATED INDIVIDUALS

I hereby authorize the designated individuals below to request, discuss, and receive PHI regarding my healthcare and treatment, including treatment information, billing, and payments. The identity of the designated individual must be verified before release of PHI.

Sensitive Services Limitation (Cal. Civil Code § 56.107, AB 1184):
A general designation below does NOT authorize disclosure of sensitive services records to the designated individual. Those records require your separate, specific written authorization. Practice staff are trained to apply this restriction regardless of any general designation on file.

This authorization may include information considered sensitive under applicable law (mental health, substance use disorder, HIV/AIDS status, genetic information, or other protected categories), which will be disclosed only as permitted by law and subject to the sensitive services limitation above.

Full Name	Relationship to Patient	Phone Number

PART 3 — DURATION AND REVOCATION

- This authorization will remain in effect from the date signed until revoked in writing.
- I have the right to revoke this authorization in writing at any time.
- Information disclosed to authorized individuals above may no longer be protected by federal or state law and may be subject to redisclosure.

- Revoking this authorization does not affect disclosures that already occurred before the practice received my written revocation.

SIGNATURES

Patient / Legal Representative Print Name:

Patient / Legal Representative Signature:

Date:

Legal Authorities: HIPAA Privacy Rule, 45 CFR § 164.522(b) Cal. Civil Code § 56.107 (AB 1184, eff. 7/1/202022) al. Civil Code § 56.10 as amended by SB 81 (eff. 9/20/2025) Cal. Civil Code § 56.101 (AB 352, eff. 7/1/2024) This form is a compliance template. Complete bracketed fields and review with legal counsel before deploying.

Notice of Privacy Practices

Effective Date: February 16, 2026

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

California law gives you certain rights that go beyond federal law, including a shorter timeframe to inspect and receive copies of your records and additional protections for certain categories of medical information.

Your Choices

You have some choices in the way that we use and share information. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care or payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference — for example, if you are unconscious — we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising: we may contact you for fundraising efforts, but you can tell us not to contact you again.

If we have your substance use disorder patient records, subject to 42 CFR part 2, we will give you clear and obvious notice in advance and a choice about whether to receive fundraising communications that use your Part 2 information.

Our Uses and Disclosures

How do we typically use or share your health information?

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

In all cases, including those listed below, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; and for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Rights — In Detail

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information. Under federal law we will usually respond within 30 days. Under California law, we will permit inspection within 5 business days and provide copies within 15 days of your written request. We may charge a reasonable, cost-based fee as allowed by law.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, generally within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, office, or cell phone) or to send mail to a different address.
- We will honor requests for confidential communications when required by applicable federal or California law.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree, and we may say "no" if it could affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If someone has authority to act as your personal representative — for example, someone with your medical power of attorney or your legal guardian — that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html.
- You may also have the right to file a complaint with an applicable California regulatory authority.
- We will not retaliate against you for filing a complaint.

Your California Rights and Additional Protections

California law provides additional protections for certain categories of medical information and certain health care services.

Written authorization for disclosures

California and federal law provide additional confidentiality protections for certain categories of medical information, which may include mental health records, HIV-related information, substance use disorder records, and certain reproductive health information. We handle these records in accordance with the laws applicable to the particular information and disclosure.

Specially protected medical information

California provides heightened protection for medical information related to "sensitive services," which include care related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, and intimate partner violence. We handle information about these services consistent with California law.

Reproductive, abortion-related, contraception, and gender-affirming care information

Consistent with California law (including CMIA amendments such as AB 352 and related statutes), we take steps to segregate and protect medical information related to gender-affirming care, abortion and abortion-related services, and contraception, and we will not disclose, transfer, or grant access to that information to

persons or entities outside of California except as permitted by California law. We will not share this information in response to certain out-of-state requests or proceedings except as California law allows.

HIV and other specially protected information

California and federal law impose additional confidentiality requirements on certain records, including some HIV-related, mental health, and substance use disorder information. We will use and disclose this information only as permitted or required by the law applicable to the record.

Oncura Health complies with applicable federal and California privacy laws governing the use, disclosure, and protection of patient health information. Patients may request confidential communications regarding their health information, including communications through an alternative method or at an alternative location, as permitted by law. Oncura Health also evaluates requests for patient records and protected health information in accordance with applicable federal and California law, including requests involving sensitive or legally protected health care. Requests from governmental agencies, law enforcement, courts, or other third parties are reviewed and handled in accordance with applicable legal requirements and Oncura Health policies.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

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Patient Portal: Oncura Health provides patients with secure online access to certain health information through the Navigating Care patient portal. Depending on the services available through the portal, patients may use it to access health information and communicate with their care team.

Contact Information

If you have questions about this notice, wish to exercise your rights, or want to file a complaint, please contact our privacy contact:

Phone: 615.880.8479
Email: ooprivacyteam@oneoncology.com