ILLINOIS CANCER SPECIALISTS

Our Only Care is You.com

Dear Patient,

Welcome to Illinois Cancer Specialists. To make your visit go more smoothly, we have included a New Patient Welcome Packet for your benefit. Please complete the following enclosed forms:

- **ASSIGNMENT OF BENEFITS FORM:** allows us to accept payment from your insurance.
- **HIPAA FORM:** indicates to whom we can release your medical information.

In addition to the above, completed forms, please bring the following with you to your appointment:

-LIST OF QUESTIONS OR CONCERNS

-LIST OF ALL CURRENT MEDICATIONS: include over the counter and herbal drugs. In lieu of a list, you may bring in your pill bottles.

-MOST RECENT INSURANCE AND PRESCRIPTION CARDS, referral from primary care physician when necessary

-PREFERRED PHARMACY INFORMATION. Name, address, and phone number.

VISITORS: Illinois Cancer Specialists welcomes your friends or loved ones to visit during your treatment. Together, we share a common desire to create a safe and comfortable environment for your treatment or office visit. For the safety of our patients and staff, Illinois Cancer Specialists asks that you limit visitors to 1-2 people and do not allow children in the lab or treatment areas. Children must remain in the main lobby area and accompanied by a parent or guardian at all times. Thank you for your cooperation.

You will find answers to many questions you may have in the "General Information" handout; however, should you have questions which are not addressed, feel free to call our office or ask any staff member during your visit.

Sincerely,
Illinois Cancer Specialists

GENERAL INFORMATION

THE INFORMATION TO THE RIGHT WILL ACQUAINT YOU WITH OUR SERVICES AND OFFICE PROCEDURES. OUR GOAL IS TO PROVIDE YOU WITH USEFUL INFORMATION THAT WILL HELP YOU UTILIZE OUR CENTER.

OUR PHYSICIANS ARE ON-CALL FOR EMERGENCIES AFTER HOURS AND DURING THE WEEKEND. CALL THE OFFICE NUMBER TO BE CONNECTED WITH THE PHYSICIAN ON CALL.

YOUR FIRST APPOINTMENT

Please help us by arriving at your appointment at the time requested by our staff. In addition to the completed forms in your welcome packet, please bring the following items with you to your appointment:

1. List of your questions or concerns
2. Your current medications (including over-the-counter and herbal medications) - please bring either a list or the actual bottles
3. Current insurance and prescription cards
4. Your preferred pharmacy information: name, address, and phone number

NURSE/PHYSICIAN

All calls to our nurses are routed through the Triage Nurse. Please leave a detailed message with your full name (including the spelling of your last name), date of birth, reason for calling, and a number where you can be reached. Every effort will be made to return your call as soon as possible, and our goal is to return your call the same day. If it is important that your call be returned within a certain amount of time (example; need a call back within 2 hours) you must make that clear in your message.
IF YOUR SITUATION REQUIRES IMMEDIATE ATTENTION, DO NOT CALL THE OFFICE; DIAL 911.

PRESCRIPTION REFILLS

Refills of prescription drugs can only be filled during regular business hours. This restriction is for your protection: we must be able to have access to your most up-to-date and complete medical records to ensure you receive appropriate medications and approvals from your physician.

SCHEDULING AND APPOINTMENTS

If you are calling to schedule an appointment and do not reach us, please leave a detailed message including the following information:

1. Full name (including spelling of last name)
2. Date of birth for the patient
3. Phone number where you can be reached

Please call the office and speak with the nurse before coming in for an unscheduled visit. We will always accommodate emergencies when they occur. For this reason it is very important to always schedule your visits so that time can be set aside for your care.

If you cannot keep a scheduled appointment please let us know as soon as possible so that we can release that time for another patient.

Please pay close attention to your appointment time and help us by arriving at the time designated on your appointment card. Please understand that in order to be respectful of those patients who do arrive at their scheduled times, late arrivals will be worked into the schedule as it allows. Additionally, those who arrive more than 30 minutes before their appointment will be asked to wait.

INSURANCE AND BILLING

You will be asked to provide us with your insurance coverage information at your first visit and every visit thereafter. A day or two prior to your first appointment with our office, a registration clerk will contact you to obtain and verify your insurance information.

It is a requirement of your health insurance that co-payments be collected at each visit.

We participate with most major insurance carriers. As a courtesy, claims will be filed for you. In order to ensure reimbursement, your insurance information must be kept current. Please remember that your insurance policy is a contract between you and your insurance company and we are not a party to the contract. For your convenience we accept Visa, MasterCard, Discover, and American Express.

If there is a patient responsibility due, you will receive monthly statements showing you an itemization of charges and payments made by you or your insurance company. You will be introduced to one of our Patient Financial Counselors who will assist you with your financial health.

If you have questions regarding your billing, do not hesitate to contact our billing office at (847) 585-7000.

ADDITIONAL RESOURCES

Please visit the official website for Illinois Cancer Specialists at OurOnlyCareisYou.com for more information. There you can explore the Resource Center, get directions, and find valuable links to other websites.

If you have any questions, at any time, do not hesitate to ask a ICS staff member or call our offices where we will be happy to assist you.

OFFICE LOCATIONS

Arlington Heights
880 West Central Road
Suite 8200
Arlington Heights, IL 60005
(847) 259-4482

Chicago/Resurrection
7447 W. Talcott Ave.
Suite 400
Chicago, IL 60631
(773) 763-9300

Elgin
1710 N. Randall Road
Suite 300
Elgin, IL 60123
(847) 931-0909

Hoffman Estates
1555 Barrington Road
Suite 235
Hoffman Estates, IL 60169
(847) 885-0909

Huntley
10350 Haligus Road
Suite 210
Huntley, IL 60142
(847) 802-7880

McHenry
4305 Medical Center Drive
Suite 1
McHenry, IL 60050
(815) 363-0066

Niles
8915 W. Golf Road
Niles, IL 60714
(847) 827-9060

Woodstock
3703 Doty Road
Suite 6
Woodstock, IL 60098
(815) 334-9154

OUR TEAM

OUR CANCER CARE TEAM IS MADE UP OF BOARD-CERTIFIED ONCOLOGISTS AND OTHER ONCOLOGY-TRAINED CLINICAL PROFESSIONALS WHO UNDERSTAND THE SPECIAL NEEDS OF CANCER PATIENTS AND THEIR FAMILIES.

With many years of experience caring for cancer patients, our physicians, nurses, pharmacists, counselors and other specialists work together to provide world-class, personalized cancer care.

MEDICAL ONCOLOGY & HEMOTOLOGY

Our medical oncology team plays a major role in cancer care by managing treatment plans and therapies, monitoring and evaluating progress, and collaborating on best options with other caregivers. We consult with patients on their choices and any temporary side effects they may experience during chemotherapy treatments, as well as offer medical guidance to help patients make decisions along the way.

Our hematology team has extensive experience providing high quality patient care, research, and leading-edge treatment of blood and bone marrow disorders; for both cancer and non-cancer patients.

These ICS physicians are trained in the specialties of both medical oncology and hematology.

Dr. Lisa Baddi
Dr. Susan G. Brown
Dr. Bety Ciobanu
Dr. Jay S. Dalal, FACP
Dr. John W. Eklund
Dr. Robert Galamaga
Dr. David Hakimian
Dr. Leonard M. Klein
Dr. Rajat Malhotra
Dr. Robert Mandal
Dr. Rajini Manjunath
Dr. Stan Nabrinsky
Dr. Randy S. Rich
Dr. Joel Schwartz
Dr. Richard S. Siegel
Dr. Veerpal Singh
Dr. Urszula A. Sobol
Dr. Alexander Starr
Dr. C. Yeshwant
Dr. Aslam S. Zahir

RADIATION ONCOLOGY

Today, radiation therapy is quicker, safer and more precise than ever before. Our radiation oncology team uses advanced treatment planning systems and state-of-the-art radiation technology to deliver internal and external radiation to cancerous cells, which helps prevent them from growing or dividing and spreading.

Dr. Joel Schwartz

ADVANCED PRACTICE NURSES & PHYSICIANS ASSISTANTS

Many of our sites have at least one Nurse Practitioner or Physicians Assistant on site. Patients may interface with them in between physician visits.

Often described as an art and a science, nursing is a critical link between our patients and physicians. Our nurses have many roles, from educator to practitioner and researcher, and serve all of them with passion for the profession and with a strong commitment to patient safety.

Website:
OurOnlyCareisYou.com

SERVICES

WHEN FACED WITH CANCER, PATIENTS WANT THE MOST ADVANCED CARE AVAILABLE. Thanks to the dedication of our experienced physicians and staff, Illinois Cancer Specialists provides unparalleled access to innovative therapies and the latest technologies based on the latest clinical evidence—right here in our community. From leading-edge diagnostic imaging and sophisticated radiation therapies, to new investigational drugs through clinical trials, we offer our patients advanced and comprehensive cancer care.

To us, providing comprehensive care also means understanding that having cancer is hard on patients and their families. Our physicians and staff will do whatever it takes to make everyone more comfortable. We will spend time with our patients to make sure they understand their diagnosis and treatment options, and offer educational resources and support services designed to help patients and their families understand and cope with their disease.

Services offered at Illinois Cancer Specialists include:

Medical Oncology
Radiation Oncology
Hematology
Oncology Clinical Nursing
Stem Cell Transplantation
Hormone Therapy
Immunotherapy
Chemotherapy
PET/CT
Pharmacy
Clinical Laboratory Services
Clinical Studies/Research Trials
Therapeutic Phlebotomy
Genetic Testing
Genetic Counseling
Access to Clinical Social Worker
Patient Financial Counselors
Educational Resources
Home Care Support Referral
Hospice Care Referral
Palliative Care

MISSION STATEMENT

TO DELIVER ON THE PROMISE OF PROVIDING THE BEST PATIENT CARE POSSIBLE IN A CARING AND SUPPORTIVE ENVIRONMENT WITH SEAMLESS ACCESS TO THE LATEST IN TECHNOLOGY AND RESEARCH AVAILABLE TO HELP EVERY PATIENT LIVE THEIR HIGHEST QUALITY OF LIFE.

PATIENT RIGHTS AND RESPONSIBILITIES

AS A PATIENT I HAVE THE RIGHT TO RECEIVE AN EXPLANATION OF MY DIAGNOSIS, BENEFITS OF TREATMENT, ALTERNATIVES, RECUPERATION, RISKS AND AN EXPLANATION OF CONSEQUENCES IF TREATMENT IS NOT PURSUED.

RIGHTS

As a patient I have the right to:

- Full information about my rights and responsibilities as a patient at ICS.
- Receive an explanation of my diagnosis, benefits of treatment, alternatives, recuperation, risks and an explanation of consequences if treatment is not pursued.
- An explanation of all rules, regulations and services provided by ICS, the days and hours of services and provisions for possible emergency care, including telephone numbers
- Choose my own physician/care giver, and know the names, status and experience of the staff.
- Participate in development of a plan of care and receive information on Advance Directives.
- Refuse participation in any protocol or aspect of care including investigational studies, and freely withdraw my previously given consent for further treatment
- Disclosure of any teaching programs, research of experimental programs in which the facility is participating
- Financial explanation and estimated cost for my plan of care prior to beginning treatment.
- Receive expert, professional care without discrimination, regardless of age, creed, color, religion, national origin, sexual preference, or handicap
- Be treated with courtesy, dignity and respect of my personal privacy by all employees of ICS
- Be free of physical/mental abuse and/or neglect by all employees of ICS
- Complain or file grievance with ICS practice manager without fear of retaliation or discrimination
- Access to my personal records and obtain copies upon written request
- Assistance and consideration in the management of pain

RESPONSIBILITIES

As a patient I have the responsibility to:

- Disclose accurate and complete information of my physical condition, hospitalizations, medications, allergies, medical history and related items
- Participate in developing a plan of care, advance directives and living will
- Assist in maintaining a safe, peaceful and efficient ambulatory environment
- Provide new/changed information related to my health insurance to the business office
- Contact ICS when unable to keep a scheduled appointment
- Cooperate in the planned care and treatment developed for me
- Request more detailed explanations for any aspect of service I do not understand
- Inform my physicians and nurses of any changes in my condition or any new problems or concerns
- Communicate any temporary or permanent changes in my address or telephone number which might hinder contact by the staff
- Relate my levels of discomfort and/or pain and perceived changes in my pain management to my physician

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Credit Card Policy

Lisa Baddi, DO
Susan G. Brown, MD
Bety Ciobanu, MD
Apurva Desai, MD
John W. Eklund, MD
Robert Galamaga, DO
David Hakimian, MD
Leonard M. Klein, MD
Rajat Malhotra, MD
Robert Mandal, MD
Rajini Manjunath, MD
Stan Nabrinsky, MD
Randy S. Rich, MD
Joel Schwartz, DO
Richard Siegel, MD
Veerpal Singh, MD
Urszula A. Sobol, MD
Alexander Starr, MD
Yeshwant, MD, FACP
Aslam S. Zahir, MD

Dear Patients:

This letter is to inform you of our updated billing practice in regards to receiving patient payments. Effective October 1, 2015 we now require a credit or debit card to be on file with our office for full patient payment of services at each appointment.

Why the change?

There are several reasons for this change. With the changing environment in healthcare, in particular the Affordable Care Act and High Deductible Health Plans (HDHPs) more responsibility of payment is being placed on the patient. We need to be sure that patient balances are paid in a timely manner. To do this we need to ensure we have a guarantee of payment on file in our office.

What is Deductible and How Does It Affect Me?

An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins to pay.

For example, if your policy has a $2,000 deductible, you must pay the first $2,000 of medical expenses before the insurance company begins to pay for any services.

This works just like the deductible for your car insurance or homeowners' insurance policy does.

When does a deductible begin?

Your deductible begins at the start of your plan year. Most plan years begin either January 1 or July 1, but plans can start on any date.

When do I have to pay for services?

Any time you receive medical care, you will be expected to pay in full for your services until your deductible is met. If you have a very large deductible, called a high-deductible insurance plan, you may have to pay out of pocket for most of your primary care services.

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How will I know when my deductible has been met?

You can call your insurance company at any time to check on how much of your deductible has been met and some insurance companies have this information available online. Every time you receive medical services, you will receive notification from your insurance company with how much they paid or did not pay if the amount went to your deductible when they send you an Explanation of Benefits (EOB).

But I always pay my bill, why me?

We have to be fair and apply the policy to all patients. We have wonderful patients and we know that most of you pay your balances. Unfortunately, this is not always the case.

Do I need to sign a new Financial Policy?

No. The Financial Policy you sign when you enrolled with our practice already allows for this change: *"Payment for all services is my responsibility and is due and payable at the time services are rendered."*

How will I know how much you are going to charge me?

You will receive a letter in the mail (or email) from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits (EOB). This letter tells you exactly, according to your health insurance coverage, how much of your care bill is your responsibility and how much is the responsibility of your insurance to pay.

Then What?

We receive the same Explanation of Benefits (EOB) that you do. Most insurance will send your EOB prior to us receiving our copy. It arrives about 10-20 days after your appointment has been billed. We look at each EOB carefully and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a statement for in the mail.

Will you send me a bill to let me know what I owe?

All patients with commercial insurance are required to keep a credit or debit card on file. If you do not wish to keep a card on file, we will expect an estimated payment at the time of service. For example, if your commercial insurance requires $95 to be paid for standard service and your deductible is not met, you will be expected to pay the $95 via check, credit card or cash before you are seen. This will not include ancillary charges that may arise out of your visit. Once we receive the EOB on your visit we will send a statement if your patient responsibility is higher than the originally collected amount or you will have a credit on your account if your patient responsibility is lower than the originally collected amount.

The best way to avoid this confusion is to keep your credit card on file. Once we receive the insurance EOB for your visit we will charge the credit card on file the exact amount as per the EOB that is stated to be patient responsibility.

ILLINOIS CANCER SPECIALISTS

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Credit Card Policy

But wait, I am nervous about leaving you my credit card.

We do not store your sensitive credit card information in our office. We store it on a secure website called a gateway. The gateway we use is called Go-to-Billing which is compliant and is certified by VISA®. This gateway is only used to process your payment and email you a receipt once payment is processed.

What is Go-To-Billing?

Payment Card Industry (PCI) Security Standards Council offers robust and comprehensive standards to enhance payment card data security and reduce exposure to credit card fraud. PCI Data Security Standard (DSS) provides an actionable framework for developing a robust payment card data security process, including prevention, detection and appropriate reaction to security incidents.

When do I give you my Credit Card?

We prefer for you to fill out the Credit Card Authorization Form and give us your credit card in person. We will swipe your credit card with an encrypted reader that will securely upload your credit card number into the Go-to-Billing gateway and return the card to you. With the encrypted reader, we will never see all the numbers of your credit card. You can deliver your credit card information over the phone or by mail, but the most secure way is in person through the encrypted reader.

My High-Deductible Health Plan has a Health Savings Account (HSA) card. Can I keep my HSA card on file?

Yes, you can keep your HSA card on file, however, we may require an additional card to be kept on file should the funds in your HSA account become insufficient.

What if I need to dispute my bill?

We will always work with you to understand if there has been a mistake. We will refund your credit card if we or if your insurance company has made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the EIB they send to us, in the same way that we normally determine how much to send you a bill for in the mail.

What if I have more questions?

Our staff is happy to speak with you about your account at any time.

ILLINOIS CANCER SPECIALISTS

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Credit Card Pre-Authorization Form

I authorize Illinois Cancer Specialists to keep my signature on file and to use the payment method selected below for the following:

☐ Balance remaining after claim(s) is (are) resolved not to exceed $ for:

☐ This visit only

☐ All visits this calendar year

☐ All visits from to _____ (date) to _____ (date)

☐ Recurring charges of $ _____ to be charged every _____ (frequency)

☐ From to _____ (date) to _____ (date)

☐ Charges for the following family members:

_____ (authorized family member) _____ (authorized family member)

_____ (authorized family member) _____ (authorized family member)

Check One:

☐ Visa®

☐ MasterCard®

☐ American Express®

☐ Discover Card®

☐ Checking Account: _____ (routing #) _____ (account #)

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Exp. Date: _____

Cardholder Signature: _____ Date: _____

CVV Code (three digit code on the back of the credit card): _____

Patient or Authorized Representative Signature: _____

ILLINOIS CANCER SPECIALISTS

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Are you worried about being able to afford the cost of your cancer treatments?

Our advocate team at Patient Assistance Support may be able to help you find a solution!

Due to the high cost of cancer therapy, many Patient Assistance Programs (PAPs) have been developed by pharmaceutical manufacturers and charitable foundations to help patients who have no insurance or who are underinsured get the treatment they need. However, the application process for PAPs can be difficult to navigate and require a significant amount of time and effort.

To help patients with this process, we have chosen to work with Patient Assistance Support, a team of PAP experts who will work with you to coordinate and monitor the PAP application process. We are pleased to offer this service at no cost to our patients.

How to Get Started:

1) Discuss the costs of your specific treatment plan with one of our Patient Benefits Representatives. If you are unable to cover the out-of-pocket expenses associated with that treatment and would like to seek assistance, notify the Patient Benefits Representative. He or she will contact the Patient Assistance Support team to provide general information regarding your treatment plan.

2) After speaking with the Patient Benefits Representative, a Reimbursement Counselor from Patient Assistance Support will follow up with you directly to obtain any additional information necessary regarding your treatment and specific financial situation to determine which PAPs you may qualify for and could best fit your needs.

3) The Patient Assistance Support team will assist with and monitor the application process, providing a prompt notification to both you and the Patient Benefits Representative once a final determination is made by the PAP.

Though not all applicants are guaranteed for approval since each Patient Assistance Program sets its own eligibility criteria that typically take into consideration income thresholds, household size and status of prescription insurance coverage, the Patient Assistance Support team maintains a current working knowledge of the requirements for the various programs available and is able to quickly identify the programs that best match each patient's unique situation. As a result, Patient Assistance Support has been able to achieve a high success rate, and you can feel confident that the best effort will be extended on your behalf.

We know that cancer treatment is expensive, and we are pleased to provide this resource so you can focus on the most important issue – fighting cancer!

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____

Patient Name: _____ ( ) _____
Last *First* *M.I.* *Home Telephone*

Cell ( ) _____

Home Address: _____ Mailing Address: _____
Street *Street*

_____ _____
City *State* *Zip* *City* *State* *Zip*

DOB: _____ Age _____ ☐M ☐F SS# _____ ☐Married ☐Single ☐Divorced ☐Widowed ☐Other
Sex *Check Marital Status*

Ethnicity / Race: _____

Employer _____ ( ) _____
Name *Telephone*

_____ _____
Address Occupation

Responsible Party: _____ _____ ( ) _____
Name Relationship Telephone

Emergency Contact:

Spouse/Next of Kin: _____ _____ ( ) _____
Name Relationship *Telephone*

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ ID#: _____ Group # _____

Insured Name: _____ DOB _____

Secondary Ins: _____ ID#: _____ Group # _____

Insured Name: _____ DOB _____

PHARMACY INS: _____

RXBIN: _____ **RXPCN**: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Illinois Cancer Specialists.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Illinois Cancer Specialists. 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 Illinois Cancer Specialists.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Illinois Cancer Specialists.

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 original.

_____ _____
Patient Signature Date/Time AM or PM (*circle one*)

_____ _____
Responsible Party Signature Relationship Date/Time AM or PM (*circle one*)

PHYSICIAN: _____
ACCT NBR: _____ LOC: _____
FOR OFFICE USE ONLY

EMPLOYEE INITIALS _____

ILLINOIS CANCER SPECIALISTS
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Revised March 2014

State of Illinois
Illinois Department of Public Health

Illinois Statutory Short Form
Power of Attorney for Health Care

NOTICE TO THE INDIVIDUAL SIGNING THE POWER OF ATTORNEY FOR HEALTH CARE

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your "health care agent." Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an "advance directive." You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and online resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

WHAT ARE THE THINGS I WANT MY HEALTH CARE AGENT TO KNOW?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision making authority once this document goes into effect - in most instances after you are no longer able to make your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions to direct or refuse health care interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

(i) What is most important to you in your life?

(ii) How important is it to you to avoid pain and suffering?

(iii) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?

(iv) Would you rather be at home or in a hospital for the last days or weeks of your life?

(v) Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?

(vi) Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?

(vii) Do you have an existing advanced directive, such as a living will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.

WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there is ever a period of time when your physician determines that you cannot make your own health care decisions, or if you do not want to make your own decisions, some of the actions your agent could take are to:

(i) talk with physicians and other health care providers about your condition.

(ii) see medical records and approve who else can see them.

(iii) give permission for medical tests, medicines, surgery, or other treatments.

(iv) choose where you receive care and which physicians and others provide it.

(v) decide to accept, withdraw, or decline treatments designed to keep you alive if you are near death or not likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.

(vi) agree or decline to donate your organs or your whole body if you have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research and/or education.

(vii) decide what to do with your remains after you have died, if you have not already made plans.

(viii) talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).

Your agent is not automatically responsible for your health care expenses.

WHO SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

Your agent will have the responsibility to make medical treatment decisions, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend, or other person who:

(i) is at least 18 years old;

(ii) knows you well;

(iii) you trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;

(iv) would be comfortable talking with and questioning your physicians and other health care providers;

(v) would not be too upset to carry out your wishes if you became very sick; and

(vi) can be there for you when you need it and is willing to accept this important role.

WHAT IF MY AGENT IS NOT AVAILABLE OR IS UNWILLING TO MAKE DECISIONS FOR ME?

If the person who is your first choice is unable to carry out this role, then the second agent you chose will make the decisions; if your second agent is not available, then the third agent you chose will make the decisions. The second and third agents are called your successor agents and they function as back-up agents to your first choice agent and may act only one at a time and in the order you list them.

WHAT WILL HAPPEN IF I DO NOT CHOOSE A HEALTH CARE AGENT?

If you become unable to make your own health care decisions and have not named an agent in writing, your physician and other health care providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a "surrogate".

There are reasons why you may want to name an agent rather than rely on a surrogate:

(i) The person or people listed by this law may not be who you would want to make decisions for you.

(ii) Some family members or friends might not be able or willing to make decisions as you would want them to.

(iii) Family members and friends may disagree with one another about the issue being decided.

(iv) Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

WHAT IF THERE IS NO ONE AVAILABLE WHO I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your physician and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes. You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other health care provider and ask him or her to write it down in your chart. You might also want to use written or online resources to guide you through this process.

WHAT DO I DO WITH THIS FORM ONCE I COMPLETE IT?

Follow these instructions after you have completed the form:

(i) Sign the form in front of a witness. See the form for a list of who can and cannot witness it.

(ii) Ask the witness to sign it, too. There is no need to have the form notarized.

(iii) Give a copy to your agent and to each of your successor agents.

(iv) Give another copy to your physician.

(v) Take a copy with you when you go to the hospital.

(vi) Show it to your family and friends and others who care for you.

WHAT IF I CHANGE MY MIND?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to your agents and your physicians.

WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must be executed by you. Designate an agent who is over 18 years of age and not prohibited from serving as your agent, and state the agent's powers. It need not be witnessed or conform in any other respect to the statutory health care power.

If you have questions about the use of any form, you may want to consult your physician, other health care provider, and/or an attorney.

State of Illinois
Illinois Department of Public Health

Illinois Statutory Short Form
Power of Attorney for Health Care

MY POWER OF ATTORNEY FOR HEALTH CARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE.

My name (Print your full name): _____

My address: _____

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT (an agent is your personal representative under state and federal law):

(Agent name) _____

(Agent address) _____

(Agent phone number) _____

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw, or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

(ii) Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue, or whole body donation, autopsy, cremation, and burial.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

I AUTHORIZE MY AGENT TO: (Please check only one box; if more than one box or no boxes are checked, the directive in the first box below shall be implemented.)

❑ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

❑ Make decisions for me starting now and continue after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

LIFE-SUSTAINING TREATMENTS

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements. SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES **(optional)**:

- ❑ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.
- ❑ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically on the lines below or add another page if needed:

_____

_____

_____

_____

YOU MUST SIGN THIS FORM, AND A WITNESS MUST ALSO SIGN IT BEFORE IT IS VALID.

My signature: _____ Today's date: _____

HAVE YOUR WITNESS COMPLETE THE FOLLOWING AND SIGN:

I am at least 18 years old, and (check one of the options below):

- ❑ I saw the principal sign this document, or
- ❑ The principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, mental health service provider, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness printed name: _____

Witness address: _____

Witness signature: _____ Today's date: _____

SUCCESSOR HEALTH CARE AGENT(S) (optional):

If the agent I have selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names):

_____

(Successor agent #1 name, address and phone number)

_____

(Successor agent #2 name, address and phone number)

ILLINOIS CANCER SPECIALISTS

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Illinois Cancer Specialists
HIPAA Authorization

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI).* The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

Please indicate below your preferred method of contact.

- o Home Phone _____ Can we leave a detailed message? YES NO
- o Cell Phone _____ Can we leave a detailed message? YES NO
- o Work Phone _____ Can we leave a detailed message? YES NO

I authorize Illinois Cancer Specialists to release my medical information to person(s) listed below. I understand that the person(s) named on this authorization will be given access to obtain or review my medical information and have my permission to discuss my care or obtain results/information on my behalf. I authorize the person(s) indicated below to pick-up materials pertinent to my medical care.

Name	Relationship	Telephone#

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient Signature Date

I do not authorize release or disclosure to my spouse, family member, or personal representative at this time. I may review this decision in writing at a later date, if I so choose.

_____ _____ _____
Print Patient Name Date Date of Birth

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

ILLINOIS CANCER SPECIALISTS

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You're Invited to Join the Illinois Cancer Specialists E-Mail Program

If you are interested in receiving updates from Illinois Cancer Specialists (ICS) regarding ICS news and events, please provide your name and primary e-mail address. Submit this form during your next appointment.

IMPORTANT: Please add ICS@usoncology.com to your safe sender list. Otherwise, e-mail may be directed to a SPAM or junk folder.

PLEASE PRINT CLEARLY

First/Last Name **E-mail Address**

Signature – *authorizing ICS to e-mail news/updates* **Date**

Illinois Cancer Specialists Notice of Disclosure for E-Mail Practices & Privacy Policy

Illinois Cancer Specialists (ICS) has created this policy to demonstrate our firm commitment to your privacy and the protection of your information.

Did you receive e-mail from ICS?
Our e-mail marketing program is permission based. If you receive e-mail from us, our records indicate that you have expressly shared this address for the purpose of receiving information in the future ("opt-in"). We respect your time and attention by controlling the frequency of our mailings.

If, at any time, you believe you have received unwanted, unsolicited e-mail sent via our distribution system or purporting to be sent via our system, please forward a copy of that e-mail with your comments to ICS@usoncology.com for review.

Can you stop receiving e-mail?
Each e-mail sent contains an easy, automated way for you to cease receiving e-mail from the lists to which you are subscribed, or to change your expressed interests. If you wish to do this, simply follow the instructions to unsubscribe provided in every e-mail.

How we protect your privacy
We use security measures such as encryption to protect against the loss, misuse and alteration of data used by our system.

Sharing and Usage of Account Information
We will never share, sell, or rent your personal account information or subscriber data with anyone without your advance permission or unless ordered by a court of law. Information submitted to us is only available to employees managing this information for purposes of contacting you or sending you e-mails based on your request for information and to contracted service providers for purposes of providing services relating to our communications with you.

Privacy Policy Changes
If this privacy policy changes in the future, all account holders will be notified of the change at least ten (10) days before it occurs and have the option to terminate his or her account and thus have their data removed from the system. This policy was created in August 2011.

ILLINOIS CANCER SPECIALISTS

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Notice of Disclosure for E-Mail Practices & Privacy Policy

Illinois Cancer Specialists (ICS) has created this privacy policy to demonstrate our firm commitment to your privacy and the protection of your information.

Why did you receive e-mail from ICS?
Our e-mail marketing program is permission based. If you receive an e-mail from us, our records indicate that you have expressly shared this address for the purpose of receiving information in the future ("opt-in"). We respect your time and attention by controlling the frequency of our mailings.

If you believe you have received unwanted, unsolicited e-mail sent via our distribution system or purporting to be sent via our system, please forward a copy of that e-mail with your comments to ICS@usoncology.com for review.

How can you stop receiving e-mail?
Each e-mail sent contains an easy, automated way for you to cease receiving e-mail from the lists to which you are subscribed, or to change your expressed interests. If you wish to do this, simply follow the instructions to unsubscribe provided in every e-mail.

How we protect your privacy
We use security measures, such as encryption, to protect against the loss, misuse and alteration of data used by our system.

Sharing and Usage of Account Information
We will never share, sell, or rent your personal account information or subscriber data with anyone without your advance permission or unless ordered by a court of law. Information submitted to us is only available to employees managing this information for purposes of contacting you or sending you e-mails based on your request for information and to contracted service providers for purposes of providing services relating to our communications with you.

Privacy Policy Changes
If this privacy policy changes in the future, all account holders will be notified of the change at least ten (10) days before it occurs and have the option to terminate his or her account and thus have their data removed from the system. This policy was created in August 2011.

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form.** For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

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

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

_____
Patient Name
(First Name, Middle Initial, Last Name)

_____
Email Address of Patient or Authorized

_____
Date of Birth of Patient

_____
Physician's Name

Authorized User is:

☐ Patient
☐ Patient's Designee

_____
Patient's Designee's Name (Printed)

_____
Patient's Designee's Signature

_____
Patient's Signature

_____
Date

_____
Signature of Practice Staff
[confirming user's identity and authority]

_____
Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose.

Staff Use Only:	MRN_____
Email in PMS or iKM_____	iKM Consent_____

Illinois Cancer Specialists: *Please check your hospital*

- ☐ Northwest Community Hospital: 0511111804
- ☐ Advocate Lutheran General Hospital: 1-CN9NRC
- ☐ Alexian Brothers Medical Center: 1-10B7WWE
- ☐ Resurrection Hospital: 1424210034
- ☐ Advocate Good Samaritan, Downers Grove - 1468195034
- ☐ Advocate Sherman Hospital, Elgin - 1078705034
- ☐ Presence St. Joseph Hospital, Elgin - 1078705034
- ☐ Centegra Northern Illinois Medical Center, McHenry - 1-T628UT
- ☐ Centegra Memorial Medical Center, Woodstock - 1-E3XBGZ
- ☐ St Alexis Medical Center, Hoffman Estates - 1-MWBLVL
- ☐ Adventist Hinsdale Hospital - 1-HYQUN7
- ☐ Adventist Bolingbrook Hospital - 1-1VFFTVT

Illinois Cancer Specialists
Our Only Care is You.com

Today's Date _____/_____/_____

Please fill out this form completely so that the American Cancer Society can better serve you. Thank you.

Name:_____

Phone: _____ E-Mail: _____

Can we leave a message? (Y/N)_____

Address: _____

City: _____State: _____Zip: _____

Gender (Male/Female) : _____ Race: _____ Date of Diagnosis: _____/_____/_____

Type of Cancer: _____

Treatment (Chemotherapy/Radiation): _____

Insurance:

- ☐ Private
- ☐ Medicare
- ☐ Medicaid
- ☐ Uninsured

All information you provide will remain confidential. All information and services are free. I would like information on the following American Cancer Society services (check all that apply):

- ☐ Information about my my cancer
- ☐ Understanding Treatment Options
- ☐ Transportation Assistance
- ☐ Skin Care Session with Licensed Cosmetologist
- ☐ Cancer Help Kit (Personal Health Manager)
- ☐ Resources/Guidance (i.e. financial, lodging, etc.)
- ☐ Nutrition during treatment
- ☐ Clinical Trials
- ☐ Insurance
- ☐ Support Groups
- ☐ Wigs/Turbans/Hats
- ☐ One-on-one contact with a survivor of the same cancer

Patient Signature: _____

The American Cancer Society cares about your privacy and protects how we use your information. The information on this form will be used by the society to better serve you and your community. We may also use your information to invite you to participate in an upcoming event in your area. To view the Society's complete privacy policy, or if you have questions about the Society's privacy standards, please contact us at 800-227-2345. By signing this form, you agree and give permission to the Society to use and share your information internally. The American Cancer Society is available day or night, for information and support, by calling 1-800-227-2345

PLEASE FAX THE COMPLETED FORM TO: 1-312-279-7237