



ILLINOIS CANCER SPECIALISTS

Our Only Care is You.com

Dear Patient,

Welcome to Illinois Cancer Specialists. We hope your visit is pleasant, and to make things 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.
- **MEDICAL RECORDS RELEASE FORM:** gives us permission to obtain your records from your other providers/hospitals. Please fill out the bottom portion, and we will keep this in your chart.
- **HIPPA FORM:** indicates to whom we can release your medical information.
- **PATIENT INTAKE FORM:** a form that is required by new health care standards
- **PATIENT HEALTH HISTORY FORM:** includes questions regarding your past medical history. Please fill out this form as completely as possible, as it is a valuable tool for your physician.

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 from 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 6 months 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/Northwestern Campus

676 N. St. Clair Street
Suite 2140
Chicago, IL 60611
(312) 664-5400

Chicago/Resurrection

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

Chicago/Swedish Covenant

Swedish Covenant Hospital -
Ambulatory Center/Cancer Center
5140 N. California Avenue, Suite G115
Chicago, IL 60625
(773) 878-8200, ext 5385

Niles

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

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 & HEMATOLOGY

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. Manatosh Banerji
Dr. Susan Brown
Dr. Jeffrey Cilley
Dr. John Eklund
Dr. David Hakimian
Dr. Prashant Joshi
Dr. Bruce Kaden
Dr. Leonard Klein
Dr. Rajat Malhotra
Dr. Ann L. Mellott
Dr. Steven B. Newman
Dr. Randy Rich
Dr. Christopher Rose
Dr. David Rosi
Dr. John M. Shaw
Dr. Richard Siegel
Dr. Regina Stein
Dr. Claudia Tellez
Dr. Stephanie F. Williams

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

ILLINOIS CANCER SPECIALISTS

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
Nuclear Medicine
Bone Density
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

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____

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

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

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: _____ Telephone:() _____

Insured Name: _____ DOB _____ Group # _____ Policy # _____

Secondary Ins: _____ Telephone:() _____

Insured Name: _____ DOB _____ Group #: _____ Policy # _____

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: _____ EMPLOYEE INITIALS _____
ACCT NBR: _____ LOC: _____
FOR OFFICE USE ONLY



Lisa Baddi, D.O.
 Manatosh Banerji, M.D.
 Susan G. Brown, M.D.
 Jeffrey Cilley, M.D.
 John W. Eklund, M.D.
 Marilyn Evrard, M.D.
 David Hakimian, M.D.
 Prashant K. Joshi, M.D.
 Bruce R. Kaden, M.D.
 Leonard M. Klein, M.D.
 Leonard Kosova, M.D.
 Rajat Malhotra, M.D.
 Ann Mellott, M.D.
 Steve Newman, M.D.
 Randy Rich, M.D.
 Christopher G. Rose, M.D.
 David R. Rosi, M.D.
 Joel Schwartz, D.O.
 John M. Shaw, M.D.
 Richard Siegel, M.D.
 Regina Stein, M.D.
 Claudia Tellez, M.D.
 Stephanie F. Williams, M.D.

Arlington Heights

880 W. Central Road, Suite 8200
 Arlington Heights, Illinois 60005
 Phone (847) 259-4482
 Fax (847) 259-6406

Chicago / Northwestern campus

Arkes Family Pavilion
 676 N. St. Clair Street, Suite 2140
 Chicago, IL 60611
 Phone (312) 664-5400
 Fax (312) 664-5854

Chicago / Resurrection campus

7447 W. Talcott Ave., Suite 400
 Chicago, Illinois 60631
 Phone (773) 763-9300
 Fax (773) 763-1622

Chicago/Swedish Covenant

Swedish Covenant Hospital
 Ambulatory Center/Cancer Center
 5140 N. California Avenue
 Suite G115
 Chicago, Illinois 60625
 (773) 878-8200, ext 5385

Elmhurst

1200 York Road, Ste 3280
 Elmhurst, IL 60126
 Phone (630) 941-8280
 Fax (630) 941-8330

Morton Grove

9129 Waukegan Road
 Morton Grove, Illinois 60053
 Phone (847) 965-3200
 Fax (847) 965-3270

Niles

8915 W. Golf Road
 Niles, IL 60714
 Phone (847) 827-9060
 Fax (847)827-7196

Date: _____

Medical Records Release Form

I hereby authorize and request that you release my medical records to:

For treatment relating to:

I understand that my records may contain information regarding drug, alcohol, psychological, or psychiatric conditions and communicable diseases, which are protected by federal law and cannot be disclosed without written consent, unless otherwise approved in the federal regulations. I also understand that I may revoke this consent at anytime and that in any event this consent expires automatically as described below. My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand. This release will expire in six (6) months.

 LAST NAME (PRINTED) FIRST MIDDLE INITIAL

 BIRTHDATE SOCIAL SECURITY NUMBER

 PATIENTS SIGNATURE (GUARDIAN) WITNESS

 DATE PHYSICIAN REQUESTING INFORMATION

HIPAA AUTHORIZATIONS

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.

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

- | | |
|---|---|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave messages with detailed information
<input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home
<input type="checkbox"/> O.K. to mail to my office
<input type="checkbox"/> O.K. to fax to this number _____ |
| <input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave messages with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Other _____ |
- I acknowledge that I have received a copy/have read the Notice of Privacy Practices of Illinois Cancer Specialists.

Print Patient Name

Date of Birth

Patient Signature

Date

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.

Authorized Persons to Receive Protected Health Information

Patient Intake Form

Please take a minute to complete this form to provide information to assist us in complying with new federal regulations and to update our records. Thank you.

Patient Information

Name (Please Print): _____

Date of Birth: _____ Sex (circle one): M F

Race (optional): _____

Ethnicity (optional, circle one or leave blank): Hispanic/Latino Not Hispanic/Latino

Preferred language (optional): _____

Last flu vaccine date (if applicable): _____

Were you in a hospital, skill nursing facility, emergency room, or other setting of care before your visit today (circle one): Hospital Skill nursing facility ER Other _____

Contact Information

Home phone: _____ Cell phone: _____ Work phone: _____

Email address: _____

Note: Your email address could be used by the practice to notify you on how to access information and for specific reminders. It will not be used for two-way communication regarding your medical care. Please contact our office if you have any questions or concerns related to your medical care.

Preferred method of contact (circle one): Home phone Cell phone Work phone Email

Emergency Contact Name: _____ Relationship: _____

Phone number: _____ Alternate phone number: _____

Preferred Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____ City: _____ Zip code: _____

Pharmacy Phone: _____



Patient Health History

Name: _____ Date of Birth: _____ Age: _____

SS #: _____ Today's Date: _____ Sex: Male Height: _____
Female

Primary Care Physician: _____ Phone Number: _____

Referring MD: _____ Phone Number: _____

Other MD's: Name/Specialty _____

Pharmacy Name: _____ Pharmacy Number: _____

Current problem or reason for consultation: _____

PAST MEDICAL HISTORY: *Please check all the boxes that apply*

- | | | | |
|------------------------|--------------------------|-------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | Hepatitis/Liver Disease | <input type="checkbox"/> |
| Anemia/Blood Disorders | <input type="checkbox"/> | Hypercholesterolemia | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> |
| Blood Clots | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Pancreatitis | <input type="checkbox"/> |
| Cataracts | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> |
| Colitis | <input type="checkbox"/> | Sinusitis | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | Thyroid | <input type="checkbox"/> |
| GERD | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | | |

Other: _____

Other: _____

Any unusual childhood infections or illnesses? _____

OPERATIONS: *Please list year, operation and surgeon (if known)*

1. _____
2. _____
3. _____
4. _____
5. _____

ROUTINE CANCER SCREENING TESTS: *List last date (if known)*

Mammogram: _____
Breast Exam: _____
Pap Smear/Pelvic Exam: _____
Stool for Occult Blood: _____
Prostate Exam/PSA: _____
Chest X-Ray: _____
Colonoscopy/Sigmoidoscopy: _____

SOCIAL HISTORY:

Marital Status: _____
Number of Children: _____ Age/Sex of Children: _____
Spouse Name: _____
Spouse Occupation: _____
Patient Occupation: _____
Highest Level of Education: _____

Patient Lives With: Self Child
Spouse Parent(s)
Sibling(s) Friend
Other _____

City of Residence: _____ Have you completed an advance directive? Yes
No
Have you completed a living will? Yes
No

Smoking History

Cigarettes How Many Years? _____
Cigars Number Per Day _____
Pipe If Quit, When? _____

Alcohol History

Beer How Many Years? _____
Wine How Much Per Day/Week/Month? _____
Liquor If Quit, When? _____

Recreational Drug Use Blood Transfusions HIV Testing

Nutritional Supplements: _____

CONTINUE REVIEW OF SYSTEMS: *Please check all boxes that apply*

URINARY/GYN	BLOOD IN URINE <input type="checkbox"/>	# OF PREGNANCIES _____	
	BURNING WITH URINATION <input type="checkbox"/>	# OF MISCARRIAGES _____	SPOTTING <input type="checkbox"/>
	FREQUENT URINATION <input type="checkbox"/>	# OF ABORTIONS _____	CRAMPING <input type="checkbox"/>
	DIFFICULTY STARTING TO URINATE <input type="checkbox"/>	# OF CHILDREN _____	DISCHARGE <input type="checkbox"/>
	BLADDER/ KIDNEY INFECTIONS <input type="checkbox"/>	LAST MENSTRUAL PERIOD _____	VAGINAL INFECTIONS <input type="checkbox"/>
	GETTING UP AT NIGHT TO URINATE <input type="checkbox"/>	DURATION _____	LAST PAP SMEAR _____
	SENSE OF FULL BLADDER <input type="checkbox"/>	INTERVAL _____	
SKIN	RASH <input type="checkbox"/>	ITCHING <input type="checkbox"/>	CHANGE IN HAIR OR NAILS <input type="checkbox"/>
NEURO-MUSCULAR	JOINT STIFFNESS <input type="checkbox"/>	SWELLING <input type="checkbox"/>	NIGHT CRAMPS <input type="checkbox"/>
	JOINT PAIN <input type="checkbox"/>	BACK PAIN <input type="checkbox"/>	VARICOSE VEINS <input type="checkbox"/>
HEMATOLOGICAL	EASY BRUISING OR BLEEDING <input type="checkbox"/>	ANEMIA <input type="checkbox"/>	PAST INFUSION <input type="checkbox"/>
			TRANSFUSION REACTIONS <input type="checkbox"/>
ENDOCRINE	THYROID PROBLEMS <input type="checkbox"/>	HOT OR COLD INTOLERANCE <input type="checkbox"/>	EXCESSIVE THIRST OR HUNGER <input type="checkbox"/>
PSYCHIATRIC	ANXIETY <input type="checkbox"/>	DEPRESSION <input type="checkbox"/>	MEMORY LOSS <input type="checkbox"/>
	NERVOUSNESS <input type="checkbox"/>		

PATIENT'S SIGNATURE: _____

PHYSICIAN'S SIGNATURE: _____



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.



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.

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