Dear Patient:

Welcome to Seton Healthcare Family’s Cancer Care Collaborative. We are honored you chose Seton to assist you in your medical needs. Our goal is to help you take an active role in managing your health. To do so, our team provides support, education, and encouragement throughout your treatment.

This packet includes important information for your first visit to our office. Please be sure to bring the following items with you:

- A valid driver’s license or photo ID
- Valid insurance card
- Co-pay: Co-pays and co-insurance deductibles will be collected at the time of service. (Payment amounts will vary depending on your insurance provider.) Please contact the patient access representative for questions at 512-324-3395 ext. 18296
- Completed Adult Health History form

Please arrive 15 minutes early to find parking, check-in, and complete any additional paperwork if necessary. If you must cancel your appointment, please give our office at least one business day advanced notice.

Should you have any questions prior to your appointment, please contact me at the phone number or email below.

Sincerely,

Cherise Evans, BSN, RN
Clinical Program Manager
Phone: 512-324-3395
Email: CancerCareCollaborative@seton.org

Viktoria Samuel
Office Manager IV
Phone 512-324-3395
Seton Healthcare Family’s Cancer Care Collaborative is located directly west of Seton Medical Center in Medical Park Tower. We can be found on the first floor in Suite 113.

**From IH-35:**
- Take IH-35 to the 38th St. exit.
- Drive west on 38th Street.
- Two blocks past Lamar Blvd, turn left into the driveway just past the hospital. There is parking in the front and rear of the building.

**From Loop 1 (Mopac):**
- Take Loop 1 to the 35th St. exit.
- Drive east on 35th St. and it will become 38th St.
- Turn right into the driveway just before Seton Medical Center Austin. There is parking in the front and rear of the building.

**Parking Information:**
There is parking in the front and rear of the building. You can access the rear parking lot from either 38th Street or 34th Street.

First 30 minutes: free
31-60 minutes: $2.00
1-2 hours: $3.00
Senior (55+): 25% discount
Disabled permit: 25% discount
Lost ticket: $10

**Bus Routes:**
- Bus 338 drops off on 38th and Lamar
- Bus 19, 3, and 21 drop off in front of Medical Park Tower
Understanding Your Bill

What to Expect

- After your visit, the **Cancer Care Collaborative** will file a claim with your insurance provider for the **facility fee**.
- In addition, each **provider seen will file a claim** with your insurance provider.

Frequently Asked Questions

**What is a Facility Fee?**
A facility fee is charged for services given in a hospital-based outpatient clinic or location.

**What does “hospital-based” outpatient clinic mean?**
This refers to an outpatient clinic that is run by the hospital.

**How do “hospital-based” outpatient clinic claims affect my benefits?**
Claims filed at the Cancer Care Collaborative will be applied to your **outpatient** benefits.

**Why am I receiving a bill when I already paid my co-pay?**
At the time of service, your co-pay was collected. Then, we file a claim with your insurance company. The balance due on the bill represents your deductible, coinsurance and/or other non-covered services.

**Who can I contact if I have questions about my bill?**
If you have a question regarding the facility fee please contact:
Patient Financial Services (512) 324-1125
If you have a question regarding physician fees please contact:
Central Billing: (512) 324-8960

**Our Patient Access Representative will contact you prior to your appointment to review benefits.**
**Adult Health History**

Name:________________________________________ Date of birth:____________________________

What is your reason for coming to the clinic today:
__________________________________________________________________________________________________________

Please give the history of your current problem (when it started, symptoms, treatment):
__________________________________________________________________________________________________________

Primary Healthcare Provider/Clinic: ____________________________________________

Primary Language: ❑ English ❑ Spanish ❑ Other ____________________________

Do you have any problems with ❑ Hearing ❑ Vision? ____________

Are you able to perform the activities of daily living? ❑ Yes ❑ No_________

If no, what are the limitations?____________________________________________________________________________

Do you have friends or family at home who can assist you with your care? ❑ Yes ❑ No_________

What is your best method of learning? (may select more than one)
❑ Written ❑ Oral ❑ Demonstration ❑ Video

**Social History**

Do you use tobacco? ❑ Yes ❑ No How many packs per week?________

Do you drink alcohol? ❑ Yes ❑ No How many drinks per week?________

Do you use illicit or illegal drugs? ❑ Yes ❑ No Type ____________________________

Children? ❑ Yes ❑ No Number _________

What is your Occupation?__________________________________________

**Current medications** (include over the counter prescriptions):

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often per day</th>
<th>Last dose</th>
<th>Reason</th>
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</table>
Over the counter/Vitamins/Herbals/Other: __________________________________________

Do you have any problems or concerns about obtaining your necessary medications?  ❑ Yes  ❑ No
Please list your pharmacy: ____________________________________________________________

Are your immunizations up to date?  ❑ Yes  ❑ No

**Family Medical History**
Please circle the diagnosis and list which family member had the following conditions.

<table>
<thead>
<tr>
<th>Medical Diagnosis</th>
<th>Relationship</th>
<th>Medical Diagnosis</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
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<td>Kidney Disease</td>
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<tr>
<td>Heart Attacks</td>
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<td>Cancer</td>
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<td>High Blood Pressure</td>
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<td>Aneurysms</td>
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<tr>
<td>Stroke</td>
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<td>Mental Retardation</td>
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<tr>
<td>High Cholesterol</td>
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<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Past Medical history** (please check all previous illnesses)

❑ Heart Problems  ❑ Bleeding Problems  ❑ Cancer, type: _________________________
❑ Diabetes       ❑ Circulation Problems  ❑ High blood pressure
❑ Seizures       ❑ Stroke               ❑ Thyroid problems
❑ Liver problems  ❑ Kidney/urine problems  ❑ Lung problems
❑ HIV/AIDS       ❑ Physical Limitations  ❑ Frequent infections
❑ Night Sweats   ❑ Abnormal PAP smears   ❑ Weight loss
❑ Skin cancer, type: ___________ location: ___________ treatments: ____________________

Psychiatric History: ________________________________________________________________

Other: __________________________________________________________________________

Past surgeries (include dates): _____________________________________________________________________________________________

Chemotherapy/Radiation (include dates): ____________________________________________________________________________________

________________________________________________________________________________________

Are you allergic to any medications?  ❑ Yes  ❑ No  List (Name/Type of Reaction): ____________________________

________________________________________________________________________________________

________________________________________________________________________________________

Person completing this form:  ❑ Patient  ❑ Other (relationship to patient: _______________)

Today’s date: ______________________   Time: ____________________________
1. **Consent to Treatment.** I voluntarily consent to and authorize the provision of hospital care by Seton Family of Hospitals ("SETON").

2. **Medical Services and Physicians Assigned to My Care.** I also consent to and authorize the provision of medical care ordered or approved by physicians assigned to my care.

3. **No Guarantee.** I have relied upon my attending and other physicians for information about my care and acknowledge that no guarantee has been made to me about the results of my care.

4. **My Control Over Decisions.** I understand that all decisions regarding my care will be consistent with any specific consent and/or refusal of treatment signed by me.  

5. **Financial Responsibility.** I understand that I will be held financially responsible for all charges and services that result from the care provided to me during this admission by SETON and by physicians assigned to my care, whether or not I have health insurance. In return for the care and services that will be provided to me, I promise to pay for all such charges, including charges that are not authorized by my Payors and are not timely paid by my Payors, unless prohibited by applicable law (the term "Payors" means all insurance companies, employee benefit plans, third party administrators, and/or other persons or entities responsible for payment for my health care). I further understand that such authorizations for care and services are subject to approval by my Payors and are based on the terms of my insurance benefit plan, my diagnosis(diagnoses), the applicable length of stay, the type of admission (In-patient, Out-patient, Observation, etc.), and the plan of treatment determined by the treating physician, among other potential factors. If I am notified by SETON prior to receiving a specific service or treatment that the service or treatment may be denied or considered an uncovered service, I agree that if I subsequently elect to receive the service or treatment, I shall be financially obligated to pay the charges associated with that service or treatment, to the extent permissible under existing contractual obligations and applicable law. I understand that if I am covered by Medicare or Medicaid, my obligations under this section may be limited by law.

6. **Physicians Are Independent Contractors.** I understand that physicians providing treatment and professional services to me at SETON, including but not limited to anesthesiologists, radiologists, pathologists, neonatologists and emergency room physicians, are not employees or agents of SETON, but rather are independent contractors who exercise their own professional judgment without control by SETON.

7. **Separate Bills.** I understand that I will be responsible to pay to SETON and to physicians assigned to my care charges that are not paid by my insurance, health plan or person with a duty to pay to the extent that I am legally liable. Questions regarding bills should be made directly to the provider who issued the bill.

8. **Insurance, Authorizations, and Selection of Providers.** I understand that I am solely responsible for inquiring about and understanding the coverage for items and services provided by my Payors, as well as for the selection of my providers. I further understand that only my Payors can confirm the nature and extent of my coverage, including which physicians or other providers of health care services participate in my health plan. I understand that my insurance may not cover services of the physicians assigned to my care.

9. **Insurance Certification.** I understand and agree that I am obligated and solely responsible for obtaining any pre-admission or pre-service certification(s) that may be required by my Payors. I understand that SETON may assist in the pre-admission or pre-service certification process, but this does not create a waiver of my responsibility. I further understand that if I fail to obtain any required authorization or certification, my benefits could be reduced or eliminated.

10. **Authorization to Release Information.** I authorize SETON to release to my Payors any and all healthcare information from this admission as necessary to (a) obtain payment for my medical and health facility care and (b) to conduct utilization review, peer review, and quality assurance. I also authorize SETON to release any and all healthcare information from this admission to healthcare providers who may be necessary for my care after discharge.

Patient or  
Patient's Representative Initials: ___________
I understand that this information will identify me and may relate to my history, diagnosis, treatment or prognosis; it will also include, where applicable, psychiatric, alcohol, and drug abuse information and specific laboratory results of HIV or the diagnosis of AIDS.

11. **Authorization for Direct Payment**. I authorize all payors to pay directly to SETON and physicians assigned to my care, respectively and in accordance with services provided by same during this admission, all amounts due for services and items provided during my admission to SETON.

12. **Assignment of Benefits to SETON and Physicians Assigned to My Care**. I assign to SETON my right to receive payment from third-party payors. Third-party payors include payers (such as insurance carriers or social security administrators) who provide coverage to me for care provided by SETON. Third party payors also include others from whom benefits are, or may become, payable to me. For example, a third party payor would include a person from whom I obtain a settlement or judgment flowing from the incident for which I am receiving treatment.

13. **Personal Property**. I understand that SETON does not assume the responsibility for safekeeping of any personal property other than that which is properly documented and placed in the safe and will not compensate for any lost, damaged or stolen items (i.e. glasses, dentures, jewelry)

14. **HIV and Other Testing After Accidental Exposure**. I understand that in the event a healthcare worker, including first responders, is exposed to my blood or body fluids regarding my admission, my blood may be tested for the HIV antibody and other communicable diseases of no cost to me, as permitted by applicable law.

15. **Teaching Institution**. I understand that SETON includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my stay.

16. **Notice of Privacy Practices and Patient Rights**. I acknowledge that I have received the “Notice of Privacy Practices” and a copy of “Patient Rights, Responsibilities and Healthcare Choices” from SETON.

17. **Search of Room and Belongings**. For the protection of myself and others, I understand that my person, my belongings and my room may be searched if there is reason to believe that I may possess prohibited items while I am a patient at SETON.

18. **Healthcare Operations**. I hereby consent to the taking of photographs, videotapes, digital or other images of my medical or surgical condition or treatment, and the use of the images, for purposes of my diagnosis or treatment or for SETON’s healthcare operations, including abuse reporting, peer review, quality improvement, and education or training programs conducted by SETON. In addition, I consent to the taking of photographs of my newborn child or children for possible purchase by me.

19. **Phone Authorizations**. I hereby grant permission and consent to SETON, its assignees, and third party collection agents: (1) to contact me by telephone at any telephone number associated with me, including wireless numbers; (2) to leave answering machine and voicemail messages for me, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by me; (3) to send me text messages or emails using any email addresses I provide; (4) to use pre-recorded/artificial voice messages and/or automatic dialing device (an “autodialer”) in connection with any communications made to me related to my account.

By signing below, I agree to the terms of this document, which I have read and had the opportunity to ask questions about.

Patient or Patient's Representative: ___________________________ Date: __________ Time: __________

Witness: ___________________________________________ Date: __________ Time: __________

Patient is ______ minor/ ______ unable to consent because: __________________________

My relationship to the patient is ___________________________ and I have signed this consent on the patient’s behalf.