EMERALD COAST CANCER CENTER

NEW PATIENT INFORMATION FORM

1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

Patient name:	Date of Birth:
Home address:	Social Security #:
	☐ Male ☐ Female ☐ Other: _____
	Please mark preferred contact number:
Mailing address:	☐Home phone:
(if different)	☐Cell phone:
	☐Work phone:
Email Address:	
Place of Work:	Employer Phone:
Highest grade completed: ☐ Grade School ☐ High School ☐ College ☐ Graduate School	
Race/ Ethnicity:	
Preferred language:	

Advance Directives:				
Do you have a living will?	☐ Yes	☐ No	☐ Not sure	☐ Would like more information
Do you have a power of attorney?	☐ Yes	☐ No	☐ Not sure	☐ Would like more information
Do you have a DNR (Do Not Resuscitate)?	☐ Yes	☐ No	☐ Not sure	☐ Would like more information

Insurance Information:			
Primary Insurance		Employer	
Policy #		Group Number	
Policy Holder Name		Policy Holder SSN	
Policy Holder DOB			

Secondary Insurance		Employer	
Policy #		Group Number	
Policy Holder Name		Policy Holder SSN	
Policy Holder DOB			

NEW PATIENT INFORMATION FORM

Referring Doctor/Specialty:	Phone #:
Address (if not local):	

Other Doctors:	
Physician/Specialty:	Phone #:
Address (if not local):	
Physician/Specialty:	Phone #:
Address (if not local):	
Physician/Specialty:	Phone #:
Address (if not local):	

Preferred Pharmacy:		Phone #:

Healthcare Questionnaire
Describe your current problem in your own words. Why were you referred to us? What medically bothers you? How and when did it start?

List any **medical problems** you have now or have had in the past. Continue on the back.

Illness	Date of Onset	Treating physician

Please list all **operations** that you have had, including minor surgery. Continue on the back.

Surgery	Date	Surgeon

NEW PATIENT INFORMATION FORM

Have you ever had any radiation therapy treatments? If no, leave blank.			
Area of body	Dosage	Date	Location/ physician

Do you have any allergies to medications or foods? Continue on the back.		
Medication/ Food Allergy	Reaction	Date

List all medications you are currently taking - **prescription** and **over the counter** medications. Continue on the back.			
Medication name	Dose	Frequency	Reason for taking

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NEW PATIENT INFORMATION FORM

Social History

Tobacco use: ☐ Never smoked

☐ Former smoker: Packs per day: _____ # years smoked: _____ Year quit:_____

☐ Current smoker: Packs per day: _____ # years smoked: _____

☐ Smokeless tobacco products: Type:_____ How often:_____

Alcohol use: ☐ Never

☐ Former: Approximate date stopped: _____

☐ Current: Drinks per day: _____ OR Drinks per month: _____

Recreational drug use: ☐ Never

☐ Former: Types used: _____ Last used: _____

☐ Current: Types used: _____ Last used: _____

Occupation: ☐ Never employed

☐ Full-time List: _____

☐ Part-time List: _____

☐ Retired Former: _____

☐ Disabled Former: _____

☐ Other or N/A:_____

Any hazardous occupational exposures: ☐ None ☐ Yes, type:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Children: ☐ Yes; how many: _____ ☐ No

Who do you live with? _____

Family History (please list any cancer or blood disorders in your family)

Mother	☐ Living	☐ Deceased age: _____ from _____	Other health problems:_____
Father	☐ Living	☐ Deceased age: _____ from _____	Other health problems:_____
Sibling	☐ Living	☐ Deceased age: _____ from _____	Other health problems:_____
Sibling	☐ Living	☐ Deceased age: _____ from _____	Other health problems:_____
Child	☐ Living	☐ Deceased age: _____ from _____	Other health problems:_____
Child	☐ Living	☐ Deceased age: _____ from _____	Other health problems:_____

Other family medical history:_____

Have you or anyone in your family ever had genetic testing? ☐ Yes ☐No

If so, please list results:_____

_____

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NEW PATIENT INFORMATION FORM

Healthcare maintenance

☐ Colonoscopy	Date: _____	Facility/physician: _____
☐ Stomach scope (EGD)	Date: _____	Facility/physician: _____
☐ Mammogram (if applicable)	Date: _____	Facility: _____
☐ Bone density (DEXA scan)	Date: _____	Facility: _____
☐ PSA (if applicable)	Date: _____	Physician: _____

Vaccinations

☐ Influenza (flu shot)	Date: _____	☐ COVID-19	Date: _____
☐ Shingles	Date: _____	☐ Other	Date: _____
☐ Pneumovax	Date: _____		

Miscellaneous

Have you ever had a blood transfusion?	☐ Yes	☐ No	☐ Not sure
Have you ever had or been treated for tuberculosis?	☐ Yes	☐ No	☐ Not sure
Do you drink coffee, tea, or caffeinated beverages?	☐ Yes	☐ No	_____ cups per day
Have you ever had psychiatric treatment or hospitalization?	☐ Yes	☐ No	
Have you traveled outside the United States?	☐ Yes	☐ No	

List locations:_____

Females Only

Age at first menstrual period: _____ Age at menopause: _____

# of pregnancies: _____ # of live births: _____

Age at first full term pregnancy: _____ Breastfed: ☐ yes ☐ no

Hysterectomy: ☐ yes ☐ no

Ovaries removed: ☐ yes ☐ no

☐ Birth control:	☐ yes	☐ no	Type:_____	# of years use: _____	Year stopped: _____
☐ Hormones:	☐ yes	☐ no		# of years use: _____	Year stopped: _____

EMERALD COAST CANCER CENTER

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle your answer.)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself --or that you are a failure or have let yourself or family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(Office use only) Total score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐Very difficult ☐Extremely difficult

_____

EMERALD COAST CANCER CENTER

APPOINTMENT CANCELLATION/ NO-SHOW POLICY

1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

Thank you for trusting your medical care to Emerald Coast Cancer Center. When you schedule an appointment with us, we set aside time to provide you with the highest quality care. Providing quality treatment for all our patients in a timely manner is a major priority for our practice, and last-minute cancellations can cause hardships for many individuals. Please see our Appointment Cancellation/ No-Show Policy below:

- Should you need to cancel or reschedule an appointment, please contact our office as soon as possible. This gives us time to schedule other patients who may be waiting for an appointment.
- As a courtesy, we send automated appointment reminders by text/ phone call before appointments. If you do not receive a reminder call or message, this Policy will still remain in effect. Please ensure we have your correct contact information on file.
- Effective 5/1/2023, any established patient who fails to show or cancels/ reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show.
- No Show patients will be charged a $25 fee for the first occurrence, and $50 for each subsequent occurrence. This fee will be charged to the patient, is not covered by insurance, and will be charged to a credit card on file at the office. If a credit card is not on file, the fee is due at the time of the patient's next office visit.
- If you have an emergency please let us know. Fees will be waived on a case-by-case basis.
- Patients who consistently miss an appointment or cancel at the last minute may be disenrolled from the clinic, or may be required to pay a reservation fee before scheduling future appointments.
- Patients who arrive fifteen (15) minutes late to a scheduled appointment may not receive all scheduled treatment and / or may be asked to reschedule the appointment.

I have read and agree to the above policy.

Patient Name (print): _____

Patient Signature: _____

Date: _____

EMERALD COAST CANCER CENTER

REQUEST FOR RELEASE/ REQUEST FOR MEDICAL RECORDS

1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

PLEASE COMPLETE ONLY THE BOTTOM PORTION OF THIS PAGE.

FOR OFFICE USE ONLY:

Date: _____

To: _____
(previous physician/ practice name)

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

I hereby request that my medical records be released to us or by us.

Emerald Coast Cancer Center
1024 Mar Walt Drive
Fort Walton Beach, FL 32547
Phone: 850-863-3148
Fax: 850-863-3132 Alt Fax: 850-862-8668

PLEASE COMPLETE AND SIGN:

Patient Name (print): _____

Date of Birth: _____

Patient Signature: _____

EMERALD COAST CANCER CENTER

HIPAA CONSENT

1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

Patient Name: _____

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 is made by alternative means, such as by sending correspondence to the individual's office instead of their home.

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

☐ Home/ Cell #: _____
- ☐ Do not leave a message at this number
- ☐ Ok to leave a message with details
- ☐ Ok to leave message with call-back number only

☐ Work Telephone: _____
- ☐ Do not leave a message at this number
- ☐ Ok to leave a message with details
- ☐ Ok to leave message with call-back number only

☐ Fax (if available): _____
- ☐ Ok to send fax with details to this number

I acknowledge that I have read a copy of the Notice of Privacy Practices for HIPAA.

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. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep record of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for Treatment Records, Payment Information, and Healthcare Operations may be permitted without prior consent in an emergency.

In addition to the authorization for release of my PHI, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Patient Signature: _____ Date: _____

EMERALD COAST
CANCER CENTER

INSURANCE PATIENTS – LIFETIME AUTHORIZATION & AUTHORIZATION TO RELEASE INFORMATION

1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

If you are covered by insurance and want us to file claims on your behalf, please sign the following form.

I. **Release of Information** - I hereby authorize Y. Henry Hsiang, MD, PhD, Melissa M. King MD, Aaron T. Henderson DO, and/or their authorized employees to release any medical information (including psychiatric, alcohol, or drug-related records) necessary for processing my insurance claims.

II. **Physician Insurance Assignment** - I hereby request, authorize, and direct Y. Henry Hsiang MD, PhD, Melissa M. King MD, Aaron T. Henderson DO, and/or their authorized employees to file insurance claims on my behalf to all applicable third payers. I hereby assign all benefits due directly to Y. Henry Hsiang, MD, PhD, Melissa M. King, MD, or Aaron T. Henderson, DO. In the event that my policy prohibits payment to be made directly to the doctor, I direct my insurance company to send all checks to me in care of Emerald Coast Cancer Center at the above address.

III. **Medicare/Medicaid** - I authorize Y. Henry Hsiang MD, PhD, Melissa M. King MD, Aaron T. Henderson DO, and/or their employees to bill Medicare and/or Florida Medicaid for any benefits that may be due under these programs. I certify that the info given to me pertaining to Medicare/Medicaid is correct. I hereby assign all benefits due directly to Y. Henry Hsiang, MD, PhD, Melissa M. King, MD, or Aaron T. Henderson, DO any benefits that are due under these programs. In the event that I am deemed no longer eligible for coverage under these programs, I acknowledge my responsibility for any unpaid claims.

IV**. I permit a copy of this authorization and assignment to be used in place of the original which is on file at the physician's office**. *This release will remain in effect until revoked by me in writing.*

I understand that you file insurance as a courtesy and convenience to me. I realize that I am responsible for any copayments, deductibles, non-covered services, and any claims not covered by my insurance or third party payers within 30 days from the date filed. All payments are required on a 30 day cycle, unless prior arrangements have been made and documentation signed by both myself and one of the doctor's representatives.

If this account is assigned to a collection agency or attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. The undersigned guarantor secures and warrants the timely payment of the obligation of the patient as set forth above.

Patient Name (print): _____ Signature: _____ Date: _____

Policyholder/ Guarantor:_____

Guarantor Address: _____

Guarantor Home Phone #: _____Work Phone #: _____

EMERALD COAST CANCER CENTER

PRIVATE PAY PATIENTS

1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

If you are **not** covered by insurance or prefer to file your own insurance and pay cash for medical services provided, please complete and sign the form below. We require a guarantor signature for all minors, full-time students, or other dependents.

Unless prior arrangements are made, ***payment in full is expected at the time of service***. After each visit, our business office personnel will speak privately with you and calculate your payment due for that day's medical care.

If you wish to discuss a payment plan or have questions about fees, please let the receptionist know and you may speak privately with our business manager.

By signing below, I acknowledge the above policy and agree to the following:

- I prefer to pay cash, check, or credit card for any office charges. Bills and receipts will be provided to me upon request and I will file the insurance claim myself.
- If this account is assigned to a collection agency or attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
- The undersigned guarantor secures and warrants the timely payment of the obligations of the patient as set forth above.

Date: _____

Patient Name (print): _____

Patient Signature: _____

Guarantor Name (print): _____

Guarantor Signature: _____

Witness Name (print): _____

Witness Signature: _____

Guarantor Address: _____

Guarantor Home Phone #: _____

Guarantor Work Phone #: _____

EMERALD COAST CANCER CENTER

FINANCIAL QUESTIONNAIRE FOR DRUG REPLACEMENT & COPAY ASSISTANCE

1024 Mar-Walt Drive
Fort Walton Beach, FL 32547
Phone (850) 863-3148 Fax (850) 863-3132

Y. Henry Hsiang, M.D., PhD
Melissa M. King, M.D. FACP
Aaron T. Henderson, D.O.

Information is being requested for the sole purpose of registering our patients in patient access programs in order to improve our services offered to you. These programs offer copayment / out of pocket assistance to those that qualify, and many programs will replace the medication free of charge if we receive a denial from your insurance.

Please fill out the following questions below and if possible please bring your most current tax return or other financial information (one month of recent paystubs or SSI Award Letter) to your next visit. All information will be kept confidential.

Please let us know if you do not want to share this information.

Patient Name (print): _____ Date of Birth:_____

How many in household? _____

Total income claimed on most recent tax return (if income has changed since that time, please provide most recent income amount): _____ _____

_____ Please initial if you choose not to share this information, and decline patient assistance/ drug replacement at this time.

Patient Signature: _____ Date: _____

****ALL INFORMATION PROVIDED WILL BE KEPT COMPLETELY PRIVATE AND CONFIDENTIAL****

FORM WILL NEED TO BE COMPLETED ANNUALLY.

EMERALD COAST
CANCER CENTER

Patient Acknowledgment Form

Confirmation of Receipt and Understanding of New Patient Welcome Packet

Patient Name: _____

Date of Birth: _____/_____/_____

Acknowledgment Statement:

I, the undersigned, acknowledge that I have received, reviewed, and understand the information provided in the New Patient Welcome Packet. This packet includes important details about my care, services offered, and my responsibilities as a patient.

I understand that the information provided is intended to help me navigate my treatment and care plan and that I can reach out to the Emerald Coast Cancer Center team with any questions or clarifications.

By signing this form, I confirm that I have:

1. Reviewed the New Patient Welcome Packet in its entirety.
2. Understood the information presented.
3. Been informed of my right to ask questions or request additional explanation if needed

---

Patient Signature: _____

Date: _____

Authorized Representative (if applicable):

- **Name:** _____
- **Relationship to Patient:** _____
- **Signature:** _____

Staff Member Witnessing Receipt (Optional):

- **Name:** _____
- **Signature:** _____
- **Date:** _____/_____/_____

EMERALD COAST
CANCER CENTER

Dispensary Welcome Packet

EMERALD COAST
CANCER CENTER

Thank you for being a patient of Emerald Coast Cancer Center. Our goal is to ensure that patients and their caregivers receive the attention and support they need to be successful with their treatment. You can count on our guidance, compassion, and education throughout your therapy.

Location
1024 Mar Walt Drive
Fort Walton Beach, FL 32547

Hours of Operation
Monday through Friday 8am-4pm

Emerald Coast Cancer Center is closed on the following holidays:

- Thanksgiving
- Christmas Day
- New Year's Day
- Memorial Day
- Independence Day
- Labor Day

Contact us
Phone: 850-863-3148
Toll Free Number: 877-389-2237
After-Hours Clinical Support: 850-863-3148 *(follow the prompts for on-call doctor)*
Email: ar@emeraldcoastcancercenter.com
Website: www.emeraldcoastcancercenter.com

Language and Cultural Services
We welcome diversity and comply with standards for language and cultural services. We can provide trained, qualified medical interpreters for our patients and their families at no cost to them. Interpreters can help ensure effective communication for those who are:

- Limited-English Proficient (LEP) or challenges
- Deaf/Hard of Hearing (HOH)

Medical Emergency
In case of a medical emergency, please call 911 or your local emergency department. Emerald Coast Cancer Center does not replace your local emergency services or Poison Control.

Dispensary Overview
Emerald Coast Cancer Center offers complete specialty prescription services to patients living in the Fort Walton Beach area. Our services are designed to meet the needs of each of our patients. Our team of physicians, nurses, and technicians are specially trained.

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Patient Services
We work with you and your provider throughout your therapy. Our role is to provide you with prescribed specialty medications at the highest level of care. Contact the Emerald Coast Cancer Center at 850-863-3148 ext. 107 if you have questions about:

- Filling or refilling your medication
- Transferring a prescription to our dispensary or another pharmacy
- Order status or order delays
- Insurance coverage, prescription costs, or claim related questions Medication concerns or filing a complaint

How does my new prescription get to the dispensary?
There are a few ways that we may receive your new prescription:

- Your provider will send the prescription electronically when treatment is prescribed.
- Your provider will write a paper prescription and send it to the pharmacy via mail or fax.

When will the Emerald Coast Cancer Center contact me?
Emerald Coast Cancer Center Dispensary will call you to:

- Discuss your prescription and co-pay amount
- Schedule the pick-up time or advise you of any delays in your order
- Provide counseling on your medicine and review how to store your medication
- Verify your prescription insurance information
- Get documentation of your income to enroll you in financial assistance, if you qualify
- Notify you if we must transfer your prescription to another specialty pharmacy
- Notify you of any FDA recalls of your medicine

We will contact your provider:

- At your request or when you are out of refills

If We Are Unable to Fill Your Prescription
Some medications may not be available at our dispensary and some insurance plans may have requirements where a medication must be filled. If we cannot fill a prescription, we will transfer the prescription to another pharmacy of your choice.

Co-pay Assistance and Payment
Before your care begins, a technician of Emerald Coast Cancer Center will inform you of your financial obligations for prescriptions not covered by your insurance or other third-party sources. These obligations include but are not limited to; out-of-pocket costs such as deductibles, co-pays, co-insurance, annual and lifetime co-insurance limits and changes that occur during your enrollment period. This copayment is due at the time of pickup. We accept credit cards, cash, or check. We will help you enroll in financial assistance programs that may help with copayments to minimize financial barriers prior to starting your medication. These programs include discount coupons from drug manufacturers and assistance from various disease management foundations.

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Insurance Claims
We will submit claims to your health or prescription insurance carrier on the date your prescription is filled. If the claim is rejected, we will notify you as necessary so that we can work together to resolve the issue. There may be financial obligations if our dispensary is out-of-network for your benefit plan. We will provide notice of any changes in covered costs verbally.

Refills
A technician from Emerald Coast Cancer Center will contact you before your medication is scheduled to run out. We will:

- Check on your progress
- Ask about any side effects and verify your dosage
- Determine pick-up time of your next refill

Medication Delivery and Storage
The medication will be available for pick-up at our office located on Mar Walt Drive, at no cost to you. We coordinate all refills to make sure that you or an adult caregiver is available to receive the medication. A signature will be required upon receipt of the medication. We'll contact you five to seven days prior to your refill date. You can call us and speak to any of our staff to request a refill. If needed, we will assist you with refilling a prescription which would otherwise be limited by your prescription benefit plan.

Home Safety Information

- If children are in the home, store medications and poisons in childproof containers and out of reach.
- All medication should be labeled clearly and left in original containers.
- Do not give or take medication prescribed for other people.
- When taking or giving medication, read the label and measure doses carefully. Know the side effects of the medication you are taking.
- Throw away outdated medication by mixing medications with cat litter or used coffee grounds. Place mixture in a container such as a sealed plastic bag and place in trash.

You can dispose of unused prescriptions at a medication "take-back program." Our team will assist you in finding the dates and locations of such events. Find more information at: RXdrugdropbox.org

Chemotherapy and hazardous drugs
You may NOT dispose of chemotherapy and other hazardous drugs by depositing in the trash or flushing down the toilet. There are several drop-off locations that can safely dispose of medications throughout the year.

EMERALD COAST CANCER CENTER

Home-generated biomedical waste

Home-generated biomedical waste is any type of syringe, lancet, or needle used in the home to inject medication or draw blood. Special care must be taken with the disposal of these items. These precautions will protect you and others from injury and keep the environment safe and clean.

Handling needles safely:

- Plan for safe handling and disposal before use
- Do not use a needle more than once
- Never put the cap back on a needle once removed
- Throw away used needles immediately after use in a sharps container
- Keep out of the reach of children and pets.
- Report any needle sticks or sharps-related injuries to your physician

If your therapy involves the use of needles, we will provide you with a sharps container to use for disposal. After using your injectable medication, place all needles, syringes, lancets, and other sharp objects into the sharps container.

Check with your local waste management collection service or public health department to determine disposal procedures for sharps containers in your area. If a sharps container is not available, you may use a hard plastic or metal container with a screw-on top or other tightly securable lid, such as an empty coffee canister or liquid detergent container. Once the materials are in an appropriate receptacle, you may dispose of it in the trash at home. DO NOT place sharp objects, such as needles or syringes, into the trash unless first placed in a sharps container, and DO NOT flush down the toilet.

Find more information at:

- Centers for Disease Control and Prevention (CDC) Safe Community Needle Disposal, cdc.gov/needledisposal

Planning for an Emergency

Preparing with the Emerald Coast Cancer Center Dispensary

Planning ahead for an emergency or disaster will help us ensure that you have the medications you need. The Emerald Coast Cancer Center Specialty Dispensary may ask you where you will go if an emergency occurs, which could be a shelter, home of a friend or relative, or hospital. We may also ask you for the name and phone number of a close family member, friend, or neighbor to use as an alternative contact.

Preparing at home

Know what to expect, where to go, and what to do. It is important to be aware of the natural disaster risks in your area and what to do if one occurs. Local emergency resources, such as the Red Cross, law enforcement agencies, and news and radio stations, usually provide excellent information and tips for planning. One of the most important pieces of information you should know is the location of the closest special needs shelter. These shelters are open to the public during voluntary and mandatory evacuation times. They specialize in caring for patients with special medical needs and are usually the safest place to go if you cannot get to the home of a friend or family member.

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Responding
If you expect an emergency might occur, please contact us. Providing us with as much information as possible will help ensure that you receive the supplies you need.

If you do not contact us before or during a known emergency, we will attempt to contact you. We will use the phone numbers provided to attempt to determine your location.

Evacuating your home
If the emergency requires evacuation, take your medications with you. Place any medications that need refrigeration into a cooler with ice packs. Once evacuated to a safe area, notify us of your new location so we can make sure there are no gaps in your therapy. If you need medication, please call the Specialty Dispensary as soon as possible, and we will do our best to assist you.

Reaching the Dispensary
If the Emerald Coast Cancer Center Specialty Dispensary must close due to a disaster, instructions will be provided on our answering service about how to contact our team, review medication orders, and receive other important information. If travel or access to the Emerald Coast Cancer Center Specialty Dispensary is restricted due to damage from the disaster, we will attempt to alert you through the phone numbers you provided.

Emergency & Disaster Preparedness Plan
Emerald Coast Cancer Center Specialty Dispensary has a comprehensive emergency preparedness plan in case a disaster occurs. Disasters may include fire to our facility or region, chemical spills in the community, hurricanes, snowstorms, tornadoes, and community evacuations. Our primary goal is to continue to service your prescription care needs. When there is a threat of disaster, we will ensure you have enough medication to sustain you.

- The dispensary will call you three to five days before an anticipated local weather disaster emergency utilizing the weather updates as point of reference.
    - If you are not in the dispensary local area but reside in a location that will experience a weather disaster you are responsible for calling the dispensary three to five days before the occurrence.
- If the dispensary cannot get your medication to you before an inclement weather emergency occurrence, the dispensary will transfer your medication to a local specialty pharmacy, so you do not go without medication.
- If a local disaster occurs and the dispensary cannot reach you or you cannot reach the dispensary, please listen to your local news, and rescue centers for advice on obtaining medication.
- The dispensary recommends all patients leave a secondary emergency number.

If you have an emergency that is not environmental but personal and you need your medication, please contact the dispensary at your convenience and we will aid you.

Need help? For more information on emergency preparations and responses, visit the FEMA website at fema.gov.

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Emerald Coast Cancer Center Specialty Dispensary Patient Rights

- Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care
- Be informed, in advance both orally and in writing, of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the client/patient will be responsible and receive information about the scope of services that the organization will provide and specific limitations on those services
- Participate in the development and periodic revision of the plan of care
- Refuse care or treatment after the consequences of refusing care or treatment are fully presented
- Be informed of client/patient rights under state law to formulate an Advanced Directive, if applicable
- Be treated with respect, consideration, and recognition of client/ patient dignity and individuality and be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property
- Receive information to assist in interactions with the organization
- Receive information on how to access support from consumer advocates groups
- Receive information about health plan transfers to a different facility or Pharmacy Benefit Management organization that includes how a prescription is transferred from one pharmacy service to another.
- Receive information about product selection, including suggestions of methods to obtain medications not available at the pharmacy where the product was ordered
- Receive information about an order delay, and assistance in obtaining the medication elsewhere, if necessary.
- Request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, risk of treatment or care plans, without discrimination in accordance with providers orders
- Voice grievances/complaints regarding treatment or care or lack of respect of property, or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination
- Maintain confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information
- Be advised on the agency’s policies and procedures regarding the disclosure of clinical records
- Choose a health care provider, including an attending physician, if applicable
- Be informed of any financial benefits when referred to an outside organization
- Receive pharmacy health and safety information to include consumers’ rights and responsibilities
- Have personal health information shared with the patient management program only in accordance with the state and federal law
- Identify the program’s staff members, including their job title, and to speak with a staff member’s supervisor if requested
- Speak with a health care professional
- Receive information about the Patient Management Program and any changes in, or termination of the Patient Management Program

EMERALD COAST
CANCER CENTER

Emerald Coast Cancer Center Specialty Dispensary Patient Responsibilities

- You have the responsibility to:
- Notify your Physician and the Dispensary of any potential side effects and/or complications
- Submit forms that are necessary to receive services
- Provide accurate clinical/medical and contact information and to notify the Program of any changes
- Notify the treating provider of participation in the services provided by the dispensary
- Maintain equipment provided
- Notify the dispensary of any concerns about the care or services provided
- Participate in the development and updating of a plan of care

Grievances

What if I am not happy with the services that I receive?

We will attempt to resolve any concerns or issues that you experience as quickly as possible. If you have concerns, you may contact the Emerald Coast Cancer Center Specialty Dispensary Manager at 850-863-3148 ext. 107. If we are unable to resolve your complaint, you may contact:

• Your insurance company

• Florida Health. Here are the steps to file a complaint:

- Phone: You can call the Central Complaint Registry Hotline at 850-245-4444 during business hours (Monday to Friday, 8:30 a.m. to 4:30 p.m.).
- Additional information can be found online at: https://www.floridahealth.gov/