GYNECOLOGIC ONCOLOGY ASSOCIATES

351 Hospital Road #507
Newport Beach, CA 92663
(949) 642-1361
Fax: (949) 642-1394
www.gynoncology.com

NEW PATIENT PACKET

Thank you for choosing Gynecologic Oncology Associates.

Our office and staff look forward to serving you.

Prior to your appointment:

- Please complete the attached New Patient paperwork. Be sure to read the Financial Policy and the Notice of Privacy Practices before signing the consent form.

- If for any reason you are unable to keep your appointment, please call our office to reschedule your visit to suit your needs.

The day of your appointment:

- There is additional paperwork for you to fill out once you arrive, so please be sure to arrive 30 minutes before your scheduled appointment to complete the registration process.

- Bring a current photo ID, (such as a drivers license) and your insurance cards. If you do not have your insurance card bring a legible copy. If you do not have a copy of your card, please contact your insurance carrier before your visit and bring proof of eligibility with you.

- Be prepared to pay any co-payment or un-met deductible required by your insurance at your visit.

Please feel free to call our office at (949) 642-1361 between 9:00 am and 5:00 pm, Monday through Friday, with any questions or concerns regarding this paperwork.

PATIENT INFORMATION FORM

Patient's Name: _____

Address/ Street: _____

City/State/Zip: _____

Date of Birth: _____Sex: M F

Patient's Social Security No. : _____

Status (circle one): Married Single Divorced

Widow Separated Domestic Partner

We must be able to reach you by phone at all times.

Mobile Phone #: _____

Home/ Work Phone #: _____

Employer:_____

Email Address: _____

Preferred contact method (circle one):

Patient Portal Phone Email Letter Fax

Emergency Contact Person: _____

Relationship to Patient_____

Emergency Contact Phone #: _____

Race: Hispanic Asian Caucasian Chinese Filipino

Black/African American Native Hawaiian Japanese

Alaska Native Pacific Islander Other _____

Primary Language: _____

Ethnicity: Hispanic/Latino Non-Hispanic Other

Insurance Co. Name: _____

Subscriber's Name: _____

Subscriber's SSN #: _____

Subscriber's Date of Birth:_____Sex: M F

Insurance ID #: _____

Group #: _____

Medicare #: _____

Patient's Pharmacy: _____

Pharmacy address: _____

_____

_____

PATIENT'S REFERRING DOCTOR:

Dr's Name: _____

Dr's Address: _____

City/State/Zip: _____

Dr's Phone #: _____

PRIMARY CARE DOCTOR:

Dr's Name: _____

Dr's Address: _____

City/State/Zip: _____

Dr's Phone #: _____

PATIENT'S MEDICAL HISTORY

Patient's Name _____ Date of Birth _____ Age_____

Stated Height _____ Stated Weight _____

GYNECOLOGIC HISTORY:

Date of last Menstrual Cycle: _____ Are you in Menopause? YES NO Date of onset: _____

Are you taking Hormone Replacement? YES NO If yes, name: _____

Date of last PAP smear: _____ Results of PAP: _____

Have you had a Hysterectomy? YES NO Date: _____

Details of Hysterectomy and any other *Female* surgeries you may have had had: _____

_____

REPRODUCTIIVE HISTORY:

Are you pregnant? YES NO Number of pregnancies: _____ Number of Cesarean sections: _____

Number of vaginal deliveries: _____ Number of living children: _____ Do you hope to have more children? YES NO

Have you ever had Tubal Ligation (tubes tied)? YES NO

BREAST HISTORY:

Date of last Breast Exam: _____

Date of Last Mammogram: _____ Mammogram Results: Normal Abnormal: _____

CANCER HISTORY:

Have you ever been diagnosed with a cancer? YES NO Type: _____ Date treated: _____

Chemotherapy agents used: _____

Radiation Therapy used: Site treated _____ Date treated: _____

CANCER RISK:

Please indicate if your family has a history of the following: (Only include parents, grandparents, siblings and children).

- ☐ Ovarian Cancer
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Uterine Cancer
- ☐ Other Cancer _____

GENERAL HEALTH CARE:

Do you Smoke? YES NO If smoked in the past, for how many years? _____ When did you quit? _____

Do you use recreational drugs? YES NO If yes, list type: _____

Do you drink alcohol? YES NO If yes, amount: _____

Date of last colonoscopy:_____ Date of last flu shot_____

Any other general health issues you feel the Doctor should know? _____

_____

List Current Medications, Vitamins and Herbs (Include name, dosage, frequency and how taken):

	NAME	DOSAGE	FREQUENCY	HOW TAKEN
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

List Allergies and Allergic Reactions:

1. _____ 2. _____

3._____ 4._____

5._____ 6._____

List any prior surgeries not listed on page one _____

_____

List any cardiovascular health issues, (such as high blood pressure, high cholesterol, heart attack etc.)

_____

_____

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Gynecologic Oncology Associates
Financial Policy

GOA's primary goal is to provide you with the best possible medical care and assist you with payment issues. In order to achieve this goal, you must have a clear understanding of our financial policy which is important in order to sustain a professional relationship.

As a patient entering our practice, we will require identifying information, including a current Driver's License or State ID Card, Social Security number and insurance ID cards.

1. **Uninsured or Cash Patients** – Payment is due in full at time of service.
2. **Office Visit Co-Pays** – are due at time of service.
3. **Deductible and Co-Insurance** – Any unpaid deductible, out of pocket, and share of cost is due at the time of chemotherapy and office visits.
4. **Surgery Deposits** - are due in full prior to the scheduled procedure. Deposits vary dependent on your share of costs and include any unpaid deductible or co-insurance.
5. **No show appointments** – There is a $25.00 fee for appointments not cancelled within 24 hours without valid reason. This is not payable by insurance and must be paid prior to scheduling your next appointment.
6. **Forms** – There is a $20.00 fee for any form or letter that requires a doctor's signature, including disability, Family and Medical Leave Act, travel cancellation, jury duty excuse, and any other miscellaneous requests or forms. This is also not payable by insurance and must be paid upon request.
7. **Medical Records** – There is a $15.00 fee for limited and a $30.00 fee for a complete copy of your medical chart. There is a $50.00 fee for charts that require storage retrieval.
8. **Interest** – Interest at the legal rate may be added to any balance over $250.00 and more than 90 days old, unless other payment arrangements have been agreed upon.
9. **Prior Authorizations** – Regarding HMO's, Medi-cal, Cal Optima, and any other insurance requiring authorization before services can be rendered: Many HMO's will *not* pay for medical services if they have not been authorized in advance. GOA will assist in obtaining such authorization in your behalf; however, it is your responsibility to ensure that all services have been authorized before your appointment.
10. **Commercial Carriers** – GOA will follow the insurance contract guidelines for billing and collections. Please be prepared to pay any unpaid deductible or co-insurance at the time of service.
11. **Outside Lab Tests, Radiology and Other Services** – Your visit may include outside laboratory, radiology, and other services as ordered. If you are in doubt as to whether a

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procedure, lab test or X-ray is covered by your insurance, or if you are unsure as to *where* it must be performed, please call your plan's member services department to check your benefits and eligibility. Also please let our nursing staff know if your plan requires you to uses a specific laboratory or radiology facility. This office cannot be responsible for out-of-pocket expenses incurred from using the wrong provider or undergoing non-covered tests or procedures. You will receive a separate bill from each company that is performing and providing these services. You will need to contact the outside entity regarding any billing questions.

12. **Please keep in mind** – that as health care providers, our relationship is with you, not your insurance company. Therefore, you may be responsible for charges that your insurance company does not pay in full. *IT IS YOUR RESPONSIBILITY TO KNOW THE DETAILS OF YOUR HEALTH PLAN*. We realize the temporary financial problems that may affect timely payment of your account. If such problems do arise, please contact us immediately for assistance in the management of your account.
13. **Payment methods**- include Cash, Checks, MasterCard, Visa, Discover and American Express.

If you have any questions regarding this policy, please contact our **Billing Office at (800) 416-0888**.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW GYNECOLOGIC ONCOLOGY ASSOCIATES MAY US AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Gynecologic Oncology Associates is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Gynecologic Oncology Associates or received by Gynecologic Oncology Associates from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in the Notice. Gynecologic Oncology Associates will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

Gynecologic Oncology Associates reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent:

Gynecologic Oncology Associates may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies. For example Gynecologic Oncology Associates may determine that you require the services of a specialist. In referring you to another doctor, Gynecologic Oncology Associates may share or transfer your health care information to that doctor.

Payment Activities may include:

- Activities undertaken by Gynecologic Oncology Associates to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures covered under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you. For example, Gynecologic Oncology Associates will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare Operation may include:

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions. For example, Gynecologic Oncology Associates may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Gynecologic Oncology Associates may contact you, by telephone or email, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment of care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Gynecologic Oncology Associates is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law. In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- For public health activities. We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect

agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities. We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.
- For Judicial and Administrative Proceedings. Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.
- For activities related to death. We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.
- For research. Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- To avoid a serious threat to health or safety. We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.
- For Worker's Compensation. We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Gynecologic Oncology Associates will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Gynecologic Oncology Associates has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information (PHI):

You are permitted to request that restrictions be placed on certain uses or disclosures of your PHI by Gynecologic Oncology Associates to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your PHI is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation of use) in civil, criminal, or administrative action or proceeding. Gynecologic Oncology Associates may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Gynecologic Oncology Associates send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Gynecologic Oncology Associates not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you. Let it be noted that sending health information by means of email is not fully secure and a there is a risk that someone else besides yourself can access this information. We are not responsible if the email you provide is incorrect or the information goes to the wrong address.

You have the right to request that Gynecologic Oncology Associates amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied. You may request to receive an accounting of the disclosures of your PHI made by Gynecologic Oncology Associates for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

Your PHI is protected in our Electronic Medical Records system and in our internal and external data storage. We also use secure data transmission to mobile devices. Gynecologic Oncology Associates is required to notify affected individuals following a breach of unsecured PHI.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Gynecologic Oncology Associates and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Gynecologic Oncology Associates, please contact the Privacy Officer at the following:

Privacy Officer
Gynecologic Oncology Associates
351 Hospital Rd. Suite 507
Newport Beach, CA 92663

It is the policy of Gynecologic Oncology Associates that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.

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PLEASE READ, INITIAL AND SIGN THE FOLLOWING CONSENTS:

_____ (Initial) I have insurance with _____Insurance Company and assign directly to Gynecologic Oncology Associates (G.O.A.) all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize G.O.A. to release all information necessary to my insurance company in order to secure payment benefits.

_____ (Initial) I willingly seek the medical and health care services of Gynecologic Oncology Associates, its employees and staff.

_____ (Initial) I understand that during the course of my treatment I may be tested for antibodies to the HIV (AIDS) virus.

_____ (Initial) I acknowledge that I have received a copy of Gynecologic Oncology Associates **Notice of Privacy Practices.** This notice describes how GOA may use and disclose my protected health information and the rights I have regarding my protected health information.

_____ (Initial) I have received and read Gynecologic Oncology Associate's **Financial Policy**. I understand that I am financially responsible for services rendered and agree to the terms of this Financial Policy.

_____

Signature of Patient or Responsible Party **Print Name** **Date**

I authorize the release of my patient health information to the following persons:

_____ _____

Name Relationship Name Relationship

_____

Name Relationship

RECORDS RELEASE AUTHORIZATION

DATE: _____/_____/_____

TO: _____

I authorize the release of my medical records and request they be forwarded to:

- ☐ **LISA N. ABAID, M.D.**
- ☐ **TIFFANY L. BECK, M.D.**
- ☐ **JOHN V. BROWN, M.D.**
- ☐ **ALBERTO A. MENDIVIL, M.D.**
- ☐ **JOHN PAUL MICHA, M.D.**
- ☐ **KRISTINA M. MORI, M.D.**

SEND TO:

Gynecologic Oncology Associates
351 HOSPITAL ROAD, SUITE 507
NEWPORT BEACH CA 92663
PHONE: (949) 642-1361
FAX: (949) 642-1394

Patient's Name (print): _____

Address: _____

Phone: _____

Signature: _____

FOR REVIEW ONLY – ORIGINAL WILL BE PROVIDED IN OFFICE

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____

Physician's or Authorized Representative's Signature (Date)

GYNECOLOGIC ONCOLOGY ASSOCIATES AND ITS AFFILIATED PROVIDERS

Print or Stamp Name of Physician, Medical Group, or Association Name

By: TO BE SIGNED IN OFFICE ONLY

Patient's or Patient Representative's Signature (Date)

By: _____

Print Patient's Name

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-08)

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HOAG HEALTH INFORMATION EXCHANGE:

This practice is participating in Hoag Health Information Exchange (HIE), an electronic system through which it and other participation healthcare providers can share patient information according to national recognized standards and in compliance with federal and state law that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.

If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), we will continue to use your medical information in accordance with our Notice of Privacy Practices and the law, but will not make it available to others through the HIE. To opt out of the HIE, please inform our front office personal and they will provide you with a form to fill out. Or you may contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949-764-8722.

Nancy Yeary Women's Cancer Research Foundation

PATIENT REQUEST FORM for NYWCRF Information

Dear Patient:

The Nancy Yeary Women's Cancer Research Foundation (NYWCRF) is a 501(c)(3) non-profit research organization that conducts clinical research studies in collaboration with the physicians at Gynecologic Oncology Associates (GOA). We are dedicated to studying innovative cancer treatments that increase the cure rates of women diagnosed with gynecological cancers. In 2015, our patient cure rates were higher than the national average.*(Source: Hoag Hospital 2014 Cancer Center Report)

Throughout the year, the NYWCRF publishes newsletters and other helpful and inspiring information to keep patients, their loved ones, and the community up-to-date on its work. The NYWCRF will also occasionally send out mailings regarding upcoming events and fundraisers to raise awareness of our worthwhile cause.

If you would like to be added to the NYWCRF's mailing list, please fill out this brief form below. Your information will only be used for this expressed purpose. The NYWCRF does not sell or share its mailing list.

PLEASE FILL OUT THE FOLLOWING:

(Please check ☑ appropriate.)

☐ Yes, I would like to be added to the NYWCRF mailing list.

☐ No, thank you.

(Please Print)

Your Name _____

I prefer receiving information via: ☐ regular mail

☐ email_____