Patient Policies Summary Acknowledgement

Date: _____ MRN: _____

Patient Date of Birth: _____

Legal Patient Name:_____

I acknowledge that I have received a copy of the following documents:

Notice of Non-Discrimination: It is the policy of Arizona Blood and Cancer Specialists not to discriminate on the basis of race, color, national origin, sex, age or disability.

Grievance Procedure: Arizona Blood and Cancer Specialists has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of:

Karen McCormick
Arizona Blood and Cancer Specialists
3945 E. Paradise Falls Drive, Suite 201
Tucson, AZ 85712

who has been designated to coordinate the efforts of Arizona Blood and Cancer Specialists to comply with Section 1557.

Privacy Policy: Arizona Blood and Cancer Specialists is committed to protecting your privacy and ensuring that your health information is disclosed appropriately. The Privacy Policy identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information.

Accessibility Requirements: Arizona Blood and Cancer Specialists provide free language services to people whose primary language is not English, such as:

- Qualified Interpreters
- Information written in other languages (Please see the attached list for translation)

These documents are part of your "New Patient Packet." You may request another copy at any time.

_____ I have read this form, or had it read to me and understand that by signing, I am acknowledging that I received a copy of Arizona Blood and Cancer Specialists' Notice of Non-Discrimination and Grievance Procedures, Privacy Policy and Accessibility Requirements.

_____ I understand that refusal to sign this acknowledgment will not impact my ability to obtain care from Arizona Blood and Cancer Specialists, PLLC.

If interpretation services are needed, please call your doctor's office in advance so that we can arrange for translation services to be available at the time of your appointment.

Patient Signature: _____ Date:_____ (select one) ☐ AM ☐ PM
(or authorized representative)

Physician Signature:_____ Employee Initials:_____

ARIZONA BLOOD & CANCER SPECIALISTS
A Partner of OneOncology

Patient's Contact List – HIPAA & Emergency Contacts

Date: _____ MRN:_____

Patient Date of Birth: _____

Legal Patient Name:_____

You have the option to select different types of contacts. You can designate one person to be both a HPAA and Emergency Contact but, you also can designate separate people as either a HIPAA Contact or an Emergency Contact.

A HIPAA contact is a person who you authorize Arizona Blood and Cancer Specialists to release information about your medical condition. Any physicians who provide medical care to you don't need to be listed as HIPAA contacts.

It is important for you to name an Emergency Contact. This is a person that you authorize our staff to contact in the event you have a medical emergency while being treated in our office.

				Type of Contact:	
Contact Name:				☐ HIPAA	☐ Emergency
Phone Number:		Other Phone:			
Relationship:					

				Type of Contact:	
Contact Name:				☐ HIPAA	☐ Emergency
Phone Number:		Other Phone:			
Relationship:					

				Type of Contact:	
Contact Name:				☐ HIPAA	☐ Emergency
Phone Number:		Other Phone:			
Relationship:					

_____ I understand that I am authorizing Arizona Blood and Cancer Specialists, PLLC to disclose my personal health information to the individual(s) named above whom I have identified as my HIPAA contact(s).

_____ I acknowledge that I have received a copy of Arizona Blood and Cancer Specialists, PLLC's Privacy Practices.

_____ I acknowledge that I have the right to change contacts on this list at any time; that I can re-designate the Type of Contact originally stated; and that I have the right to revoke this contact list.

_____ I acknowledge that any revocation of this list must be made in writing.

_____ I have read this form, or had it read to me and I understand the consequences of my choices.

_____ I understand that refusal to sign this authorization will not impact my ability to obtain care from Arizona Blood and Cancer Specialists, PLLC.

Patient Signature: _____Date / Time _____ (select one) ☐ AM ☐ PM
(or authorized representative)

Physician: _____ Employee Initials: _____

ARIZONA BLOOD & CANCER SPECIALISTS

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COMMUNICATION PREFERENCE AND CONSENT

In addition to delivery by United States Postal Service to my home or other place of residence as provided in the Patient Registration, I consent to communication with me through the following methods. I understand that I may revoke or modify this consent at any time by completing the **REQUEST FOR COMMUNICATION RESTRICTION FORM.** In the event of a communication required by law, such as notice of breach, I acknowledge that the method of communication may be set by law.

Section A: Communication Method

Please choose one or more of the following:

☐	Home Number:	(_____) _____	Voice Messages permitted :	☐ Yes	☐ No
☐	Cell Number:	(_____) _____	Voice Messages permitted :	☐ Yes	☐ No
			Text Messages permitted :	☐ Yes	☐ No
☐	Work Number:	(_____) _____	Voice Messages permitted :	☐ Yes	☐ No
☐	Alternate Number:	(_____) _____	Voice Messages permitted :	☐ Yes	☐ No
☐	Email address:	_____			
☐	Alternate email address:	_____			

Section B: Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communication

Patients in our practice may be contacted via email and/or text messaging by Arizona Blood and Cancer Specialists or its authorized agents to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

____ (Patient Initials) If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

____ (Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above.

____ (Patient Initials) I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (*Request for Communication Restriction Form*). The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

In some cases, emails and/or text communication will be delivered to you through an encrypted communication format to ensure protection of your health information. If you decline encrypted communications, then email and/or text communication may not be available to you.

ARIZONA BLOOD & CANCER SPECIALISTS

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COMMUNICATION PREFERENCE AND CONSENT

Section C: Signature – This document must be signed by the individual, parent of minor child or the individual's Personal Representative.	
I consent to communication by Arizona Blood and Cancer Specialists or its authorized agents with me as specified above. I understand that if I am signing on behalf of a minor child, this request will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.	
Signature _____	**Date: mm/dd/yyyy**

If signed by a Personal Representative, please complete the information below.

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, attach a copy of the legal documents. You do NOT have to attach copies of these documents if they are already on file with Arizona Blood and Cancer Specialists.

_____ _____

Personal Representative's Name **Relationship to Individual**

_____ _____

Personal Representative's Address **City, State, ZIP**

_____ _____

Personal Representative's Telephone Number **Personal Representative's E-Mail Address (optional)**

ARIZONA BLOOD & CANCER SPECIALISTS
A Partner of OneOncology

Patient Portal / Electronic Mail Authorization Form

Date: _____ MRN: _____

Patient Date of Birth: _____

Legal Patient Name:

_____

Arizona Blood and Cancer Specialists / Arizona Breast Health Specialists provides secure access to your personal health record through our CareSpace patient portal. Only you, or those you authorize will have access to your health information.

Your authorization to activate your personal CareSpace account and consent to electronic mail is required. If you do not authorize this; we will not send any communication to you electronically.

Your CareSpace portal will include personal identifying information and other information about your health and medical history, so it is important that you keep your password private. Your password should not be shared with others unless you authorize them to access your account. Please don't share your password with anyone else that is not authorized or keep it in a place where is can be easily accessible to others.

If you choose not to sign this Patient Portal / Electronic Mail Authorization Form, you will not be able to access the CareSpace patient portal. By authorizing this form, you are consenting for us to email you a link for you to use to establish your account and create a password. The link will be sent after submitting this form, and for your protection, it is designed to expire quickly if not used.

Please contact your physician's office in the event that you have a new email address so we can update your account. Please make sure that the email address that you provide cannot be accessed by any person that you have not authorized, or that you don't trust.

At any time, you can discontinue use of your CareSpace patient portal. Please contact your physician's office to assist you with deactivating your account.

_____ I understand that by signing below, I am consenting to use Arizona Blood and Cancer Specialists CareSpace Patient Portal / Electronic Mail.

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

_____ E-mail Address of Patient

_____ ABCS Physician's Name

_____ E-mail Address of Authorized User

Authorized User is: _____

_____ Patients Designee's Name (Printed)

_____Patient _____ Patient's Designee

_____ Patient Designee's Signature

_____ Patient's Signature

_____ Date

_____ Staff Signature (confirming user's identity and authority)

_____ Date

Staff Notes: *When accepting this form, the identity and authority of the signing person MUST be confirmed, and the signing person (i.e., the Patient or Patient's Designee) understands and agrees to use the listed e-mail address for this purpose.*

A copy of this completed / signed document should be given to the patient.

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ARIZONA BLOOD & CANCER SPECIALISTS
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Patient Financial Data / Assignment of Benefits

Date: _____ MRN: _____

Patient Date of Birth: _____

Legal Patient Name: _____

What is the name you use? _____

Home Phone#: _____ Cell Phone#: _____

Home Address: _____ City: _____ State: ____ Zip Code: _____

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Current Age: _____ ☐ M ☐ F SS# _____

☐ Single ☐ Married ☐ Divorced / Separated ☐ Widowed

Employer: _____ Phone#: _____

Employers Address: _____

Responsible Party: _____ Relationship: _____

Responsible Party Address: _____

Primary Insurance: _____ Telephone: _____

Insured Name: _____ DOB: _____

Group #: _____ Policy #: _____

Secondary Insurance: _____ Telephone: _____

Insured Name: _____ DOB: _____

Group #: _____ Policy #: _____

Prescription Ins: _____ Telephone: _____

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

Pharmacy Name: _____ Telephone: _____

Please initial each line to indicate that you understand and accept the terms as stated below:

_____I understand that I am responsible for all charges not covered by this assignment or reimbursed by the insurance companies listed above. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

_____I authorize my primary insurance carrier, and my secondary insurance (if any) to release information regarding my coverage to Arizona Blood and Cancer Specialists.

_____I understand that all payments for pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits, are hereby assigned to Arizona Blood and Cancer Specialists. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans.

_____I acknowledge that this document is 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 Arizona Blood and Cancer Specialists.

_____I understand that I have a right to request and receive a Notice of Privacy Practices from Arizona Blood and Cancer Specialists.

_____I understand that this document is accurate and that it will remain in effect unless revoked by me in writing.

_____I have read this form, or had it read to me, and I understand it. I have received a copy of the above statements. A duplicate of the statement is considered the same as the original.

Patient Signature: _____ Date / Time _____ (select one) ☐ AM ☐ PM
(or authorized representative)

Physician: _____ Employee Initials: _____

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ARIZONA BLOOD & CANCER SPECIALISTS
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Patient Demographic Data

Date: _____ MRN: _____

Patient Date of Birth: _____

Legal Patient Name:

_____

What is the name you use?_____

Birth Sex: ☐ Male ☐ Female Current Gender: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female

RACE (Please Check One):

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African/American
☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Decline to answer
☐ Other_____

ETHNICITY (Please Check One):

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to answer

PREFERRED LANGUAGE (Please Check One)

☐ English ☐ German ☐ French ☐ Korean ☐ Arabic ☐ Vietnamese
☐ Spanish ☐ Chinese ☐ Decline to answer ☐ Other _____

VETERAN STATUS (Please Check One):

☐ I am a Veteran ☐ I am not a Veteran ☐ Decline to answer

CURRENT RELATIONSHIP STATUS (Please Check One):

☐ Single ☐ Married ☐ Divorced / Separated ☐ Widowed

EMPLOYMENT STATUS / HISTORY (Please Check One):

Are you currently : ☐ Employed ☐ Retired ☐ Unemployed ☐ on Disability

OCCUPATION(S) (CURRENT OR FORMER): _____ _____

Who referred you to our practice? _____

Who is your Primary Care Physician? _____

Who is your Medical Oncologist? _____

Who is your Surgeon? _____

Please list any other Doctors you see: _____

By law we are required to maintain the privacy of your health information. At any time, you are entitled to receive notice of our legal duties with respect to your health information, and we are required to provide you with a copy of our privacy practices.

Patient Signature: _____ **Date:** _____
(or authorized representative)

ACCESS YOUR HEALTH INFORMATION

ARIZONA BLOOD & CANCER SPECIALISTS
A Partner of OneOncology

ARIZONA BREAST HEALTH SPECIALISTS
at the Breast Center of Southern Arizona
A Partner of OneOncology

CareSpace is easily accessible on your personal computer, tablet or mobile device. You have 24 / 7 access to your medical information.

Communicate with your team.

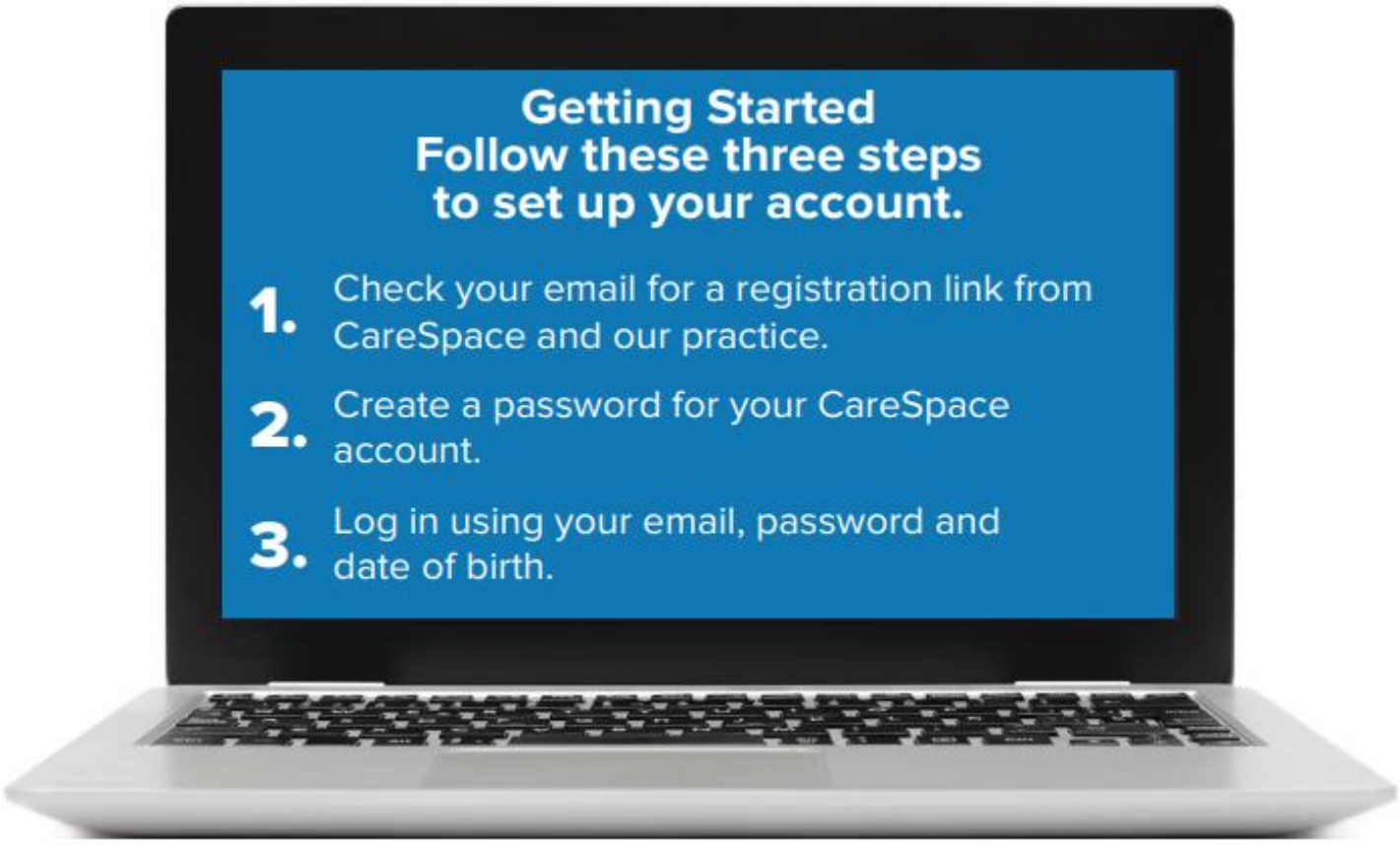
CareSpace provides you a place to communicate with your care team at our practice and have your questions answered seamlessly.

Keep friends, family and caregivers informed.

By inviting friends and family to your CareSpace Account, your support team can stay informed on your treatment plan and progress.

Download and securely send your health information.

From CareSpace you can securely send your health information to providers outside of our practice, like your primary care doctor.



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FREQUENTLY ASKED QUESTIONS

Where does information in CareSpace come from?

The information in CareSpace comes from your medical records at our practice.

Can I see my health records from all of my doctors?

Your CareSpace account at our practice will only include your medical records from our practice. Any labs, imaging or other tests will need to be seen on the providers' patient portal where the services were performed. You will only be able to see your records from our practice using the login credentials you created when you received an invitation to join our portal.

It is possible to have CareSpace accounts for other providers, but each provider's office will only display the records associated with their practice. You will need to contact each of your providers to be set up on their portal.

Who can see my account?

Only you and the people you invite can see your account. If you invite someone to your CareSpace account, they can see all of the information you can.

Is the information in CareSpace private and secure?

Yes, CareSpace is certified on the latest security standards, and your information will stay private and secure. CareSpace access is only permitted to authorized users who have been verified through a registration process.

NEED HELP? TIPS FOR REGISTERING YOUR ACCOUNT.

My registration link has expired. How do I set up my account?

To make sure that your information stays safe, registration links expire after four days. Give our practice a call if you need us to send you a new link.

What do I do if I never received a registration link from my practice?

Check your spam folder. If you still don't see one, give our practice a call.

Where do I log in for CareSpace?

You can always access CareSpace by visiting www.carespaceportal.com from a browser on your personal computer, tablet or mobile device.

What happens if I forgot my password?

No problem, you can reset your password yourself. Look for the "forgot password" link on the login page at www.carespaceportal.com

ARIZONA BLOOD & CANCER SPECIALISTS
A Partner of OneOncology

Patient's Health Information History

Date: _____ MRN: _____

Patient Name: _____ Date of Birth: _____

Legal Patient Name: _____

Please list all current medications including non-prescription medications:		
Medication	**Dose Strength**	**Frequency (How often)**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Do you have any drug or food allergies? ☐ **Yes** ☐ **No** **If yes, please list below:**	
Name of Drug/Food:	Reaction:
Name of Drug/Food:	Reaction:
Name of Drug/Food:	Reaction:
Name of Drug/Food:	Reaction:
Name of Drug/Food:	Reaction:

Please mark any of these you have had: **CT / MRI** ☐ Yes ☐ No **Dye Sensitivity** ☐ Yes ☐ No

Are you **claustrophobic?** ☐ Yes ☐ No

IMMUNIZATIONS: **COVID** ☐ Yes Date: _____ ☐ No **FLU** ☐ Yes Date: _____ ☐ No

SHINGLES ☐ Yes Date: _____ ☐ No **PNEUMONIA** ☐ Yes Date: _____ ☐ No

Have you ever had radiation, radium, radioactive implants or cobalt treatments? ☐ Yes ☐ No

If yes, provide dates and place of treatment. _____

Have you ever been treated for cancer? ☐ Yes ☐ No If Yes, when and what type _____

Have you ever had **chemotherapy?** ☐ Yes ☐ No If yes, date of last treatment _____

Physicians Notes:

ARIZONA BLOOD & CANCER SPECIALISTS
A Partner of OneOncology

Patient's Health Information History

Date: ____ /____ /____ MRN:_____

Patient Date of Birth: _____ /_____ /_____

Legal Patient Name: _____

Medical History	YES	NO	Medical History	YES	NO
Arthritis			Kidney Disease		
Auto-Immune Disorder			Lung Disease		
Diabetes			MRSA /C-Diff (other infectious disease)		
Heart Disease			Neurological Disease		
Hepatitis B			Pacemaker / Medical Device		
Hepatitis C			Seizures / Strokes		
HIV (AIDS)			Skin Disorders		
High Blood Pressure			Blood Clots		
Osteoporosis			Tuberculosis		
Thyroid			Other		
Mental Health Disorders			**Other Cancers**		

PAST SURGERY ☐ Yes ☐ No (include age and date) Have you had any of the following:

Type of Surgery	Reason for Surgery	Date / Age	Complications
Breast			
Breast Lumpectomy			
Mastectomy ☐ R ☐ L			
Mastectomy (Bilateral)			
Hysterectomy			
Removal of Ovaries			
Appendectomy			
Gall Bladder			
Bowel / Colon			
Lung			
Other Surgery			

Are you of Ashkenazi decent? ☐ **Yes** ☐ **No** **(Has anyone in your family had Cancer?)** ☐ **Yes** ☐ **No** **If yes, please list:**

This includes first degree relatives (parents, siblings, children) and second-degree relatives (grandparents, grandchildren, uncles, aunts, nephews, nieces and half siblings). **How many siblings do you have?_____**

Relative	Type of Cancer	Maternal	Paternal	Age (at diagnosis)	Age (if living)	Deceased

Physicians Notes:

ARIZONA BLOOD & CANCER SPECIALISTS
A Partner of OneOncology

Patient's Health Information History

Date: _____ MRN: _____

Patient Date of Birth: _____

Legal Patient Name: _____

WEIGHT / NUTRITIONAL STATUS:

In the last three months, have you had a weight change? ☐ Yes ☐ No Was this intentional? ☐ Yes ☐ No
If yes, please indicate the number of pounds you have _____lost _____ gained
Please describe your diet: ☐ regular ☐ soft ☐ liquid ☐ diabetic ☐ supplements ☐ other
Please describe your appetite: ☐ good ☐ fair ☐ poor

Cancer Screening:

Date of last pap smear: _____ Date of last mammogram: _____ Date of last skin exam: _____
Have you had a colonoscopy or Cologuard® test? ☐ Yes ☐ No If yes, date: _____

FOR MEN ONLY:

Do you currently have / have you had:
☐ discharge from the penis ☐ sore on penis
☐ lump in testicles ☐ breast lump
☐ a testicular exam ☐ a test to check your PSA level
☐ erectile dysfunction ☐ a prostate exam

FOR WOMEN ONLY:

Menstrual Period: Age at your first period? _____
Age at your last period? (menopause) _____ Date of your last menstrual period? _____

Pregnancy / Reproductive: Age at your first pregnancy? _____ Age at your first delivery? _____
Could you be pregnant now? ☐ Yes ☐ No ☐ Unsure
Number of: pregnancies: _____ live births: _____ miscarriages: _____ abortions: _____
Have you had a tubal ligation? ☐ Yes ☐ No Has your husband or partner had a vasectomy? ☐ Yes ☐ No

Infertility Treatments: Have you ever undergone any type of fertility treatment? ☐ Yes ☐ No
If yes, type and duration: _____

Breast Health: Do you perform a breast self-exam? ☐ Yes ☐ No
Have you had any of the following? ☐ tenderness ☐ nipple discharge ☐ lump ☐ fibrocystic disease
If yes, how often? ☐ monthly ☐ every few months ☐ few times a year
If no, do you need help learning how to perform a breast self-exam? ☐ Yes ☐ No

Gynecologic Health:

Do you currently have or have you had: ☐ vaginal discharge ☐ vaginal bleeding or spotting
Do you or have you taken estrogen therapy, birth control pills or other hormones? ☐ Yes ☐ No
If yes, what type: _____
Are you currently using them? ☐ Yes ☐ No If no, date discontinued: _____
How many years have you taken them? _____

Physician Notes:

ARIZONA BLOOD & CANCER SPECIALISTS
A Partner of OneOncology

Patient's Health Information History

Date: _____ MRN: _____

Patient Date of Birth: _____

Legal Patient Name: _____

RELATIONSHIP STATUS (Check One): ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

EMPLOYMENT STATUS/HISTORY (Check One): ☐ Employed ☐ Retired ☐ Unemployed ☐ on Disability

OCCUPATION(S) (current or former):_____ _____

SOCIAL HISTORY & HABITS?

Do you now, or have you ever smoked? ☐ Yes ☐ No If yes, how long have / did you smoke?

Number of Years _____ If you quit, when did you quit/ how many years ago did you quit? _____

Please describe what you smoke / smoked and how much per day?

Cigarettes: ☐ Yes ☐ No If yes, how many cigarettes per day? _____

Pipe: ☐ Yes ☐ No If yes, how much tobacco per day? _____

Vaping: ☐ Yes ☐ No If yes, how much per day? _____

Do you chew tobacco/use other smokeless tobacco products? ☐ Yes ☐ No How much per day? _____

Do you drink alcohol (wine, beer, liquor)? ☐ Yes ☐ No How often? _____ Quantity consumed? _____

Do you have a history of drug abuse: ☐ Yes ☐ No Do you use recreational drugs? ☐ Yes ☐ No

DENTAL HEALTH: Do you see a dentist regularly? ☐ Yes ☐ No If so, date of last visit: _____

HAZARDOUS MATERIALS EXPOSURE:

Have you ever been exposed to any hazardous materials? ☐ Yes ☐ No
(including by not limited to: Asbestos, Agent Orange, Heavy Metals, Pesticides, Petroleum)

If yes, what kind?_____ When was your exposure? _____

PATIENT'S ACTIVITY LEVEL: (please check all that apply to best describe patient's level of activity)

☐ Fully active, and can walk without aid ☐ Somewhat restricted but is ambulatory and able to do light work

History of falling ☐ Yes ☐ No Do you use a: ☐ cane ☐ walker ☐ wheelchair ☐ motorized scooter

☐ Out of bed and awake more than 50% of the day

☐ Capable of all self-care ☐ Capable of limited self-care (need help showering, dressing, eating)

ADVANCE CARE PLANNING DOCUMENTS: Please check any of the following documents you have:

☐ **Living Will** ☐ **Advance Directives including DNR Status** ☐ **Medical Power of Attorney**

If yes, who is your medical power of attorney?

Name or Medical Power of Attorney: _____ Contact Number: _____

Can you please provide a copy for our records of any of the above items you have?

Would you like to receive any information on any of the documents mentioned above? ☐ Yes ☐ No

If yes, please indicate which one(s): _____

Physician Notes:

Date: _____ MRN:_____

Patient Date of Birth: _____

Legal Patient Name: _____

PAIN ASSESSMENT:

(This should be completed up to 5 days prior to appointment.)

Are you currently experiencing pain? ☐Yes ☐No

Please rate your current level of pain:

(no pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - **10 (extreme pain)**

Does your pain medication control your pain? ☐100% ☐75% ☐50% ☐25% ☐Not at all

DISTRESS ASSESSMENT:

Please indicate the number on the scale below that best describes how much distress you have experienced over the last week, and that you are experiencing today:

(no distress) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - **10 (extreme distress)**

Please complete ALL pages of this questionnaire.

PLEASE NOTE BELOW ANY OF THE FOLLOWING COMPLAINTS YOU CURRENTLY HAVE

GENERAL	YES	NO		YES	NO
fever			sleep difficulties		
chills			swollen glands / lymph nodes		
easy bruising			skin rash or irritation		
general weakness			open sores / skin injury		

EARS / NOSE / THROAT	YES	NO		YES	NO
pain in ears			dry mouth		
hearing difficulty or deafness			bleeding gums		
discharge from the ear			nose bleeds		
ringing or buzzing in ears			persistent neck stiffness		
wear hearing aids			voice changes / hoarseness		
sinus problems			swelling or lumps in the neck		
sores on tongue or in mouth			difficulty swallowing		

EYES	YES	NO		YES	NO
vision changes			double vision		
light flashes / halos			glaucoma or cataracts		
eye pain			wear glasses or contacts		

Physicians Notes:

ARIZONA BLOOD & CANCER SPECIALISTS
A Partner of OneOncology

Patient's Health Information History

Date: _____ MRN: _____

Patient Name: _____ Date of Birth: _____

Legal Patient Name: _____

HEART / CIRCULATION	YES	NO	RESPIRATORY	YES	NO
chest pain			difficulty breathing		
unusual heartbeat			spitting up blood		
heart defects			chronic cough		
legs / ankles swelling			shortness of breath		
dizziness / fainting spells			wheezing		
poor exercise tolerance					

STOMACH AND INTESTINES	YES	NO		YES	NO
abdominal pain or cramps			diarrhea		
nausea / vomiting			blood in stools		
indigestion or heart burn			hemorrhoids		
poor or decreased appetite			constipation		
vomiting blood			change in bowel habits		

GENITAL AND URINARY SYSTEM	YES	NO		YES	NO
difficulty controlling urine			blood in urine		
trouble starting stream			kidney stones		
pain or burning with urination			sexual difficulties		
frequency			impotency		
night urination					

MUSCLES AND JOINTS	YES	NO	ENDOCRINE	YES	NO
tingling sensations / numbness			thirsty all of the time		
weakness in arms or legs			heat or cold intolerance		
limited range of motion			hot flashes		
difficulty with balance			unusually tired or sluggish		
joint problems including: pain, swelling, redness			night sweats		

NEUROLOGIC	YES	NO	MENTAL HEALTH	YES	NO
severe headaches			depression		
speech changes			mood changes		
involuntary movement (i.e. spasms or tremors)			anxiety		
memory loss					
paralysis					

Physicians Notes:

ARIZONA BLOOD & CANCER SPECIALISTS
A Partner of OneOncology

Patient's Health Information History

Date: _____MRN:_____

Patient Name: _____ Date of Birth: _____

Legal Patient Name: _____

Please tell us the name of your preferred pharmacy:

Pharmacy Name: _____ Telephone: _____

Location: _____

_____I have read this form, or had it read to me.

Patient Signature: _____ **Date / Time** _____**(select one)** ☐ AM ☐ PM

(or authorized representative)

Physician: _____

Clinical Notes: (please don't mark anything in this box)

Patients Age _____ Patients Pulse: _____

Patients Height: _____ Patients Respiration: _____

Patients Weight:_____ Patients Pain: _____

Patients Blood Pressure: _____ /_____

Physicians Notes: (please don't mark anything in this box)

Notice of Privacy Practices for Protected Health Information

Effective Date: 06/03/2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

Arizona Blood and Cancer Specialists, PLLC provides each patient of an affiliated physician group with a Notice of Privacy Practices (NPP) that is written in plain language and that contains the elements required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Regulations.

Arizona Blood and Cancer Specialists, PLLC is committed to protecting the patient's personal and heath information at each affiliated physician group. Additionally, both federal and state laws require Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups to maintain the privacy of patient personal health information. This Notice explains Arizona Blood and Cancer Specialists, PLLC and affiliated physician group's privacy practices, our legal duties, and your rights concerning your personal and health information. In this Notice, your personal or protected health information (PHI) is referred to as "healthcare information" and includes information about your health treatment and care when it contains identifiable information such as your name, age, address, income, and other financial information.

Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups are permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and healthcare operations. Protected healthcare information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services. Examples related to treatment, payment, and healthcare operations are listed below.

Use of your health information for treatment purposes:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist. He/she will share the information with such a specialist and obtain his/her input.

Use of your health information for payment purposes:

- Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups submit requests for payment to your health insurance company. The health insurance company or business associate helping Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups obtain payment requests information from us regarding your medical care given. Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups will provide information to them about you and the care given.

Use of your information for healthcare operations:

- Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups will share information about you with such business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups. You have the following rights with respect to your protected healthcare information:

Right to Inspect and/or Obtain a Copy

You have the right to inspect and obtain a copy of your completed health records unless your doctor believes that disclosure of that information to you could harm you. You may not see or get a copy of information gathered for a legal proceeding or certain research records while the research is ongoing. Your request to inspect or obtain a copy of the records must be submitted in writing, signed and dated, to the medical records department of the Arizona Blood and Cancer Specialists, PLLC's facility that maintains the records. (Requests for billing records should be sent to the billing departments.) We may charge a fee for processing your request. If Arizona Blood and Cancer Specialists, PLLC denies your request to inspect or obtain a copy of the records, you may appeal the denial in writing to the Arizona Blood and Cancer Specialists, PLLC Office of Compliance at the following address: 3945 E. Paradise Falls Drive, Suite 201, Tucson, AZ 85712.

Right to Request an Amendment

If you feel that health information Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups have about you is incorrect or incomplete, you have the right to ask us to amend your medical records. Your request for an amendment must be in writing, signed, and dated. It must specify the records you wish to amend, identify the Arizona Blood and Cancer Specialists, PLLC facility that maintains those records, and give the reason for your request. You must address your request to the Compliance Department at 3945 E. Paradise Falls Drive, Suite 201, Tucson, AZ 85712 or to the Arizona Blood and Cancer Specialists, PLLC facility that maintains the records you wish to amend. Arizona Blood and Cancer Specialists, PLLC will respond to you within sixty (60) days. We may deny your request; if we do, we will tell you why and explain your options.

Right to an Accounting of Disclosures

You may request an accounting, which is a listing of the entities or persons (other than yourself) to whom Arizona Blood and Cancer Specialists, PLLC has disclosed your health information without your written authorization. The accounting would not include disclosures for treatment, payment, healthcare operations, and certain other disclosures exempted by law. Your request for an accounting of disclosures must be in writing, signed, and dated.

It must identify the time period of the disclosures and the Arizona Blood and Cancer Specialists, PLLC facility that maintains the records about which you are requesting the accounting. We will not list disclosures made earlier than six (6) years before your request. Your request should indicate the form in which you want the list (for example, paper or electronically). You must submit your written request to the medical records department of the Arizona Blood and Cancer Specialists, PLLC facility that maintains the records or to the Compliance Department at 3945 E. Paradise Falls Drive, Suite 201, Tucson, AZ 85712.

We will respond to you within sixty (60) days. We will give you the first listing within any 12-month period free of charge, but we will charge you for all other accountings requested within the same 12-months.

Right to Breach Notification

In the event of any breach of unsecured PHI, Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups shall fully comply with HIPAA/HITECH breach notification requirements, including notification to you of any impact that the breach may have had on you and/or your family member(s) and actions Arizona Blood and Cancer Specialists, PLLC undertook to minimize any impact the breach may have had on you.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. Unless otherwise required by law, you have a right to restrict certain health information disclosures to health insurers if you pay full cost of services at the time of your visit. To request a restriction, you must make your request in writing to the Compliance Department located at 3945 E. Paradise Falls Drive, Suite 201, Tucson, AZ 85712. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure, or both, and to whom you want the limits to apply, for example, disclosures to your spouse. All requests will be reviewed for consideration of acceptance; therefore, you will not receive immediate response to your request. Every effort will be made to provide you a response to your request within thirty (30) days.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Compliance Department located at 3945 E. Paradise Falls Drive, Suite 201, Tucson, AZ 85712. We will not ask you the reason for your request. Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. You may obtain a paper copy of this Notice at any of our facilities or by calling 1-520-689-7022. You also can view this Notice at our website www.arizonabloodandcancerspecialists.com

Personal Representative

Your "personal representative" may exercise the rights listed above on your behalf if under an applicable law, that person has legal authority to act on your behalf in making decisions related to healthcare.

How Arizona Blood and Cancer Specialists, PLLC Protects Your Health Information.

Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups are required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable requests regarding methods to communicate health information with you; and
- Accommodate your request for an accounting of disclosures.

Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the PHI we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our Notice or by visiting one of our offices and picking up a copy. New policies will be posted in the waiting room as well as our website www.arizonabloodandcancerspecialists.com

Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your healthcare information, you may contact the Compliance Department at:

Direct reporting:	Anonymous reporting:
OneOncology Attn: Compliance Officer 1-520-689-7022 karen.mccormick@oneoncology.com	Compliance Hotline website at: **oneoncology.ethicpoint.com** or report by phone call at **1-844-473-5115**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at any Arizona Blood and Cancer Specialists, PLLC and affiliated physician group facility. You may also file a complaint with the U.S. Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201
(800) 368-1019 | www.hhs.gov/ocr

- We cannot, and will not, require you to waive the right to file a complaint with the U.S. Department of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the U.S. Department of Health and Human Services.

Uses and Disclosures Requiring Authorization

Patient Contact

Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. For example, we may leave voice messages at the telephone number you provide with us.

Opportunity to Agree or Object to Notification

Unless you object, Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

No information about you will be disclosed without your written authorization. The only exceptions include essential business operations, life-threatening emergencies, a court order, or instances involving our ethical and legal duty to report abuse.

Philanthropic Support

Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may use or disclose certain health information about you to contact you in an effort to raise funds to support Arizona Blood and Cancer Specialists, PLLC and its operations. You have the right to choose not to receive these communications and we will tell you how to cancel them.

Disaster Relief Efforts

Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may use and disclose your PHI to assist in disaster relief efforts.

Uses and Disclosures with Neither Consent nor Authorization

Public Health Activities

1. Controlling Disease
    a. As required by law, Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

2. Child Abuse and Neglect
    a. Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose PHI to public authorities as allowed by law to report child abuse or neglect.
3. Food and Drug Administration (FDA)
    a. Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post- marketing surveillance information to enable product recalls, repairs, or replacements.

Victims of Abuse, Neglect, or Domestic Violence

Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups can disclose PHI to governmental authorities to the extent the disclosure is authorized by statute or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victims.

State Specific Requirements

Each state has unique requirements for reporting data, including population-based activities relating to improving health or reducing healthcare cost. Be sure to reference the state regulations based on the location of the Arizona Blood and Cancer Specialists, PLLC facility.

Oversight Agencies

Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations, inspections, licensures or disciplinary actions, and for similar reasons related to the administration of healthcare.

Judicial/Administrative Proceedings

Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, or as directed by a proper court order or administrative tribunal, provided that only the PHI released is expressly authorized by such an order, or in response to a subpoena, discovery request or other lawful process.

Law Enforcement

Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose your PHI for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.

Coroners, Medical Examiners and Funeral Directors

Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose your PHI to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

Organ Procurement Organizations

Consistent with applicable law, Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of donation and transplant.

Research
Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Threat to Health and Safety
To avert a serious threat to health or safety, Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose your PHI consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions
Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Correctional Institutions
If you are an inmate of a correctional institution, Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Workers Compensation
If you are seeking compensation through Workers Compensation, Arizona Blood and Cancer Specialists, PLLC and affiliated physician groups may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Other Uses and Disclosures
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.

Website
You will find this "Notice of Privacy Practices" on the Arizona Blood and Cancer Specialists, PLLC's website at: www.arizonabloodandcancerspecialists.com

If you have additional questions concerning this "Notice of Privacy Practices" they may be addressed to the OneOncology VP of Compliance via email:

karen.mccormick@oneoncology.com.

Arizona Blood and Cancer Specialists, PLLC cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al: 1-520-689-7022.

Arizona Blood and Cancer Specialists, PLLC bik'ehgo hójił'įnígíí bidadeeti'ígíí Wááshindoon t'áá át'é bilá'ashdla'ii bee bá ádahaazt'i'ígíí bibee haz'ąąnii dóó doo ak'íjį' nitsáhákees da díí ninahjį' ał'ąą dadine'é, dine'é bikágí át'ehígíí, binááhai'ígíí, nazhnitł'ago da, éí doodaii' asdzání dóó diné át'ehígíí.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih. 1-520-689-7022.

Discrimination is Against the Law

Arizona Blood and Cancer Specialists, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Arizona Blood and Cancer Specialists, PLLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Arizona Blood and Cancer Specialists, PLLC provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact: Karen McCormick.

Karen McCormick
3945 E. Paradise Falls Drive, Suite 201
Tucson, AZ 85712
1-520-689-7022

If you believe that Arizona Blood and Cancer Specialists, PLLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Karen McCormick
3945 E. Paradise Falls Drive, Suite 201
Tucson, AZ 85712
1-520-689-7022

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Karen McCormick is available to help you.

You can also file a civil rights complaint with the:

U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHS Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)

Complaint forms are available at: https://www.hhs.gov/ocr

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Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih. 1-520-689-7022.

Section 1557 of the Affordable Care Act Grievance Procedure

It is the policy of Arizona Blood and Cancer Specialists, PLLC not to discriminate on the basis of race, color, national origin, sex, age or disability. Arizona Blood and Cancer Specialists, PLLC has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Karen McCormick, 3945 E. Paradise Falls Drive, Suite 201, Tucson, AZ 85712, who has been designated to coordinate the efforts of Arizona Blood and Cancer Specialists to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Arizona Blood and Cancer Specialists, PLLC to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.

A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Arizona Blood and Cancer Specialists, PLLC relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Chief Executive Officer within 15 days of receiving the Section 1557 Coordinator's decision. The Chief Executive Officer shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at:

https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHS Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)

Complaint forms are available at: https://www.hhs.gov/ocr

Such complaints must be filed within 180 days of the date of the alleged discrimination.

Arizona Blood and Cancer Specialists, PLLC will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectfully, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al: 1-520-689-7022.

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Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę́', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih. 1-520-689-7022.

ARIZONA BLOOD & CANCER SPECIALISTS

A Partner of OneOncology

Arizona Blood and Cancer Specialists will provide free language services to people whose primary language is not English, such as: Qualified interpreters and/or information written in other languages.

Including but not limited to:

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-520-689-7022.

Diné Bizaad (Navajo)

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-520-689-7022.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-520-689-7022.