



COMPREHENSIVE  
CANCER CENTERS

LUNG CENTER OF NEVADA  
A Division of Comprehensive  
Cancer Centers

## HEALTH HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ D. O. B.: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Pharmacy Name and Address: \_\_\_\_\_

Medical Equipment Company (oxygen, nebulizer, CPAP, BiPAP): \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

### Medication Allergies:

\_\_\_\_\_

**Medications:** List your current prescription and non-prescription drugs or attach a list if more room is needed.

Name	Dosage	Times per Day
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_____	_____	_____
_____	_____	_____

Past Medical History: \_\_\_\_\_

Past Thoracic Surgery: \_\_\_\_\_

### Social:

Have you ever smoked? <input type="checkbox"/> yes <input type="checkbox"/> no	Lived with someone who smokes? <input type="checkbox"/> yes <input type="checkbox"/> no
How many years have you smoked? _____	Exposure to second hand smoke? <input type="checkbox"/> yes <input type="checkbox"/> no
If quit, when? _____	Exposure to toxic chemicals or substances? <input type="checkbox"/> yes <input type="checkbox"/> no
How many packs a day? _____	Marijuana or hard drugs use: <input type="checkbox"/> yes <input type="checkbox"/> no

### Health Maintenance

Flu shot: When? \_\_\_\_\_ TB skin test: When? \_\_\_\_\_

Prevnar 20: When? \_\_\_\_\_ Results:  positive  negative

Most Recent Tests:	Date	Location
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Last Colonoscopy:	_____	_____
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Last Mammogram:	_____	_____
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## Sleep History

1. Do you snore?  Yes  No  Don't know
- In which position do you snore?  Back only  All position
- Do you snore if you fall asleep in a chair?  Yes  No  Don't know
- Does your snoring disturb anyone?  Yes  No  Don't know
- Has anyone ever noticed if you stop breathing in your sleep?  Yes  No  Don't know
- Do you gasp or choke while you sleep?  Yes  No  Don't know

2. Do you suffer from either of the following in the morning?  Dry mouth  Headache

3. Do you feel sleepy during the daytime?  Yes  No  Don't know

How many days per week? \_\_\_\_\_

What age did it start? \_\_\_\_\_

Is it worsening?

Yes  No  Don't know

4. Have you ever had a car accident due to sleepiness?  Yes  No  Don't know
5. Do you suffer from memory problems?  Yes  No  Don't know
6. Are you more irritable lately?  Yes  No  Don't know
7. Do you take any daytime naps?  Yes  No  Don't know

How many per week? \_\_\_\_\_

How long do you nap? \_\_\_\_\_

Are your naps refreshing?  Yes  No

9. What is your bedtime? \_\_\_\_\_

How long does it take you to fall asleep? \_\_\_\_\_

When do you wake up? \_\_\_\_\_

Do you wake up during the night?  Yes  No  Don't know

How many times per night? \_\_\_\_\_ What awakens you? \_\_\_\_\_

10. How likely are you to doze off or fall asleep in the following situations?

0 = Would **NEVER** doze 1= **SLIGHT** chance of dozing 2 = **MODERATE** chance of dozing 3 = **HIGH** chance of dozing

Situation	Chance of Dozing
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place (e.g. a theater or a meeting)	0 1 2 3
As a passenger in a car for an hour, without a break	0 1 2 3
Lying down to rest in the afternoon, when circumstance permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without having had any alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3



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CANCER CENTERS**

cccnevada.com

**PATIENT ACKNOWLEDGEMENT**

The undersigned patient of Comprehensive Cancer Centers of Nevada (“CCCN”) acknowledges and agrees as follows:

1. My CCCN practitioner may refer me to non-CCCN healthcare providers for services including but not limited to diagnostic testing, imaging, and/or specialist consultation (each an “Outside Provider”);
2. Outside Providers are not affiliated with CCCN, and CCCN has no control over their services;
3. CCCN is not responsible for any delays in my care or other disruptions to my diagnosis or treatment which may be caused by Outside Providers beyond CCCN’s control; and
4. CCCN is not responsible for the costs of any services provided by Outside Providers, which may or may not be covered in whole or in part by my insurance plan.

Signed Electronically

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

FOR CCCN USE ONLY:

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_

Title: \_\_\_\_\_

400 N. Stephanie Street, Suite 300 • Henderson NV 89014 • 702.952.3350

**SERVICES:** Medical Oncology | Hematology | Radiation Oncology | Breast Surgery | Pulmonology & Sleep Disorders  
Cancer Genetic Counseling | Diagnostics | Clinical Trials & Research | CyberKnife® Radiosurgery



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CANCER CENTERS

LUNG CENTER OF NEVADA  
A Division of Comprehensive  
Cancer Centers

653 N. Town Center Drive Suite 604, Las Vegas, NV 89148  
Ph# 702-737-5864 Fx# 702-463-7015

**Medical Records Request**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Signed Electronically

**I Hereby Authorize:**

Name: Lung Center of Nevada Phone Number: 702-737-5864 Fax: 702-463-7015

Address: 653 N Town Center Dr. Suite 604 Las Vegas, NV 89144

**To: Request Records From: \_\_\_\_\_ Release Records to: \_\_\_\_\_ (Please Check One)**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

**Purpose of Release: (Please Check One)**

\_\_\_\_\_ Continuity of Care \_\_\_\_\_ Personal Use \_\_\_\_\_ Other: \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

\_\_\_\_\_ All Records \_\_\_\_\_ Progress Notes \_\_\_\_\_ Sleep Studies  
\_\_\_\_\_ Labs \_\_\_\_\_ Stress Test  
\_\_\_\_\_ PFT \_\_\_\_\_ Echo Report  
\_\_\_\_\_ CXR/CT Chest Reports  
\_\_\_\_\_ Other (Specify): \_\_\_\_\_

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office and obtain a copy of the Privacy Notice.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_

**IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE IN 12 MONTHS**



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**Meaningful Use Update**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Preferred Method of Contact

Email: \_\_\_\_\_

Cell: \_\_\_\_\_

Home: \_\_\_\_\_

Other: \_\_\_\_\_

**Marital Status**

Married

Single

Widowed

Divorced

Life Partner



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**Using and Disclosing Protected Health Information for  
Involvement in the Individual's Care and Notification Purposes**

As per the notice of privacy practices, Comprehensive Cancer Centers must provide the patient with an opportunity to agree or disagree to the use or disclosure of patient health information to a patients' family member, friends or acquaintances involved in their care.

This document will serve as a written agreement between \_\_\_\_\_ (patient) and Comprehensive Cancer Centers as a list of those designated by the patient as having direct involvement in the patient's care.

In the event you are unable to sign a medical release for your records, please provide us with a list to include your next of kin and/or persons names you will authorize us to release your medical records to. It will be the patient's responsibility to update as necessary.

Next of kin:

Name	Phone	Relationship
_____	_____	_____

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes / No    Per My Permission – Leave medical information on my answering machine.

I hereby authorize Comprehensive Cancer Centers to use or disclose my personal health information to the above mentioned for the purpose of my care or payment related to my care. This information may also be used for the purpose of notifying, or assist in notification of (including identifying or locating), a family member, personal representative or another person responsible for my care, of my location and/or condition.

\_\_\_\_\_  
Signed Electronically  
Patient Signature

\_\_\_\_\_  
SS #

\_\_\_\_\_  
Date



COMPREHENSIVE  
CANCER CENTERS

**ACKNOWLEDGEMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICES**

Comprehensive Cancer Centers of Nevada is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

**I acknowledge that I have received a copy of the Notice of Privacy Practices of Comprehensive Cancer Centers of Nevada.**

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ Signed Electronically

**Name of Personal Representative (if appropriate):** \_\_\_\_\_

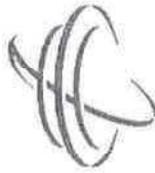
**Signature of Personal Representative (if appropriate):** \_\_\_\_\_ Signed Electronically

Comprehensive Cancer Centers of Nevada Use Only

Date acknowledgment received: \_\_\_\_\_ -OR-

Reason acknowledgment was not obtained: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## COMPREHENSIVE CANCER CENTERS

### **Patient Financial Policy**

We, the staff at Comprehensive Cancer Centers of Nevada, thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family.

We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to speak to a Patient Benefits Representative who is available in the office where your care is provided. Insurance Specialists are also available to answer questions Monday through Thursday from 8:30 AM to 5 PM at our Central Business Office at (702) 952-3350. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

Payment for our services is due at the time that those services are provided to you, and we expect that all charges we present to you at a visit will be paid at the time of the visit. This includes, among other things, co-pay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as your responsibility to pay after coverage by insurance programs. We may also present charges to you by written statement or letter via the mail following a visit. If we do this, we expect that each charge will be paid in full the first time it is presented to you.

We make payment as convenient as possible. Payment may be made in person at any of our locations or by return mail, by phone call or via our payment portal at [www.cccnevada.com](http://www.cccnevada.com). We accept cash, money order, MasterCard, Visa, American Express, Discover and in-state checks. A \$25 service fee will be charged for all returned checks.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

We will remind you of unpaid charges monthly by statement through the mail. If, after four statements, charges remain unpaid and you have not made payment arrangements, you may be contacted in writing or by phone by a third party. By accepting our services, you are consenting to receive these communications.

**Insurance**

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment of services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with their insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information.

It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payment, co-insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

**Missed Appointments**

We currently do not charge for missed appointments. We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

**Timeliness of Appointments**

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy.

Patient Name (Please Print): \_\_\_\_\_

Signature of Insured or Authorized Representative: \_\_\_\_\_

Signed Electronically

Date: \_\_\_\_\_



COMPREHENSIVE  
CANCER CENTERS

## NOTICE OF PRIVACY PRACTICES

Effective Date: May 1, 2016

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

### About Us

In this Notice, we use terms like "we," "us," "our" or "Practice" to refer to Comprehensive Cancer Centers of Nevada, its physicians, employees, staff and other personnel. All of the sites and locations of Comprehensive Cancer Centers of Nevada follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

### Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

### Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

### How We May Use or Disclose Your Health Information

**The following categories describe examples of the way we use and disclose health information without your written authorization:**

**For Treatment:** We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another healthcare provider to be sure they have all the information necessary to diagnose and treat you.

**For Payment:** We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

**For Health Care Operations:** We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and

collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

**Individuals Involved in Your Care or Payment for Your Care and Notification:** If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

We may use or disclose your information to notify or assist in notifying a family member, personal representative or any other person responsible for your care regarding your physical location within the Practice, general condition or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status and location.

**We are also allowed to the extent permitted by applicable law to use and disclose your health information without your authorization for the following purposes:**

**As Required by Law:** We may use and disclose your health information when required to do so by federal, state or local law.

**Judicial and Administrative Proceedings:** If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Health Oversight Activities:** We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

**Law Enforcement:** We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

**Public Health Activities:** We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- Activities related to the quality, safety or effectiveness of FDA-regulated products;
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

**Serious Threat to Health or Safety:** If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement authorities to identify or apprehend an individual.

**Organ/Tissue Donation:** If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation or banking of organs, eyes, or tissues.

**Coroners, Medical Examiners, and Funeral Directors:** We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

**Workers' Compensation:** We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

**Victims of Abuse, Neglect, or Domestic Violence:** We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

**Military and Veterans Activities:** If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

**National Security and Intelligence Activities:** We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Protective Services for the President and Others:** We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

**Research:** We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

#### **Other Uses and Disclosures of Your Health Information that Require Written Authorization:**

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- **Psychotherapy Notes:** We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.
- **Marketing:** We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.
- **Sale of Your Health Information:** We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

#### **Your Rights Regarding Your Health Information**

**You have the following rights regarding the health information we maintain about you:**

**Right to Request Restrictions:** You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **In most circumstances, we are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

**Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about your care. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you

designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend:** If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.**

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us that will become part of your medical record.

**Right to an Accounting of Disclosures:** You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

**Right to a Paper Copy of This Notice:** You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please alert the receptionist at the front desk of any of our locations or contact **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** You may also obtain a paper copy of this Notice at our website, **www.cccnevada.com.**

#### **Changes to this Notice**

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the patient waiting areas at each facility. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, **www.cccnevada.com.**

#### **Complaints**

If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014,** or phone **(702) 952-3350.** You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing a complaint.

#### **Questions**

If you have questions about this Notice, please contact **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014,** or phone **(702) 952-3350.**



COMPREHENSIVE  
CANCER CENTERS



Banbury Cross Dr

Las Vegas Fire & Rescue  
Station #7



Parking Garage  
(Shared)

Medical Office  
Building II

Medical Office  
Building I

Summerlin Hospital  
Medical Center



**Lung Center of Nevada**  
*A Division of Comprehensive Cancer Centers*

N Hualapai Way

N Town Center Dr



COMPREHENSIVE  
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*LUNG CENTER OF NEVADA*  
*A Division of Comprehensive  
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653 N. Town Center Drive, Suite 604  
Las Vegas, Nevada 89144

Tel: 702.737.5864  
Fax: 702.737.6885