PATIENT INTRODUCTION (Please Print) **Carolina Oncology Specialists, P.A.**

DATE _____

Patient's Name Mr. / Mrs. / Miss. _____
Last First Middle Maiden

Date of Birth _____ / _____ / _____ ❑ Male ❑ Female

Mailing Address _____ City _____ County _____

State _____ Zip _____ Home Phone # _____

Cell # _____ Work # _____ Social Security # _____

Race: ❑ African American ❑ White ❑ Hispanic ❑ Other _____ Marital Status _____

Patient's Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Primary Care Dr. _____ Referred By: _____ Are you a Hospice Patient? Yes No

Spouse's Name _____

Age _____ Date of Birth _____ Social Security Number _____

Spouse Employed By _____ Telephone _____

Spouse's Employer Address _____ City _____ State _____ Zip _____

Notify in Case of Emergency _____ Telephone _____

INSURANCE INFORMATION

Are you a Hospice Patient? No Yes

INSURANCE (1)

Insurance Co. Name & Address _____

Policy Number _____ Group Number _____

If Group, thru which Company? _____

Primary Care Physician _____ Preferred Hospital _____

In whose name is this policy? _____ Date of Birth _____ SS# _____

INSURANCE (2)

Insurance Co. Name & Address _____

Policy Number _____ Group Number _____

If Group, thru which Company? _____

Primary Care Physician _____ Preferred Hospital _____

In whose name is this policy? _____ Date of Birth _____ SS# _____

*** PLEASE GIVE US YOUR INSURANCE CARD SO THAT WE CAN MAKE A COPY FOR OUR FILE.**

Payment for services at the time they are rendered in this office is greatly appreciated. If you have insurance that covers outpatient services, we will be happy to provide you with the necessary information so that your insurance carrier may reimburse you. If necessary we will gladly assist you in any other way you require in filing your insurance claims. We invite you to frankly discuss any questions you may have regarding services provided by this office at any time. Good medical care is based on a mutual understanding and open communication between physician and patient, Person accepting responsibility for payment of services rendered in the event the patient is unable to assume responsibility.

✶ Signed _____ Print Name _____

Address (If different from patient) _____ Telephone _____

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN: I hereby authorize payment directly to Carolina Oncology Specialists, P.A. of the Surgical and/or Medical benefits, if any, otherwise payable to me for his services as described but not to exceed the reasonable and customary charge for those services.

Signed (Patient) _____ Date _____
(If minor-parent or guardian)

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS: I hereby consent to the use or disclosure of my protected health information by Carolina Oncology Specialists, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of COS. I understand that diagnosis or treatment of me by COS may be conditional upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations. COS is not required to agree to the restrictions that I may request.

I have the right to revoke this consent, in writing, at any time, except to the extent that COS has already taken action in accordance with the consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review COS's Notice of Privacy Practices prior to signing this document. COS's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosers of my protected health information that will occur in my treatment, payment of bills or the performance of health care operation of COS. The Notice of Privacy Practices also describes my rights and COS's duties with respect to my protected health information. COS reserves the right to change privacy practices that are described in the Notice of Privacy Practices. COS will provide a revised notice if changes are made.

Signed (Patient) _____ Date _____
(If minor-parent or guardian) Expires five years from this date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name of Entity: **Carolina Oncology Specialists, P.A.**
I have received a copy of the Notice of Privacy Practices for the above named practice.

Signed (Patient) _____ Date _____

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

An emergency existed & a signature was not possible at the time.

The individual refused to sign.

A copy was mailed with a request for a signature by return mail.

Unable to communicate with the patient for the following reason: _____

Other: _____

Prepared by _____ Signature _____ Date _____

HIPAA RELEASE

Patient Name _____ Date of Birth _____

Address_____City_____State_____Zip_____

Carolina Oncology Specialists, P.A. is authorized to disclose protected health information as described below.

Initial each that is subject to this authorization.

_____ Leave information on my answering machine/voice mail. (if needed)

_____ May call my workplace to contact me. Work # _____

_____ May contact pharmacy for a prescription request. Preferred Pharmacy: _____

_____ Leave and/or release information to the following persons:

Name : Relation: Contact #:

_____

_____

_____

_____

Initial all releases that apply for the above listed people .

_____ Appointment information (date, time, with whom & what for).

_____ Information & results from any tests or x-rays.

_____ Pick up prescriptions from office.

Initial all releases that apply for present and future purposes.

_____ Information necessary to complete a prescription request.

_____ Information necessary to complete forms for disability, FMLA, insurance, etc.

_____ Information necessary to complete request for handicap parking tag for DMV.

_____ Information necessary for dismissal from jury duty or legal proceedings.

_____ Other information as described:_____

*This authorization shall be in force and effect until revoked by the patient or representative signing the authorization. The permitted use of the information is to inform the patient.

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending a written notification to Linda Travis (Practice Administrator) or Erin Baker (Privacy Officer).

I understand that a revocation is not effective in cases where information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to the above named persons.

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

Signature X_____ Date_____
(Patient or Personal Representative)

Print Name_____
(Patient or Personal Representative)

_____
*If applicable-(Description of Personal Representative's Authority-attach necessary documentation)

Carolina Oncology Specialists, PA

PO Box 3710 * 2406 Century Place SE * Hickory, NC 28603
(828) 324-9550 * Fax (828) 324-4154

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please release medical information to include history, physical, pathology reports, and radiological reports on:

Name:_____ **DOB:**_____

Please send information from: _____

_____

_____

_____

Please send to our office by fax: (828) 324-4154

*The intent of requesting these medical records is for my treatment. I understand I may revoke authorization by a written request and also understand that this information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient.

Patient's Signature:_____

Date: _____

*This authorization expires only if revoked by person signing.

Advanced Directive Questionnaire

Do you have a living will or Healthcare Power of Attorney?

_____Yes _____No

Did you bring it with you? _____Yes _____No

____Copy in chart
____Will provide copy
____Unable to provide copy

Have you designated a Healthcare Power of Attorney? ____Yes____No
Name of healthcare POA: _____
Address: _____
Phone: _____

Do you wish to speak to someone further about a living will or Healthcare Power of Attorney?

____Yes _____No

_____ _____

Patient/Family Representative *Date*

Carolina Oncology Specialists, PA
Medication List

Patient Name: _____DOB:_____Date: _____

Preferred Pharmacy: _____Phone #: _____

Do you have any known allergies? _ Yes _ No
If yes, please list: _____
_____
_____

***Please include all medications you are currently taking.**
(Prescription Drugs and Over the Counter)

Name of Drug	Dose	Frequency	Prescribed By

Please inform us of any medication change, throughout your care.

CAROLINA ONCOLOGY SPECIALISTS, PA

NEW PATIENT MEDICAL HISTORY

Patient Name _____ **Date** _____

Primary Care Physician _____

Other Physicians in your care: _____

_____

_____

Diagnosis or Reason for your visit today: _____

Past Medical History:

Surgical: List any surgery that you have had, even if it was a long time ago such as; hysterectomy, prostate, hernia, gallbladder, breast biopsy, broken bones, etc. Include dates. _____

_____

_____

_____

Medical: List your medical conditions that you have now or in the past such as; diabetes, high blood pressure, heart attack, angina, heart failure, prostate, migraines, liver disease, emphysema, asthma, positive TB skin test, pneumonia, kidney condition, etc. _____

_____

_____

_____

Allergies: List the name of the drug, the type of reaction, and the severity of the reaction. _____

_____

Family History: Please list illnesses of your blood relatives. List any cancers or blood disorders and if relatives are deceased, give cause of death and age at time of death.

Father: Alive/deceased _____

Mother: Alive/deceased _____

Brothers: Alive/deceased _____

_____

Sisters: Alive/deceased _____

_____

Children: Alive/deceased _____

_____

OVER

Social History:

Patient: Occupation _____
Marital Status: (Circle One) Single Married Divorced Separated Widowed
Spouse: Occupation _____

Hobbies:

_____

Alcohol Use:
Drink alcohol: Now _____In the past _____How much? _____

_____

Related Problems:

_____

Tobacco Use:
Cigarettes: Now: _____Past _____ Cigars: Now _____ Past _____
Pipe: Now _____ Past _____ Snuff: Now _____ Past _____
Chewing tobacco: Now _____ Past _____
Number of tobacco use years over lifetime? _____ If you have quit, how long ago did you quit? _____ Why did you quit? _____

Sexual Activity:
Are you currently, or have you previously been sexually active? ___Yes ___ No
Please specify current or previous sex partner(s). ___Men ___ Women ___ Both
Have you currently, or previously had unprotected sex? ___ Yes ___ No
Have you ever been diagnosed with HIV or other STD(s)? ___ Yes ___ No

Female Only:
Are you still having menstrual periods? ____ Yes _____No
Are your periods regular? ____ Yes _____No
If you are not having periods, then how old were you when they stopped? _____
Have you had vaginal bleeding after your periods stopped?___ Yes ___No
Have you taken estrogen hormone pills? (Premarin, birth control pills) ____ Yes _____ No Drug: _____
Are you taking hormone (estrogen) pills now? __ Yes __ No Drug_____

_____
How many times have you been pregnant? _____
Births:_____ **Abortions/Miscarriage:**_____

Patient Signature _____ **Date:**_____
Parent/guardian if minor _____

NOTICE OF PRIVACY POLICY

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.

UNDERSTANDING YOUR ONCOLOGY AND/OR HEMATOLOGY HEALTH INFORMATION

Each time you visit our office, we make a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is known as your medical record. It serves as a:
*basis for planning your care and treatment.
*means of communication among the many healthcare professionals who contribute to your care.
*legal document describing the care you received.
*means by which you or a third-party payer can verify that you actually received the services billed
*a tool in medical education.
*a tool to assess the appropriateness and quality of care you received.
*a tool to improve the quality of healthcare and achieve better patient outcomes.

Understanding what is in your health records and how your health information is used helps you to:
*ensure its accuracy and completeness.
*understand who, what, why, and how others may access your health information.
*make informed decisions about authorizing disclosure to others.
*better understand the health information rights detailed in this notice.

*You will be asked to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this notice. Your protected health information may be used and disclosed by our physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

YOUR RIGHTS UNDER THE FEDERAL PRIVACY STANDARD

Although your health records are the physical property of the healthcare provider who completed it, you have certain rights with regard to the information contained therein. You have the right to:

- request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. "Health care operations" consist of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under 164.502(a)(2)(i) (disclosures to you),164.510(a) (for facility directories, but note that you have the right to object to such uses), in 164.512 (uses and disclosures not requiring a consent or an authorization). We will adhere to it unless you request restriction. We do not, however, have to agree to the restriction. If we do, however, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means and, if the method of communication is reasonable, we must grant the alternate communication request.

- obtain a copy of this notice of information practices. Although we have posted a copy in a prominent location within the facility, you have a right to a hard copy.
- inspect and copy your health information upon request. Again, this right is not absolute. In certain situations, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
    - *Psychotherapy notes. Such notes comprise those that are recorded in any medium by a healthcare provider who is a mental health professional documenting or analyzing a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.
    - *Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
    - *Information was obtained from someone other than a healthcare provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

In other situations, the provider may deny you access but, if it does, the provider must provide you with a review of the decision denying access. These "reviewable" grounds for denial include:

- Licensed healthcare professional has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of the individual or another person.
- Private health information makes reference to another person (other than a healthcare provider) and a licensed healthcare provider has determined, in the exercise of professional judgment that the access is reasonably likely to cause substantial harm to such other person.
- The request is made by the individual's personal representative and a licensed healthcare professional has determined, in the exercise of professional judgment, that the provider of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review.

If we grant access, we will tell you what, if anything, you have to do to get access. *WE RESERVE THE RIGHT TO CHARGE A REASONABLE, COST-BASED FEE FOR MAKING COPIES.*

- request amendment/correction of your health information. We do not have to grant the request if:
    - *we did not create the record, if, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If they amend or correct the record, we will put the corrected record in our records.
    - *the records are not available to you as discussed immediately above.
    - *the record is accurate and complete.

If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those you identify to us that you want to receive the corrected information.

*Obtain an accounting of "non-routine" uses and disclosures-those other than for treatment, payment, and health care operations. To individuals of protected health information about them. We do not need to provide an accounting for:

- For the facility directory or to persons involved in the individual's care or other notification purposes as provided in 164.510 (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for the care of the individual, of the individual's location, general condition, or death).
- To correctional institutions or law enforcement officials under 164.512(k)(5) disclosures not requiring consent, authorization, or an opportunity to object).
- That occurred before April 14, 2003.

We must provide the accounting within 60 days. The accounting must include:
Date of each disclosure; Name of the organization or person who received the protected health information; Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of the written request authorizing disclosure.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

*Revoke your consent or authorization to use or disclose health information except to the extent that we have already taken action in reliance on the consent or authorization.

OUR RESPONSIBILITIES UNDER THE FEDERAL PRIVACY STANDARD

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to:

- maintain the privacy of your health implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- provide you with this notice as to our legal duties and privacy practices with respect to individually identifiable health information we collect and maintain about you.
- abide by the terms of this notice
- train our personnel concerning privacy and confidentiality.
- implement a sanction policy to discipline those whom breach privacy/confidentiality or our policies with regard thereto.
- mitigate (lessen the harm of) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make once you have signed our consent form.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health care information, as necessary, to a health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and/or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (Ex., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis and/or treatment to your physician.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to your for medical necessity, and undertaking utilization review activities. For example, obtaining approval for hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or reschedule your appointment. We will share your protected health information with "business associates" that perform various activities (Ex. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

MORE EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

If you give us consent, we will use your health information for treatment.

Example: A physician, nurse, or other member of your healthcare team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the healthcare team to do to treat you. Those other members will then document the actions they took and their observations. In that way, the primary caregiver will know how you are responding to treatment.

We will also provide your physician, other healthcare professionals, or subsequent healthcare provider with copies of your records to assist them in treating you.

If you give us consent, we will use your health information for payment.

Example: We may send a bill to you or to a third party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

If you give us consent, we will use your health information for health operations.

Example: Members of the medical staff may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Business associates: We provide some services through contracts with business associates. Examples include certain diagnostic tests, sending billing statements, and the like. When we use these services, we may disclose your health information to the business associate so that they can perform the function or functions we have contracted with them to do and bill you or your third-payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Unless you object, health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We 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 health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Marketing continuity of care: We may contact you to provide appointment reminders, reschedule, or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration(FDA): We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post marketing surveillance information to enable to product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information purposes as required by law or in response to a valid subpoena.

Health oversight agencies and public health authorities: If a member of our work force or a business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the department of health.

The Federal Department of Health and Human Services(DHHS): Under the privacy standards, we must disclose your health information to DHHS as necessary for them to determine our compliance with those standards.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION WE MAINTAIN. SHOULD WE CHANGE OUR INFORMATION PRACTICES, WE WILL DISTRIBUTE A REVISED NOTICE.

HOW TO GET MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and/or would like additional information, you may contact any of these privacy officers: Linda Travis, Ginna Deal, Denise McDaniel, or Erin Baker at our office. You may also send an e-mail to lindatrucdr@hotmail.com.

Carolina Oncology Specialist - Hickory Office

in the **McDonald Crossing Professional Park**
just past the intersection of Tate Blvd. and McDonald Parkway
Address: 2406 Century Place, SE • Hickory, NC 28602
Phone: (828) 324-9550
Office Hours: 8:00 AM – 5:00 PM (Monday - Friday)

Driving Directions From I-40:

From Morganton
- Take I-40 East to Exit 126
- Take Exit 126 and turn left onto McDonald Parkway
- Drive north 1.5 miles to the 4th light. Turn right into the McDonald Crossing Professional Park. Carolina Oncology Specialist is the first office on the right.

From Statesville
- Drive approximately 23 miles on I-40 West to Exit 126
- Take Exit 126 and turn right onto McDonald Parkway
- Drive north 1.5 miles to the 3rd light. Turn right into the McDonald Crossing Professional Park. Carolina Oncology Specialist is the first office on the right.

From Lenoir
- Drive approximately 17 miles on Hwy. 321 South to the intersection of Hwy. 321 and I-40
- Take the I-40 East exit and drive 2.5 miles to Exit 126
- Take Exit 126 and turn left onto McDonald Parkway
- Drive north 1.5 miles to the 4th light. Turn right into the McDonald Crossing Professional Park. Carolina Oncology Specialist is the first office on the right.

From Taylorsville
- Drive approximately 16 miles on Hwy. 16 South to the intersection of Hwy. 16 and Thornburg Drive, SE (at WalMart).
- Turn left onto Thornburg Drive, SE
- Turn right onto I-40 West and drive 5 miles to Exit 126
- Take Exit 126 and turn right onto McDonald Parkway
- Drive north 1.5 miles to the 3rd light. Turn right into the McDonald Crossing Professional Park. Carolina Oncology Specialist is the first office on the right.

From Lincolnton
- Take Hwy. 321 North to Exit 33 Startown Road (NC 1005)
- Turn right at top of ramp onto Startown Road
- Stay on Startown Road to Hwy. 70
- Startown Road becomes McDonald Parkway after crossing Hwy. 70
- Drive north 2 miles to the 5th light. Turn right into the McDonald Crossing Professional Park. Carolina Oncology Specialist is the first office on the right.