

**SUBURBAN HEMATOLOGY ONCOLOGY ASSOCIATES, PC**

**EFFECTIVE DATE: APRIL 1, 2003**

**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE  
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize Suburban Hematology Oncology Associates, PC to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Suburban Hematology Oncology Associates, PC to use or disclose to:  
*(Please list the individuals that we have permission to speak with regarding your care)*

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the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.). ***IF IT OKAY TO RELEASE ALL INFORMATION WE DEEM NECESSARY, THEN PLEASE JUST WRITE "ALL"***

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This authorization will expire on \_\_\_\_\_.  
{Expiration Date or Defined Event, OR INDEFINITE}.

**There may be times that we have to contact you regarding test results or appointments. Please indicate below the methods by which it is acceptable to contact you and leave detailed information.**

Leave message on home phone:  Leave message on work phone:

**IF IT IS NOT ACCEPTABLE TO LEAVE ANY INFORMATION OTHER THAN A CALL BACK NUMBER ON YOUR RECORDING, THEN PLEASE CHECK HERE**

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Suburban Hematology Oncology Associates, PC has acted in reliance upon this authorization. My written revocation must be submitted to Candace Hayes, Privacy Officer at 631 Professional Drive, Suite 450, Lawrenceville, Ga 30046.

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian Relationship to Patient

\_\_\_\_\_  
Patient's Name Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

**SUBURBAN HEMATOLOGY-ONCOLOGY ASSOCIATES, P.C.**

**DATE:** \_\_\_\_\_ **DRUG ALLERGIES:** \_\_\_\_\_

Please supply the following information. It will become a part of your medical record and will be held in the strictest confidence.

**FULL NAME:** \_\_\_\_\_  
(FIRST) (MIDDLE) (LAST) (AGE)

**DATE OF BIRTH:** \_\_\_\_\_ **MARITAL STATUS:** \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_  
(NO. & NAME OF STREET) (CITY) (STATE) (ZIP)

**HOME PHONE:** \_\_\_\_\_ **SOCIAL SECURITY #:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ **BUSINESS #:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_ **MOBILE #:** \_\_\_\_\_

**SPOUSE'S NAME:** \_\_\_\_\_ **MOBILE #:** \_\_\_\_\_

**SPOUSE'S DOB:** \_\_\_\_\_ **SPOUSE'S SS#:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**EMERGENCY CONTACT (NOT LIVING WITH YOU):** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **TEL #** \_\_\_\_\_

*MOBILE #* \_\_\_\_\_

**NAME OF INSURANCE COMPANY:** \_\_\_\_\_

**POLICY HOLDER:** \_\_\_\_\_ **GROUP # :** \_\_\_\_\_  
**POLICY #:** \_\_\_\_\_

**REFERRING MD:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**PRIMARY CARE MD:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

I hereby authorize Drs. Freedman, Landis, Saker, Sarma, Hagenstad, Singh and Montero to release any information acquired in the course of my examination and treatment for processing insurance or upon my written request. I hereby authorize the direct payment of any benefits due for medical services to Suburban Hematology-Oncology. I also fully understand that I am financially responsible for payment to Suburban Hematology-Oncology and agree to pay all expenses and costs of collections including all attorney fees in case of default.

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(Patient's Signature)

**PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices. Suburban Hematology Oncology Associates, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Candace Hayes, Privacy Officer, at 600 Professional Drive Suite 210, Lawrenceville, Georgia 30045.

**I hereby acknowledge that Suburban Hematology Oncology Associates, PC will use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).**

**I hereby acknowledge that Suburban Hematology Oncology Associates, PC may call my home or other alternative location and leave a message on voice mail or in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.**

**I hereby acknowledge that Suburban Hematology Oncology Associates, PC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.**

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**Signature of Patient or Legal Guardian**

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**Patient's Name**

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**Date**

**SUBURBAN HEMATOLOGY ONCOLOGY ASSOCIATES, PC  
600 PROFESSIONAL DRIVE, SUITE 210, LAWRENCEVILLE, GA 30045  
1700 TREE LANE, SUITE 490, SNELLVILLE, GA 30078  
3855 PLEASANT HILL ROAD, SUITE 360, DULUTH, GA 30096**

**NOTICE OF PRIVACY PRACTICES  
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and  
Accountability Act of 1996 (HIPAA)**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

**A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

**The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

**Candace Hayes, Privacy Officer, 600 Professional Dr. Suite 210, Lawrenceville, Ga 30045 (770-963-8030)**

**C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS**

The following categories describe the different ways in which we may use and disclose your IIHI.

**1. Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

**2. Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

**3. Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

**4. Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

**5. Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

**6. Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

**7. Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a friend take their loved one to the physician's office for treatment. In this example, the friend or family member may have access to the patient's condition and/or medication information.

**8. Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

#### **D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

**1. Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

**2. Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**3. Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

**4. Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process

- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

**5. Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**6. Organ and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

**7. Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

**8. Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**9. Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

**10. National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

**11. Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

**12. Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

## **E. YOUR RIGHTS REGARDING YOUR IIHI**

You have the following rights regarding the IIHI that we maintain about you:

**1. Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Candace Hayes, Privacy Officer, 600 Professional Drive, Suite 210, Lawrenceville, GA 30045 (770) 963-8030** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

**2. Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Candace Hayes, 600 Professional Drive, Suite 210, Lawrenceville, Ga 30045 (770) 963-8030**. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

**3. Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Candace Hayes, Privacy Officer, 600 Professional Drive, Suite 210, Lawrenceville, Ga 30045 (770) 963-8030** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with

your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

**4. Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Candace Hayes, Privacy Officer, 600 Professional Drive, Suite 210, Lawrenceville, Ga 30045 (770) 963-8030**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

**5. Accounting of Disclosures.** All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Candace Hayes, Privacy Officer, 600 Professional Drive, Suite 210, Lawrenceville, Ga 30045 (770) 963-8030**. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before **April 14, 2003**. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

**7. Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Candace Hayes, Privacy Officer, 600 Professional Drive, Suite 210, Lawrenceville, Ga 30045 (770) 963-8030**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

**8. Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Candace Hayes, 600 Professional Drive Suite 210, Lawrenceville, Ga 30045 (770) 963-8030**.

## **SUBURBAN HEMATOLOGY-ONCOLOGY**

Allan Freedman, M.D. Anthony Landis, D.O. Alexander Saker, Jr., M.D. P. Ravi Sarma, M.D. Christopher Hagenstad, M.D. Aldemar Montero, M.D.  
Satvir Singh, M.D.

Thank you for choosing our office to provide you with your specialized medical needs. Your concerns are very important to us and we want to assure you that it is our intent to give you the best care possible for your medical condition. In an effort to assist you with questions that you may have once you return home, we are providing you with the following information. Please refer to this prior to calling our office, except in the case of an emergency.

- Our office hours are Monday through Friday, 9:00am to 5:00pm.
- If you are in need of medical advice after our office is closed, dial 770-963-8030 and our answering service will pick up your call. They in turn will take your message and contact the physician on call for that day. You must disable your caller ID block in order for the doctor to return your call. Please be aware that after hour calls may not be returned by the physician that you normally see in our office.
- **FOR ALL LIFE THREATENING EMERGENCIES, DIAL 911.**
- To call our office to make an appointment or to inquire about an existing appointment, please call 770-963-8030 during office hours.

**The Physicians and Staff will do all that we can to stay on schedule. Unfortunately with our specialties, we have patients that come in for a regularly scheduled appointment, who have relapsed or have developed complications that require more of the physician's time than we allowed for. We ask your patience if this should happen, as we know you would want the physician to spend the necessary time with you if this unfortunate occurrence should happen to you.**

- Prescription refills need to be done through your pharmacy, Monday through Thursday. It is best not to wait until Friday, as we do not refill prescriptions over the weekend. The pharmacy will call us with the proper information that we need in order to authorize your refill. If your refill requires a written script each time, you will need to call our nurses' voice mail at 678-533-1563 and leave a message during office hours. This voice mail is checked frequently throughout the day.

**ALL REFILLS REQUIRE A MINIMUM OF 24 HOURS NOTICE. (It takes time for your pharmacy to contact our office, for our staff to discuss your request with the physician and for us to call your pharmacy back or to have the signed, written script ready for you to pick up.) WE DO NOT WANT ANYONE TO GO WITHOUT THEIR NECESSARY MEDICATION, SO PLEASE ALLOW 24 HOURS FOR OUR OFFICE TO TAKE CARE OF YOUR REFILL NEEDS. In addition, please be aware that our office is closed for the following holidays; New Year's Day, Memorial Day, 4<sup>th</sup> of July, Labor Day, Thanksgiving and the Friday after and Christmas Day. So as with weekends, please make sure you have enough of your medications to get through the holidays.**

- To leave a message for the nurses, for a non-urgent issue, dial 678-533-1563, for their voicemail. They check this at least every hour and return ALL calls by the end of the business day. Calls will be returned in the order of urgency. **Please** do not make repeated calls. Different nurses may pick up the messages throughout the day and repeated calls could result in several different nurses trying to find the same chart and ask the same physician the same question. This will delay your return call as well as those of other patients.
- For urgent calls, dial 770-963-8030 and make sure you convey the urgency of your call to the receptionist.

- You may see containers throughout the office (red or yellow plastic containers) marked as "Bio-Medical" or "Hazardous Waste". These are not wastebaskets or garbage cans and **must not** be used as such. The only items to be placed in these containers are medical hazardous waste, discarded by the physicians or staff. Your cooperation is appreciated, as this is a safety issue for our staff.
- We will make every attempt to make sure your insurance requirements are met prior to services being rendered. Ultimately however, it is the patients' responsibility to verify that referrals and authorizations have been taken care of. Consequently, it is in your best interest to apprise us of all insurance changes promptly.
- If you have insurance forms, such as disability, that require some portion of it be filled out by your physician and/or his signature, please bring them in with you to your next appointment. Please be aware that forms take a minimum of 7 to 10 business days to complete and plan accordingly.
- You will need to check in with the Front Desk each visit so that we may verify that you have not had any changes since your last visit. i.e. address, phone, insurance changes etc.
- Copays are required to be paid at the time of service.
- To contact our patient accounts department, contact Allison Grayson at 770-963-2095.

(If you find that other information would have been helpful to you, please let us know, enabling us to add that information to future printings.)

To Our Patients:

Welcome to our practice! In order to provide you with the best possible care, we would like to share the following information with you.

Office Hours: All offices are open from 9:00 a.m. to 5:00 p.m. Monday through Friday.

Front Office Staff: Our ancillary staff is here to assist you to schedule appointments, schedule tests, and answer general questions.

Clinical Staff: Our office employs Oncology Certified Nurses and medical assistants to help you with your medical needs. Our nurses are specially trained in caring for patients with your condition. In addition to office care, the nurses triage incoming phone calls and work closely with your physician to facilitate your care.

Benefits Counseling: We offer this unique service for our patients. If you have questions regarding your benefits coverage or billing, you are encouraged to make an appointment, by phone or in person, with our benefits counselor. For the Lawrenceville and Duluth offices, contact Allison Grayson at 770-963-2095. For Snellville, contact Jill Suchar at 770-979-2828.

Billing Questions: All billing is done through our Lawrenceville Billing office. Please call the number listed at the bottom of your statement for any billing questions. In addition, you may receive services from other professional groups, related to laboratory and/or radiological tests. You should expect to be billed separately for services provided by those facilities, and we request that you call them directly regarding any billing issues.

Medical Questions: If you have a question related to your medical condition, please call the phone number of the office location where you are being treated. Unless your call is an emergency, you will be transferred to the nurses' voice mail. The direct line to the nurses' voice mail in Lawrenceville is 678-215-0410. **Please leave a detailed message, including your name if you are not the patient, the patient's name and your telephone number. If you are calling for a prescription refill, please leave your pharmacy phone number.** Please know that the nurses are constantly monitoring calls, and every attempt will be made to return your call in a timely manner. All calls are returned by the end of the business day.

Medical Emergency: In the event of a medical emergency, please call the phone number of the office location where you are receiving care. If the office is closed, you will reach our answering service. You must disable your caller ID block in order for the doctor to return your call. The answering service will then contact the physician on call.