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WHEN THE RETURN ON YOUR MARKETING INVESTMENT MATTERS.

OVER 15 YEARS
Specializing in Healthcare Marketing

Tools & Tips To Build Your Referral Base

By Michele Krohn

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Michele Krohn,

President and Managing Founder

As one of the original marketers for the BayCare Health System's Morton Plant Hospital in the Tampa Bay area, Michele noticed that physicians were desperately seeking ways to grow their practices. Combining her education in marketing from the University of South Florida with her extensive experience, Michele established Full Circle PR in 2007 to meet that need. Since then, the Full Circle PR team has grown to assist nearly 350 medical practices nationwide. Known for creative thinking and cost consciousness, Full Circle PR has a knack for changing physician referral patterns and greatly expanding their clients' market share.

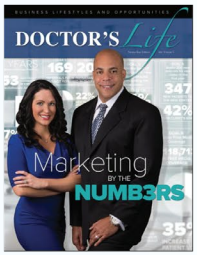
Who We Are

Full Circle PR is an award-winning medical marketing & public relations agency specializing solely in the healthcare profession.

Simply put, we help practices grow their patient base with measurable results. Since 2007, we have expertly utilized key resources to employ a cost-effective marketing approach. Your practice will connect with new patients, expand referrals, and boost your reputation with a proven public relations and marketing strategy.

The best investment you can make is to partner with experts to market your practice.

Recent Recognition



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Overview

- Walk away with the tools needed for building your referral base.
- Understand where your patients are coming from and how important that data is.
- Know how to build a marketing budget.

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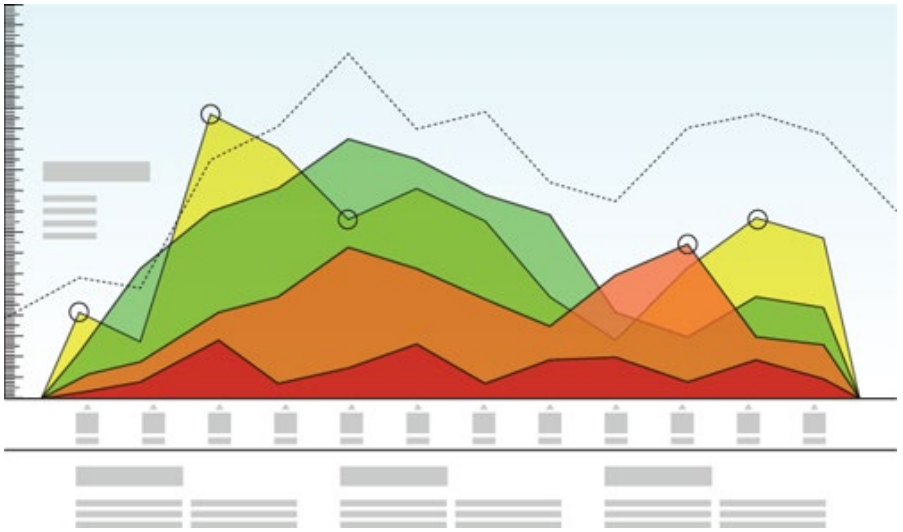
Increase Referral Base

Strategies to ultimately increase your referral base.

- Analyze data
- Develop plan
- Take action
- Analyze results



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Question…

How accurate is your data?

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WHO ARE YOUR PATIENTS?

Demographics

- Male/Female
- Age
- Where do they live
- Where do they work
- Other similarities

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Tracking

- Must be able to identify where patients are coming from, top referral sources, top specialties, potential referral sources and trends

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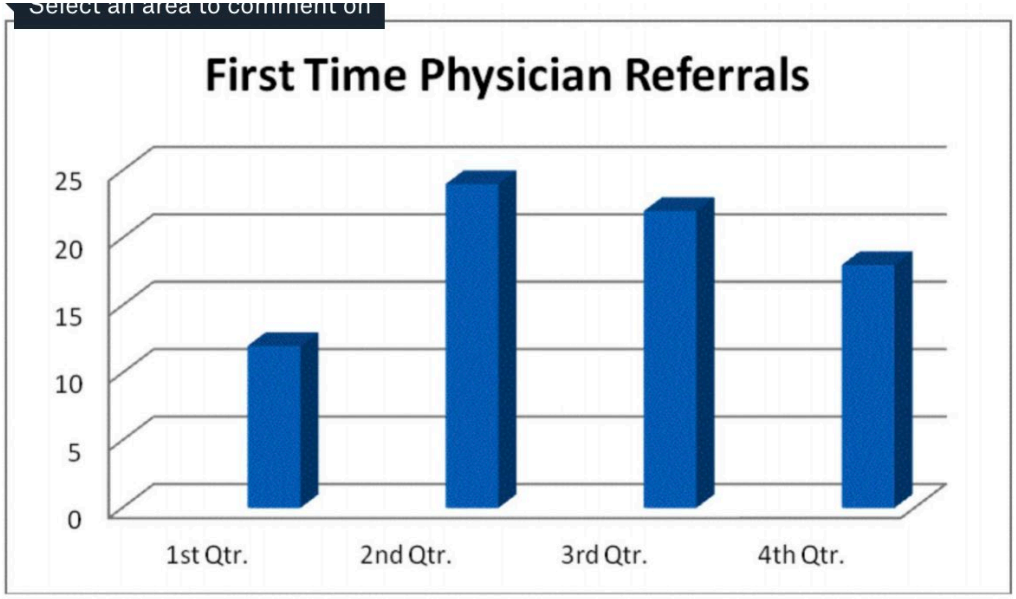
New Physicians



- 76 new physicians referred for the first time this year.
- 40 of these offices were visited prior to their first referral.

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- **New Physician Visit Breakdown:**

Dermatology	7 new 5 visited
Family Practice	11 new 9 visited
General Surgery	4 new 1 visited
Geriatrics	2 new 1 visited
Gynecology	3 new 3 visited
Hematology/Oncology	1 new 1 visited
Internal Medicine	19 new 11 visited
Nephrology	1 new 1 visited
Neurology	2 new 1 visited
Nurse Practitioner	2 new 1 visited
Otolaryngology	7 new 3 visited
Plastic Surgery	2 new 1 visited
Urology	4 new 2 visited

Physician	Specialty	Year 1	Year 2	Year 3	Jan.	Feb.	March	April	May	June	July	Year 4
Amazzi, Mark	Oncology	12	19	19	2	4	3	2	3	3		17
Alenasi, John	Hematology/ Oncology	1	6	1				1	2	1	1	5
Daley, Craig	Internal Medicine	0	0	0			1				2	3
Dammer, Howard	ENT	2	2	2			2					2
Diamond, Christopher	Family Practice	0	0	0						1		1
Deser, David	Oncology	0	0	0			1	1		1	1	4
Dyson, John C.	Neurosurgeon	0	3	3		2		3		1		6
Dunevy, Timothy	ENT	6	4	0								0

New Referral

New Referral from a Full Circle PR Visit

Full Circle PR Office Visit

Physician Breakfast/Lunch includes Staff

Attended Dinner Event

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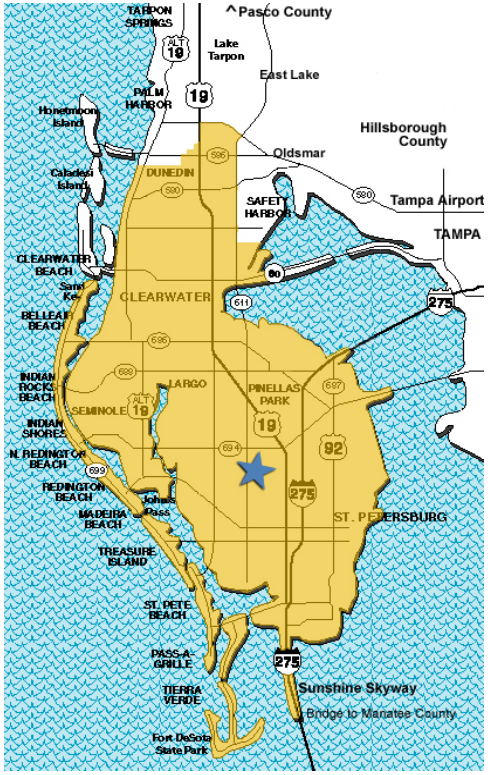
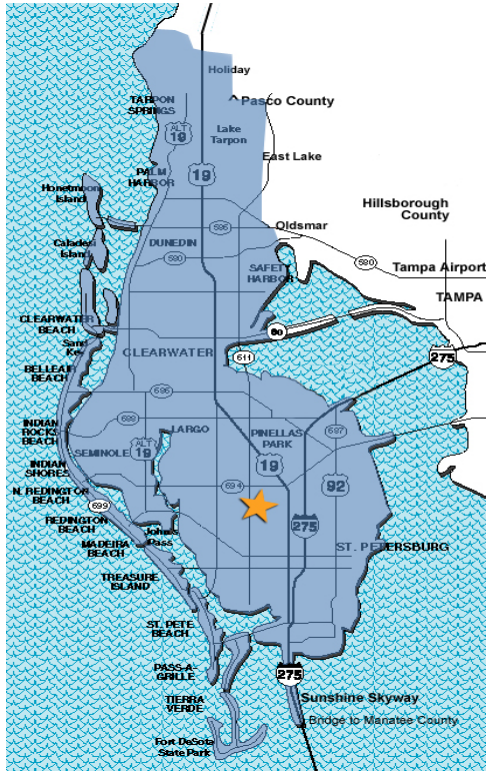
PATIENT DEMOGRAPHIC EXPANSION

Year 1



Year 2



Year 3

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UNDERSTAND YOUR COMPETITION

- What sets you apart
- What are your advantages
- What are your disadvantages

Foundation - The basis on which a thing stands, is founded, or is supported

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THE BUDGET

Gross Revenue $2,750,000 **$192,500 (7%) - $302,500 (11%)**

CATEGORY	Spent	Budget
PR/ Marketing	$83,940	$85,000
SEO	$30,000	$30,000
Google PPC	$19,500	$20,000
Community Relations	$14,675	$20,000
Printing	$13,450	$15,000
Promotional items	$9,890	$13,000
Sponsorships	$4,750	$6,000
Misc.	$1,200	$3,500
TOTAL	**$177,405**	**$192,500**

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Time to take action!

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Referring Physicians

- Relationship – provide value
- Lunches/dinners
- Thank you program
- Birthdays/anniversaries

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Physician Liaison(s)

- Dedicated personnel
- Building relationships
- Proper training
- Proper reporting
  - Including Stark Non-Monetary Compensation
- Management

Referral Binder

- How to refer a patient to you
- Physician specific number
- Insurance list
- Case studies
- Business cards
- Brochures


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Selection of Accepted Insurances

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Specialty Specific Marketing

Marketing Material

- Case Studies
- Fact Sheets
- Journal Articles
- Pieces for Patients
- E-Newsletters

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Value Added Marketing Pieces

CyberKnife Radiosurgery for Trigeminal Neuralgia

Expanding Stereotactic Radiosurgery Applications

K. Larsen, R. Miller, R. Musella, L.S. Pettegrew
Bayfront Medical Center, St. Petersburg, FL
University of South Florida, Tampa, FL

Nearly five in every 100,000 individuals suffer from trigeminal neuralgia (TN), which is characterized as a sharp, stabbing or burning sensation in the jaw or cheek. The name originates from the source of the pain - the trigeminal nerve.

Although the pain only lasts for a short period, episodes can recur. Often, drug treatments provide little to no relief and carry a range of potential side effects. Until recently, the most common alternative was surgery.

New work, headed by Dr. Rosario Musella, is leading the way to offer patients a painless and non-invasive alternative option with CyberKnife radiosurgery.

Study Introduction

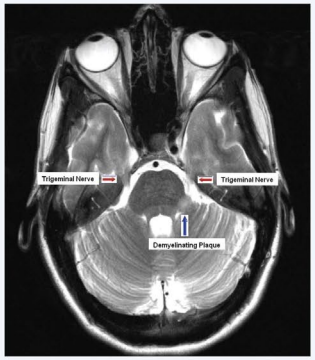
Frame-based radiosurgery has been established as an effective treatment modality for TN. The development of CyberKnife radiosurgery in 1994 added a promising new treatment option for this disease. Using non-invasive head immobilization and advanced image-guidance technology, the CyberKnife dynamically tracks skull position and orientation during treatment, thereby ensuring targeting accuracy throughout the entire procedure, and patients are spared the discomfort of frame fixation onto their skulls. CyberKnife radiosurgery is unique in that it offers the ability to deliver nonisocentric, conformal and homogeneous radiation doses to nonspherical structures such as the trigeminal nerve.

Objective

This eight-year-long, collaborative study evaluated the effectiveness of pain relief in patients treated with radiosurgery for trigeminal neuralgia.

Methods

Seventy-eight patients with typical clinical symptoms of TN were treated with radiosurgery. All patients first received 50-90 Gy using a single 4 mm radiosurgery therapy session. Pain relief was classified as excellent (no pain, off medication), good (no pain with medication), fair (tolerable pain with medication), and poor (severe pain despite medication).



MRI sequences of trigeminal nerve set to receive single 4mm treatment of 80-90 Gy

Results

Comparison of Modalities

	Excellent	Good	Fair	Poor
CyberKnife[1]	72%	24%	0%	4%
Gamma Knife[2]	29%	25%	9%	36%

Radiosurgery for TN resulted in high rates of pain relief and a more acceptable incidence of facial numbness than reported previously. Predictors of favorable outcome included: long history of the disease, one versus multiple branches involved, and age older than 70. None of these characteristics, however, achieved statistical significance. Women had a statistically significant better outcome than men ($p<.004$). Escalation beyond 85 Gy was not associated with improved outcome and resulted in higher incidence of sensory dysfunction. Patients who initially responded but relapsed, 21 (27%), were re-treated and achieved a better response rate than those treated only once but with a higher incidence of numbness.

Conclusion

Stereotactic radiosurgery is an effective treatment in patients with TN. It is suggested that 85 Gy represents the dose that is associated with the best pain control and the least toxicity. Patients who respond initially but have a recurrence of pain may be re-treated with favorable results, but with more toxicity.

CyberKnife Centers of Tampa Bay Welcomes Dr. Rosario Musella!

Rosario Musella, M.D. graduated from the University of Naples, Italy, where he received his medical degree with honors. He completed his general surgery residency in Italy, followed by a neurosurgical residency at McGill University in Montreal, Canada, and received additional training with two fellowships in neurophysiology, for a total of 12 years of post-graduate work.

Since moving to Florida, Dr. Musella established his own practice and taught courses in neurosurgery at both the University of South Florida and the University of Florida. In addition to leading the way with Gamma Knife surgery at Bayfront Medical Center in St. Petersburg and publishing over 35 medical articles, Dr. Musella now brings more than 50 years of expertise to CyberKnife Centers of Tampa Bay. He is Board Certified in neurosurgery and has many memberships including the American College of Surgeons and the Congress of Neurological Surgeons.

1. Adler JR Jr, Bower R, Gupta G, Lim M, Efron A, Gibbs IC, Chang SD, Soltys SG.
Source: Department of Neurosurgery, Stanford University Medical Center, Stanford, California 94305, USA
2. 1% of study participants non-reporting.

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Tampa Bay Radiation Oncology

CASE STUDY

Pancoast Tumor Lung Cancer Treatment

Background

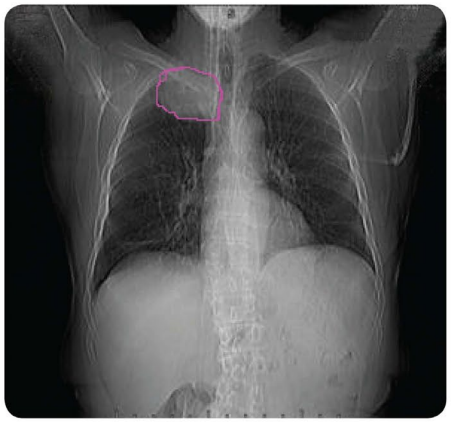
- 55-year-old male patient
- Patient was a smoker for 16 years and has no family history of cancer
- Patient lost 30 pounds in 2 months
- Developed right shoulder pain and sought treatment from an orthopedic surgeon
- MRI of the shoulder revealed an upper lobe lung mass

Diagnosis

Lung cancer – Pancoast tumor on the right with pancoast syndrome

Pancoast tumors are lung cancers that begin at the top of the right or left lung and invade the chest wall. They are also called superior sulcus tumors. Pancoast tumors often present with unique symptoms known as "pancoast syndrome," which consists of pain in the shoulder and the inside of the arm and hand.

Patient had a 7.1 x 4.8 cm tumor on right lung.



Chest x-ray showing tumor in upper right lung

Treatment

The patient was treated with Taxane, Plantinol and radiation, including intensity modulated radiation therapy (IMRT).

Over a 36 day period, treatment was administered to the right upper lobe and mediastinum and right hilum.

The patient was given four fractions APPA at 180 cGy per fraction with 18 MV photons.

Additionally, the patient was given five fractions per week of IMRT at 180 cGy per fraction with 6 MV photons.

The patient was treated with a total of 25 fractions and a total dose of 4,500 cGy. This was designed as a preoperative dose in preparation for right pancoast resection surgery.

Tampa Bay Radiation Oncology

CASE STUDY

Pancoast Tumor Lung Cancer Treatment

Physics Treatment Summary

Site	Technique	Fractions	Start Date	End Date	Elapsed Days	Total Dose (cGy)
Right Lung	APPA and IMRT	25	6/22	7/27	36	4,500

Outcome

Postoperatively the patient has done well. He gained nearly 40 pounds in the months after the surgery and is clinically stable. No evidence of recurrence to date.

Treatment was delivered as prescribed. The patient tolerated the procedure well and there were no complications of treatment.

A check-up appointment will be scheduled every six months.

At TBRO, we believe in a **team approach**, working with other cancer specialists in the Tampa Bay area to coordinate our patients' care. Our cancer experts work to develop a **personalized treatment plan** tailored to each patient's unique needs and diagnosis. This provides patients with the **best cancer care possible** so they receive their customized treatment in a convenient manner while not having to travel far from home.

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Ovarian Cancer

Combining Hormonal Agents with Adjuvant Chemotherapy

Shoba Kankipati, M.D. | Medical Oncology

Patient History

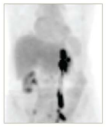
The patient is a 76-year-old female with recent lower abdominal discomfort. After an inconclusive ultrasound, she was ordered to have a CT of the abdomen and pelvis, revealing possible diverticular disease. Upon a re-review of the scan, physicians located intra-abdominal masses with a CA-125 level at 165. Normal levels range from 0 – 35. This cancer antigen is found elevated in 90% of advanced ovarian cancer patients.

Treatment Plan

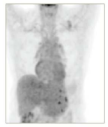
The patient underwent exploratory laparotomy with a working diagnosis of ovarian cancer. During the procedure, she had a total debulking of the intra-abdominal carcinoma with a total abdominal hysterectomy, bilateral salpingo-oophorectomy, omentectomy, resection of the transverse colon, resection of the rectosigmoid colon with anastomosis and appendectomy. Her postoperative course was complicated by intra-abdominal sepsis requiring IV antibiotic treatment and postop ileus.

Pathology reports found stage T3cN1Mx, at least a stage IIIC, high-grade, poorly-differentiated serous carcinoma of the right ovary measuring 8x8x7 cm. A metastatic adenocarcinoma involving the transverse colon and the rectosigmoid was also found. Of eight lymph nodes tested, seven were positive for malignancy.

Epic Care Board Certified Medical Oncologists devised a treatment plan utilizing six rounds of chemotherapy. The adjuvant therapy consisted of six rounds of carboplatin-Taxol and was recommended to prolong survival.

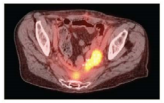


PET scan indicating cancer in the pelvis prior to treatment.

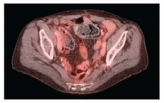


PET scan showing cancer in the pelvis, one year later, responding to treatment.

A year later, the patient's CA-125 was rising and a PET/CT scan found an uptake in the right iliac, right anterior cardiophrenic and right internal mammary nodes. Epic Care Medical Oncologists individualized a recommended plan to include Avastin with hormonal agent Femara concurrently. Femara blocks estrogen receptors and Avastin prevents new blood vessels to grow and feed the cancer. When used in conjunction the combination aids in the degeneration of tumor growth.



Cross-sectional PET/CT image highlighting the cancer in the pelvis.



Cross-sectional PET/CT image one year after treatment.

Results

Three years from initial diagnosis; the patient shows no evidence of disease recurrence. As part of a maintenance program, the patient will continue the Avastin and Femara combination with routine CA-125 testing. Prognosis is good to impede tumor growth and prevent metastasis.

What the stages of ovarian cancer mean

Ovarian cancer is the ninth most common cancer among women, excluding nonmelanoma skin cancers. A woman's risk of getting ovarian cancer during her lifetime is about 1 in 71. While there is not a widely accepted screening test for this cancer, it can be caught early knowing the symptoms and risk factors. Often times, women experience abdominal swelling or bloating (due to a mass or accumulation of fluid), pelvic pressure or abdominal pain, difficulty eating or feeling full quickly, and/or urinary symptoms (having to go urgently or often). Risk factors include:

- Age
- Obesity
- No Pregnancies
- Family History (10% of Ovarian Cancers are Inherited)
- Breast Cancer Diagnosis and/or Presence of BRCA1 and BRCA2 genes

Stage I

The cancer is still contained within the ovary (or ovaries). It has not spread outside the ovary.

Stage II

The cancer is in one or both ovaries and has involved other organs (such as the uterus, fallopian tubes, bladder, the sigmoid colon, or the rectum) within the pelvis. It has not spread to lymph nodes, the lining of the abdomen (called the peritoneum), or distant sites.

Stage III

The cancer involves one or both ovaries, and one or both of the following are present: (1) cancer has spread beyond the pelvis to the lining of the abdomen; (2) cancer has spread to lymph nodes.

Stage IV

This is the most advanced stage of ovarian cancer. In this stage the cancer has spread to the inside of the liver, the lungs, or other organs located outside of the peritoneal cavity. (The peritoneal cavity, or abdominal cavity is the area enclosed by the peritoneum, a membrane that lines the inner abdomen and covers most of its organs.) Finding ovarian cancer cells in the fluid around the lungs (called pleural fluid) is also evidence of stage IV disease.

Certified

Epic Care, Partners in Cancer Care, is a QOPI® Certified Practice. The Quality Oncology Practice Initiative (QOPI) Certification serves as a designation from the QOPI Certification Program (QCP), an affiliate of the American Society of Clinical Oncology, for hematology-oncology practices that the care in this practice meets quality and safety standards. QCP provides a three-year certification to high performing practices, and requires ongoing participation in the QOPI program throughout the 3-year term. To learn how an oncology practice achieves QCP's Certification visit qopi.asco.org/certification.

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Cancer Care Update

Radiation Therapy for Head and Neck Cancers

David Horvick, MD, Alexis Harvey, MD

Introduction

Head and neck cancers (HNC) encompass malignant tumors that arise within the upper aerodigestive tract. Cancers diagnosed in this area have unique epidemiology that require unique treatment considerations. Since most patients with HNC present with advanced-stage locoregional disease, the treatment usually requires a multidisciplinary approach involving otolaryngologists, medical oncologists, radiation oncologists, speech therapists, pathologists, dentists, oral surgeons and radiologists. A patient's treatment depends on a number of factors, including: tumor location, cancer stage, and the patient's age and general health. In the early stages (I and II), head and neck tumors may be treated by surgery or radiation therapy. Patients with more advanced disease (stages III or IV) or with recurrent cancer frequently benefit from using multi-modality treatments.

Surgical resection with or without adjuvant radiation therapy has been considered the standard of HNC treatment. Over the past two decades, treatment focus has shifted to organ preservation and function, while maintaining or exceeding survival rates of non-organ preserving strategies.[1] Today, treatment options include concomitant chemoradiotherapy. Intensity Modulated Radiation Therapy, improved surgical techniques with innovative reconstruction strategies and molecular-targeted agents.

Incidence and Etiology

According to the American Society of Clinical Oncology (ASCO), HNC account for approximately 3-5% of all cancers diagnosed in the United States. In 2013 alone, an estimated 53,640 people (39,300 men and 14,340 women) will develop HNC.[2] It is estimated that 11,520 deaths (8,360 men and 3,160 women) will occur in 2013.[3]

More than 90% of HNC are squamous cell carcinomas, which originate from the mucosal surfaces of the lip and oral cavity, nasopharynx, oropharynx, hypopharynx and larynx. The involvement of human papillomavirus (HPV) in HNC was first noted in 1983, based on characteristic HPV morphological and immunohistochemical properties seen on squamous cell carcinoma biopsies.[4]

Treatment

Over the past decade, Intensity Modulated Radiation Therapy (IMRT) has gained widespread use in the treatment of HNC. It provides highly conformal radiation dose distributions needed to irradiate

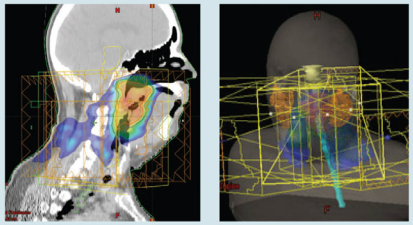

Figure 1. IMRT radiation plan generated from CT scan images

complex targets positioned near sensitive healthy structures. Unlike conventional radiation treatment that utilizes between 2 and 4 uniform beams of radiation, IMRT uses multiple beams to best cover the target volume. Each IMRT beam is further divided into multiple segments to modulate the radiation distribution, thus maximally sparing the healthy tissue around the tumor.

The role of IMRT in the treatment of HNC continues to evolve. Study results not only show favorable treatment outcomes of specific HNC, but also resulting increases in patient quality of life after treatment. At the Multidisciplinary Head and Neck Cancer Symposium held in January, 2012, a study was presented showing that patients treated with IMRT for HNC reported a better quality of life post treatment, compared to patients receiving other forms of treatment.

At one year post treatment, 51% of the patients treated with IMRT rated their quality of life as very good or outstanding, compared to 41% of non-IMRT patients.

80% of the IMRT treated patients reported their health-related quality of life was much better or somewhat better, compared to the month before their cancer diagnosis.

At two years after treatment, the percentages of positive quality of life changed to 73% and 49% respectively. Also, 80% of the IMRT treated patients reported their health-related quality of life was much better or somewhat better, compared to the month before their cancer diagnosis. In contrast, only 61% of the patients treated by non-IMRT techniques felt similarly.[5]

21st Century Oncology of California
A Medical Corporation

According to the National Comprehensive Cancer Network (NCCN), IMRT is now widely used in the treatment of HNC and is the predominant technique used by their centers. This technology helps reduce long-term toxicity by limiting the exposure to one or more major salivary glands, temporal lobes, mandible, auditory structures and optic structures.[6]

Another benefit of IMRT for HNC is the decrease in common treatment-related side effects. In a phase III randomized trial comparing conventional radiotherapy with parotid-sparing IMRT, data indicates that IMRT decreases xerostomia (dry mouth), a common side effect in the treatment of patients with non-nasopharyngeal carcinomas. This study included patients who were treated to a total dose of 60-65 Gy in 30 fractions either with conventional radiation therapy or with IMRT. One year after treatment, 74% of the patients that received conventional radiation therapy had grade two or worse xerostomia, compared to 38% of patients that received IMRT.[7]

More findings emerged from RTOG 00-22, a multiinstitutional study where researchers used IMRT for T1 or T2, N0 or N1 squamous cell carcinoma of the oropharynx to 66 Gy in 30 fractions. Investigators found that treatment using moderately accelerated hypofractionated IMRT without chemotherapy for early oropharyngeal cancer is an excellent choice for these patients, achieving higher tumor control rates (95% local control) and reduced salivary toxicity when compared with treatment of similar patients in previous RTOG studies.[8]

Demonstrated Efficacy

External Beam Radiation Therapy has been used in the treatment of oropharyngeal carcinomas for more than 80 years. Local tumor control rates with radiation therapy alone for all primary sites (including the tonsils, soft palate, base of the tongue, and posterior oropharyngeal wall) are as follows: T1, 90%; T2 80%; T3, 64%; and T4, 55%.8 Cancers of the tonsillar fossa are better controlled by radiation than are cancers arising in other areas of the oropharynx.[8]

A study of 170 patients published in March, 2013, confirmed that IMRT yields excellent treatment outcomes for oropharyngeal carcinoma. The three-year local control, locoregional control, disease-free survival, and overall survival rates were 92%, 91%, 80% and 87%.[9]

Conclusion

IMRT is an effective treatment option for those who meet treatment criteria. Benefits include tumor control, reduction of treatment side effects and improved quality of life for the patient after the completion of treatment.

Advances in radiation therapy allow more treatment options for HNC patients. At 21st Century Oncology, we offer the latest technology for HNC, including Intensity Modulated Radiation Therapy and continue to make available all advances as they arise.

Sources:

[1] Mehta PS. Harrison LB. Function and organ preservation in adult cancers of the head and neck. Expert Rev Anitcancer Ther. 2007, 7:361-71.

[2] http://www.cancer.net/cancer-types/head-and-neck-cancer/statistics

[3] American Cancer Society's publication, Cancer Facts & Figures 2013.

[4] Syrjänen K, et. al. Morphological and immunohistochemical evidence suggesting human papillomavirus (HPV) involvement in oral squamous cell carcinogenesis. Int J Oral Surg 1983;12:418-24.

[5] Allen Chen, MD. Newer radiation technology improves head and neck cancer patients' long-term quality of life. Presented at ASTRO: Jan. 26, 2012.

[6] NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). Head and Neck Cancers. Version 2.2011. NCCN.org

[7] Nutting CM, et al.; PARSPORT trial management group. Parotid-sparing intensity modulated versus conventional radiotherapy in head and neck cancer (PARSPORT): a phase 3 multicentre randomised controlled trial. Lancet Oncol. 2011 Feb;12(2):127-36.

[8] John Andrew Ridge, MD, PhD, Ranee Mehra, MD, Miriam N. Lango, MD, Steven Feigenberg, MD. Head and Neck Tumors. Cancer Management Online. http://www.cancernetwork.com/cancer- management/head-and-neck/article/10165/1802498.

[9] May JT, Rao N, Sabater RD, Boutrid H, Caudell JJ, Merchant F, Han G, Padhya TA, McCaffrey JC, Tanvetyanon T, Deconti R, Kish J, McCaffrey TV, Trotti A. Intensitymodulated radiation therapy as primary treatment for oropharyngeal squamous cell carcinoma. Head Neck. 2013 Mar 6. doi: 10.1002/hed.23245. [Epub ahead of print]

CI16100093316505

Locations ›

21st Century Oncology of California
1316 Nelson Avenue
Modesto, CA 95350

P › (209) 575-5870

Digital

E-newsletters

- Patients
- Referral sources

Social Media

- Facebook
- Instagram
- LinkedIn
- YouTube

SEO/ Google ads

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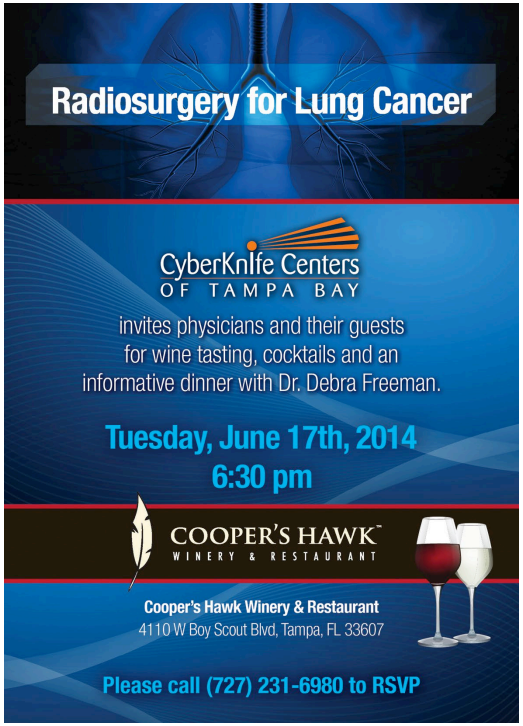
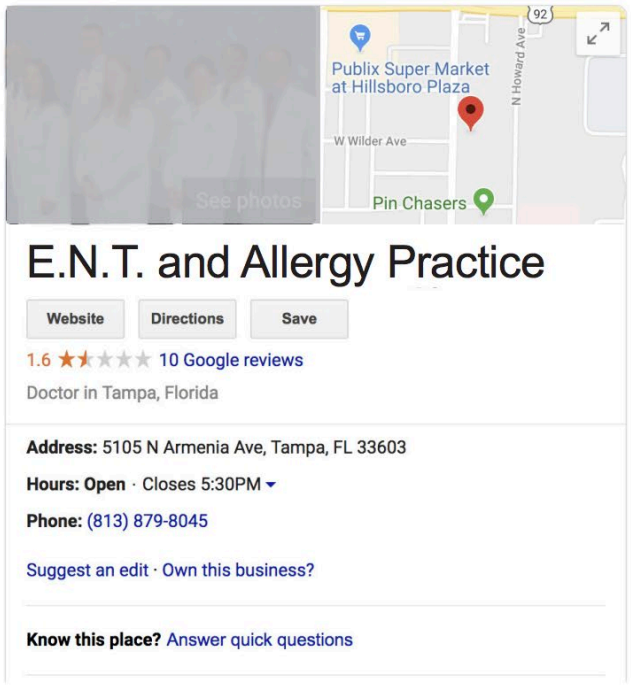
Specialty Specific Dinners

- Create presentation targeting their specialty



Online Reviews

BEFORE:



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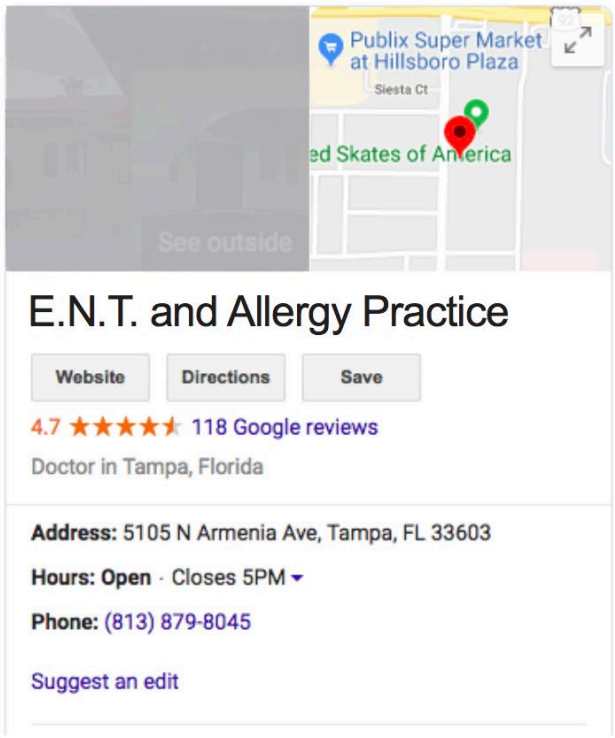

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Online Reviews

- HIPAA
- Google “alerts” or calendar reminder
- Don’t ignore
- Watch for trends

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Suggested Responses

- Hi, please feel free to contact me, Carlos Whitmore, Chief Administrative Officer at 813-425-2388 so that I may address your concern personally.
- At Premier Heart Center, we truly care about our patients and strive to gain excellent rapport with them and their families. Our physicians' primary concern is saving lives and making a difference each day. Please feel free to call us at 305-788-1400 so that we may address your concerns.
- We strive to exceed our patient’s expectations and take all feedback and privacy seriously. Please contact us at 617-649-3812.
- Thank you for your kind words.

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Medical Societies/Associations

- Become a “partner”
- Host events
- Attend events
- Advertise
- Speaking engagements
- Exhibit opportunities

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Community Events

- Neighborhood community events
- Support groups
- Employee health fairs
- Speaking engagements

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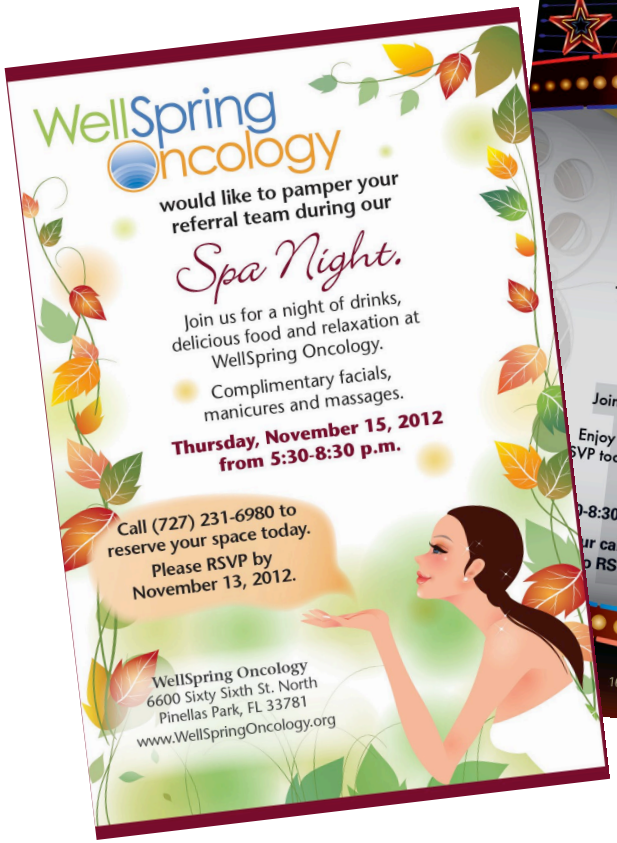
Referral Source Events

- Movie Night
- Spa Night
- Museums
- Picnic



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TIME SEEMS TO GO BY IN A *FLASH.*

Who wouldn't love to do a quick **dine and dash**?

You're invited to pick up a family meal for 4 on
Wednesday, November 17th
from 5 p.m. to 6:30 p.m.

Downtown St. Petersburg
501 Dr. MLK Jr. St. S.
St. Petersburg, FL 33705

The Oncology Institute of Hope & Innovation

Call (813) 603-7159 or email RSVP@fullcircle-pr.com by **Wednesday, November 10th** to ensure your meal is prepared and ready for your arrival.

About the Oncology Institute

The Oncology Institute of Hope and Innovation (TOI) is one of the largest community oncology practices in the country, bringing comprehensive, integrated cancer care into community settings, including Clinical Trials, Stem Cell Transplants, Transfusions, and more. TOI is committed to healing and empowering cancer patients through compassion, innovation and state-of-the-art medical care.

PROVIDERS


Ali Naboush, MD


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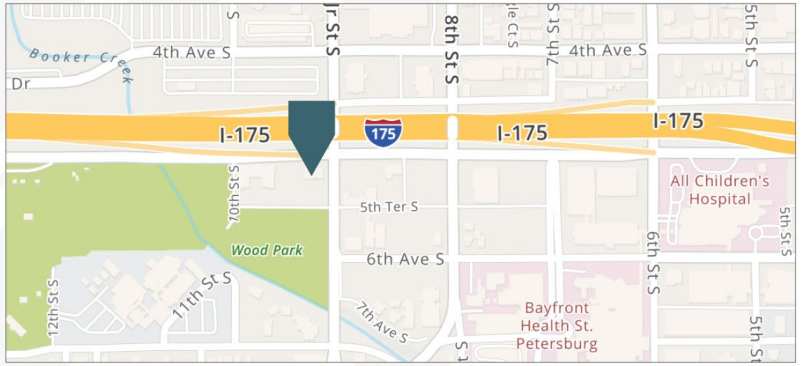

Downtown St. Petersburg
501 Dr. MLK Jr. St. S., Suite 201 | St. Petersburg, FL 33705
Phone: (727) 250-0094 | E-Fax: (727) 499-5473

TheOncologyInstitute.com

Public Relations

- Media relations
- Patient stories
- Exhibit opportunities

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AUTHORIZATION FOR PUBLIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

Patient Name	Date of Birth	Physician Location Acronym
John Doe	**7/31/1951**	**ABC**
Patient Address (Street, City, State, ZIP Code) **123 Fake Street. Fort Myers, FL 33908**		Patient Telephone Number **(239) 555-5555**

Name of the news media or other organization to which the information will be disclosed:

[redacted] Practice Name
[redacted] Other (must be specific) _____**Full Circle PR and any media outlets locally or nationally.** _____

Purpose of Disclosure (must be specific, i.e., for use in news report-date, for use in magazine article-date, company brochure, etc.)

____**For use in public news report. Broadcast, print and/or online. Date to be determined.**_____

The following information is to be disclosed (must be specific, i.e., full-face photograph, recorded video, specific medical information):

_____ _____

Photographs, video and any information disclosed to interviewer. _____

_____ _____ ____

Understanding of Disclosure and Re-Disclosure: I understand that news media organizations are not covered by federal privacy regulations and that the information described above, once released, may become available for use by the media at any time in the future.

I understand that any photograph, movie, video or audiotape taken will become and remain the sole property of Practice Name, its affiliates, or of the authorized media organization named above. I agree that the interview, negatives, prints, videotapes, audiotapes or computer graphics prepared there from may be used for any purpose, including medial research, professional or patient education, brochures, newspapers, magazines, web sites, television, billboards, exhibits, audiovisual or multimedia presentations, kiosk imaging, radio broadcasts and any other news, public service, promotional or advertisement reason.

Right to Revoke: I understand that I have the right to revoke this authorization at any time to prevent additional release of the information. I understand that if I revoke this authorization I must do so in writing to:

Privacy Officer
2270 Fake St
New York, NY 33907

I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will remain in full force and effect.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524.

If I have any questions about disclosure of my health information, I can contact the Practice Name Privacy Officer at (866) 679-8944.

Signature of Patient or Legal Representative	Date

Print Name of Patient or Legal Representative:

If Signed by Legal Representative, Relationship to Patient

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Advertising

- Google ad words
- TV/radio
- Billboards
- Neighborhood news
- Paper
- Church bulletins

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Advertising

- Understand your competitive advantage
  - Uniqueness
    - Technology
    - Locations

- Keep ads simple
  - Main message
  - Image
  - Call to action statement

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Final Rule: Effective 2/22/2021

- Intended to promote permitting physicians and other healthcare providers enter into value-based arrangements to improve the quality of care for patients and lower costs would violate the Stark Law and Anti-Kickback Statute.
- Exceptions apply regardless if care furnished to patients with Medicare or other patients.

CAN-SPAM Act

- Permission
- Don’t use false or misleading header information
- Don’t use deceptive subject lines
- Opt out must be available
- Don’t use false or misleading header information
- Must include physical address

Monitor what others are doing on your behalf

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Offering the best care in the tri-state area!

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www.ABCdoc.com

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Advertising Rules - FTC

- Avoid false, misleading or untrue statements
- No omissions of material fact
- Be able to substantiate claims
- Medical terms
- Images
- Testimonials

Examples

Absolute phrases

- “the best” vs. “among the best”
- “first in the nation” vs. “among the first in the nation”

Use trademarks

- TomoTherapy®
- Trilogy®
- Mammosite®

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IN CONCLUSION

- Data
- Liaisons
- Tracking
- Basics
- Public Relations
- Advertising

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Thank You.

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