PATIENT INFORMATION: *To Be Completed By All Patients Upon Initial Consultation*

Patient Name _____ Date of Birth _____ / _____ / _____

Sex: Male Social Security Number _____ - _____ - _____

Marital Status: Married Spouse's Name:_____

Current Address:_____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail Address: _____ Race/Ethnicity: _____

PHYSICIAN INFORMATION:

Referring Physician: _____ Primary Care Physician:_____

Address: _____ Address: _____

City, State Zip:_____ City, State, Zip:_____

Phone Number: _____ Phone Number: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Address: _____ Telephone_____

PATIENT EMPLOYMENT INFORMATION

Occupation:_____ Employer _____

Employer Telephone: _____ You Work: Select one of the Following

SPOUSE'S EMPLOYMENT INFORMATION

Employer: _____ Telephone:

INSURANCE INFORMATION

Policyholder _____ ID# _____ Group _____

If Policyholder is not patient: Date of Birth _____/_____/ _____ Social Security Number_____ - _____ - _____

Insurance Company Name _____ Address_____

Secondary Insurance:

Policyholder _____ ID#_ _____ Group _____

If Policyholder is not patient: Date of Birth _____/_____/ _____ Social Security Number_____ - _____ - _____

Insurance Company Name _____ Address_____

Do you have a Cancer Insurance Policy? Choose one of the following

I will need an itemized copy sent for these services Choose one of the following

I will need a detailed listing of visits for mileage reimbursement. Choose one of the following

PLEASE KEEP US INFORMED OF ANY CHANGES IN YOUR INSURANCE INFORMATION. THANK YOU FOR YOUR COOPERATION.

Signature _____ Date _____

PERMISSION TO DISCLOSE INFORMATION TO THOSE INVOLVED IN MY CARE

I hereby allow *Central Care, P.A.* to disclose the following Protected Health Information:

- ☐ Appointment times and dates
- ☐ Tests that have been received
- ☐ Test results
- ☐ Other health information

To the following people because they are involved with my healthcare or payment:

- ☐ Self
- ☐ Spouse Name: _____ Phone: _____
- ☐ Family friend Name: _____ Phone: _____
- ☐ Child Name: _____ Phone: _____
- ☐ Other Name: _____ Phone: _____

In the following forms of communication:

- _____ Home telephone
- _____ Work telephone
- _____ Home voice messaging system
- _____ Work voice messaging system
- _____ Cellular phone
- _____ Other _____

_____ _____

Patient Signature Date

CONSENT TO AND CONDITIONS OF TREATMENT

Central Care Cancer Center and Heartland Oncology, LLC are herein after referred to as "The Cancer Center". Any and all physicians providing medical care and treatment, including consultations, during the course of my treatment are herein after referred to as "physicians".

1. **CONSENT FOR TREATMENT**: Knowing that I have a condition requiring diagnosis and medical treatment, I do hereby consent to and authorize all medical treatment, laboratory, and other medical procedures as may be performed or prescribed by my physician or any persons including other physicians, assistants, and personnel who assist in my treatment. I further acknowledge that no guarantees have been made to me regarding the success of my examination or treatment at The Cancer Center.

2. **RELEASE OF INFORMATION**: I HEREBY AUTHORIZE The Cancer Center, physicians and staff to release any or all of my medical record, verbally, via fax machine, via photocopy, via encrypted data, or via onsite review to other healthcare institutions that I may be transferred to, or am being evaluated for transfer to, and agencies or physicians that may become involved in further treatment or follow-up care. I further authorize The Cancer Center to release any or all information to my insurance company, third party payor, or assistance foundation for utilization review purposes and for the purpose of processing my claim and obtaining payment of the account of The Cancer Center and physician for medical care and treatment provided. I will hold harmless The Cancer Center, physicians, and staff should my information unintentionally fall into the wrong hands.

3. **PRIVACY NOTICE, PATIENT RIGHTS AND FINANCE POLICIES**: I acknowledge that I have been given the opportunity to receive a copy and/or have been instructed to read the The Cancer Center Privacy Notice/Patient Rights and Financial Policies, and that I can view these at any time as they are available in the reception area and online at cccancer.com.

4. **MEDICARE/MEDICAID AUTHORIZATION**: I hereby authorize The Cancer Center, physicians, and staff to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, review organizations, or any peer review organization, any information needed for Medicare and/or Medicaid claim. I request the payment of authorized benefits to be made on my behalf to The Cancer Center and the physicians for medical care and treatment, including consultations provided to me. I certify that the information given to me in applying for payment under Title XVII and Title XIX of the Social Security Act is correct.

5. **ASSIGNMENT OF INSURANCE BENEFITS**: I hereby authorize the payment of, and assign payment directly to The Cancer Center and the physicians, of any major medical or basic health insurance benefits, and/or assistance foundation benefits payable to me. I understand that I am responsible for charges not covered by this assignment and further agree to make full payment of all medical expenses which are not covered by insurance, third party payors, or foundations.

6. **PRE-CERTIFICATION/AUTHORIZATION FOR INSURANCE:** It is my responsibility to obtain pre-certification and/or authorization of professional services if required by my insurance carrier. I understand that if I have treatment, labs, or any other medical service without certification or authorization, I will be personally responsible for all of the cost of treatment and professional services not paid by my insurance carrier.

7. **ANCILLARY SERVICES:** You may receive ancillary medical services while a patient of The Cancer Center such as: telemedicine appointments, laboratory services, imaging services (e.g., CTs, PET scans), interpretation of tests, and pathology specimen examination. By signing below, you understand that some providers may not provide services in your presence, but are actively involved in the course of diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges as a result of these ancillary services. You agree to pay all charges due with respect to such services after benefits paid on your behalf by any third-party are credited to your account.

8. GUARANTEE OF PAYMENT: The undersigned spouse, policy holder, or guarantor, if other than the patient identified below to whom medical services will be rendered, in consideration of services to be rendered to the patient identified, does herby guarantee payment of the medical expense for such services, including the charges of The Cancer Center and physicians.

MY SIGNATURE BELOW INDICATES THAT THE INFORMATION I PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE AND I HAVE READ THIS AGREEMENT AND UNDERSTAND IT FULLY:

_____ _____

Print Name of Patient Date

_____ _____

Signature of Patient If other than the patient, state relationship and reason for signing for the patient.

_____

Signature of Relative or Legal Guardian

_____ _____

Signature of Spouse, Policyholder, or Guarantor Witness/Translator

MEDICARE SECONDARY PAYER QUESTIONNAIRE
(To be completed by ALL Medicare Patients)

Patient Name _____ Date _____

1) Are you a Veteran? _____ Yes ____ No
   Did the VA refer you here for treatment? _____ Yes ____ No
   Do you have a VA "Fee Basis ID Card"? _____ Yes ____ No

2) Do you have a Federal Black Lung Card? _____ Yes ____ No

3) Is this medical condition due to an accident of any kind? _____ Yes ____ No
   If yes: _____work related ____ auto _____injured at home ____ other

4) Are you currently working? _____ Yes ____ No
   _____full time ____ part time _____not working ____ retired

5) Do you have insurance through work? _____ Yes ____ No

6) Is your spouse currently working? _____ Yes ____ No
   _____full time ____ part time _____not working ____ retired ____ not applicable

7) Do you have insurance through your spouse's work? _____ Yes ____ No

8) Please check the reason you are eligible for Medicare:
   _____age 65 or older _____disabled ____ end stage renal disease

_____
Patient or Representative Signature

If you answered "YES" to questions 1 or 2, please continue completing the form.

Veterans Administration (VA) Authorization Information

Do you authorize us to bill the VA? _____ Yes _____ No

Black Lung Insurance Information

Are you entitled to benefits under the Department of Labor's Black Lung Program? _____ Yes _____ No

_____
Patient or Representative Signature

PATIENT HEALTH HISTORY

Patient Name: _____ Date: _____

Date of Birth: _____ Read & Write English: Yes/No

Diagnosis: _____

Nursing Home Status: _____ Skilled Care: _____

Reason for Visit: _____

Name of Primary Physician: _____

Other Physicians involved in your care at this time: _____

ALLERGIES: Are you *allergic to any medications?* Yes/No If yes, list below:

Medication Type of Reaction

_____

_____

_____

Have you had contrast dye? Yes/No

Are you allergic to contrast dye? Yes/No

Type of Reaction: _____

CURRENT MEDICATIONS: *Please **list** the medications, vitamins, or herbal supplements that you are presently taking below:*

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY:

Have you ever been diagnosed with cancer before? Yes/No

Describe: _____

Were you ever treated with Radiation/Cobalt or Chemotherapy? Yes/No

Describe: _____

Have you ever had a blood or platelet transfusion? Yes/No

Date of last transfusion: _____

Have you ever been diagnosed with Diabetes? Yes/No *(Please **circle**)* Type I Type II

Are you claustrophobic? Yes/No

PLEASE CHECK YOUR PHYSICAL ABILITY USING THIS KARNOFSKY SCALE:

_____20% Very sick, hospitalized, active support needed
_____30% Severely disabled, needs hospitalization, death not imminent
_____40% Disabled, needs special care and assistance
_____50% Requires frequent medical help and considerable assistance
_____60% Able to care for most needs, requires occasional help
_____70% Unable to do active work, but able to care for self
_____80% Normal activity, but requires effort
_____90% Normal, only minor signs and symptoms
_____100% Normal, no complaints

*Please **check** the items that apply to your medical history:*

_____ Diabetes
_____ Chronic Obstructive Pulmonary Disease (COPD)
_____ Congestive Heart Failure (CHF)
_____ Coronary Artery Disease (CAD)
_____ Pacemaker/Defib-Provide Card
_____ Cardiac Arrhythmia
_____ History of Heart Attack
_____ Tuberculosis
_____ Peripheral Vascular Disease (PVD)
_____ Pulmonary Embolism
_____ Emphysema
_____ High Blood Pressure
_____ Stroke
_____ Liver Disease

____Gallbladder Disease
____Hepatitis
____Gastrointestinal Bleed
____Acid Reflux
____Blood Disorder
____Sickle Cell Disease
____History of Blood Clots
____Arthritis
____Thyroid Disease
____Kidney Disease
____Joint Replacement/Metal in Body
____Other: _____
_____
_____

Gynecological (Female)

Age at onset of menses: _____
Date of last menstrual cycle: _____
Number of Pregnancies: _____ Living Children: _____ Miscarriages: _____

PAST SURGICAL HISTORY: *Please **list** any surgery that you have had below:*

Operation	Date	Hospital

PREVENTIVE CARE AND SCREENING: *Please enter the date of your last:*

Mammography:_____ PAP smear/Pelvic Exam:_____ PSA: _____
Colonoscopy: _____ Flu Shot: _____

SOCIAL HISTORY:

Marital Status: M S W D Do you have a living will? Yes/No

Last Year of School Completed: _____

Occupation: (Present) _____ (Past) _____

Children (Gender & Ages) _____

Siblings (Gender & Ages) _____

Home Support: Yes/No Stress Level: Low/Moderate/High

HABITS:

Cigarettes: _____ pack/day for _____years. _____When did you quit? _____

Alcohol: _____ # of drinks (*Please **check** box*): per ❑ day ❑ week ❑ month

Recreational drugs: _____

Exposure to toxic chemicals: Yes/No _____

HEALTHY HABITS:

Dietary Habits: _____

Exercise Routine:_____

Religious Preference: _____

PAST INJURIES: *Please **list** any major injuries that you have had below:*

Injury	Date	Treatment

FAMILY HISTORY: *Please **list** any history of cancer or blood disorders that are present in your immediate family – grandparents, parents, sisters, brothers, children:*

Relationship to You	Type of Cancer/Blood Disorder	Age at Diagnosis

Parental Status:

Mother – *Please **circle***: Living Deceased

If deceased, cause and age of death: _____

Father – *Please **circle***: Living Deceased

If deceased, cause and age of death: _____

Number of Daughters: _____ Number of Sons: _____

Sibling Status: Number of Sisters: _____ Number of Brothers: _____

REVIEW OF SYSTEMS: *Please **check** the items that apply to your health history:*

GENERAL:
____ Weight loss
____ Weight gain
____ Fever
____ Night Sweats
____ Use walker/wheelchair
____ Require assistance with daily activities

EYE:
____ Blurred vision
____ Swelling of eye
____ Contacts/glasses
____ Cataracts/surgery
____ Double vision
____ Eye pain
____ Watery eyes
____ Impaired vision
____ Legally blind
____ Traumatic injury of the eye
____ Optometrist/ophthalmologist: _____

CARDIOVASCULAR:
____ Chest pain
____ High blood pressure
____ Low Blood Pressure
____ Palpitations
____ Swelling
____ Syncope/fainting
____ Cardiologist: _____

RESPIRATORY:
____ Asthma
____ Bronchitis
____ Chest pain
____ Chest wall trauma
____ Cough
____ Shortness of breath – Dyspnea
____ Coughing up blood
____ Pneumonia
____ Wheezing
____ Oxygen
____ Pulmonologist: _____

BREAST:
____ Underarm pain
____ Breast mass
____ Breast tenderness
____ Change in size
____ Change shape
____ Swelling of breast
____ Breast MRI
____ Breast Ultrasound

ENT/MOUTH:
____ Thrush
____ Congestion
____ Trouble swallowing
____ Earache
____ Ear infection
____ Nose bleed
____ Gum bleeding
____ Hay fever
____ Hearing loss
____ History of dental problems
____ Hoarseness
____ Nasal discharge
____ Nasal obstruction
____ Oral dryness
____ Oral ulcers
____ Painful swallowing
____ Upper respiratory infection
____ Runny nose
____ Sinus pain
____ Sore throat
____ Tonsillitis
____ Ringing in ears – Tinnitus
____ Dizziness
____ Dentures
____ Last Dental Appt:_____
____ Dentist: _____

GASTROINTESTINAL:
____ Abdominal bloating
____ Abdominal cramping
____ Abdominal pain
____ Blood in stool – Melena or Hematochezia
____ Change in bowel movements
____ Constipation
____ Diarrhea
____ Indigestion – Dyspepsia
____ Fullness
____ Stool incontinence
____ Flatulence
____ Heartburn
____ Vomiting blood – Hematemesis
____ Hemorrhoids
____ Loss of appetite – Anorexia
____ Nausea
____ GERD
____ Ulcers
____ Vomiting
____ Difficulty swallowing – Dysphagia
____ Painful swallowing – Odynophag

FEMALE GYNECOLOGICAL:

_____ Abnormal bleeding
_____ Abnormal menstrual periods
_____ Change in menses
_____ Dry vaginal mucosa
_____ Pain during period – Dysmenorrhea
_____ Painful intercourse – Oyspareunia
_____ Pelvic pain
_____ Rash
_____ Post-coital bleeding – Bleeding after sex
_____ Spotting
_____ Vaginal discharge
_____ Vaginal itching
_____ Last Gynecology Appt: _____

MALE GENITOURINARY:

_____ Catheter
_____ Groin skin changes
_____ Impotence
_____ Scrotal swelling
_____ Straining to urinate
_____ Testicular mass
_____ Testicular/scrotal pain
_____ Blood in semen
_____ Last Urology Appt: _____
_____ Urologist: _____

SKIN:

_____ Hair loss – Alopecia
_____ Change in nail appearance
_____ Dry skin
_____ Redness – Erythema
_____ Itching without rash
_____ Yellow skin
_____ Itching
_____ Rash
_____ Skin color change
_____ Skin lesions
_____ Skin cancer
_____ Excessive sun exposure
_____ Sunburns easily
_____ Tans easy
_____ Dermatologist:_____

HEMATOLOGIC:

_____ Anemia
_____ Bleeding disorder
_____ Easy bruising
_____ Nose bleed – Epistaxis
_____ Excessive bleeding on tooth extraction
_____ Fatigue

GENITOURINARY:

_____ Bladder spasm/pain
_____ Burning with urination
_____ Cloudy urine
_____ Dark urine
_____ Difficulty urinating
_____ Foul smelling urine
_____ Blood in urine
_____ Urinating at night – Nocturia
_____ Low urine output – Oliguria
_____ High urine output – Polyuria
_____ Urinary hesitancy
_____ Incontinence
_____ Urinary tract infection

MUSCULOSKELETAL:

_____ Walk with walker/cane
_____ Joint pain – Arthralgia
_____ Back pain
_____ Bone pain
_____ Fracture
_____ Joint swelling
_____ Joint redness
_____ Limited joint movement
_____ Muscle weakness
_____ Muscle pain – Myalgia
_____ Neck/back trauma
_____ Spine tenderness

NEUROLOGICAL:

_____ Language difficulty – Aphasia
_____ Loss of energy – Asthenia
_____ Involuntary body movement – Atari
_____ Blackout
_____ Confusion
_____ Dizziness
_____ Drowsiness
_____ Falls
_____ Headache
_____ Hiccups
_____ Memory loss
_____ Numbness
_____ Pain
_____ Seizures
_____ Speech change
_____ Fainting
_____ Tingling – Paresthesia
_____ increased bleeding
_____ Neurologist: _____

LYMPHATIC:
____ Swollen lymph nodes – Lymphadenopathy
____ Painful lymph nodes
____ Autoimmune disease

PSYCHIATRIC:
____ Anxiety
____ Hallucinations
____ Depression
____ Mood swings
____ Nervousness
____ Poor concentration
____ Sleep disorder
____ Suicidal attempts/thoughts
____ Psychiatrist:_____

ENDOCRINE:
____ Sensitive to cold
____ Sensitive to head
____ Hot flashes, menopausal

ALLERGY:
____ Eczema
____ Frequent infections
____ Pollen allergies
____ Recurrent sinus infections
____ Recurrent skin infections
____ Recurrent hives

ADDITIONAL INFORMATION:

I certify that the above information is correct to the best of my knowledge. I will not hold by doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient's Signature Date

_____ _____
Nurse's Signature Date

_____ _____
Physician's Signature Date

For Nurse to complete:
Height:_____ Weight_____ Vital Signs: _____

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, It is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form.** For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue unitizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

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

Email address of Patient/Authorized User

Date of Birth of Patient

Physician's Name

Authorized User is:

- ☐ Patient
- ☐ Patient's Designee

Patient's Designee's Name (Printed)

Patient's Medical Record Number

Patient's Designee's Signature

Patients Signature

Date

Signature of Practice Staff
(Confirming user's identity and authority)

Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose. Please make a copy for patient.

Staff Use Only:	MRN_____
Email in AMD or ikm____	iKM Consent_____

Name: _____ Date of Birth: _____ Date: _____

Please complete and sign this form to help us provide you with the best care.

I'M DOING FINE – NO CONCERNS AT THIS TIME ❑

Rate each of the following by circling the number that represents your level of concern:

1-Not a problem 2-Mild Problem 3-Moderate Problem
4-Severe Problem 5-Very Severe Problem

Please circle **YES** if you would like a member of our staff to contact you.

Work Related Issues	1	2	3	4	5	**YES**
Medical Bills/Insurance	1	2	3	4	5	YES
Lodging	1	2	3	4	5	YES
Transportation	1	2	3	4	5	YES
Sadness/Depression	1	2	3	4	5	YES
Anxiety, Worry or Fear	1	2	3	4	5	YES
Difficulty Coping	1	2	3	4	5	YES
Spiritual/Religious Concerns	1	2	3	4	5	YES
Sleeplessness	1	2	3	4	5	YES
Nutrition/Dietitian	1	2	3	4	5	YES

Patient Signature: _____

To Be Completed by Physician:

Comments: _____

Refer to (Please Circle): **Dietitian Financial Counselor Social Worker Home Health Chaplain Hospice Emotional Health Palliative Care Support Group**

Physician Initial: _____ Date_____