Name:

PATIENT SUMMARY

Patient Overview

Nickname	
Birthdate	
Gender	
Ethnicity/Race	
Preferred language	
Spoken languages	
Read languages	
Primary care physician	
Referring physician	

Employment

Employment Status		
Employer		
Employer Address		
Employer Phone		
Occupation 1		
Dates	From:	To:
Occupation 2		
Dates	From:	To:
Military service:	From:	To:

Spouse Information

Marital status	
Spouse	
Birthdate	
Employer	
Employer address	
Employer phone	

Patient Contact Information & Preferences

Address			
Home phone			
Work phone			
Cell phone			
Email:			
Phone messages ok?	Home?	Work?	Mobile?
Medical records access allowed to	Name: Relation: Phone:		
Emergency contacts	Name: Relation: Phone:		

Primary Insurance

Insurance company	
Policy/Member #	
Group/Plan #	
Policy holder name	
Policy holder relation	
Policy holder birthdate	
Copay amount	
Is a referral required?	
Claims Address	
Prescription card number	
Mail-order pharmacy phone number	

Secondary Insurance

Insurance company	
Policy/Member #	
Group/Plan #	
Policy holder name	
Policy holder relation	
Policy holder birthdate	
Copay amount	
Is a referral required?	
Claims Address	
Prescription card number	
Mail-order pharmacy phone number	

Tertiary Insurance

Insurance company	
Policy/Member #	
Group/Plan #	
Policy holder name	
Policy holder relation	
Policy holder birthdate	
Copay amount	
Is a referral required?	
Claims Address	
Prescription card number	
Mail-order pharmacy phone number	

Preferred Pharmacy

Name	
Address	
Phone	

Name:

Living Will & Power of Attorney

Have a living will?	
Medical Power of Attorney to make medical decisions on your behalf?	Name: Relation: Phone:

Name:

INDIVIDUAL CONSENT

Agreement

h5. *INDIVIDUAL CONSENT*

CONSENT TO THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND/OR HEALTH CARE OPERATIONS

I understand that as part of my health care, Hematology Oncology Associates of the Treasure Coast receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, billing and health insurance information.I understand that this practice may use this information to perform the following tasks:

* Diagnose my medical/psychiatric/psychological condition
* Plan my care and treatment
* Communicate with other health professionals concerning my care
* Document services for payment/reimbursement
* Conduct routine health care operations, such as quality assurance (the process of monitoring and the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel)

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that if I do not consent, the practice may refuse to provide me health care services unless applicable state or federal law requires this practice to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that this practice is not required to agree to the requested restrictions unless I revoke this request in writing or this practice notifies me that it is no longer going to honor the request.

I understand that I have the right to request restrictions as to the method of communications to me. For example, I might request that all medical bills be mailed to a certain post office box rather than my home.

I further understand that this practice must honor this request if the method of communications is reasonable. This practice may not ask me why I want the alternative method of communication. I understand and authorize that, at times, it will be necessary for this practice to call my home or place of business and leave a message on an answering machine or voice mail.

I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information for facility directions and to family members.

For purposes of proper medical treatment, this practice will give personal health information (PHI) including medical history and all tests and lab results directly to hospitals and other specialist needed for continued patient care. Transfer of this information will help hospital staff and other needed specialist appropriately care for and treat our patients.

I understand that I may revoke this consent in writing, but that the revocation will not be effective to the extent that this practice has already taken action in reliance on my earlier effective consent

Commercial Insurance:
I hereby authorize the release to the above named carriers or authorized agents thereof any information needed for services provided by Hematology Oncology Associates of the Treasure Coast, PA when assignment has been taken. I hereby authorize payment to be made directly to Hematology Oncology Associates of the Treasure Coast, PA . I understand I am financially responsible for any services not covered by my insurance.

Medicare Lifetime Authorization:
I authorize any holder of medical records or any information about me to release to the social security administration or it's intermediaries or carriers any information needed for this or related Medicare claims. I request that the payment of authorized benefits be made on my behalf.

Name:

Signature

I agree to the above and accept responsibility for payment of all services.

Signature	

Name:

NOTICE OF PRIVACY PRACTICE

Agreement

h5. *NOTICE OF PRIVACY PRACTICES*

FOR HEMATOLOGY ONCOLOGY ASSOCIATES OF THE TREASURE COAST

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

Introduction

At Hematology Oncology Associates of the Treasure Coast, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Hematology Oncology Associates of the Treasure Coast, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

* Basis for planning your care and treatment,
* Means of communications among the many health 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 services billed were actually provided,
* A tool in educating health professionals,
* A source of data for medical research,
* A source of information for public health officials charged with improving the health of this state and the nation,
* A source of data for our planning and marketing,
* A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in you record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Hematology Oncology Associates of the Treasure Coast, the information belongs to you. You have the right to:

* Obtain a paper copy of this notice of information practices upon request,
* Inspect and copy your health record as provided for in 45CFR 164.524,
* Amend your health record as provided in 45 CFR 164.528,
* Obtain an account of disclosures of your health information as provided in 45 CFR 164.528,
* Request communications of your health information by alternative means or at alternative locations,
* Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
* Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Hematology Oncology Associates of the Treasure Coast is required to:

* Maintain the privacy of your health information,
* Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about

Name:

you,
* Abide by the terms of this notice,
* Notify you if we are unable to agree to a requested restriction, and
* Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, at (772) 335-5666.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 409F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations:

We will use your health information for treatment.

For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contact with business associates. Examples include physician services in the emergency department and radiology department, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-part payer for services rendered. To protect your health information, however, we require the business associates 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

Name:

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: Health professionals, using their best judgment, 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 carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing/continuity of care: We may contact you to provide appointment reminders 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 events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

*Fund-raising: We may contact you as part of a fundraising effort.

Workers compensation: We may disclose health information to the extent authorized by and 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: If you are an inmate or a correctional institution, we may disclose to the institution, or agents thereof, health information necessary for your health and the health and safety or other individuals.

Law enforcement: We may disclose health information for law enforcement 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 we 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 to determine our compliance with those standards.

Signature

I acknowledge that I have been provided a Notice of Privacy Practices that fully explains the uses and disclosures that this practice will make with respect to my individually identifiable health information. I understand that I have the right to review the Notice before signing this consent. This practice has afforded to me sufficient time to review the Notice and has answered any questions that I have to my satisfaction. I understand that this practice cannot use or disclose my individually identifiable health information other than as specified on the Notice. I also understand, however, that this practice reserves the right to change it's Notice and the practices detailed therein prospectively (for the uses and disclosures occurring after the revision) if it sends a copy of the revised notice to the address I have provided.

Name:

Signature	

Name:

INITIAL CONSULTATION

Agreement

It is our policy at Hematology Oncology Associates of the Treasure Coast that we will NOT administer any treamtent on your first visit to our practice. A treatment plan and all appropriate paperwork need to be in order before the start of any treatment.

Signature

I agree to the above and accept that there will be no treatment on my first visit.

Signature	

Name:

MEDICAL HISTORY REPORT

Patient Overview

Nickname	
Understanding of reason for visit	
Birthdate	
Gender	
Ethnicity/Race	/
Preferred language	
Spoken languages	
Read languages	
Level of education	
Marital status	
Primary care physician	
Referring physician	
Other care provider	
Other care provider	

Employment

Employment Status		
Employer		
Employer Address		
Employer Phone		
Occupation 1		
Dates	From:	To:
Occupation 2		
Dates	From:	To:
Military service:	From:	To:

Tests & Procedures

Test	Date	Location	Provider	Abnormal	Results/Notes
Monthly self breast exam					
Last mammogram (female)					
Last PAP smear (female)					
Last PSA test (male)					
Last colonoscopy or sigmoidoscopy					
Last prostate exam (male)					
Last bone density scan					
Biopsy					

Name:

Immunizations

Type	Date	Comments

Cancer & Blood Disorder History

Have you ever been diagnosed with cancer or a blood disorder? Circle one: Yes / No

Diagnosis	Date	Doctor	Chemo	RT	Sur	Alt	Additional Comments

Other Diagnoses & Medical Conditions

Diagnosis	Date	Additional Comments

Past Surgeries & Hospitalizations

Have you ever been hospitalized or had any surgeries? Circle one: Yes / No

Surgeries

Type of surgery:	Date	Hospital/Doc/Notes:

Hospitalizations

When	Where	Reason

Name:

Medications

Are you currently taking any prescriptions, over-the-counter medications, or alternative medications on a regular basis? Circle one: Yes / No

Medication	Frequency	Dosage	Started on	Stopped on

Allergies

Do you have any allergies? Circle one: Yes / No

Allergic to	Reaction:

Name:

Female History

Menstrual Period History

Age at first menstrual period	
Last menstrual period	
Reason period stopped	
Notes	

Pregnancy History

Ever been pregnant	
Number of pregnancies	
Number of births	
Age at first birth	
Age at last birth	
Notes	

History of Hormone Use

Have you ever taken birth control hormones? (i.e. pill, patch, injection)

Have you ever taken medication to increase your chance of pregnancy?

Have you ever had Hormone Replacement Therapy (HRT)?

Have you ever had anti-hormonal therapy?

Name:

Family Health History

Are you adopted?	
Twin	

Immediate Family

Relation	Name	Status	Cancer	Other illness	Notes

Do you have any biological children?

Children

Gender	Name	Status	Cancer	Other illness	Notes

Have any of your blood relatives had cancer? (include aunts, uncles, and grandparents)? Circle one: Yes / No

Extended Family

Relation	Name	Status	Cancer	Side

Social & Lifestyle

Tobacco Use	Ever used?	Frequency	Number of years	Stopped?	Interested in stopping
Cigarettes					
Cigars					
Pipe					
Chewing Tobacco					

Other Substance Use	Ever used?	What kind?	Frequency	Interested in stopping
Alcohol				
Caffeinated Beverages				
Recreational Drugs				

Name:

Assistance

Emotional Assistance

Have you ever seen a professional for help with emotional problems? Explain.

Professional Needs

At this time, do you feel you need help with any of the following areas?

	Coping
	Financial assistance
	Nutrition
	Social work
	Home assistance
	Insurance
	Transportation
	Other

Health Maintenance

Date of last family doctor visit	
Date of last dental exam	
Recent dermatologist visit	Circle One: Yes / No Date: Reason:
Exercise frequency	
Diet	Circle one: diabetic liquid regular vegetarian
Mobility device used	Circle one: cane walker wheelchair none
Describe any assistance needed for daily activities	
Are you in an assisted-living environment? If so, which one?	
Are you currently under hospice care? If so, which one?	
Religious beliefs you would like us to be aware of	

Name:

REVIEW OF SYSTEMS

General	Y	N
Fatigue		
Fever/chills		
Night sweats		
Weight gain		
Loss of appetite		
Unplanned weight loss		
Change in diet		
Diabetes: diet control		
Diabetes: oral medications		
Diabetes: Insulin dependent		
Other related issues		
Pain		
Leg pain, walking		
Leg pain, resting		

Lungs & Breathing	Y	N
Coughing up blood		
Short of breath, resting		
Short of breath, walking		
Wheezing		
Other related issues		
Cough		

Heart, Blood & Circulation	Y	N
Chest pain		
Palpitations		
Ankle/foot swelling		
Other related issues		
Bleeding problems		
Bruise easily		
Legs/arms swelling		

Digestive/Gastrointestinal	Y	N
Abdominal pain		
Constipation		
Rectal bleeding		
Diarrhea		
Heartburn		
Hemorrhoids		
Difficulty swallowing		
Vomiting blood		
Yellow skin/jaundice		
Other related issues		
Nausea/Vomiting		

Urinary	Y	N
Dark urine		
Blood in urine		
Burning		
Dribbling		
High frequency		
Urgency		
Loss of control		
Pain with urination		
Other related issues		

Neurological	Y	N
Headache		
Numbness/tingling		
Fainting spells		
Dizziness		
Memory loss		
Seizures		
Coordination problems		
Trouble talking		
Other related issues		

Musculoskeletal	Y	N
Muscle weakness		
Swollen joints		
Joint/back pain		
Bone pain		
Muscle pain		
Muscle cramps		
Stiffness		
Other related issues		

Eyes	Y	N

Name:

Blurred vision		
Red eyes		
Double vision		
Eye pain		
Other related issues		
Visual changes		

Ears	Y	N
Ear drainage		
Ringing in ears		
Ear pain		
Other related issues		

Mouth, Nose & Throat	Y	N
Sinus pain		
Nose bleeds		
Sore throat		
Hoarseness		
Mouth sores		
Other related issues		
Runny/stuffy nose		

Lymphatics	Y	N
Swollen glands in neck		
Groin/armpit swelling		

Endocrine	Y	N
Increased thirst		
Heat or cold intolerant		
Hot flashes		
Nervousness		
Other related issues		

Skin	Y	N
Open sores		
Change in moles/freckles		
Abnormal coloration		
Rashes/hives		
Dry skin		
Hair loss		
Other related issues		

Breast/Chest	Y	N
Breast changes		
Lumps		
Nipple discharge		
Breast pain		
Other related issues		

Psychological	Y	N
Worried/anxious		
Difficulty sleeping		
Excessive sleeping		
Mood swings		
Panic attacks		
Psychiatric problems		
Mood medications/supplements		
Other related issues		
Confused/forgetful		
Depressed		
Agitated		

Men	Y	N
Impotence		
Trouble passing urine		

Women	Y	N
Vaginal dryness		
Vaginal discharge		
Abnormal vaginal bleeding		
Irregular menses		
Painful intercourse		

HEMATOLOGY
ONCOLOGY
ASSOCIATES OF THE
TREASURE COAST

MICHAEL S. WERTHEIM, M.D. • NICHOLAS O. IANNOTTI, M.D.,F.A.C.P. • PAUL M. SWANSON, M.D. • HEATHER YECKES-RODIN, M.D. • SETH D. ROSEN, M.D.

Authorization for Release of Medical Records

I, _____ hereby authorize Hematology Oncology Associates of the Treasure Coast, PA to request medical records, X-rays, pathology slides, blocks and reports from any physician, hospital, or clinic where I have been treated.

Please submit requested records to the office indicated below.

HEMATOLOGY ONCOLOGY ASSOCIATES OF THE TREASURE COAST, PA

- ☐ *2100 Nebraska Ave., Suite 107 • Ft. Pierce, FL 34950 • (772) 464-0880 • Fax (772) 466-9348*
- ☐ *1871 SE Tiffany Ave., Suite 100 • Port St. Lucie, FL 34952 • (772) 335-5666 • Fax (772) 335-3781*
- ☐ *140 SW Chamber Ct., Suite 300 • Port St. Lucie, FL 34986 • (772) 336-2992 • Fax (772) 340-7647*
- ☐ *501 SE Osceola St., Suite 303 • Stuart, FL 34994 • (772) 223-5982 • Fax (772) 223-5998*

Patient name: _____

Date of Birth _____ *Social Security Number* _____

Records requested from _____

_____

Records requested _____

Dates of service _____

Patient signature _____ *Date* _____

Commercial Insurance: *I hereby authorize the release to the above named carriers or authorized agents thereof any information needed for services provided by Hematology Oncology Associates of the Treasure Coast, PA when assignment has been taken. I hereby authorize payment to be made directly to Hematology Oncology Associates of the Treasure Coast, PA . I understand I am financially responsible for any services not covered by my insurance.*

Medicare Lifetime Authorization: *I authorize any holder of medical records or any information about me to release to the social security administration or it's intermediaries or carriers any information needed for this or related Medicare claims. I request that the payment of authorized benefits be made on my behalf.*

The parties by signing below have individually/jointly accepted responsibility for payment of all services.

Patient or Legal Representative Signature _____ ***Date*** _____

Spouse's signature _____ ***Date*** _____