COMPREHENSIVE
Hematology Oncology

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITIES

Date:_____ Physician: _____
Location: _____ Acct #: _____
(For office use only)

Patient Name:_____ Email Address: _____
Home Address: _____City:_____
State: _____ Zip code: _____ Home Phone (w/area code): _____
Mailing Address: _____City: _____
State: _____ Zip code: _____ Cell Phone (w/area code): _____
Date of Birth: _____ Age: _____ SSN: _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other
Employer: _____ Occupation: _____
Employer Address: _____
City, State, Zip code: _____ Employer Phone #(w/area code): _____
Referring Physician: _____ Primary Care Physician: _____

Primary Insurance: _____ Insured's Name: _____
Insured's DOB: _____ Group#: _____ Policy #: _____
Secondary Insurance: _____ Insured's Name: _____
Insured's DOB: _____ Group #: _____ Policy #: _____

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1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree in the event of non-payment to assume the costs of interest, collection, and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Comprehensive Hematology Oncology. I also authorize the release of any medical information and/or reports related to my treatment to any physician.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies, and nursing/physician services, including major medical benefits, are hereby assigned to Comprehensive Hematology Oncology. This assignment covers any and all benefits under Medicare, other government-sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event that my insurance carrier does not accept Assignement of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Comprehensive Hematology Oncology.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Comprehensive Hematology Oncology.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

Patient Signature: _____ Date: _____ Time: _____

Responsible Party Signature: _____ Date: _____ Time: _____

Relationship: _____

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PATIENT HEALTH HISTORY

Name:_____ Todays Date:_____
SSN:_____ Date of Birth: _____ Age:_____ Height: _____ Sex: Male ☐ Female ☐
Emergency Contact: _____ Phone Number: _____
Primary Care Physician: _____ Phone Number: _____
Referring MD: _____ Phone Number: _____
Other MD's Name/Specialty:_____
Pharmacy Name: _____Pharmacy Number: _____
Current problem or reason for consultation: _____
_____

Past Medical History: *Please check all the boxes that apply.*

☐ Allergies	☐ Cancer	☐ Heart Disease	☐ Pancreatitis
☐ Anemia/Blood Disorders	☐ Colitis	☐ Hepatitis/Liver Disease	☐ Sickle Cell Anemia
☐ Arthritis	☐ Diabetes	☐ Hypercholesterolemia	☐ Stroke
☐ Asthma	☐ Emphysema	☐ Hypertension	☐ Thyroid
☐ Blood Clots	☐ GERD	☐ Kidney Disease	☐ Ulcers

Other: _____
Other: _____
Any unusual childhood infections or illnesses? _____

OPERATIONS: ***Please list year, operation and surgeon (if known).***

1. _____
2. _____

SMOKING HISTORY: ☐ Cigarettes ☐ Cigars ☐ Pipe
How many years? _____ Number per day? _____ If quit, when: _____

ALCOHOL HISTORY: How many years? _____ Number per day? _____ If quit, when: _____

☐ Recreational Drug Use? Nutritional Supplements? _____

SOCIAL HISTORY:

Marital Status: _____ Number of Children: ____ Age/Sex of Children: _____
Spouse Name: _____
Patient Occupation: _____
Patient Lives With: ☐ Self ☐ Spouse ☐ Sibling(s) ☐ Child ☐ Parent(s) ☐ Friend ☐ Other _____

ROUTINE CANCER SCREENING TESTS: (*List last date if known*).

Mammogram: _____ Pap Smear/Pelvic Exam: _____ Stool for Occult Blood: _____
Prostate Exam/PSA: _____ Colonoscopy/Sigmoidoscopy: _____

ALLERGIES TO MEDICATIONS: ☐ YES ☐ NO

NAME OF DRUG(S)/TYPE OF REACTION: _____

_____

FAMILY HISTORY:

Relative	Age (If Living)	Health Problems	If Deceased, Cause
Father			
Mother			
Sister/Brother			
Sister/Brother			
Sister/Brother			

MEDICATIONS:

NAME OF DRUG	DOSE (mg or mcg)	HOW MANY TIMES DAILY	HOW LONG (MONTHS/YEARS))

Do you have a living will? ☐ Yes ☐ No Do you have a Healthcare Power of Attorney? ☐ Yes ☐ No

Would you like further information on either of the above questions? ☐ Yes ☐ No

REVIEW OF SYSTEMS: *Please check all boxes that apply.*

GENERAL	☐ Fever ☐ Chills	☐ Weight Loss ☐ Weight Gain	☐ Fatigue ☐ Night Sweats
HEAD	☐ Headaches ☐ Blackouts ☐ Seizures ☐ Dizziness ☐ Hearing Loss ☐ Earache ☐ Bleeding Gums	☐ Ringing in Ears ☐ Sinusitis ☐ Post Nasal Drip ☐ Sore Throat ☐ Hoarseness ☐ Sore Tongue ☐ Nosebleeds	☐ Toothache ☐ Double Vision ☐ Blurred Vision ☐ Cataracts ☐ Glaucoma ☐ Toothache Last Eye Exam:_____

CHEST	☐ Cough ☐ Sputum ☐ Coughing up blood ☐ Wheezing ☐ Bronchitis	☐ Shortness of Breath ☐ Chest Pain ☐ Palpitations ☐ Swelling of Feet ☐ Asthma	☐ Heart Murmur ☐ Rheumatic Fever ☐ High Bloodpressure Last Chest X-Ray _____
NECK	☐ Wheezing	☐ Goiter	☐ Pain or Stiffness
BREAST	☐ Coughing up blood	☐ Coughing up blood	☐ Coughing up blood
ABDOMEN	☐ Nausea ☐ Vomiting ☐ Pain in Swallowing ☐ Difficulty Swallowing ☐ Indigestion	☐ Abdominal Pain ☐ Hiatal Hernia ☐ Ulcer ☐ Gas ☐ Bloating	☐ Constipation ☐ Diarrhea ☐ Hemorrhoids ☐ Blood in Stools ☐ Black Stools
URINARY/GYN	☐ Blood in Urine ☐ Burning w/Urination ☐ Frequent Urination ☐ Difficulty Starting to Urinate ☐ Bladder/Kidney Infections ☐ Getting up at night to Urinate ☐ Sense of Full Bladder	☐ # of Pregnancies ☐ # of Miscarriages ☐ # of Abortions ☐ # of Children Last Menstrual Period _____ Duration: _____ Interval: _____	☐ Spotting ☐ Cramping ☐ Discharge ☐ Vaginal Infections Last Pap Smear:_____
SKIN	☐ Rash	☐ Itching	☐ Change in hair or nails
NEURO-MUSCULAR	☐ Joint Stiffness ☐ Joint Pain	☐ Swelling ☐ Back Pain	☐ Night Cramps ☐ Varicose Veins
HEMATOLOGICAL	☐ Easy Brusing or Bleeding	☐ Anemia	☐ Past Infusion ☐ Transfusion Reaction
ENDOCRINE	☐ Thyroid Problems	☐ Hot or Cold Intolerance	☐ Excessive Thirst or Hunger
PSYCHIATRIC	☐ Anxiety ☐ Nervousness	☐ Depression	☐ Memory Loss

PATIENT'S SIGNATURE: _____

PHYSICIAN SIGNATURE: _____

Date: _____

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GENERAL CONSENT FOR TREATMENT

I, knowing that I am experiencing a condition requiring diagnostic, medical, or surgical treatment, do hereby volutarily consent to such procedures and care to such medical, surgical, or other services under the general and specific instructions of Dr. _____ his/her assistants or his/her designees as is necessary in his/her judgement.

I acknowledge that the parctice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examinations by Dr. _____.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received a new patient information packet that includes the following:

☐ Patient Letter ☐ Rights & Responsibilities of Patients ☐ Advance Directive Information ☐ Notice of Privacy Practices

PATIENT AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I, _____ , **hereby authorize Comprehensive Hematology Oncology to use and disclose my health information in the manner described below.** I understand that my health information may be re-discolsed by the persons or oganizations receiving my health information from Comprehensive Hematology Oncology, and that it may no longer be protected by federal and state privacy laws. I understand that I have a right to request and receive a Notice of Privacy Practices from Comprehensive Hematology Oncology. I voluntarily sign this authorization, and I stand that my ability to obtain healthcare from Comprehensive Hematology Oncology will not be affected if I refuse to sign this authorization.

1. Describe, specifically the health information you are authorizing for use and/or disclosure by Compehensive Hematology Oncology including, dates and types of service: _____
   _____
2. The health information described above may be used and/or disclosed for the following purpose(s): _____
   _____
3. Persons or organization that you authorize to use/or disclose the health information described above: _____
   _____
4. Persons or orangizations that you authorize to receive the health information described above: _____
   _____
5. This authorization expires upon _____ (date or event that trigger expiration).
6. I understand that I may revoke this authorization at any time by notifying Comprehensive Hematology Oncology in writing. I am aware that my revocation is not effective to the extent that persons I have authorized to use and/or disclose my health information have acted in reliance upon this authorization.

PATIENT SIGNATURE: _____ DATE: _____

If authorization is signed by a patient's personal representative of behalf of the patient, please complete the Authorization to Release Medical and Billing Records form.

I have read and understand these documents.

PRINTED NAME OF PATIENT: _____

PATIENT SIGNATURE: _____

OR LEGAL GUARDIAN: _____ DATE: _____

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AUTHORIZATION TO RELEASE MEDICAL AND BILLING RECORDS

I, _____ , the undersigned, do hereby authorize

Name of Physician: _____
Address of Physician: _____

to release any and all medical and billing information from the medical records compiled during my term as his/her patient to the following:

Name of person records are released to: _____
Address of person to received records: _____

Name of person records are released to: _____
Address of person to received records: _____

Name of person records are released to: _____
Address of person to received records: _____

Name of person records are released to: _____
Address of person to received records: _____

I will notify Comprehensive Hematology Oncology in writing any changes/termination to this authorization.

_____
Signature of patient or person authorized to consent for patient.

Date Signed: _____

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Hematology Oncology

By Signing this form, I understand the following:

1. I understand that the laws that protect privacy and the cofidentiality of medical information also apply to telemedice, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recrded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communcation of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated,d and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____ (*Name of Provider)* to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____

Date: _____

If authorized signer, relationship to patient: _____

Witness: _____

Date: _____

I have been offered a copy of this consent form (patient's initials): _____