ONCOLOGY SPECIALISTS OF CHARLOTTE

A Partner of OneOncology

Welcome ☺ Please fill out the items on this form and return to the Front Desk. Thank You!

Date _____ Account # [office use only] _____

Reason for Visit _____

Patient Information

□Mr. □Mrs. □Ms. □Miss □Married □Single □Divorced □Widowed

Last _____First _____ Middle _____

Maiden Name _____ Preferred Name _____

Social Security # _____-_____-_____ Date of Birth _____ Sex: □M □F

Race: □American Indian or Alaska Native □Asian □Black or African American
□Native Hawaiian or Other Pacific Islander □White

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino

Home Phone _____ Cell Phone _____

Street _____ City _____

State _____ Zip _____

Email: _____

□Employed □Retired Employer _____ Work Phone _____

Do you currently live in a nursing home or assisted living? □Yes □No

Are you currently enrolled in Hospice Care? □Yes □No

If Yes, effective date _____ Name of Hospice Care_____

Emergency Contact Physician, Pharmacy

Emergency Contact Name_____ Relation _____

Phone _____ Cell Phone _____

Referring Doctor _____ Phone _____

Primary Physician _____ Phone _____

Pharmacy _____ Phone _____

Pharmacy Location_____

Advance Directives

Do you have a Living Will ? □Yes □No

A Living Will is a legal document detailing one's wishes regarding medical treatment in circumstances in which you are no longer able to express informed consent.

Do you have a Durable Power of Attorney? □Yes □No

A Durable Power of Attorney is a person who is appointed to handle your health, legal and financial affairs as outlined in a legal document, should you become incapacitated.

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Authorization for Release of Information – Compound Release

Name of Patient: _____ Date of Birth: _____
Oncology Specialists of Charlotte, PA is authorized to release PHI about the above named patient in the following manner and/or to selected persons.

CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.	**CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.**
☐ Voice Mail	☐ Appointment Reminders
☐ Other person (s) (provide name and phone number) (Example: Spouse, Parent, Relative, Grandparent, Stepparent) ☐ _____ ☐ _____ ☐ _____	☐ Financial ☐ Treatment
☐ Email communication-Provide email address* _____ *For email communication to occur, accept the disclosure below:	☐ Financial ☐ Treatment ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____

☐ For **text and email communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive text and email communication as selected.

- I have the right to revoke this authorization at any time by contacting this office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: _____ Date: _____

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on _____.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

ONCOLOGY SPECIALISTS OF CHARLOTTE
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PATIENT'S FINANCIAL POLICY

Oncology Specialists of Charlotte cost-effectively provide high-quality medical care. We realize this may be a stressful time in your life, and we would like to make your experience with us as pleasant as possible. We are committed to the success of your treatment, and to fulfill that commitment, it is important that you *have* a clear understanding of our financial policy and guidelines.

Co-Payments, Deductibles, and FEES: We are required by our contracts with Insurers to collect applicable deductibles, co- insurance, and/or co-payments of services at the time they are rendered. As a courtesy, we will file your claims with your insurance, and to provide this service, we must have your most current insurance information. Insurance cards must be presented at each visit, or you may be treated as self-pay until active *coverage* has been verified. Although we estimate what your insurance will pay, the insurance company determines your eligibility and benefits. Please understand that filing with your insurance does not guarantee payment, and you will be responsible for amounts not covered,

Medicare Patients: The providers at OSC participate in the Medicare Part B program for medical services. As participating providers, we agree to accept a payment equal to Medicare allowable for covered services. Medicare pays *80%* of the allowable, and the patient, or the patient's secondary insurance, is responsible for paying the remaining 20% of the allowable amount and any deductibles. Please verify who will pay primarily if you have a group health plan in addition to Medicare. Failure to do so may result in reduced benefits by either the group health plan or Medicare.

Self-Pay: Patients who are uninsured or have no proof of valid insurance will be required to make payment for services rendered at the time of visit. You will be provided with an estimate for services before your appointment, and you will also need to complete a self-pay agreement.

Authorizations and Referrals: We participate in most local insurance plans. Some plans require a referral or prior authorization before visiting a specialist. If your plan requires a referral and/or preauthorization, please get in touch with your Primary Care Provider to confirm one has been acquired.

Pre-Certification: As a courtesy, OSC will work to secure necessary pre-certifications before receiving drug therapy, elective hospital admissions, and radiology studies. While we provide this service, we encourage all patients to contact their plan for pre- certification requirements and to ensure that necessary authorizations are in place. In doing so, you are assisting in preventing any potential delays in receiving treatment or reimbursement.

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PATIENT'S FINANCIAL POLICY

Treatment: Before beginning treatment, you will meet with one of our financial counselors to discuss insurance coverage and authorization information and to be provided with estimated costs for your care. If there is any projected patient responsibility, payment will be expected before the start of treatment. Remember that the benefits and estimates quoted are based on information from your insurance carrier during verification. OSC is not to be held responsible for any inaccurate information received.

Diagnostic Testing and Outside Labs: Diagnostic testing and lab tests may be necessary for your care and treatment by OSC. Diagnostic testing and some lab tests may be performed or provided by outside facilities. When outside providers are used, you understand that you may receive a bill directly from that outside facility.

Financial Assistance Authorization: I authorize income verification and inquiries through third-party vendors such as Experian Health to determine eligibility for financial assistance. I authorize enrollment on my behalf with not-for-profit organizations for out-of-pocket patient assistance that I may qualify for. I understand this is not a guarantee of payment on or for my out-of-pocket responsibility. This authorization will remain in effect until I revoke it in writing. A photocopy of this authorization will be considered as valid as the original.

Billing Inquiries: Our billing staff and financial counselors are available to address all billing inquiries, The business office can be reached at 704-342-1900, option 5, between the hours of 8:00 a.m. to 5:00 p.m. Monday through Thursday and on Fridays, 8:00 a.m. until noon.

I have read the Patient's Financial Policy and provided accurate insurance information. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for services rendered.

Patient's Signature_____

Printed Name _____ Date _____

ONCOLOGY SPECIALISTS OF CHARLOTTE

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Acknowledgement of Receipt_ Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____ _____

Prepared By _____

Signature _____

Date _____

ONCOLOGY SPECIALISTS OF CHARLOTTE, PA
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Patient Name_____ DOB____/_____/_____(mm/dd/yyyy)

Date of Appointment _____/_____/_____ (mm/dd/yyyy)

Please fill this form out as completely as possible and bring this to your appointment

PAST MEDICAL HISTORY (please check any medical problems that you have had in the past)

CANCER HISTORY

- ☐ Bladder cancer
- ☐ Bone cancer
- ☐ Brain cancer
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Colon cancer
- ☐ Esophageal cancer
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Prostate cancer
- ☐ Skin cancer
- ☐ Small intestine cancer
- ☐ Stomach cancer
- ☐ Uterine cancer
- ☐ Other (list) _____

MEDICAL HISTORY

- ☐ Allergies
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood transfusion
- ☐ Breast problems
- ☐ Cataracts
- ☐ Chronic bronchitis
- ☐ Cirrhosis
- ☐ Clotting disorder
- ☐ Congestive heart failure
- ☐ COPD (lung disease)
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Emphysema
- ☐ Fibrocystic breast
- ☐ GERD (heartburn)
- ☐ Glaucoma
- ☐ Heart murmur
- ☐ HIV/AIDS
- ☐ Hypertension (high blood pressure)
- ☐ Kidney disease
- ☐ Lupus
- ☐ Meningitis
- ☐ Myocardial infarction (heart attack)
- ☐ Nerve/muscle disease
- ☐ Osteoporosis
- ☐ Polycythemia vera
- ☐ Polymyalgia rheumatic
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Sickle cell anemia
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ TIA (transient ischemic attack)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other (specify)_____

SURGICAL HISTORY

- ☐ Appendectomy
- ☐ Arterial bypass
- ☐ Back Surgery
- ☐ Biopsy
- ☐ Cholecystectomy (gall bladder)
- ☐ Other (list)_____
- ☐ Hysterectomy
- ☐ Splenectomy

Do you have a Living Will? ☐ Yes ☐ No

Do you have a Healthcare Power of Attorney (POA)? ☐ Yes ☐ No

If Yes, Name of POA_____

Patient Name_____ DOB____/_____/_____(mm/dd/yyyy)

ALLERGIES

Are you allergic to any medications? ☐ Yes ☐ No If YES, please list med and reaction:

_____

_____

MEDICATIONS: Please list current prescriptions and over-the-counter medications, as well as herbals, supplements and vitamins

	Medication	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

FAMILY HISTORY

Check below to report problems your family members have had. Please state the age when they had the problem if you know.

☐ I was adopted and my family medical history has not been disclosed to me

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Anesthesia problems							
Bleeding disorder							
Blood count disorder							
Cancer- breast							
Cancer- colon							
Cancer- leukemia							
Cancer- lung							
Cancer- lymphoma							
Cancer- melanoma (skin)							
Cancer- multiple myeloma							
Cancer- ovarian							
Cancer- sarcoma							
Cancer- other (specify)							
Clotting disorder							
Diabetes							
Heart disease							
Hypertension							
Kidney disease							
Stroke							
Other (specify)							
Alive and Age (Yes, No, n/a)							

Patient Name_____ DOB____/_____/_____(mm/dd/yyyy)

IMMUNIZATIONS: Please indicate any immunizations you were given by listing the estimated month and year it was administered.

Influenza ____/_____ Pneumonia ____/_____

Shingles ____/_____ HPV (genital warts) ____/_____

REVIEW OF SYSTEMS (please circle any ***current*** problems you have on the list below)

General
Fatigue / Weakness
Restless Sleep
Daytime Drowsiness
Unhappiness
Depression / Sadness
Feeling "Blue" or "Hopeless for more than 2 weeks
Lack of Motivation
Excessive Irritability
Feelings of Worthlessness
Nervous / Anxiety
Unexplained Fever >100°
Frequent Night Sweats
Unexplained Weight Loss
Unexplained Weight Gain
Excessive Thirst

Skin
Changes in Moles
Rash / Skin Spots / Growth
Bruise Easily
Itching
Excessive Hair Growth
Hair Loss

Ears/Nose/Throat
Allergy Symptoms
Hearing Loss
Ringing in Ears
Dizziness / Dizzy Spells
Nose Bleeds
Sinus Problems
Hoarseness

Eyes
Eye Pain
Double Vision
Change in Vision
Itchy / Watery Eyes

Lungs
Cough / Wheeze
Snoring/ Gasping
Difficulty Breathing
Positive TB Skin Test

Heart
Chest Pain / Pressure
Exercise Intolerance
Heart Mumur
Palpitations
Irregular Pulse
Fainting Spells
Swollen Ankles
Leg Pain with Walking

Gastrointestinal
Heartburn / GERD
Change in Bowel Habits
Difficulty Swallowing
Abdominal Pain
Nausea / Vomiting
Diarrhea / Constipation
Bloody / Black Stools
Frequent Laxative Use

Musculoskeletal
Muscle / Joint Pain
Joint Swelling
Chronic Back Pain
Gout

Genitourinary
Frequent Urine Infections
Painful Urination
Frequent Urination
Urinary Leakage / Incontinence
Blood in Urine
Overnight Urination> 2 trips
Sexual Function Problems

Male
Decrease in Force Urination
Erection Problems
Testicle Lumps / Swelling

Female
Vaginal Discharge / Itching
History of Abnormal Pap Smear
Pain / Bleeding During Intercourse
Significant Menstrual Cramps
Hot Flashes / Night Sweats

Menstrual History
Age of onset_____ or Menopause
Reg or Irreg cycle
Flow: light / moderate / heavy
Length of cycle: Days of flow_____
# of pregnancies_____/ births _____
# of miscarriages / abortions _____

Breast
Pain / Lumps / Discharge

Neurological
Frequent Headaches
Numbness / Tingling
Memory Loss
Tremor / Shaking

Explanation:_____

Patient Name_____ DOB____/_____/_____(mm/dd/yyyy)

ROUTINE CANCER SCREENING TESTS (list date of last test)

TEST	DATE OF LAST	TEST	DATE OF LAST
Mammogram		Prostate Exam	
Breast Exam		Prostate PSA	
Pap Smear/Pelvic Exam		Chest X-Ray	
Stool for Occult Blood		Colonoscopy	

SOCIAL HISTORY

Tobacco Use

(please check one)

☐ I have never smoked

☐ I have smoked, but rarely
When was the last time? _____

☐ I have quit smoking. Quit Date_____
How many packs/day? _____ # years_____

☐ I currently smoke _____ packs/day
years? _____

Other Tobacco:
☐ pipe ☐ cigar ☐ snuff ☐ chew ☐ vape
Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

Average # of drinks/week:

5 oz. wine _____
12 oz. beer _____
1.5 oz. liquor _____
Is alcohol use a concern for you or others? ☐ Yes ☐ No

Drug Use

Do you use recreational drugs? ☐ Yes ☐ No
Have you ever used needles? ☐ Yes ☐ No
Do you currently use marijuana? ☐Yes ☐No

Sexual History

Are you sexually active? ☐ Yes ☐ No
Current sexual partners(s): ☐ male ☐ female
Birth control method _____

Exercise

Do you exercise regularly? ☐ Yes ☐ No
How often? ☐ Daily ☐ 4-6 times/week ☐ 1-3 times/week ☐ less than one time a week

What form of exercise? (ie: walking, jogging, cycling, swimming) _____

Safety

Do you use seat belts consistently? ☐ Yes ☐ No
Is violence at home a concern for you? ☐ Yes ☐ No
Are you currently in a relationship? ☐ Yes ☐ No
If yes, do you feel safe in this relationship? ☐ Yes ☐ No
Any other concerns? _____

Social Demographics

Marital Status: ☐ single ☐ engaged ☐ living w/partner
☐ married ☐ separated ☐ divorced ☐ widowed

Occupation_____
Education completed ☐ grade school ☐ high school ☐ college ☐ graduate school
Number of children _____ Who lives with you?_____
Frequent foreign travel? ☐ Yes ☐ No Where? _____