ONCOLOGY SPECIALISTS OF CHARLOTTE, PA

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.

ONCOLOGY SPECIALISTS OF CHARLOTTE, PA

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, PA

Patient Financial Policy

Oncology Specialists of Charlotte is dedicated to providing high quality medical care in a cost effective manner. We realize this may be a stressful period 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 in order 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 deductible, 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. In order 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, it is the insurance company that makes final determination of 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 with Medicare Part B program for medical services. As participating providers, we agree to accept an amount of payment equal to the 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 primary if you have a group health plan in addition to Medicare. Failure to do so may result in a reduction of 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 an estimate for services prior to your appointment and you will also need to complete a self-pay agreement.

Authorizations and Referrals: We participate in most local insurance plans. Some of those plans require that you obtain a referral or prior authorization prior to visiting a specialist. If your plan requires a referral and/or preauthorization, please contact your Primary Care Provider to confirm one has been acquired.

Pre-Certification: As a courtesy, OSC will work to secure necessary pre-certifications prior to 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 necessary authorizations are in place. In doing so, you are assisting in preventing any potential delays in receiving treatment or reimbursement.

Treatment: Prior to beginning treatment, you will meet with one of our financial counselors to discuss insurance coverage, authorization information, and to be provided estimated costs for your care. If there is any projected patient responsibility, payment will be expected prior to the start of treatment. Keep in mind, the benefits and estimate quoted are based on information received from your insurance carrier at the time of 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 as part of 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.

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, extension/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 above Patient Financial Policy and have provided true and 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, P.A.
Notice of Privacy Practices

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice describes how Oncology Specialists of Charlotte may use and disclose your protected health information (PHI) to provide treatment, obtain payment and conduct health care operations (TPO) and for other purposes permitted or required by law. It also describes your rights concerning your PHI. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example, we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your care.

Payment: We may use and disclose your information to obtain payment for services rendered. For example, we will send the necessary information to your insurance carrier to obtain authorization and/or payment for treatment provided.

Healthcare Operations: We may use or disclose your PHI to conduct the business activities of our office. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, certification and/or credentialing activities.

We may use a sign-in sheet at the registration desk. We may also call you by name in the waiting room when we are ready to initiate treatment. Prior to your appointment, we may call and remind you of the appointment. We may leave a message on your voice mail or with another member of the household.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Your rights with respect to your PHI and how you may exercise those rights are outlined below.

You have a right to obtain a copy and/or inspect your health information. You may obtain a form from our office to request access. A reasonable cost-based fee will be charged for expenses such as staff time, copies and postage.

You have a right to request a restriction on the use and disclosure of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request.

You have the right to request confidential communications from us by alternative means or at an alternate location. We will accommodate reasonable requests.

You may have the right to request and amendment to your PHI. Your request must be in writing with an explanation. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Questions and Complaints

If you have any questions, concerns or want more information about our privacy practices, please contact us using the information below.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we have made regarding your access to your health information or any other request you have made in the exercise of your rights, you may send your complaint to us. You may also submit a written complaint to the Secretary of Health and Human Services.

We support your right to the privacy of your health information and we will not retaliate against you in any way for filing a complaint.

This notice was published and became effective April 14, 2003.

HIPAA Compliance Officer
Oncology Specialists of Charlotte, PA
2630 E. 7th Street, Suite 210
Charlotte, NC 28204
Phone 704-342-1900
Fax 704-377-0353

ONCOLOGY SPECIALISTS
OF CHARLOTTE, PA

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

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)
- ☐ Never/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)

Mammogram	Prostate Exam/PSA
Breast Exam	Chest X-Ray
Pap Smear/Pelvic Exam	Colonoscopy/Sigmoidoscopy
Stool for Occult Blood	

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? _____

ONCOLOGY SPECIALISTS of CHARLOTTE, PA

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient's Name _____

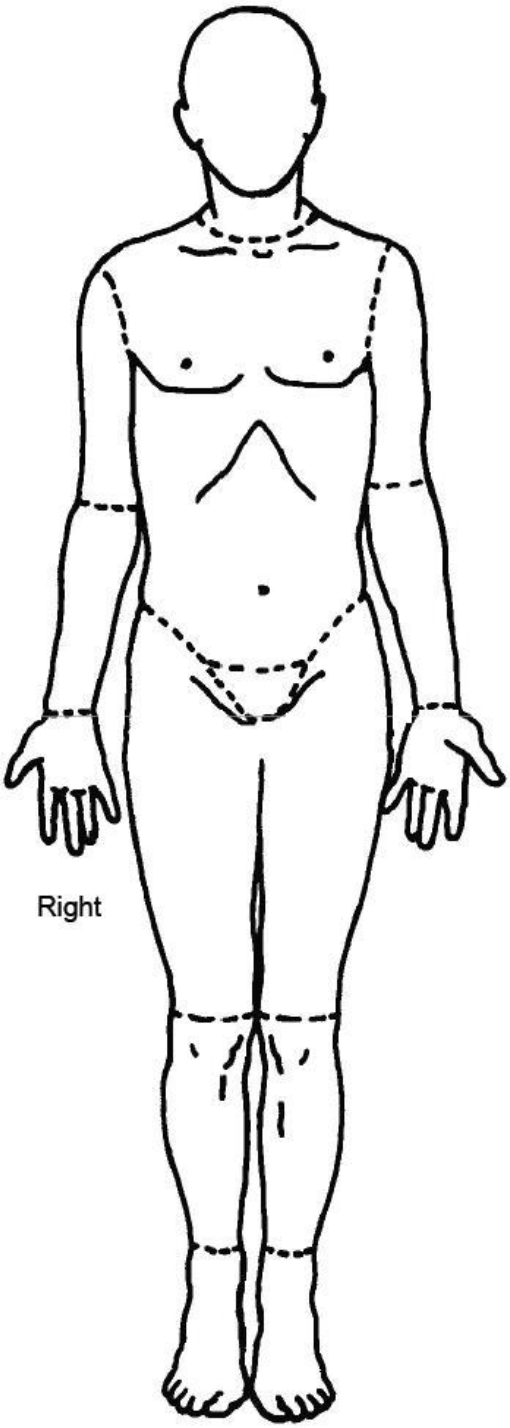
Date _____ Time _____

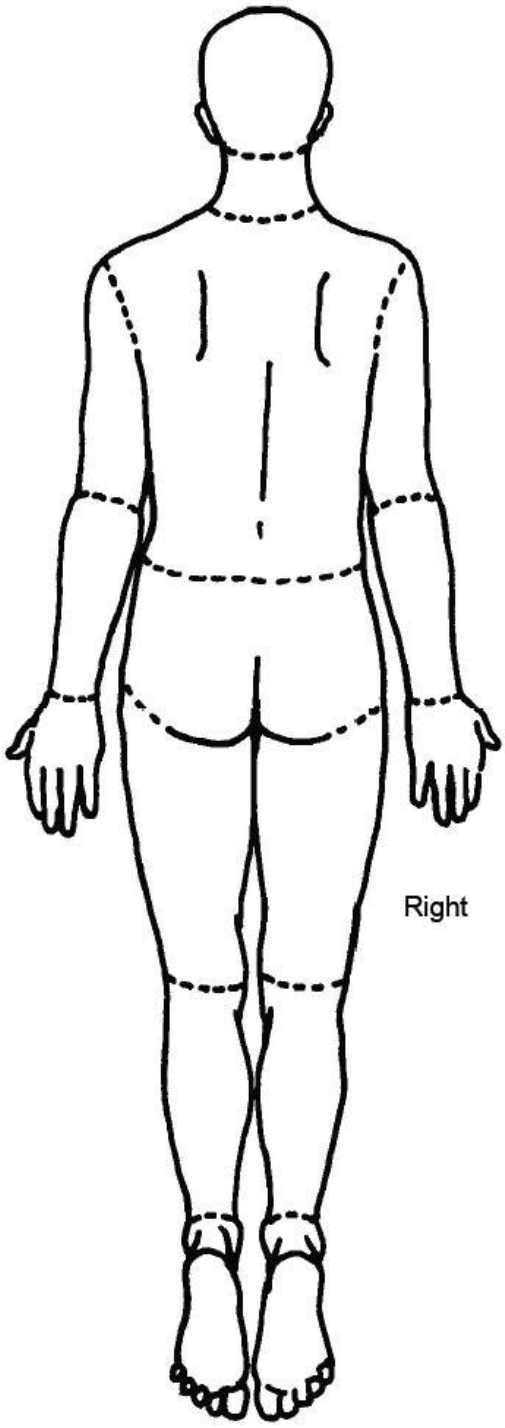
Completed by (check one):
- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

ESAS-r

Please mark on these pictures where it is that you hurt:





Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	none	–	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 yrs
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic cancer								
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
_____								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

If answered "yes", obtain copy of relatives test result.

FOR OFFICE USE ONLY

☐ Patient appropriate for further risk assessment and/or genetic testing
- ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer syndrome
- ☐ COLARIS® – A test for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- ☐ COLARIS *AP*® – A test for Adenomatous Polyposis syndromes
- ☐ MELARIS® – A test for Hereditary Melanoma

☐ Discussed hereditary cancer risk with patient
☐ Patient offered genetic testing
- ☐ ACCEPTED ☐ DECLINED

☐ Follow up appointment scheduled
Date: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.myriadtests.com

FHQ/09-11

MYRIAD®