



## RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE

I, hereby authorize Hematology Oncology Consultants, P.A. to release medical information to my referring physician, primary care doctor, case manager and any other individual involved in my medical care for the sole purpose of facilitating my treatment. I give permission to have my records either faxed or mailed. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician any of the individuals involved in my care to whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original.

I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to those terms.

\_\_\_\_\_  
**Patient or Legal Guardian Signature**

\_\_\_\_\_  
**Date**

## RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES

I, hereby authorize Hematology Oncology Consultants, P.A. to release medical information to Medicare, my employer's Benefits Department, or my insurance company for the sole purpose of obtaining payment for my medical care. Although medical information is confidential, many carriers require medical documentation prior to payment for services. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release may be used in place of the original.

I am aware that I may request that this Release of Medical Information be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to these terms.

\_\_\_\_\_  
**Patient or Legal Guardian Signature**

\_\_\_\_\_  
**Date**

## PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles, and balances of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payment in full for my medical treatment within 30 days, I agree to call the business office and make payment arrangements.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to the Hematology Oncology Consultants, P.A. for services rendered.

I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy.

\_\_\_\_\_  
**Patient or Legal Guardian Signature**

\_\_\_\_\_  
**Date**

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The education pamphlet entitled "Notice of Privacy Practices" provides information about how Hematology Oncology Consultants, P.A. may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability & Accountability Act of 1996 (HIPPA).

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or healthcare operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

\_\_\_\_\_  
**Patient or Legal Guardian Signature**

\_\_\_\_\_  
**Date**

Review of Systems/Medical and Family History Update

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have an advance directive? ..... no    yes    Had a flu shot this year? ..... no    yes  
 Are you a victim of violence or abuse?..... no    yes    Had a pneumonia shot? ..... no    yes

HAVE YOU OR MEMBERS OF YOUR FAMILY RECENTLY BEEN HOSPITALIZED FOR ANY REASON? NO YES

ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

**General, constitutional**

Good general health lately..... no    yes  
 Recent weight change..... no    yes  
 Fever ..... no    yes  
 Fatigue ..... no    yes

**Eyes and vision**

Eye disease or injury ..... no    yes  
 Wear glasses or contact lenses ..... no    yes  
 Blurred or double vision ..... no    yes  
 Glaucoma ..... no    yes

**Ears, Nose, Throat**

Hearing loss ..... no    yes  
 Ringing in the ears ..... no    yes  
 Earaches or drainage ..... no    yes  
 Sinus problems ..... no    yes  
 Nose bleeds ..... no    yes  
 Mouth sores ..... no    yes  
 Bleeding gums ..... no    yes  
 Bad breath or bad taste ..... no    yes  
 Sore throat or voice change..... no    yes  
 Swollen glands in neck..... no    yes

**Heart and Cardiovascular**

Heart trouble ..... no    yes  
 Chest pains ..... no    yes  
 Sudden heartbeat changes ..... no    yes  
 Swelling of feet, ankles, hands..... no    yes

**Respiratory**

Frequent coughing ..... no    yes  
 Spitting up blood ..... no    yes  
 Shortness of breath ..... no    yes  
 Asthma or wheezing ..... no    yes

**Gastrointestinal**

Loss of appetite ..... no    yes  
 Change in bowel movements ..... no    yes  
 Nausea or vomiting ..... no    yes  
 Frequent diarrhea ..... no    yes  
 Painful bowel movements or constipation..... no    yes  
 Blood in stool ..... no    yes  
 Stomach pain ..... no    yes

**Genitourinary**

Frequent urination ..... no    yes  
 Burning or painful urination..... no    yes  
 Blood in urine ..... no    yes  
 Change in force or strain w/urination.... no    yes  
 Incontinence or dribbling ..... no    yes  
 Kidney stones ..... no    yes  
 Sexual difficulty ..... no    yes  
 Painful or irregular periods..... no    yes  
 Vaginal discharge ..... no    yes

**Musculoskeletal**

Joint pain..... no    yes  
 Joint stiffness or swelling..... no    yes  
 Weakness of muscles/joints..... no    yes  
 Muscle pain or cramps..... no    yes  
 Back pain ..... no    yes  
 Cold extremities ..... no    yes  
 Difficulty in walking ..... no    yes

**Skin and breasts**

Rash or itching ..... no    yes  
 Change in skin color ..... no    yes  
 Change in hair or nails ..... no    yes  
 Varicose veins ..... no    yes  
 Breast pain ..... no    yes  
 Breast lump ..... no    yes  
 Breast discharge ..... no    yes

**Neurological**

Frequent or recurrent headaches..... no    yes  
 Light headed dizzy ..... no    yes  
 Convulsions or seizures..... no    yes  
 Numbness or tingling sensations..... no    yes  
 Tremors ..... no    yes  
 Paralysis ..... no    yes  
 Stroke ..... no    yes  
 Head injury ..... no    yes

**Psychiatric**

Memory loss or confusion..... no    yes  
 Nervousness ..... no    yes  
 Depression ..... no    yes  
 Sleep problems ..... no    yes

**Endocrine**

Glandular or hormone problem..... no    yes  
 Thyroid disease ..... no    yes  
 Diabetes ..... no    yes  
 Excessive thirst or urination..... no    yes  
 Heat or cold intolerance ..... no    yes  
 Dry skin ..... no    yes  
 Change in hat or glove size ..... no    yes

**Hematologic/Lymphatic**

Slow to heal after cuts ..... no    yes  
 Easily bruise or bleed ..... no    yes  
 Anemia ..... no    yes  
 Phlebitis ..... no    yes  
 Transfusion ..... no    yes  
 Swollen glands ..... no    yes

If you have not had a hysterectomy, please give the date of your last menstrual period \_\_\_\_\_

Patient signature: \_\_\_\_\_