PATIENT INFORMATION

Mr./ Mrs./ Miss_____

Address _____
Street Name City State Zip Code

Social Security #_____ Date of Birth _____

Home Phone ( ) _____ Marital Status _____

Cell Phone ( ) _____ Diagnosis:_____

Referring Physician _____ Referring Physician Phone:_____

Referring Physician Address:_____

Employer's Name:_____ Work Phone Number:_____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name	Subscriber Name
Subscriber Date of Birth	Subscriber Date of Birth
Group Number	Group Number
Contract Number	Contract Number

EMERGENCY CONTACT (please fill out completely)

Name Relationship

Home Phone Number Work Phone

Next of Kin(not living with you) Relationship

Address City State Zip Code

Home Phone Number Work Phone

HEMATOLOGY-ONCOLOGY CONSULTANTS BRIEF HEALTH HISTORY

NAME: _____ BIRTH DATE: _____ DATE: _____

Referring Doctor's Name, Phone, Fax Number and Address:

Name	Phone	Fax	Address

Other Doctors involved in your care (include phone and fax numbers):

Name	Phone	Fax	Name	Phone	Fax

Current & Prior Medical Problems:

1.	2.	3.	4.
5.	6.	7.	8.

Prior Surgeries & Hospitalizations:

Surgery	Date	Hospitalization & Reason	Date

Current Medications: List all the prescribed & over the counter medications you are currently taking:

Name	Dose	Frequency	Name	Dose	Frequency
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

Allergies:

Medication: No Yes If "Yes," list drug(s) and type of reaction_____

IV Contrast Dye: No Yes If "Yes," describe your reaction:_____

Do you have any metal in your body? Surgical Non-Surgical

Personal/Social History:

Have you ever used tobacco: No Yes If "yes" type: Cigarettes Chewing Cigar Pipe

How much per day? _____ How many years?_____

Have you stopped? _____ If "yes" when? _____

Do you drink alcoholic beverages? _____ How much: _____

Have you ever used illicit/recreational drugs? No Yes If "yes" list type(s):_____

Current and prior employment history:_____

Any toxin/chemical exposure? **No** **Yes if yes, please specify:**_____

_____

Family History: Please list family history of cancer, blood related problem & any other significant history:

Relative	Problem/Diagnosis	Relative	Problem/Diagnosis
1.		3.	
2.		4.	

Personal History:

Any prior personal history of Cancer? No Yes - If yes, please complete below:

Type of Cancer	Yr. Diagnosed	Name of facility & physician:	Phone # of MD:

Have you had previous chemotherapy No Yes If "Yes," complete below:

Facility	Name of physician	Chemotherapy drug received	# of Cycles	Start Date	End Date

Have you had previous radiation treatment No Yes If "Yes," complete below:

Area(s) of Body	Name of Facility	Name of Radiation Oncologist	Phone # of MD:

NAME_____ Date: ____/____/_____

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Please circle Yes or No.

Constititutional Symptoms:
Fever Y / N
Chills Y / N
Headache Y / N
Other: _____

Eyes:
Blurred vision Y / N
Double vision Y / N
Pain Y/N
Other: _____
Other: _____

Ear/ Nose/ Throat/ Mouth:
Sore throat Y / N
Sinus problems Y / N
Other: _____

Integument:
Skin rash Y / N
Boils Y / N
Persistent itch Y / N
Other: _____

Endocrine:
Excessive thirst Y / N
Too hot or cold Y / N
Tired or sluggish Y / N
Other: _____

Cardiovascular:
Chest pain Y / N
Varicose veins Y / N
High blood pressure Y / N
Other: _____

Gastrointestinal:
Abdominal pain Y / N
Nausea or vomiting Y / N
Indigestion or heartburn Y / N
Other: _____

Genitourinary:
Urine retention Y / N
Painful urination Y / N
Urinary frequency Y / N

Musculoskeletal:
Joint pain Y / N
Ear infection Y / N
Neck pain Y / N
Back pain Y / N
Other: _____

Neurological:
Tremors Y / N
Dizzy spells Y / N
Numbness Y / N
Tingling Y / N
Other: _____

Psycho logic:
Generally satisfied with your life? Y / N
Do you feel severely depressed? Y / N
Have you considered suicide? Y / N
Other: _____

Hematological / Lymphatic
Swollen glands Y / N
Blood clotting Y / N
Other: _____

Exercise:
Do you exercise Y / N
If yes, how often?:_____

Assistance with Daily Activities:
Walking Y / N
Bathing Y / N
Dressing Y / N
Eating Y / N

Do You Use the Following:
Cane Y / N
Walker Y / N
Wheelchair Y / N

Advanced Care Directive:
Have you completed one? Y / N
Would you like to discuss? Y / N

Allergic / Immunologic
Hay fever Y / N
Other: _____

Respiratory:
Wheezing Y / N
Frequent cough Y / N
Shortness of breath Y / N
Other:_____

Health Maintenance:

	Date of Last PCP Visit	
	Date of Last Colonoscopy	
	Date of Last Flu Vaccine	
	Date of Last Pneumonia Vaccine	
MEN:	Date of Last PSA	
WOMEN:	Date of Last Pap/Pelvic Exam	
	Date of Last Mammogram	
	Date of 1st Period	
	Date of Last Period	
	Age at 1st Pregnancy	
	Number of Children	
	Birth Control Pills:	Y / N
	If "yes" how long?	
	Hormonal Replacement Therapy:	Y / N
	If "yes" how long?	
	If "yes" what medication?	

We are now sending most prescriptions to your pharmacy through electronic mail so we will need the following information:

NAME_____

DATE OF BIRTH_____

DRUG ALLERGIES_____

_____

_____

_____

Pharmacy Information:

*Pharmacy Name*_____

*Pharmacy Phone Number*_____

*Pharmacy City*_____

*Pharmacy Street*_____

Meaningful Use Patient Registration Form:

Please complete the information below.

Patient Name:_____ **DOB**_____ **Age**_____ **Date**_____

Email:_____

Race:

African-American ___ Arabic ___ Asian___ Caucasian___
Filipino___ Hispanic___ Other: _____

Ethnicity

__ Hispanic __ Non-Hispanic

Primary Language:

__ Arabic
__ Chinese
__ English
__ French
__ Korean
__ Spanish
__ Other _____

Please provide information about previous tests, immunization (including date or year of the last).

Flu Shot_____ Pneumococcal Vaccine_____ DTaP_____
Prevnar 13 Vaccine___ Shingles (Zoster) Vaccine_____

Male:
Colonoscopy_____

Female:
Colonoscopy_____ Mammogram_____
PaP/Pelvic Exam_____

Tobacco Use:

Never:_____ Current Every Day Smoker:____
Current Smoker - Does Not Smoke Every Day:____ Former Smoker: ____

Advance Directive:

Would you like to set up an Advance Directive?
** Yes__ No___ Already Have One__ (Please provide office a copy)

Do you have a Patient Advocate? Yes __ No__ If yes, name of advocate:_____

An individual that can make medical decisions for you in the event that you are unable to make them for yourself

_____

Patient Signature Date:

**For our patients we have available 3 Advance Directives: Planning for Medical Care in the Event of Loss of Decision-Making Ability, Durable Power of Attorney for Health Care and Living Will. We are happy to print thi for you and you can also find by going to the following link:
https://www.michigan.gov/documents/miseniors/Advance_Directives_230752_7.pdf

Please let us know if we can be of any assistance. When completed please return to our office so that we can make a part of your medical record.

Patient Provider Agreement

Working Together for Your Health

Our mission at Hematology-Oncology Consultants is to provide the best medical care for patients with cancer and blood disorders, in the most professional and compassionate manner. We continuously strive to provide cutting edge treatment options, personalized for each individual patient. We are dedicated to foster an environment of mutual respect and open communication between patients, our staff and the physicians. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if we work together. This concept is called the Patient Centered Medical Home.

Patient Responsibilities:

- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms, and other important information about your health
- Tell your doctor about any changes in your health and wellbeing
- Take all of your medicine as prescribed and follow your doctor's advice
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Call your doctor *first* with all problems, unless it is a medical emergency
- End every visit with a clear understanding of your doctor's expectations, treatment goals, and future plans

Doctor Responsibilities:

- Explain diseases, treatments, and results in an easy-to-understand way
- Listen to our patient's feelings and questions to help them make decisions about their care
- Keep treatments, discussions, and records private
- Provide 24 hour access to medical care and same day appointments, whenever possible
- Provide instructions on how to meet your health care needs when the office is not open
- To care for you to the best of my abilities based on my understanding of current medical methods available
- Give my patients clear directions about medicines and other treatments
- Send my patients to trusted experts, if needed
- End every visit with clear instructions about expectations, treatment goals, and future plans
- Communicate with other providers who are involved in your care as appropriate to discuss your health care information

By signing below I agree that I have read and understood the above agreement and agree to take an active role in my healthcare.

Print Name: _____

Signature: _____ Date:_____

Physician Signature: _____ Date:_____

Patient Privacy Requested Guidelines

Hematology Oncology Consultants PC has my permission to discuss my medical information with the following:

Name:	Relationship to Patient:

Patient Name: _____

Signature: _____

Hematology Oncology Consultants

No Show Policy

We are glad that you have chosen us to provide your oncology and hematology care. However, missed appointments may compromise that care.

We request that if you are unable to keep your scheduled appointment, you contact our office at least 24-hours in advance. Without appropriate notification, you will be considered a "No Show". **Late cancellations due to hospitalization or emergencies are excluded from this policy, but please try to notify us if possible so we can open up that appointment for another patient.**

• First "No Show": We will call and offer to reschedule your appointment.

• Subsequent "No Show": We will call and offer to reschedule your appointment. You will be charged a no show fee of $35. This fee cannot be billed to your insurance and will be your direct responsibility.

Our main concern is to manage our patients' health care with the highest quality of skill and efficiency. Please don't be a "No Show" - let's work together so we can provide the care you deserve!

If you have questions, please feel free to ask any of our staff.

Patient Signature:_____ Date:_____

Print Name:_____ DOB:_____

Hematology Oncology Consultants, A Division of MHP

Iqbal G. Boxwala, M.D.
Laura M. Nadeau, M.D.
Matthew Cotant, M.D
Padmaja Venuturumilli, M.D
Martin Tapia- Postigo, MD
Deepa Jagtap, M.D
Mohammed Ibrahim, M.D.
Yusuf Qamruzzaman, M.D.

Fees for all professional services are the patient's responsibility. If we do not participate with your insurance plan, it is your obligation to pay for services rendered. The cost of the Office Consultation is approximately $300, depending on services received. Please ask any questions you may have about your insurance plan or your billing, we want to help you in any way we can.

Date **Signature**

ONE TIME MEDICAL RECORD RELEASE AND INSURANCE ASSIGNMENT

I hereby authorize Hematology Oncology Consultants,. to furnish information to insurance carriers and physicians concerning my illness and treatments. I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance. This request is in effect until revoked in writing by myself.

Date **Signature**

Beaumont Cancer Center
3577 West 13 Mile Road, Suite 103
Royal Oak, MI. 48073
248-288-4500

4550 Investment Drive
Suite B-120
Troy, MI 48098
248-267-6569

6770 Dixie Highway
Suite 106-A
Clarkston, MI 48346
248-922-9175

Hematology-Oncology Consultants, P.C.
William Beaumont Hospital
Rose Cancer Center
3577 W. 13 Mile Rd, Suite 103
Royal Oak, MI 48073
Phone (248) 288-4500
Fax (248) 288-0450

Dear Doctor or Facility,

The following patient has requested that his/her medical records be forwarded to Hematology-Oncology Consultants, P.C. Please fax records if there are less than twenty pages, or mail them to the address above. Thank you for your attention to this matter.

_____

_____

_____

_____

Patient Name: _____

Date of Birth: _____

Signature of patient or authorized individual

_____

Patient Authorization for Disclosure of Protected Health Information via Alternative Means

Form 7.34

Please print all information, then sign and date authorization form at bottom.

Patient Name: _____ **Date of Birth:** _____

Purpose of Authorization – It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, "*by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care.*" The practice requires the following authorization for release of protected health information (PHI) via alternative means (other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide PHI to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

☐ cell phone: ☐ email address: ☐ US Mail: ☐ fax number: ☐ phone:

_____

Description of information to be disclosed - I authorize the practice to disclose the following PHI about me. *(Provide a written description of the information to be disclosed.)*:

_____

_____

Purpose of disclosure – I am authorizing the alternative means of communication for disclosure of my PHI to ensure the confidentiality of communications from the practice.

Expirations or termination of authorization – This authorization will renew automatically, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.

(Please list desired expiration date):_____

Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in person or by mailing a written request to the practice, Attn: Privacy Manager.

Non-Conditioning Statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.

Redisclosure Statement – I understand that the practice has no control regarding persons who may have access to the mailing or email address, telephone, cell or fax number I have designated to receive my PHI. Therefore, I understand that my PHI disclosed under this authorization will no longer be the responsibility of this practice.

Secure Communication – Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice. Do not designate email as your preferred method of communication if this is of concern to you.

_____ _____

patient signature date

Copies of signed authorizations are available upon request.

Patient Authorization for Personal Representative

Form 7.30

Please print all information, then sign and date form at bottom.

Name of Practice: _____

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

_____

Name of Personal Representative Phone

_____

Address

_____

City, State, Zip

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

_____

_____

_____

Attn: Privacy Manager.

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

_____ _____

patient signature date

Copies of signed authorizations are available upon request.

HEMATOLOGY ONCOLOGY CONSULTANTS
PATIENT ASSISTANCE PROGRAM
AUTHORIZATION

PLEASE FILL OUT ALL INFORMATION BELOW. FULL SOCIAL SECURITY NUMBER IS NEEDED FOR ANY TYPE OF CO-PAY CARD OR PATIENT ASSISTANCE PROGRAM.

ASSISTANCE PROGRAMS MAY CONSIST OF POSSIBLE FREE DRUG PROGRAMS AND/OR COPAY CARD PROGRAMS WITH REDUCED OUT OF POCKET COST TO YOU.

WE OFFER THIS AS A COURTESY TO OUR PATIENTS TO HELP REDUCE THEIR OUT OF POCKET COST ON CHEMOTHERAPY TREATMENTS IN THE OFFICE AND ORAL PRESCRIPTION TREATMENTS TAKEN AT HOME.

WE WILL SEARCH ALL PROGRAMS AVAILABLE TO US AND ENROLL YOU IN ANY PROGRAMS THAT MAY APPLY BASED ON YOUR ELIGIBILITY.

NAME (FIRST) _____ (MI) _____ (LAST) _____

STREET ADDRESS_____**CITY**_____**ZIP**_____

PHONE _____ **SOC. SEC #** _____ **DATE OF BIRTH** _____

ARE YOU: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

☐VETERAN ☐STUDENT ☐ US CITIZEN ☐DECLARED DISABLED BY SOCIAL SECURITY

NUMBER OF PEOPLE IN HOUSEHOLD_____

TOTAL HOUSEHOLD INCOME $_____

PLEASE READ CAREFULLY

I authorize the Hematology Oncology Consultants (HOC) staff to use this information to apply on my behalf for participation in any indigent program I am eligible for. I understand HOC staff will complete all necessary forms/applications as required for my enrollment in the assistance programs. This includes signing my name on my behalf. I further understand that these assistance programs are not guaranteed, are temporary in nature, and may change or be discontinued at any time. I certify that I do not have the ability to pay for my medication. I attest that the information that I have provided is correct and complete and that HOC is relying on the information I provide to complete enrollment in the assistance programs. In the event HOC needs further information to enroll me in assistance programs, I shall cooperate to provide such information at HOC's request. I understand the information I provide to HOC will be considered confidential in nature and will only be used to access these prescription assistance programs. I authorize information related to my diagnosis, health care, financial and other related information to be released to the pharmaceutical companies sponsoring the programs and I release HOC from any liability related to any improper disclosure of such information by any receiving third party, including but not limited to the pharmaceutical companies sponsoring the programs.

SIGNATURE_____ **DATE**_____