Patient Privacy Requested Guidelines

Patient Name (print) ____

Date of Birth ____________________ SSN ________ — ________ — ____________

Primary Phone ____________________ Secondary Phone ____________________

Emergency Contacts

Name ______________________________ Relationship ______________________

Home __________________ Cell __________________ Work __________________

Name ______________________________ Relationship ______________________

Home __________________ Cell __________________ Work __________________

Name ______________________________ Relationship ______________________

Home __________________ Cell __________________ Work __________________

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

Name	Relationship

Pharmacy Information

Pharmacy Name ______________________________ Phone Number ____________________

Address ____________________ City ____________________ Zip ____________

Drug Allergies ____

Patient Signature ______________________________ Date ____________

HEMATOLOGY-ONCOLOGY CONSULTANTS - BRIEF HEALTH HISTORY

Name ______________________________ Date of Birth ______________ 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 / Hospitalization Reason	Date

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

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

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? ☐ No ☐ Surgical ☐ Non-Surgical

Personal/Social History:

Have you ever used tobacco: ☐ No ☐ Yes Type: ☐ Cigarettes ☐ Chewing ☐ Cigar ☐ Pipe

How much per day?________ How many years?________ Have you stopped?________ If yes, when?____________

Do you drink alcoholic beverages? ☐ No ☐ Yes How much? ______________________

Have you ever used illicit/recreational drugs? ☐ No ☐ Yes List type(s): ______________________

Current and Prior Employment History: ______________________

Any toxin/chemical exposure? ☐ No ☐ Yes Please specify ______________________

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

Relative (age at diagnosis)	Problem / Diagnosis	Relative (age at diagnosis)	Problem / Diagnosis
1.		3.	
2.		4.	

Personal History:

Any prior personal history of cancer? ☐ No ☐ Yes

Type of Cancer	Year 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	State 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

REVIEW OF SYSTEMS

Name ______________________________ Date:______________

Do you now, or have you had any problems related to the following systems? Please check "Yes" or "No"

Constitutional Symptoms:

Fever ☐ Yes ☐ No
Chills ☐ Yes ☐ No
Headache ☐ Yes ☐ No
Other:______________________

Eyes:

Blurred vision ☐ Yes ☐ No
Double vision ☐ Yes ☐ No
Pain ☐ Yes ☐ No
Other: ______________________

Ear/Nose/Throat/Mouth:

Sore Throat ☐ Yes ☐ No
Sinus Problems ☐ Yes ☐ No
Other: ______________________

Integument:

Skin rash ☐ Yes ☐ No
Boils ☐ Yes ☐ No
Persistent itch ☐ Yes ☐ No
Other: ______________________

Cardiovascular:

Chest pain ☐ Yes ☐ No
Varicose veins ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
Other: ______________________

Allergic / Immunologic:

Hay Fever ☐ Yes ☐ No
Other: ______________________

Gastrointestinal:

Abdominal Pain ☐ Yes ☐ No
Nausea or vomiting ☐ Yes ☐ No
Indigestion / heartburn ☐ Yes ☐ No
Other: ______________________

Genitourinary:

Urine retention ☐ Yes ☐ No
Painful urination ☐ Yes ☐ No
Urinary frequency ☐ Yes ☐ No
Other: ______________________

Musculoskeletal:

Joint pain ☐ Yes ☐ No
Ear infection ☐ Yes ☐ No
Neck pain ☐ Yes ☐ No
Back pain ☐ Yes ☐ No
Other: ______________________

Neurological:

Tremors ☐ Yes ☐ No
Dizzy spells ☐ Yes ☐ No
Numbness ☐ Yes ☐ No
Tingling ☐ Yes ☐ No
Other: ______________________

Respiratory:

Wheezing ☐ Yes ☐ No
Frequent cough ☐ Yes ☐ No
Shortness of breath ☐ Yes ☐ No
Other: ______________________

Exercise:

Do you exercise? ☐ Yes ☐ No
If yes, how often do you exercise?
____

Assistance with Daily Activities:

Walking ☐ Yes ☐ No
Bathing ☐ Yes ☐ No
Dressing ☐ Yes ☐ No
Eating ☐ Yes ☐ No

Do You Use the Following:

Cane ☐ Yes ☐ No
Walker ☐ Yes ☐ No
Wheelchair ☐ Yes ☐ No
Other: ______________________

Endocrine:

Excessive thirst ☐ Yes ☐ No
Too hot or cold ☐ Yes ☐ No
Tired or sluggish ☐ Yes ☐ No
Other: ______________________

Hematological / Lymphatic:

Swollen glands ☐ Yes ☐ No
Blood clotting ☐ Yes ☐ No
Other: ______________________

Advanced Care Directive:

Have you completed one? ☐ Yes ☐ No
Would you like to discuss? ☐ Yes ☐ No

Psychologic:

Are you generally satisfied with your life? ☐ Yes ☐ No
Do you feel severely depressed? ☐ Yes ☐ No
Have you considered suicide? ☐ Yes ☐ No
Other: ______________________________

Health Maintenance:

Date of Last PCP Visit ______________
Date of Last Flu Vaccine ______________
Date of Last COVID-19 Vaccine ______________
Date of Last Pap/Pelvic Exam (Women) ______________
Date of 1st Period (Women) ______________
Age at 1st Pregnancy (Women) ______________
Birth Control Pills: ☐ Yes ☐ No
If "Yes", how long? ______________

Date of Last Colonoscopy ______________
Date of Last Pneumonia Vaccine ______________
Date of Last PSA (Men) ______________
Date of Last Mammogram (Women) ______________
Date of Last Period (Women) ______________
Number of Children ______________
Hormone Replacement Therapy: ☐ Yes ☐ No
If Yes,how long and what medication ______________

Meaningful Use Patient Registration Form

Please complete the information below.

Patient Name ______________________ DOB __________ Age ________ Date ________

Phone Number ____________________ Email Address ______________________________

Race:

☐ African-American ☐ Arabic ☐ Asian ☐ Caucasian
☐ Filipino ☐ Hispanic ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Other

Ethnicity:

☐ Hispanic ☐ Non Hispanic

Primary Language:

☐ Arabic ☐ Chinese ☐ English ☐ French
☐ German/Dutch ☐ Korean ☐ Spanish ☐ Other ____________________

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

Flu Shot __________ Pneumococcal Vaccine __________ Prevnar 13 Vaccine __________

DTaP __________ Shingles (Zoster) Vaccine __________ COVID-19 Vaccine __________

Male:

Colonoscopy ______________

Female:

Colonoscopy ______________

Mammogram ______________

PaP/Pelvic Exam ______________

Tobacco Use:

☐ Never ☐ Current Everyday 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 copy)

Do you have a Patient Advocate? ☐ Yes ☐ No

If yes, name of advocate: ______________________________________

A "Patient Advocate" is 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 Directive: 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 this 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 it a part of your medical record.

PATIENT NEED SURVEY

Your insurance company requires us to work with you, our patient, to help care for all of your needs that could affect your health. Please let us know if you need or do not need assistance with any of the following. Please sign below and date. We will keep this on file as directed. If you have any questions, please ask. Thank you.

Name ____ Date of Birth _______ / _______ / ____________

Item:	Do Not Need Help	Need Help
Medical Transportation	____________________	____________________
Food Assistance	____________________	____________________
Assistance with Prescription Costs	____________________	____________________
Find community support for depression and other challenges	____________________	____________________
Finding community support for weight loss and exercise	____________________	____________________
Help with personal care, home-making and/or home health	____________________	____________________
Where to obtain training for Self Management for Chronic Illness	____________________	____________________
Help for uninsured and those needing financial help	____________________	____________________
Learning about your chronic condition	____________________	____________________

____ ________________________

Patient Signature Date

Patient Referred to (if applicable) ____

____ ________________________

Staff Signature Date

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

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.

First Name ____________ Middle Initial ____ Last Name ____________

Street Address ____________ City ____________ Zip Code ____________

Phone Number ____________ Social Security Number ____________ 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 ____________

Patient Name Date of Birth

Insurance Acknowledgment

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 rendered. Please ask any question you may have about your insurance plan or billing, we want to help you in any way we can.

Signature Date

Medical Release and Insurance Assignment

I hereby authorize Hematology Oncology Consultants to furnish information to insurance carriers and physicians concerning my illness and treatment. 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 insurance. This request is in effect until revoked, in writing, by me.

Signature Date

Michigan Healthcare Professionals Acknowledgement of Receipt of Patient Notice of Privacy Practices

Our HIPPA policy is available on our website **hocpc.com** under the forms section (MHP Notice of Privacy Practices) and is posted in our office. If you would like a paper copy of the form, please request it at the front desk.

I acknowledge that I have read, received or am able to obtain a copy of the Michigan Healthcare Professionals, PC Patient Notice of Privacy Practices effective September 23, 2013.

Signature Date

Hematology Oncology Consultants No Show Policy

We request that if you are unable to keep your scheduled appointment, that 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 emergency are excluded from this policy, but please try to notify us as soon as possible.

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

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

Signature Date