## Patient Privacy Requested Guidelines

Patient Name (print) _____

Date of Birth _____ SSN _____

Primary Phone #: _____ **Ok to Leave Detailed Voicemail: Yes or No**

Secondary Phone #: _____ **Ok to Leave Detailed Voicemail: Yes or No**

Communication Preference: _____

**Emergency Contacts**

Name _____ Relationship _____

Home Phone _____ Cell _____ Work _____

Name _____ Relationship _____

Home Phone _____ Cell _____ Work _____

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

| Name | Relationship |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Pharmacy Information:**

Drug Allergies _____

Pharmacy Name _____

Pharmacy Phone _____

Pharmacy City _____

Pharmacy Street _____

**Patient Signature** _____

## 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**
**please write date or year of the last:**
Colonoscopy_____

**Female - please write date or year of the last:**
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*

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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 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 a part of your medical record.

# 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:** _____

_____

**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.

**Constitutional 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 | |
| | Date of Prevnar 13 Vaccine | |
| | Date of Shingles (Zoster) Vaccine | |
| | Date of Last DTaP (diphtheria, tetanus, & whooping cough)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? | |

# Hereditary Cancer Questionnaire

Name: _____ Date of Birth: _____

Today's Date: _____

Instructions: This is a screening tool for cancers that run in families. Next to each **blood-related** family member, please list any cancer(s) they have been diagnosed with and their age of diagnosis (if known). If you do not know the exact age of diagnosis, you can put an estimate, ex. 50s or 80s.

**Examples of cancer types to consider: bladder, breast, colon/rectal, kidney, leukemia, lymphoma, ovarian, pancreatic, prostate, testicular, uterine, brain, liver, lung, melanoma, penile, sarcoma, skin, small bowel, stomach, thyroid**

Be as thorough as possible

☐ Please check if you do not know your blood-related family history (Ex. I'm adopted)

| Relationship | Sex | Cancer Type(s) | Age(s) at Diagnosis |
|---|---|---|---|
| Child 1 | M☐ F☐ | | |
| Child 2 | M☐ F☐ | | |
| Child 3 | M☐ F☐ | | |
| Sibling 1 | M☐ F☐ | | |
| Sibling 2 | M☐ F☐ | | |
| Sibling 3 | M☐ F☐ | | |
| **Mother's Side** | | | |
| **Relationship** | **Sex** | **Cancer Type(s)** | **Age(s) at Diagnosis** |
| Mother | M☐ F☐ | | |
| Grandmother | M☐ F☐ | | |
| Grandfather | M☐ F☐ | | |
| Aunt/Uncle 1 | M☐ F☐ | | |
| Aunt/Uncle 2 | M☐ F☐ | | |
| Aunt/Uncle 3 | M☐ F☐ | | |
| **Father's Side** | | | |
| **Relationship** | **Sex** | **Cancer Type(s)** | **Age(s) at Diagnosis** |
| Father | M☐ F☐ | | |
| Grandmother | M☐ F☐ | | |
| Grandfather | M☐ F☐ | | |
| Aunt/Uncle 1 | M☐ F☐ | | |
| Aunt/Uncle 2 | M☐ F☐ | | |
| Aunt/Uncle 3 | M☐ F☐ | | |

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐ Yes ☐ No

**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

_____

**Print Name _____ DOB_____**

**Insurance Acknowledgement**

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 questions you may have about you insurance plan or billing, we want to help you in any way we can.

Date _____ Signature _____

**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 .

Date _____ Signature _____

**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.

Date _____ Signature _____

**Hematology Oncology Consultants No Show Policy**

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 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 charge a $35 no show fee. This fee cannot be billed to your insurance and will be your direct responsibility.

Date _____ Signature _____

# MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

# ACKNOWLEDGEMENT OF RECEIPT OF

# PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the **Michigan Healthcare Professionals, P.C.** Patient Notice of Privacy Practices effective February 11, 2026 (prior notices apply before this date).

Date: _____ Patient Signature: _____

(or Guardian, if applicable)

# ***Hematology Oncology Consultants Financial Policy***

Hematology Oncology Consultants (HOC) participates with most insurance plans. When you contact our office to schedule an appointment, we will verify whether we participate with your insurance. We also recommend that you contact your insurance carrier directly to confirm that we are in-network with your specific plan.

Participation with your insurance carrier means that HOC agrees to accept the amount approved by your insurance company for covered services, in addition to any patient responsibility determined by your plan, including copayments, deductibles, and coinsurance.

It is the patient's responsibility to understand their insurance benefits. While our staff will make reasonable efforts to verify coverage, your insurance policy is a contract between you and your insurance company.

You are financially responsible for payment of all copays, deductibles, coinsurance, non-covered services, and/or out-of-pocket amounts as determined by your insurance carrier at the time of your visit.

If your insurance plan requires a referral, you are responsible for obtaining the referral from your primary care provider prior to your appointment, each time it is required.

Patients are required to review and sign this Financial Policy and complete a Patient Information Form prior to being seen in the office.

**Payment and Insurance Guidelines**

1. Your insurance policy is a contract between you and your insurance carrier. It is your responsibility to understand your benefits. For questions regarding coverage, please contact your insurance company directly.

2. You are responsible for letting our office know of any changes to your insurance or demographic information. You must present a copy of your insurance card if there are any changes and annually at first of the year.

3. All copays, deductibles, coinsurance, non-covered services, and out-of-pocket amounts are due at the time of service. We accept cash, checks, and credit cards.

4. We understand that temporary financial hardships may occur. When possible, we are willing to discuss payment arrangements; however, arrangements must be made prior to services being rendered.

5. For diagnostic studies such as CT, PET, MRI, MUGA, or Bone Density scans, please allow at least 72 hours' advance notice so that any required insurance authorizations can be obtained.

**Acknowledgment**

I acknowledge and understand that, as a patient, I have financial responsibilities related to my care. I understand that my insurance policy may result in personal financial obligations and that I am responsible for payment as outlined above to ensure proper billing and reimbursement.

Patient Signature: _____ Date: _____

Printed Name: _____ DOB: _____