LANCASTER HEMATOLOGY ONCOLOGY CARE

PERSONALIZED CANCER MEDICINE

PATIENT HEALTH QUESTIONNAIRE and NEW PATIENT FORMS

NAME: _____

DOB: ____/____/____ **AGE:** _____ **Appt Date:** ____/____/____

PHONE NUMBER(s): _____ **(home)**

_____ **(mobile)**

_____ **(work/other)**

Email Address: _____

Best Way to Contact You: _____

FAMILY DOCTOR: _____ **REQUESTING PROVIDER:** _____

PROVIDER(s) YOU WISH TO BE NOTIFIED OF TODAY'S VISIT:

Based on regulated guidelines for electronic health records, the government requires that we request the following information from you:

Primary Language: _____

Race: (circle one) White African American Asian Declined Other: _____

Ethnicity: (circle one) Non-Hispanic or Latino Hispanic or Latino Declined Other:_____

_____

MEDICATIONS/SUPPLEMENTS: (if none, please indicate)

NAME	DOSAGE

ALLERGIES: (if none, please indicate)

What are you allergic to?	What reaction occurs?

PAST SURGERIES:

Surgery (please circle)	Year	Hospital
Wisdom Teeth		
Heart Surgery		
Thyroid Surgery		
Mediport		
Appendectomy		
Pacemaker		
Hysterectomy		
Breast Biopsy/Lumpectomy		
Gall Bladder Removal		
Blood Transfusion		
Joint/Bone Surgery		
Mastectomy		
Colonoscopy		
Other:		

SOCIAL HISTORY:

Do you smoke tobacco? (circle one) YES NO

If YES:

How long did you smoke?	
How many packs per day?	
Have you quit smoking?	
If yes, when did you quit?	
Have you had exposure to secondhand smoke?	

Do you drink alcohol? (circle one) YES NO

If YES, how often? (circle one) Daily Weekly Monthly Occasionally

Do you use recreational drugs? (circle one) YES NO

If YES: What type? _____ How long?_____

Do you exercise? (circle one) NO Daily Weekly Monthly Occasionally

_____

FAMILY HISTORY:

	Relationship to You	**Their Age at Diagnosis**
Blood Clot (legs / lungs)		
Lung Cancer		
Rectal Cancer		
Breast Cancer		
Pancreatic Cancer		
Other Cancer		

REVIEW OF SYSTEMS:

Please circle all that CURRENTLY apply:

GENERAL	fatigue	weight loss	weight gain	fever
EYES	blurry vision	double vision	visual changes	headache
HEART	chest pain	heart palpitations	irregular heart rate	
RESPIRATORY	short of breath	pain with breathing	coughing	wheezing
GI	diarrhea	constipation	abdominal pain	blood in stool
URINARY	pain with urination	blood in urine	frequency	urinating at night
MUSCLE / BONE	weakness	muscle aches	joint pain	
SKIN	rash	swelling	itching	
NEUROLOGIC	tingling	numbness	dizziness	trouble walking
PSYCHIATRIC	anxiety	depression		
ENDOCRINE	hot flashes	night sweats		
BLOOD	easy bleeding	easy bruising	unusual bruising	enlarged glands

PAST MEDICAL HISTORY:

Please circle all that apply:

high blood pressure	high cholesterol	heart disease	diabetes	GERD
depression / anxiety	blood clots- leg/lung	pneumonia	osteoporosis	osteopenia
pacemaker	asthma/COPD	sleep apnea	hepatitis _____	jaundice
liver disease	HIV / AIDS	MRSA	stroke	migraines
Parkinson's	Alzheimer's	seizure disorder	anemia	sickle cell anemia
cancer:_____	heart attack	bipolar	dialysis	bleeding disorders
diverticulosis	stomach ulcers	arthritis	kidney disease	Crohns disease
ulcerative colitis	organ transplant:	_____	Other:	_____

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

From time to time it may be necessary for representative of <insert practice name> to contact patients for various notification purposes that could include Protected Health Information such as:

- Appointment reminders/confirmation/rescheduling
- Prescription renewal/reminder information
- Lab test results
- Requests to call the doctor for other issues

We would like to know how we can contact you and with whom we can leave a message or share other information about your Protected Health Information.

I authorize Lancaster Hematology Oncology Care physicians and/or staff to contact me and leave messages that could include Protected Health Information pertaining to my care by the methods selected below.

I authorize Lancaster Hematology Oncology Care to leave detailed, personal health information by the following means:
Check and complete all that apply:

	Method	Number w/ Area Code
	Home telephone/voice message	
	Cell Phone/voice message	
	Work telephone/voice message	
	Other_____	
X	***Email**	**Via Patient Portal ONLY**

*** I understand that Physicians' Alliance Ltd. will only use the patient portal to transmit email messages to patients.**

AUTHORIZATION TO SHARE PERSONAL
HEALTH INFORMATION WITH CERTAIN INDIVIDUALS

In addition, I give permission for the following individuals to receive my Protected Health Information:

Name	Relationship	Number w/ Area Code

With my signature below, I acknowledge and understand that this Authorization will be kept as part of my medical record and that the communication instructions listed above will remain in effect until revoked by me in writing. It is my responsibility to notify Lancaster Hematology Oncology Care in writing should I wish to change any of information noted above and to notify Lancaster Hematology Oncology Care if my contact information changes.

Patient or Legally Authorized Representative's Signature:

_____

Date:_____

FINANCIAL POLICY

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear communication of our financial policies.

1) We will ask you for your insurance information at each visit. Please be sure to inform us of any changes.

2) If we are a contracted provider for your insurance plan, we will file a claim with your carrier and you will be billed for any amounts which are deemed the patient's responsibility. These will include copays, coinsurance amounts, deductibles, and anything else considered 'not covered' by your carrier.

3) When your insurance carrier processes your claim, you will receive a notification from them indicating what they paid, what they denied, and what your responsibility is according to your plan provisions.

4) If we are not a contracted provider for your insurance plan, we will try to refer you to a practice that participates with your plan so that you incur as little financial responsibility as possible.

5) If you receive services at our practice and your insurance coverage has changed to a plan we do not participate with and you do not notify us, we will unfortunately have to bill you for any and all services unpaid by your new carrier.

6) If you have an insurance plan that requires a referral or prior authorization for any service here in our office, we will require that the referral or authorization be in place before we can see you. We will do our best to assist you in obtaining this information, but it is ultimately your responsibility to make sure everything is in place with your insurance carrier prior to treatment.

AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of all medical information necessary to process insurance claim(s) and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to Lancaster Hematology Oncology Care. To the extent necessary to determine liability of payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. This Assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment will be considered as valid as an original.

MEDICARE LIFETIME SIGNATURE ON FILE and LIFETIME CONSENT

I request that payment of authorized Medicare benefits be made on my behalf to Lancaster Hematology Oncology Care for any services furnished me by its providers. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap or other Secondary or Tertiary benefits be made on my behalf to Lancaster Hematology Oncology Care for any services furnished me by its providers. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I assume responsibility to inform the practice of changes in my phone number(s) or my preferred method of communication.

I also understand the financial policy and accept responsibility for payment of any services received.

In addition, I authorize and consent to the Authorization to Release Medical Benefits and the Medicare Lifetime Signature on File and Lifetime Consent as stated above.

- ❑ **Patient Signature: _____ Date: _____**

- ❑ **Responsible Party (if patient is under 18): _____**
  Date:_____