Central Florida Cancer Institute

There is Hope

PATIENT REGISTRATION

Patient Name:	Sex:	SSN:
Street Address (Winter):	Date of Birth:	Age:
City:	State:	Zip:
Home Telephone:	Office Telephone:	
Street Address (Summer):	Email:	
City:	State:	Zip:
Home Telephone:	Office Telephone:	
Referred By:	Telephone No.:	
Primary Care Physician:	Telephone: No.:	
Guarantor's Name:	SSN:	Date of Birth:
Guarantor 's Address:		
Emergency Contact:	Telephone No.:	Relationship:
Diagnosis/Reason for Visit:		
Have you ever been treated with radiation or chemotherapy? Yes or No	*If* ***Yes,*** when?	
Where:	Physician's Name:	

PATIENT EMPLOYER INFORMATION

Employer Name:	Telephone No.:	
Employer Street Address:	City/State:	Zip:
Patient's Occupation:		

INSURED PERSON (IF NOT PATIENT)

Name:	Telephone No.:	
Street Address:	City/Stale:	Zip:
Relationship to Patient:	Employer Name:	

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: I authorize the release of any medical or other information necessary to process insurance claims on *my* behalf. I also request payment of government benefits either to myself or to Central Florida Cancer Institute who accepts this assignment. I further authorize payment of medical benefits to Central Florida Cancer Institute for services rendered

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OE PRIVACY PRACTICES: I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above-named practice's "Notice of Privacy Practices."

Patient/Authorized Person's Signature: ______________________ Date: ______________

PATIENT MEDICAL HISTORY:

Name:______________________________

How did you hear about us? ______________________________

Do you have any ALLERGIES to medications? (Please list) ______________________________

Pharmacy: ______________________________

ECOG- (Administrative purpose only) ______________________________

Present Medications:	Dosage:	Frequency:

Have you previously been diagnosed with cancer? Yes No

Have you ever been treated with radiation? Yes No If yes, when?_______________Where? _______________

Have you ever been treated with chemo? Yes No If yes, when? _______________ Where? _______________

Physicians name:______________________________

Circle all illnesses that you have had:

Pneumonia	Neuralgia	Tuberculosis	High Blood Pressure	Liver Disease
Pleurisy	Anemia	Diabetes	Polio	Kidney Disease
Heart Trouble	Jaundice	Hepatitis	Hemorrhoids	Breakdown
Arthritis	Migraine Headaches	Cancer	Thyroid	Asthma
Neuritis	Seizures			

Hospitalizations: ______________________________

____

Have you undergone any surgeries? Please list approximate date: ______________________________

____

____

Do you have: pacemaker or defibrillator? Pacemaker Yes No Defibrillator Yes No

Do you have an artificial prosthetic device? (example: artificial hip) Yes No

SOCIAL HISTORY:

What is your occupation or previous occupation? ______________________________

Do you presently smoke or have you ever smoked cigarettes? Yes No

If yes, how many packs per day?__________and how long?______________________________

If you quit, please list date:______________________________

Do you presently drink or have you ever drank alcoholic beverages? Yes No

If yes, how many drinks per day? _______________

Have you ever been treated for drug habits? Yes No If yes. Where/ when?______________________________

Name: ________________________

FAMILY HISTORY:

NAME	AGE	HEALTH (Good, Fail, Poor)	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Siblings				
Spouse				
Children				

HAVE YOU OR ANY OF YOUR BLOOD RELATIVES HAD THE FOLLOWING DISEASES? INDICATE SELF OR WHICH RELATIVE.

Y N Cancer ________________

Y N Stroke ————————————

Y N High Cholesterol ____________

Y N Diabetes ________________

Y N High Blood Pressure ——————————

Y N Heart Trouble ________________

Please check the appropriate box for the symptoms that you have experienced within the last 3 months:

GENERAL

Y N Easily fatigued

Y N Weakness with activity

Y N Weight loss amount____
and duration_____

Y N Fever

Y N Chills

Y N Night Sweats

Y N Pain - Where ____________
—

RESPIRATORY

Y N Cough

Y N Shortness of breath with or without exertion

Y N Wheezing

Y N Coughed up blood

Y N Persistent hoarseness

Y N Sore/bleeding gums

Y N Sores in mouth

GASTROINTESTINAL

Y N Darrhea

Y N Constipation

Y N Bloody stools

Y N Nausea

Y N Vomiting

Y N Indigestion

Y N Vomited blood

Y N Stomach pain

Y N Change in size shape or texture of stools

Y N Difficulty swallowing

Y N Poor appetite

CARDIOVASCULAR

Y N Chest Pain/Angina

Y N Congestive Heart Failure

Y N Leg Swelling

GU

Y N Night-time urination

Y N Urinary burning

Y N Blood in urine

NEUROLOGIC

Y N Seizures

Y N Headaches

Y N Confusion/disorientation

Y N Numbness in hands or feet/neuropathy

Y N Dizziness with positron change

Y N Decreased hearing

Y N Blurred or change in vision

Y N Difficulty walking or unable to walk straight

LYMPH NODES

Y N Noticed lumps or swelling anywhere in body

PSYCH

Y N Depression

SKIN

Y N Easy bruising

Y N Rashes

CPI-22467-9/05

AUTHORIZATION FOR USE OR DISCLOSURE OFPROTECTED HEALTH INFORMATION

Name: ____________________________ Date of Birth: ____________________

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (45 CFR§l64.508]. I authorize the above-named practice, my physician and/or administrative and clinical staff to (check all that apply):

___ Leave detailed appointment information on my answering machine/voicemail to include date and time

___Use the following protected health information, and/or

____ Disclose the following protected health information to *[Name of entity or class of persons to receive information]:*

____

____

Description of information to be used or disclosed :

____

____

This protected health information is being used or disclosed for the following purposes: *[List specific purposes here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose.}*

____

____

This authorization shall be in force and effect until: (I) *(expiration date]* date or (2) ____________________ *[Event that relates to the patient or the purpose of the use or disclosure]* at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at the above practice address. I understand that a revocation is not effective to the extent that the above-named has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (I) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. I understand that I may refuse to sign this Authorization.

If the use/disclosure is for marketing, I understand that the use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. ______ *[Patient Initials if applicable]*

____________________________	____________________________
Signature of Patient or Personal Representative	Dated
____________________________	____________________________
Print Name of Patient or Personal Representative	Description of Personal Representative's Authority

(Provide a copy of this form to the patient.)

THE OFFICE OF
CENTRAL FLORIDA CANCER INSTITUTE:

FINANCIAL POLICY

WE KNOW THAT CHOOSING A PHYSICIAN IS A VERY IMPORTANT DECISION AND WE THANK YOU FOR CHOOSING OUR OFFICE. PLEASE TAKE A MINUTE TO CAREFULLY READ THIS OVERVIEW OF SOME OF OUR FINANCIAL POLICIES.

INFORMATION REGARDING YOUR INSURANCE COVERAGE

You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (e.g., pre-certification, obtaining referrals, providing information regarding pre-existing conditions, etc.). It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing office (internal and/or external) and if your failure to timely provide this information or assistance results in a denial of coverage, you may (in certain circumstances) become personally responsible for paying for the services.

UNINSURED PATIENTS

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service unless other arraignments' have been made.

NON-PARTICIPATING PROVIDER OR NON COVERED BENEFITS

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health insurance plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes. (Please Note: ln certain rare circumstances - and in our sole discretion- we may directly bill your insurance carrier as an out-of-network provider in lieu of accepting payment directly from you and if we do so, you agree to assign your payment rights to our office and forward us any checks you receive relative to the services we have provided to you.)

PARTICIPATING PROVIDER AND COVERED BENEFITS

If we participate with your health insurance earner and the services sought are covered services under your particular health insurance plan, then we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (e.g., co-payments, deductibles and fees for non-covered services), which are due at the time of service.

TYPES OF PAYMENT; DISHONORED CHECKS

Our office accepts cash, check or credit card (Master Card or Visa). If your check is dishonored (e.g., refused for insufficient funds), you will be required to pay an additional fee of $35.00, which shall be due and owing immediately.

COLLECTION OF 0UTSTANDING BALANCES

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at the time of your visit. Balances that remains outstanding for a period of 90 days or more

may be referred to a collection agency or attorneys' office. If your account is referred to a collection agency, you will be responsible for paying a collection charge equal to 35% of your outstanding balance, which is in addition to your outstanding balance and any applicable interest. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance and any applicable interest.

MISSED APPOINTMENTS

It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled appointment. If speaking to you is not possible for any reason, we attempt to leave a reminder message with a family member or on an answering machine/voicemail. Your failure to cancel an appointment in a timely manner (i.e., at least 24 hours prior to the visit) deprives other patients of an opportunity to visit our office. You will be responsible for a paying a missed appointment fee of $50.00 if you fail to appear for a scheduled visit and have not provided at least 24 hours advanced notice of cancellation, missed lab or chemotherapy appointments will incur a $25.00 No Show fee. This policy is aimed at minimizing the waiting time and ensuring availability of prompt medical care. We recognize the fact that there may be circumstances which may not permit you to give us 24 hours prior notice but such circumstances are exceptional and extremely infrequent and shall be considered on a case to case basis. Please be adware this charge is not covered by you insurance and you will be responsible for this charge.

RELEASE OF MEDICAL RECORDS

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPAA or other controlling laws (or under other circumstances as required by law). In accordance with Florida Jaw, we charge a photocopying fee of $1.00 per page for the first ten pages and $0.25 per page thereafter and have up to 14 days to produce your records. If permitted under the law, we may charge higher fees to attorneys who request your records.

MISCELLANEOUS FEES

Certain services (e.g., family conferences, completing forms, producing narrative reports, personal letters, etc.) may entail additional fees. Prior to requesting any such services, you should request a copy of our miscellaneous services fee schedule.

By signing below, patient or responsible party acknowledges that he or she bas read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein.

____

Signature of Patient or Responsible Party

____

Print Name of Patient and Responsible Party (if any)

____

Date

REQUEST TO RELEASE HEALTHCARE INFORMATION

Patients Name: ______________________________ Date of Birth: ________________________

Previous Name: ______________________________ Social Security #: ____________________

I request and authorize ____________________________________ to release healthcare information of the patient mentioned above to:

Name: Central Florida Cancer Institute ____________________
Address: ____
City: ______________________ State: FL Zip Code: __________

This request and authorization applies to:
( ) Healthcare information relating to the following treatment, conditions, or dates: ____________________
____
( ) All healthcare information ____
( ) Other: ____

Definition: Sexually transmitted disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VORL, chancroid, lymphogranuloma, venereuem, HIV (Human Immunodeficiency Virus), AIDS(Acquired Immunodeficiency Virus), and gonorrhea.

( )Yes ( ) No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

( ) Yes ( ) No I authorize the release of any specific records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________________ Date Signed: ________________________

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

Davenport
40107 Highway 27
Davenport FL 33837
863-419-0692
Fax: 863-419-1695

Lake Wales
2 State Rd 60 W
Lake Wales FL 33853
863-679-2960
Fax: 863-679-2781

www.cfcancerinst.com