CONFIDENTIAL OFFICE USE ONLY

CENTRAL FLORIDA CANCER & BLOOD CENTER, P.A.

P O Box 1988 • Ocala, FL 34471 • Phone : 352-671-4422 • Fax : 352-671-4423

Date _____

Name _____
Last First Middle

Date of Birth _____ Age _____ Phone _____

Referring Physician
_____
Family Physician
_____

Please answer all questions. If you are unable to answer any question, please circle it and call it to the attention of the examining doctor.

HISTORY OF PRESENT ILLNESS: _____

What problem were you referred here for? _____

Do you have a history of:
Blood Disease _____ YES _____ NO WHEN? _____
Cancer _____ YES _____ NO WHEN? _____
Other _____ YES _____ NO WHEN? _____

If yes, what type?_____

Prior Treatment:	YES	NO	WHEN	X-Ray Treatment:	YES	NO	WHEN
Chemotherapy				Skin			
Radiation				Thyroid			
Surgery				Tonsils			
Other							

MEDICATIONS:

List all medications you take (prescription and over the counter)

Medication	Dosage	Times Per Day	How long have you taken medication

Do you have any other drug allergies? _____ YES _____ NO Allergic to what? _____

_____

If yes, what type of reaction? _____

_____

PRIOR BLOOD TRANSFUSIONS: _____ YES _____ NO WHEN? _____

VACCINATIONS RECEIVED:

TYPE	YES	NO	WHEN	TYPE	YES	NO	WHEN	TYPE	YES	NO	WHEN
Flu				Pneumovax				Hepatitis			

Patient Name: _____

OTHER MEDICAL PROBLEMS (diabetes, hypertension, etc)					
Date	Doctor	Diagnosis	Date	Doctor	Diagnosis

List all hospitalizations and surgeries (if none, PLEASE write "none").

Year	Duration	Reason/Result	Hospital/Physician
Additional Information			

OCCUPATIONAL EXPOSURE				
Have you had exposure to any:	YES	NO	WHEN	
Toxins/asbestos				

SOCIAL HISTORY

Marital Status: S M D W Current occupation: _____

If retired, last employment: _____

Have you ever smoked cigarettes? _____ YES _____ NO. If yes, last year smoked _____

Do you drink alcohol? _____ YES _____ NO. If yes, average daily consumption _____ for _____years.

Education – circle last year completed			G 7 8 9 10 11 12 C 1 2 3 4 P.G.		
Do you:	YES	NO	Do you:	YES	NO
Live alone?			Drive?		
If not, with whom?					
Who can you depend on?					

Patient Name: _____

FAMILY HISTORY								
	YES	NO		YES	NO		YES	NO
Diabetes			Anemia			Cancer		
Heart Disease			Kidney Disease			Melanoma		
Strokes			Tuberculosis			Bleeding Tendency		

Additional Information

Did someone other than patient complete this form? ____ YES ____ NO

If yes, your relationship to patient _____

Patient Signature _____ Date _____

Central Florida Cancer & Blood Center

2494 SW 19th Avenue Road,
Ocala, FL 34471
(Ph) 352-671-4422 (Fax) 352-671-4423

1. Name: _____ SSN: _____

Address: _____

Home phone: _____ Cell: _____ Work: _____

Gender: M ____ F ____ DOB: _____ Marital Status: _____

Race:

____ American Indian or Alaska native

____ Asian

____ Native American

____ White

____ African American

____ More than one

____ Refused to answer

Ethnicity:

____ Hispanic or Latino

____ Not Hispanic or Latino

____ Refused to answer

Preferred Language:

____ English

____ Spanish

____ Other: _____

Meaningful Use is the name of a new nationwide initiative to improve the health of our nation. As part of this initiative, Central Florida Cancer & Blood Center is required to gather information for compliance with the Meaningful Use guidelines. Part of this information includes adding patient's Race, Ethnicity and Preferred Language to our electronic medical record. The government requires we gather this information to better identity possible disparities in access and quality of healthcare based on race and ethnicity on a national level. If you have additional questions please visit the Office of the National Coordinator for Health Information Technology at www.healthit.hhs.gov and search Meaningful Use.

2. Name of Policy Holder (If different than the patient): _____

Relationship: _____ DOB: _____ SSN: _____

Address (if different than above): _____

3. Name of Patient's Employer: _____

4. Emergency Contact (Name, Number, Relationship): _____

5. Pharmacy (Name, Location, Phone number): _____

6. Email address: _____

7. Preferred Method of Contact: _____

8. Referred By: _____

9. Primary Care Physician: _____

10. Preferred Method of Contact: Phone _____ Email _____

11. Insurance Company Name: _____ Policy Number: _____

12. Secondary Insurance: _____ Policy Number: _____

13. Were you injured on the job? _____ Have you notified your employer: _____ Date of Original Injury: _____

Central Florida Cancer & Blood Center, P.A.
Privacy practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How we use your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations.

Treatment: We will use and disclose your health information to provide you with medical treatment of services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your prescriptions, and to family members who are helping with your care.

***Payment*:** We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

***Health Care Operations*:** We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposed:

Required By Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research:

We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensations: We may release information about you to workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosure of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcard to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Ravi K. Koti, M.D.

Effective Date: _____

I, _____ hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement: _____ Date: _____

Central Florida Cancer & Blood Center, P.A.

Financial Policy

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED

We accept cash, personal checks, Mastercard and Visa. Returned checks are subject to a service charge of $35.00

CANCELLED APPOINTMENTS

Patients who do not cancel appointments will be charged $15.00 for a no-show appointment. After the 3rd no-show appointment, the patient will be discharged from the practice.

BLUE CROSS/BLUE SHIELD PPC COVERAGE

CO-PAYMENT AND DEDUCTABLE MUST BE PAID AT THE TIME OF SERVICE. Because we are under contract with these insurance companies, we will file your insurance.

MEDICARE

Your deductible and 20% of the allowable charges are due at time of service. Since we are a Medicare provider, we will file your Medicare. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare pays. If you have a secondary insurance, please check with the front desk to see if we file with that company. Please bring your Medicare Explanation of Benefits (EOB) showing you have met your deductible

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain service that will not cover (eg, yearly physicals).

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED. On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable cost of collection, including attorney's fees, whether suit is filed or not.

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Financial Policy

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you. I have read and understand the above Financial Policy.

_____ _____

Date Signature