CANCER & BLOOD CARE

NAME: _____

The following questionnaire will be used for retrieving your medical records. If you are not certain of the exact date, please give an approximate month and the year the procedure or treatment was performed:

□ Have you or any member of your family been seen here at Cancer and Blood Care?
If so, Who? _____

When? _____

□ Have you had any imaging or radiology testing done?

o	MRI	o	Radiology
o	XRays	o	Mammogram
o	Bone Scan	o	_____ Biopsy
o	Colonoscopy	o	CT Scan

Which Doctor or Hospital: _____

When? _____

□ Have you had any treatments the last 12 months?

o	Iron	o	Radiation
o	Chemotherapy	o	Oral Chemo Medication

Which Doctor or Hospital: _____

When? _____

□ Have you had a surgical procedure done?

o	Lumpectomy	o	Mastectomy
o	Colon Resection	o	_____

Which Doctor or Hospital: _____
When? _____

□ Any other procedure or treatment you would like to add?

o _____
Which Doctor or Hospital: _____
When? _____

Who referred you to our clinic? Friend / Family / Doctor / Radio

- _____

What is your favorite TV channel? _____ TV Show: _____

What is your favorite Radio station _____ Radio Show: _____

CANCER & BLOOD CARE

PATIENT DEMOGRAPHICS

Personal Information Today's Date: _____

Name: _____ Patient's SSN: _____

Home Address: _____ City/State/Zip: _____

Home telephone: _____ Alternate phone number: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: _____ Marital status: _____

Drivers License #: _____ Email Address: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Phone Number: _____Spouse's SSN_____

Employment Information: Full-time ( ) Part-time ( ) Self Employed ( ) Retired ( ) Retired ( ) Student ( )

Employer: _____ Work Phone: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

How did you hear about us? Family ( ) Friend ( ) Television ( ) Radio ( ) Another Physician ( )

Person(s), who does not live with you, to contact if Unable to Reach you or your Spouse:

1. Name: _____ Address: _____

City/State/Zip:_____Phone:_____ Relationship:_____

2. Name: _____ Address: _____

City/State/Zip:_____Phone:_____ Relationship:_____

3. Name: _____ Address: _____

City/State/Zip:_____Phone:_____ Relationship:_____

Physician Information:

Referring Physician? (Name)_____ City/State _____ Phone No:_____

Primary Care Physician? (Name)_____ City/State _____ Phone No:_____

Financial Information:

Primary Insurance: _____Group #: _____ Membership ID#_____
Who is the insured? _____ Covers: ( ) Self ( ) Family Member's SSN#_____

Secondary Insurance: _____Group #: _____ Membership ID#: _____
Who is the insured? _____ Covers: ( ) Self ( ) Family Member's SSN#_____

I hereby authorize my physician, Dr. Ogundipe, to furnish information to insurance carriers concerning my illness and treatments.
I hereby assign all payments for medical services rendered to me. **(I understand that I am responsible for any amount not covered by insurance.)**

Patient's Signature: _____ Date: _____ / _____ / _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification

Printed Name: _____ Date of Birth: _____

Address:_____

_____

Social Security #_____ Telephone: _____

Information to Be Released: Covering the Periods of Health Care

From (date) _____ to _____

From (date) _____ to _____

Please check type of information to be released:

__Pertinent documentation __Operative Report__Lab results __Complete health record

__History and Physical __Consulting reports __Progress notes __EKG

__Discharge Summary __X-ray reports __X-ray films/images __EEG

__Photographs, videotapes __Complete billing file __Itemized bill __ All Records

__Other, (specify) _____

Purpose of Request

____Treatment or Consultation ____At the request of the patient ___Billing or Claims payment

____ All ____Other, (specify)_____

I, the undersigned authorize and request Cancer and Blood Care to:

_____Release information to: _____Obtain information from:

Name: _____

Address: _____

_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release.

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on the authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at {609 Virginia Ave., Ponca City, OK 74601}. Unless revoked, this authorization will expire on the following date or event _____, or one year from the date of signature, unless other wise specified.

Re-Disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that I do not have to sign the authorization or payment for services will be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize Cancer and Blood Care to use and disclose the protected health information specified above.**

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Signature of Patient or Representative Date

_____ _____

Representative's Relation to Patient Expiration Date of Authorization

_____ _____

Signature of Witness Date

CONSENT TO DISCUSS PATIENT'S MEDICAL CONDITION WITH FAMILY OR FRIENDS

I, _____, GIVE THE PHYSICIANS AND STAFF OF; **CANCER AND BLOOD CARE P.C.**, PERMISSION TO DISCUSS MY MEDICAL CONDITION **(PLEASE LIST FAMILY MEMBERS & FRIENDS ONLY),**

WITH:_____

WHO IS _____ AT PH #_____
(RELATIONSHIP)

AND/OR_____

WHO IS _____ AT PH #_____
(RELATIONSHIP)

THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED.

_____ _____
PATIENT SIGNATURE DATE

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Cancer & Blood Care, P.C. originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means for a third party payer to verify that services were billed as actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Cancer & Blood Care, P.C. is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you that the information authorized for release may include, but not limited to, records involving diseases such as hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

I hereby give my permission for any employee of Cancer & Blood Care, P.C. to leave messages regarding my care or appointments with family members or on my answering device.

PATIENT SIGNATURE: _____
DATE: _____

FINANCIAL POLICY

609 Virginia Avenue
Ponca City OK 74601
Telephone (580) 767-1300

Susanna Ulahannan, M.D.

This is an agreement between ***Cancer & Blood Care, P.C.,*** as creditor, and _____, as Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to *Cancer & Blood Care, P.C.*

By executing this agreement, you agree to pay for all services that are received.

Effective Date: Once you have signed this agreement, you agree to all terms and conditions contained herein and the agreement will be in full force and effect. If you do not sign this agreement we will be unable to render any professional services to you.

Co-signature/Guarantor: Due to the expensive nature of the treatments for cancer and blood disorders, ALL patients must have a guarantor. This applies to all patients including those who have insurance.

Charges: You are responsible for all charges incurred on your account.

- You will be provided an estimate of charges during your patient/financial education visit. However, it is understood that your final charges will depend on the actual services received.
- You may choose to pay by cash, check, or money order on the day of the treatment is rendered. Cancer drugs are to be paid for prior to the treatment. If you have insurance, we may choose to bill your insurance companies for you. (**Refer to Insurance details**)
- For your convenience, we may accept Visa, MasterCard, and Discover.
- On extensive treatments, you may prefer to secure a bank, credit union, or third party financing for the entire amount and make your payments to the lending institution.
- We have the right to report your account status to any credit reporting agencies, such as a credit bureau.

Insurance: The insurance carrier is a contract between you, your employer and your insurance company. We are <u>not</u> a party to these contracts. It is in your best interest to know

and understand your plan benefits, as well as any deductible and co-payment amounts that you are responsible for paying. While we may estimate your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

- If you have medical insurance, we will bill your insurance carrier for your convenience. As a courtesy we will also bill any secondary insurance coverage that you may have.

- Some insurance companies require co-pays to be paid at the time of service. All co-pays must be paid at the front desk during check-in. This fee will not be waived. It is your responsibility to know if your insurance requires you to pay co-pay.

- Any unpaid balance after the insurance is patient's responsibility. Not all services are covered in all insurance contracts. It is your responsibility to know what your contract covers or pays and to communicate this to our staff.

- **If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it.** Failure to obtain the referral and/or pre-authorization may result in no payment from insurance company, and you will be responsible for this charge.

- It is also your responsibility to notify us of any changes, additions, or amendments with your insurance company or policy coverage in a timely manner. We will not make adjustments to previously billed charges prior to this notification.

- We do not accept any insurance carrier's determination of reasonable and customary, allowable, or scheduled benefit as payment in full. We will be happy to provide additional information to your insurance company if requested. However, the remaining balance is the responsibility of the patient and / or the guarantor.

- In the rare instance, when an account is over 90 days past due, and has been sent to collections, all future visits would then need to be paid at the time of service.

Monthly Statements: Itemized billing statements will be provided to you on a regular basis or on your request detailing the specific services. It is important to note that your initial itemized statement may not reflect all charges and payments posted at time of your departure. If there is an amount due, this is payable upon receipt. Please note that in order for us to purchase the required treatment drugs for you; your account must be up to date.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $25.00) if you want to have copies of your health records sent to non-medical organization. We do not charge to send copies to another doctor or medical organization.

Currency: All payments are expected to be in U.S. dollars. Personal and cashier's checks also are acceptable when written on a U.S. bank. Checks written on banks outside the United States are not accepted.

Finance Charges: A finance charge may be imposed on each item of your account, which has not been paid within ninety days from the date of service is rendered.

Returned Checks: There is a fee of $25.00 for the first check returned by the bank. There is a fee of $50.00 for the second check returned by the bank. Further checks will not be accepted, you must pay by cash or money order.

Past due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of balance to an attorney, you agree to pay all attorneys' fees, which we incur plus all court costs. In case of a lawsuit, you agree the venue shall be in Kay County, Oklahoma.

Collection: We may choose to use a collection agency if there is any unpaid balance from you within or after 90 days. If your account has been turned over to collection it will also be changed to a "cash only" account. This means that all services will need to be paid in full at time of service. A letter will be sent to inform you if your account has been changed to a "cash only" basis.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may becomes a matter of public record.

I have read, understand, and agree to the above "Financial Policy". I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for all professional services, administered drugs and treatments rendered for my care. I also understand that I am responsible for all charges incurred at Cancer and Blood Care, P.C. and I agree that these expenses are not to be discharged at bankruptcy. If there is no guarantor, patient must pay balance in full before each visit.

PATIENT'S NAME: PRINT _____

SIGNATURE OF PATIENT: _____

DATE: _____

**Please submit a copy of your driver's license or any state issued picture ID card for identification purposes.

Guarantor Agreement

CBC must purchase all drugs that are used to treat the patients. Due to the high expense of these drugs, **all patients must have a guarantor.**

I _____ understand, and agree that I am jointly and severally liable for the balance of charges on the account of _____ if he/she is unable or unwilling to pay.

1. **GUARANTOR'S NAME:** PRINT _____
2. **SIGNATURE OF GUARANTOR:**_____
3. **RELATIONSHIP TO PATIENT:**_____
4. **DOB:** _____ 5. **SSN:** _____
6. **ADDRESS:** _____
7. **PHONE NUMBER:** _____
8. **WORK ADDRESS:** _____
9. **WORK NUMBER:** _____
10. **DATE:** _____

**Please submit a copy of your driver's license or any state issued picture ID card for identification purposes.

Cancer and Blood Care is committed to providing the best treatment for every one of our patients and while you are responsible for the payment at the time services are rendered, our business department is available to answer any questions you may have regarding your insurance. You may call them at (580)767-1300.

CANCER & BLOOD CARE

PATIENT HISTORY FORM

Your physician will have more time to talk to you and be able to do a more thorough job if he or she can quickly learn about your health background. All of the information you provide will be confidential and will remain filed on your medical chart. Please fill in the following information prior to your visit.
(PLEASE PRINT)

Today's Date _______________ **Date of Last Physical Exam _______________**

Last Name _____ First Name_____Middle _____

Social Security Number_____ Date of Birth _______________

Do you have the following? (Circle one)
AN ADVANCE DIRECTIVE LIVING WILL POWER OF ATTORNEY
If you do not have any of the above would you like information about theses options? YES NO

Chief Complaint

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

Pharmacy _____ Pharmacy Phone Number _____

History of Present Illness

Please answer the following questions (please circle)

- Are you pregnant? YES NO Are you trying to get pregnant? YES NO
- If you are of childbearing age, are you on any form of contraceptives (birth control)? YES NO
- Have you had a recent weight gain / loss? YES NO
  If yes, please specify how much and when _____
  _____

ALLERGIES

- Are you allergic to any medications – drugs? (*Please Circle)* YES NO

(Please list the medication and the appropriate reaction):

Drugs:	**Reaction:**				
1.	Hives	Rash	Redness	Swelling	Choking
2.	Hives	Rash	Redness	Swelling	Choking
3.	Hives	Rash	Redness	Swelling	Choking
4.	Hives	Rash	Redness	Swelling	Choking
5.	Hives	Rash	Redness	Swelling	Choking

Please circle all that apply:

- Are you allergic to: Iodine Adhesive Tape Plastic Bandages
  Merthiolate Latex Other:_____

MEDICINES:

- Do you take prescription medications presently? (*Please Circle)* *YES* *NO*
  If so, please list them *(including dosage),* when you take them, and why you take each on below:

Medications	Dosage/MG	When (how many times a day)	Why you take this medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

- Do you take non-prescription medications? For example: Aspirin, Tylenol, laxatives, diet pills, vitamins, antacids, herbal remedies supplements or cold remedies.
  (*Please circle)* YES NO

  If so, please list them below, when you take them, and why you take each one below:

Medications	Dosage/MG	When (how many times a day)	Why you take this medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

HABITS:

- Smoking (*please circle)* cigarettes pipe cigar none # years: _____Daily amount: _____
- Alcohol (*please circle)* beer wine liquors other none Amount per week: _____
- Do you smoke marijuana, use inhalants (glue or paint), or any other illegal substances? YES NO How often? _____
- Hours of sleep per night: _____
- Meals per day: _____

FAMILY HEALTH HISTORY:

- Please list your family members and their health status: (*if there is not enough room please use the back of this page)*

Family member	Year Born	If living, present health Good	Fair	Poor	If not living Age at death	Cause of Death
Mother:						
Father:						
Brothers/Sisters: ***(Please list):***						
Children *(please list):*						

- Does anyone in your family have heart disease? (*Please circle)* YES NO
- Does anyone in your family have diabetes? YES NO
- Does anyone in your family have a hereditary disease? YES NO
- Does anyone in your family have a history of cancer? YES NO

PAST MEDICAL HISTORY

- Do you take non-prescription medications? For example: laxatives, diet pills, vitamins, antacids, or cold remedies. (*Please Circle)*: YES NO
- List all your prior hospitalizations or operations and Chronic Problems:

Illness / operation	*Where*	*Year*

CANCER & BLOOD CARE

YOUR HEALTH HISTORY

- Please mark (*with an X)* if you've had any of the following now or if you have had them in the past:

NOW	PAST	SYMPTOMS
		EYES
		Glaucoma
		Eye Infection
		Cataracts Surgeries
		Vision Loss (please describe):
		EARS
		Hearing Loss
		Tinnitus (ringing in ears)
		Infection (please describe):
		CEREBRO VASCULAR
		Stroke
		TIA (mini-stroke)
		Cerebral Hemorrhage (bleeding in brain)
		Temporal Arteritis
		Other (please describe):
		BREAST
		Breast Biopsy
		Mastitis (infection of the breast)
		Lumps or Cysts (please describe):
		GASTROINTESTINAL
		Appendicitis
		Hepatitis (Infection of Liver)
		Ulcerative Colitis
		Crohn's Disease
		Cirrhosis (scars in Liver)
		Ulcers Peptic
		Reflux Disease (GERO)
		Gastrointestinal Bleeding
		Irritable bowel Syndrome (IBS)
		Pancreatitis
		Barrett's Esophagus
		RENAL/ GI
		Renal Failure (kidney)
		Bladder Infection/Urinary Tract Infection (UTI)
		Other Kidney Disease (please describe):
		Kidney Cysts
		Kidney Cancer
		Nephritis
		Nephrotic Syndrome
		Pyelonephritis
		Hydronephrosis

NOW	PAST	SYMPTOMS
		RESPIRATORY
		Asthma
		COPD (Emphysema)
		AROS (Acute Respiratory Failure)
		Other (please describe)
		Acute Bronchitis
		Chronic Bronchitis
		Pulmonary
		Lung Nodule or Sarcoid (granulomatous lung disease)
		CARDIO VASCULAR
		Aortic Aneurysm
		Coronary Heart Disease
		Atherosclerosis (Harding of arteries)
		Hypertension (high blood pressure)
		Rhythm Disturbance (irregular heartbeat) (please describe):
		Angina (Chest Pain)
		Cardiomyopathy
		Chronic Heart failure
		Acute Heart failure
		Endocarditis (Infection in heart)
		Pericarditis
		Rheumatic Fever
		Heart Attack (myocardial infarction)
		Pulmonary Embolism (blood clot in lung)
		MALE GI
		BPH
		Prostate Cancer
		Prostatitis
		Sexually Transmitted Disease (STD'S)
		FEMALE GI
		Amenorrhea-No Periods
		Bleeding between Periods
		Abnormal Menstrual Bleeding
		Infertility
		Ovarian Cysts
		Uterine or Ovarian Cancer
		Fibroid Tumors
		Sexually Transmitted Diseases (STD'S)

NOW	PAST	SYMPTOMS
		MISCELLANEOUS
		Osteoarthritis
		Rheumatoid Arthritis
		Osteoporosis
		Fractures or Broken Bones
		Sciatica
		Spinal Problems (please describe):
		Vascular
		Peripheral Vascular Disease
		Thrombosis Blot Clots (please describe):
		Vasculitis
		Neurological
		Bells Palsy
		Seizures (Epilepsy)
		Parkinson's Disease
		Benign Tumors
		Migraine Headaches
		Neuropathy Nerve Damage (please describe):
		Paralysis
		Multiple Sclerosis
		SKIN
		Acne (Acne Treatments)
		Drug Rash or Reactions
		Dermatitis
		Eczema
		Pruritis (Chronic Itching)
		Skin Ulcers

NOW	PAST	SYMPTOMS
		PSYCHIATRIC
		Endocrine
		Diabetes Type I
		Diabetes Type II
		Thyroid Problems
		HEMATOLOGY
		Vitamin Deficiency (please describe):
		Anemia
		Abnormal Blood Counts
		Clotting Disorders (please describe):
		Transfusions in the Past
		Metabolic
		Gout
		INFECTIONS
		HIV/AIDS Exposure
		Tuberculosis Exposure
		Pneumonia
		Fungal Infections (please describe):
		Shingles
		Other Infections (please describe):