

Prashant R. Patel, MD
Christine G. Simone, MD

STUART ONCOLOGY
ASSOCIATES., P. A.

Joseph My, DO

** Please provide ALL information requested**

NEW PATIENT INFORMATION

Name _____ SSN _____
Last First MI

Address _____ City _____ ST _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ D.O.B. ____/____/____

Emergency Contact _____
Name Phone Number Relationship

RACE: () American Indian () Asian () African American () Caucasian () Hawaiian Pacific () Other

ETHNICITY: () Hispanic () Non-Hispanic () Prefer Not Answer () Preferred Language _____

Are you currently in a Nursing home? _____ Nursing home name _____

Do you have a current DNR? Yes/ No Do you have a living will? Yes/ No **PCP:** _____

Referring Physician _____ **Which doctor are you seeing today?** _____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME _____

ID# _____ Group Control # _____ Copayment _____

Address _____ City _____ ST _____ Zip _____

Home Phone _____ Work Phone _____ Employer _____

Name of Insured as it appears on card _____ Sex _____
Last First MI

Relation to patient _____ Card Holder SSN _____ Card Holder Birthdate _____

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME _____

ID# _____ Group Control # _____ Copayment _____

Address _____ City _____ ST _____ Zip _____

Home Phone _____ Work Phone _____ Employer _____

Name of Insured as it appears on card _____ Sex _____
Last First MI

Relation to patient _____ Card Holder SSN _____ Card Holder Birthdate _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Stuart Oncology Associates, PA all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

Signature _____ Date _____

New Patient Medical History Form

Patient Name _____ MRN# _____

Reason for Visit _____

Medical History (Check the items that apply to you, currently or in the past)

- | | | |
|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Pneumonia/Bronchitis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> TB (tuberculosis) | <input type="checkbox"/> Chronic back pain |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> GERD/Heartburn | <input type="checkbox"/> Migraines Shingles |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Glaucoma/ cataracts |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Cirrhosis of liver | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart attack-MI | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Heartburn/ Reflux | <input type="checkbox"/> Kidney disease/failure | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Frequent urinary tract infections | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Enlarged prostate | <input type="checkbox"/> Problems with anesthesia |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Lupus-autoimmune | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Reynaud's syndrome | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic lung (COPD) | <input type="checkbox"/> Rheumatoid arthritis | |

Details of Medical History _____

Cancer History Type _____ Date diagnosed _____

Treatment Type _____ Date _____

Location of treatment _____ Treating Physician _____

Past Surgical History (Please circle and date any of the surgeries and/or procedures that you have undergone)

- | | | | |
|-----------------------|------------|---------------------|------------|
| Coronary Bypass | Date _____ | Rotator Cuff Repair | Date _____ |
| Angioplasty | Date _____ | Cataract | Date _____ |
| Pacemaker | Date _____ | Gallbladder Surgery | Date _____ |
| Cardiac Valve Surgery | Date _____ | Hysterectomy | Date _____ |
| Hemorrhoidectomy | Date _____ | Prostatectomy | Date _____ |
| Prostate Operation | Date _____ | Appendectomy | Date _____ |
| Hernia Repair | Date _____ | Hip Replacement | Date _____ |
| Tonsillectomy | Date _____ | Lumpectomy | Date _____ |
| Mastectomy | Date _____ | Other | Date _____ |
| Knee Replacement | Date _____ | Other | Date _____ |

New Patient Social History Form

Tobacco Use (Present And/or Past)

Never smoked Quit smoking when? How many years did you smoke? ____ Year How many packs? ____ Day
 Currently smoke cigarettes pipe cigars How many packs? ____ Day how many years? ____
 Chewing tobacco

Alcohol History (Present And/or Past)

Non Drinker Beer Number Of Bottles Per ____ Day ____ Week ____ Month
 Wine Number Of Glasses Per ____ Day ____ Week ____ Month
 Liquor Number Of Glasses Per ____ Day ____ Week ____ Month

Are You Employed/Self Employed Unemployed Retired Disabled

(Former) Occupation _____

Name Of Employer _____ Work Phone (____) _____

Marital Status

Married Single Widowed Divorced Lives with Family Lives Alone
 Lives in Nursing Home Winter Resident Year Round Resident Other

Local address _____ City _____ ST _____ Zip: _____

Permanent Address (If different) _____ City _____ ST _____ Zip: _____

Children Yes No Number _____

Health Maintenance

Sigmoidoscopy/Colonoscopy Yes No Date _____

Findings _____

Last Mammogram Date _____ Last Bone Density Date _____

Last Pelvic Exam Date _____ Influenza (Flu) Shot Date _____

Pneumococcal Shot Date _____ Last Shingles Shot Date _____

Last EGD Date _____

Family Medical History indicate any family members with cancer, blood disease or other disease.

	Age	Disease	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Siblings	_____	_____	_____
Siblings	_____	_____	_____
Siblings	_____	_____	_____

In your opinion, are there any diseases that run in your family? Yes No

Please List _____

New Patient Medication Form

Name _____ Date _____
Date of Birth _____

Allergies List all medication allergies

Medication _____ Reaction _____
Medication _____ Reaction _____
Medication _____ Reaction _____

- Iodine Latex Shellfish CT Scan Dye / IV Contrast Eggs Peanuts

Pharmacy _____ Ph# _____
Address _____ City _____

List all medications (including non-prescription) that you are currently taking.

Medication	Dose	Frequency	Ordering Physician

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HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you if used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect and disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability And Accountability Act Of 1996 (HIPAA).

The patient understands that:

I authorize Stuart Oncology Associates P.A. to release to my insurance company and to communicate with hospitals and other medical providers any required information regarding services provided including; medical, psychiatric, laboratory studies, HIV testing and other medical data related to my care. I authorize any insurer or payor to make payment directly to Stuart Oncology Associates P.A.. A photocopy of this authorization shall be considered as effective and valid for the duration of this claim.

Protected health information may be disclosed or used for treatment, payment, or health care options.

The practice has a notice of privacy practices and that the patient has the opportunity to review this notice.

The practice reserves the right to change the notice of privacy practices.

The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.

The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The practice may condition receipt of treatment upon the execution of this consent.

Acknowledgement Of Notice Of Privacy Practices

My signature below verifies that I, _____, have received a copy
(Print Name)
of notice of privacy practices from Stuart Oncology Associates P.A.

Signature of Recipient _____ Date ____/____/____

PROTECTED HEALTH INFORMATION AUTHORIZATION (OPTIONAL)

Consent to Disclose Medical Information

Please check one of the following:

____ I give my permission to the employees of Stuart Oncology Associates P.A. to disclose my protected health information to me and the following family and friends

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

____ I request that all my protected health information be disclosed only to me and no other family or friends. I understand that I may revoke or change this consent at any time by filling out another consent form to replace this one.

Patient's Signature _____ Date _____

Patient Print Name _____

Patient Financial Responsibility Form

Dear Patient,

Thank you for choosing Stuart Oncology Associates, P.A. as your health care provider. We are committed to providing you with quality health care. Occasionally patients have questions regarding patient and insurance responsibility for services they receive. We have developed a payment policy to help you understand your responsibility and that of your insurance carrier (if applicable). Please read the policy and sign in the space provided. A copy will be provided to you upon request. If you have questions, please let us know.

Insurance. Your insurance policy is an agreement between you and your insurance company. We are not a party to your contract. As a courtesy, we will bill your insurance plan for you, as long as you provide us with accurate information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding coverage.

- ___1. The patient (or patient's guardian, power of attorney) is ultimately responsible for the payment of treatment and care.
- ___2. Patients are responsible for payment of copays, coinsurance, deductibles, and any non-covered treatment and services not paid for by your insurance.
- ___3. If you fail to provide us with the correct insurance information in a timely manner you will be billed for all insured charges.
- ___4. Your insurance may need certain information directly from you. It is your responsibility to comply with their request.
- ___5. Stuart oncology will attempt to bill your insurance company twice in an effort to collect payment. In the event your insurance does not pay for billed services the balance will be your responsibility.
- ___6. HMO insurance companies require a referral, it is the patient's responsibility. To ensure that a current and valid referral is obtained.
- ___7. Missed appointments - there may be a 40.00 fee for appointments not cancelled more than 24 hours in advance. Patients who do not reschedule within 30 days or have a history of repeatedly not showing may be subject to dismissal for "noncompliance."
- ___8. Financial Agreement- I understand that my insurance contract is between me and my insurance company. I also agree that I am responsible for any charges that my insurance company will not cover. I understand that failure to pay my account or make suitable financial arrangements may result in my account being turned over to an outside collection agency. If this becomes necessary, I agree to pay all collection fees which include but are not limited to collection agency fees, court fees, attorney fees, and any other fees for the collection of my account balance. Further, I consent to Stuart Oncology Associates, P.A. inquiries into my credit history in conformity with legitimate business needs and applicable laws, rules, and regulations.

Signature _____ Date _____

Spouse/Guarantor _____ Date _____

Witness _____ Date _____

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ASSOCIATES, P. A.

Joseph My, DO

MEDICAL RECORDS RELEASE

Date ____/____/____

I hereby request that my medical records be sent to one indicated below, thank you.

Stuart Oncology Associates, P.A.

501 SE Osceola St
Suite 301
Stuart, FL 34994
Phone (772) 223-5955
Fax (772) 223-5954

8980 S US Hwy 1
Suite 100
Port St Lucie, FL 34952
Phone (772) 807-6525
Fax (772) 807-6526

1780 SE Hillmoor Dr
Port St Lucie, FL 34952
Phone (772) 807-6525
Fax (772) 807-6526

451 SW Bethany Dr
Suite 100
Port St Lucie, FL 34986
Phone (772) 204-0795
Fax (772) 204-0796

Patient's Name (Please Print)

Patient's Signature

(Patient's Address) City State Zip

Birthdate ____/____/____ **Last four digits of Social Security #** ____

Reason for Request of Records

Request Authorized by _____
(Physician's Signature)

How Records to be Sent

Pick up _____ Date ____/____/____ Patient's Signature _____
(At Time of Pick Up)

Fax # _____ Date ____/____/____ Employee Signature _____

Mail _____ Date ____/____/____ Employee Signature _____