



ASSIGNMENT OF BENEFITS/ FINANCIAL RESPONSIBILITIES

Account # _____ Today's Date: _____

Patient Name: _____ Last First M.I. Account #

Home Phone Cell Phone Work Phone

Email Address: _____ Note: Your email address could be used by the practice to notify you on how to access information and for specific reminders. It will not be used for two-way communication regarding your medical care. Please contact our office if you have any questions or concerns related to your medical care.

Home Address: _____ Street Mailing Address: _____ Street City State Zip City State Zip

DOB: _____ Age: _____ M F SS# _____ Married Single Divorced Widowed Other

Race (optional): _____ Ethnicity _____ Preferred Language _____

Employer: _____ Name Telephone Address Occupation

Responsible Party: _____ Name Relationship Telephone

Emergency Contact Spouse/Next of Kin: _____ Name Relationship Telephone

Preferred Method of Contact (circle one): Home Phone Cell Phone Work Phone Email Mail

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone

Insured Name: _____ DOB: _____ Group #: _____ Policy #: _____

Secondary Ins: _____ Telephone

Insured Name: _____ DOB: _____ Group #: _____ Policy #: _____

- 1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to MARYland Oncology Hematology, P.A. - (MOHPA).
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to MOHPA. The assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to MOHPA.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from MOHPA.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

Patient Signature Date/Time AM or PM (circle one)

Responsible Party Signature Date/Time AM or PM (circle one)



AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

****NOTE: Health information will not be released under any circumstances to any relative(s) (spouse, mother, father, sister, brother, etc), friend(s) or other person(s) unless specifically listed and authorized by the patient below**

Patient Name: _____ Date of Birth: _____
(First) (MI) (Last)

Address: _____ Phone No. _____
(Street) (City) (State) (Zip code)

For this authorization, "My Health Information" means any and all information relating to my course of examination, test results and treatment. "My Health Information" may include: Genetic Counseling/Testing information HIV/AIDS
Drug/Substance and/or Alcohol Abuse Mental Health

I authorize Maryland Oncology Hematology, P.A. to discuss My Health Information, general information and inquiries, arranging appointments, identifying medications, discussing billing and payment and any other related matters with:

Name: _____ Relationship: _____ Phone No: _____
Name: _____ Relationship: _____ Phone No: _____
Name: _____ Relationship: _____ Phone No: _____
Name: _____ Relationship: _____ Phone No: _____

- I understand that:*
- * This authorization is voluntary. My treatment will not be impacted no matter if I sign this authorization or not.
 - * If I do not sign this authorization, Maryland Oncology Hematology, P.A. will not discuss My Health Information, unless permitted without an authorization by the HIPAA Privacy Rule such as for treatment, payment, or health care operations purposes, as required by law, etc. Our Notice of Privacy Practices provides additional information.
 - * I will receive a copy of this authorization upon signature (if requested).
 - * This authorization is valid for one year from date signed unless I revoke this authorization or unless an earlier date is specified: _____. I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization.
 - * Once My Health Information is disclosed as requested, it may no longer be protected by federal and/or state privacy laws and could be re-disclosed by the person(s) receiving it. The medical information released may contain information related to HIV status, AIDS, sexually transmitted disease, genetic information, mental health and alcohol abuse, etc.

Authorization for Use of Answering Machine and/or Voice Mail: Maryland Oncology Hematology, P.A. physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our office would like to leave a detailed message on communication devices provided by our patients. Protected Health Information that we may possibly disclose on your home, cell or work phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures and surgical posting/scheduling information. Please check your consent or objection for us to leave you a message containing Protected Health Information:

YES, I authorize Maryland Oncology Hematology, P.A. physicians and healthcare staff to leave messages that include Protected Health Information on the following communication devices: **(please check & provide number for each)**

home number cell number work number

NO, I do not authorize Maryland Oncology Hematology, P.A. physicians and healthcare staff to leave messages that include Protected Health Information on my home, work, or cell phone. A message may be left requesting that you return a call to Maryland Oncology Hematology, P.A. so that we may speak with you. . Please check and provide number where you want a return call message to be left.

home number cell number work number

SIGNATURE OF PATIENT ONLY: _____ **DATE:** _____

If you are NOT the patient, but are signing on behalf of the patient, please complete the following:

I, _____, confirm that I am the legal representative for the patient above and I have CHECKED my relationship to the patient below:

- Medical Power of Attorney Power of Attorney with Right to see medical records Court Appointment Guardian
 Registered Kinship Care Relative Legally Appointed Healthcare Agent Surrogate Decision Maker

REPRESENTATIVE'S SIGNATURE: _____ **DATE:** _____

(NOTE: You must have on file or attach proof of your authority to act on behalf of the patient as checked above (other than parent).



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Maryland Oncology Hematology, P.A. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Maryland Oncology Hematology, P.A.

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

(Practice Name) Use Only _____

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained: _____



USER ELECTRONIC MAIL AUTHORIZATION FORM PATIENT PORTAL

Maryland Oncology Hematology's Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your portal record: we will not activate your personal account unless you authorize us to do so. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal.

Please look for an email within 24 hours after submitting this form. The email will be from MyCare Plus (Columbia, Silver Spring, Wheaton or Laurel, MD location Patients) or from Medfusion (Clinton, MD and Lanham, MD location Patients)
(For your protection, the link is designed to expire quickly if not used.)

Note: Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

IMPORTANT ACTION: When you have logged in for the first time, we request that you send us a message through the Portal so we know that you are able to communicate with us via the Portal.

If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you choose not to execute the User Electronic Mail Authorization Form, you will not be able to access the Portal.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

You are receiving access to the Portal. The terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

Patient Name
(First Name, Middle Initial, Last Name)

Email Address of Patient / Authorized User

Date of Birth of Patient
(First Name, Middle Initial, Last Name)

Physician's Name

Authorized User is:

- Patient
 Patient's Designee

Patient's Designee Name (Printed)

Patient's Medical Record Number

Patient's Designee Signature

Patient's Signature

Date

Signature of Practice Staff
(For confirming user's identity and authority)

Date



MARYLAND
ONCOLOGY
HEMATOLOGY

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Reason For This Visit: _____

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

- | | | |
|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lupus-Autoimmune |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Lung (COPD) | <input type="checkbox"/> Reynaud's Syndrome |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Pneumonia/Bronchitis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> TB (Tuberculosis) | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Chronic back pain |
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> GERD/Heartburn | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Heart Attack-MI | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cirrhosis of Liver | <input type="checkbox"/> Glaucoma / Cataracts |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hepatitis A/ B/ C | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Heartburn / Reflux | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Kidney Disease/Failure | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Freq. Urinary Tract Infections | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Drug Use | <input type="checkbox"/> Problems with Anesthesia |

Details of Medical History:

Cancer History:

Type: _____ Date diagnosed: _____

Treatment (Type, Date, and location of treatment):

Treating Physician: _____

Patient Initials

Patient Name _____

Past Surgical History: (Please circle and date surgeries and/or procedures you have undergone)

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

Other Operations _____ Date: _____

Social History:

Tobacco Use: (Present &/or Past):

Never Smoked

Quit Smoking When? _____ How many years did you smoke? _____ yr(s) How many packs? _____ /day

Currently Smoke Cigarettes How many packs? _____ /day How many years? _____

Other Chewing Tobacco Cigars Pipe Vaping

Alcohol Use:

Non Drinker

Beer number of bottles _____ per day week month

Wine number of bottles _____ per day week month

Liquor number of bottles _____ per day week month

Are you: Employed/Self Employed Unemployed Retired Disabled

(Former) Occupation: _____

Name of Employer: _____

Marital Status: Married Single Widowed Divorced Other

Lives Alone Lives with Family Lives in Nursing Home

Winter Resident Year Round Resident

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:	_____	_____	_____
	_____	_____	_____

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

Please list: _____

Genetic Testing: Have you had cancer related genetic testing? Yes No

Patient's Initials

Patient Name _____

Review of Symptoms: (Please check any current symptoms you have.)

- GENERAL:**
- Weight loss
How much? _____
Over what time period _____
 - Fevers
Max temp _____
 - Chills
 - Night sweats
 - Fatigue
- EYES:**
- Wear Glasses/Contact Lenses
 - Blurred Vision
 - Double Vision
- EARS, NOSE & THROAT**
- Hard of hearing or deaf
 - Ringing in Ears
 - Enlarged lymph nodes
 - Chronic sinus Problems
 - Sore throat
 - Mouth pain/sores
- CHANGES/DIFFICULTY IN:**
- Taste
 - Smell
 - Voice
- CARDIOVASCULAR:**
- Chest pain/Angina Pectoris
 - Palpitations/heart murmur
 - Irregular heart beat Pressure
- RESPIRATORY:**
- Chronic or Frequent Cough
 - Bloody Sputum
 - Shortness of Breath
- NEUROLOGICAL:**
- Numbness, tingling
 - Arm or leg weakness
 - Light-Headed, dizzy, fainting spells
 - Headache
 - Tremors
- GASTROINTESTINAL:**
- Difficult or painful swallowing
 - Abdominal pain
 - Nausea
 - Vomiting
 - Heartburn
 - Indigestion
 - Lump or sensation in throat
 - Food sticking
 - Bloating
 - Belching
 - Diarrhea
 - Constipation
 - Rectal bleeding
 - Black or tarry stools
 - Hidden blood in stool
 - Excessive rectal gas/flatul
 - Loss of stool/fecal accident
 - Poor appetite
 - Jaundice
- GENITOURINARY:**
- Kidney Stones
 - Pelvic Pain
 - Incontinence
 - Burning or pain on urination
 - Blood in Urine
 - Difficult urination
 - Men: Prostate problems
- MUSCULOSKELATAL:**
- Joint Pain/Arthritis
 - Muscle or joint weakness
 - Back Pain
 - Bone Pain
 - Muscle aches
- GYNECOLOGY:**
- Age at start of menses _____
 - Last menstrual period _____
 - Vaginal discharge
 - Menstrual irregularity or abnormal bleeding
 - Number of Pregnancies _____
 - Number of Deliveries _____
 - History of Birth Control Pills
 - History of Hormone Replacement Therapy
 - History of Abnormal PAP
- SKIN:**
- Rashes or itching
 - Changes in skin color or moles
 - Varicose veins
 - Skin Cancer
- PSYCHIATRIC:**
- Anxiety/Agitation
 - Depression
 - Crying for no reason
 - Insomnia
 - Alcoholism
 - Drug Problem (Now/Past)
- HEMATOLOGIC:**
- Easy bruising
 - Gum or nose bleeding
 - Blood transfusion in past
 -
- ALLERGIES/IMMUNOLOGY:**
- History of chronic infections History of allergies
 - History of allergies
- ENDOCRINE:**
- Heat or cold intolerance
 - Excessive Skin Dryness
 - Excessive thirst or urination
 - Weight problem
 - Hot flashes
- BREAST:**
- Rashes or itching
 - Change in skin color or moles
 - Varicose veins
 - Skin Cancer
 - Breast pain/lump
 - Breast discharge or rash

Patient's Initials

Patient Name _____

Your treatment can be affected by any medication that you take, and it is important that your physician has updated and correct information.

Drug Allergies: List all medication allergies

Medication: _____

Reaction: _____

Medication: _____

Reaction: _____

Medication: _____

Reaction: _____

Medication: _____

Reaction: _____

Are you allergic to:

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

Other:

Type of Reaction: _____

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

Medication	Dose	Frequency	Ordering Physician

Patient's Initials