Maryland Oncology Hematology

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Jessica Mukherjee, C.R.N.P.

Dear New Patient:

Welcome to Associates in Oncology and Hematology. Your visit has been scheduled and for your convenience an appointment card has been attached.

Please **complete all** the enclosed forms and bring them with you to your first appointment. This will assure maximum time with your physician. If the forms are not completed when you arrive, your appointment may need to be rescheduled. In addition, the following items will be needed: 1) List of current medications, 2) Insurance card(s), 3) Driver's License or picture ID, 4) Referral form (if required by your insurance company), 5) Method of Payment (we accept cash, check, Visa, Discover, MasterCard or American Express)

Prior to your appointment, our medical records team will be calling your referring and primary physicians to secure medical records for continuity of care. It may be necessary for us to use the medical release form that is enclosed in your packet which you may need to sign and send back to us prior to your appointment.

DIRECTIONS TO
AQUILINO CANCER CENTER:
Rockville Office *9905 Medical Center Drive, Suite 200, Rockville, MD 20850 – Phone: 301-424-6231 Fax: 866-353-7127*
From I-270 North take exit #8 (Shady Grove Road). From I-270 South take Exit #8. Go West on Shady Grove Road for five stoplights; at the fifth stoplight make a right turn at Medical Center Way into the Shady Grove Medical Center Complex. At the first stop sign turn left onto Medical Center Drive. Parking located in front of the Aquilino Cancer Center building.

JOHNS HOPKINS MEDICINE HEALTH CARE & SURGERY CENTER:
Bethesda Office *6420 Rockledge Drive. Suite 4200, Bethesda, MD 20817 – Phone: (301) 929-0765 Fax: 866-353-7127*
From Frederick take I-270 S to exit 1 Rockledge Drive toward MD 187/Old Georgetown Road. From Baltimore I-495 N / I-95 N towards Silver Spring/Baltimore, keep left to take I-495W / Capital Beltway W towards Silver Spring. Merge right onto 1-270 N. Take exit 1B for Rockledge Drive. From Northern Virginia take I-495 towards Maryland. Slight left at I-270 N. Take exit 1 for Democracy Blvd. Turn right at Democracy Blvd. Turn left at Rockledge Rd. Parking available in the garage or surface.

OFFICE HOURS FOR OUR ROCKVILLE AND BETHESDA LOCATIONS:

Monday	Tuesday	Wednesday	Thursday	Friday
8 am – 5 pm	8 am – 5 pm	8 am – 5 pm	8 am – 5 pm	8 am – 4:30 pm

WESTFIELD WHEATON NORTH BUILDING:
Wheaton Office 2730 University Blvd. W. Suite 400, Wheaton, MD 20902 – Phone: (301) 942-9220 Fax: 301-866-353-1727
The easiest path to the office from Northern Montgomery County is to take I-270 South to I-495 East to exit 31 for MD-97/Georgia Ave. toward Silver Spring/Wheaton. Keep right at the fork, follow signs for MD-97 North and merge onto MD-97 North/Georgia Ave.
Take a slight left onto Veirs Mill Road, and our shopping center will be located on your left.

OFFICE HOURS FOR OUR WHEATON LOCATIONS:

Monday	Tuesday	Wednesday	Thursday	Friday
8:30 am – 4 pm	8:30 am –4 pm	8:30 am – 4 pm	9:30 am – 5 pm	9 am – 4:00 pm

Our staff will be happy to accommodate your needs, but we ask that you please help us by alerting the front desk staff to any changes with your insurance, address or phone numbers.

If you have any questions, please do not hesitate to call before your appointment. We look forward to participating in your medical care.

The Physicians and Staff of MOH, Rockville Division

Maryland Oncology Hematology

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

ACCOUNT #: _____ Today's Date: _____

Patient Name: _____
Last *First* *M.I.*

Home Phone ( ) _____ Cell ( ) _____

Home Address: _____ Mailing Address: _____
Street *Street*

_____ _____
City *State* *Zip* *City* *State* *Zip*

DOB: _____ Age _____ ☐M ☐F SS# _____ ☐Married ☐Single ☐Divorced ☐Widowed ☐Other
Sex *Check Marital Status*

Email: _____ Race: _____

Ethnicity* Hispanic/Latino ____Yes ____ No

Preferred Language*: _____

Preferred Contact Method: (check one) ☐ Cell ☐ Home ☐ Work ☐ Email ☐ Home address

Employer _____ ( ) _____
Name *Telephone*

_____ _____
Address Occupation

Responsible Party: _____ _____ ( ) _____
Name Relationship Telephone

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

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.
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 Maryland Oncology Hematology, P.A. This 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 Maryland Oncology Hematology, P.A.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Maryland Oncology Hematology, P.A.

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 Relationship Date/Time AM or PM (*circle one*)

PHYSICIAN: _____

ACCT NBR: _____ LOC: _____

EMPLOYEE INITIALS

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Patient's Account Number

AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

NOTE: Healthcare 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: _____
(LAST) (FIRST) (MI)

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.

I authorize Associates in Oncology/Hematology to discuss My Health Information, general information and inquires, 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: _____

Authorization for Use of Answering Machine and/or Voice Mail: Associates in Oncology/Hematology, P.C. physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPPA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Healthcare 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.

☐ **YES,** I authorize Associates in Oncology/Hematology, P.C. physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following communication devices: (***please check***) ☐ **home number** ☐ **cell number** ☐ **work number**

☐ **NO,** I do not authorize Associates in Oncology/Hematology, P.C. physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work or cell phone.

I understand that:
- *** If I do not sign this authorization, Associates in Oncology/Hematology will not disclose my health information.**
- *This authorization is voluntary. My treatment will not be impacted no matter if I sign this authorization or not.
- * I will receive a copy of this authorization upon signature (if requested).
- * This authorization is valid unless I revoke this authorization in or unless an earlier date is specified me: _____.
- * 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.

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

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).

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AUTHORIZATION TO OBTAIN AND/OR RELEASE PROTECTED HEALTH INFORMATION (PHI)

(Phone #: 301-424-6231 - Fax #: 866-353-7127)

I hereby authorize Associates in Oncology/Hematology to ☐obtain and/or ☐release medical information concerning my medical treatment to the following physician(s) and/or medical facility (ies) for the purpose of continued medical care:

1) Physician/Facility Name: _____

Address: _____

Phone No: _____ Fax No: _____

2) Physician/Facility Name: _____

Address: _____

Phone No: _____ Fax No: _____

Copies of **ALL** the following records shall be: ☐obtained and/or ☐released unless otherwise specified below:

List Treatment Date(s) or Date range: _____

☐ Progress Note(s)	☐ Pathology Report(s)	☐ Other _____
☐ Lab Report(s)	☐ Consultation Report(s)	_____
☐ Imaging/Radiology Report(s)	☐ History & Physical Report(s)	_____
☐ Operative Report(s)	☐ Discharge Summary(ies)	_____
☐ Radiation Treatment Records (EOT)	☐ Chemotherapy Treatment Records	_____

Other than continued medical care, the purpose for the release of information requested by the patient is: **(check all applicable)**

☐Personal Use ☐Insurance ☐Legal Action ☐Other (please specify): _____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric, genetic counseling and/or testing, alcohol and/or drug abuse, and/or AIDS, which may include the result of an HIV test or the fact that an HIV test was performed. I consent to the release of information as designated above unless checked below: **(check all applicable)**

☐Genetic Counseling/Testing Information ☐HIV/AIDS ☐Mental Health ☐Drug/Alcohol Abuse ☐Other (please specify): _____

I understand that **THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING** where the original authorization is retained, except to the extent that action has already been taken on this authorization.

I understand that my protected health information (PHI) that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer by protected by law.

_____ _____

Patient Signature or Legal Representative **(see note)** Date

_____ _____

Printed Name of Patient or Legal Representative **(see note)** Relationship

_____ _____

Patient Address Patient Date of Birth

NOTE: Legal Representative must have on file or attach proof of your authority to act on behalf of the patient (other than parent of a minor).

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Medical Information

Office use only
INT_____ Date_____

PATIENT NAME: _____ **Date of Birth:** _____ **Marital Status:** _____

1) ALLERGIC REACTION to any Medication? ☐ **No** ☐ **Yes** *(If yes, please list drug(s) and reaction(s) below)*

Drug	***Reaction***	***Drug***	***Reaction***

2) HAVE YOU:

EVER had:	**YES**	**NO**
High blood pressure		
Diabetes		
High cholesterol		
Heart disease / Heart Attack		
Stroke		
Blood clots		
Thyroid disease		
Asthma		
Emphysema/COPD		
Cancer		
Kidney disease / Kidney Stones		
Sleep apnea		

	YES	**NO**
Abdominal cramps or pain		
Tuberculosis		
Liver disease (jaundice, hepatitis)		
Prolonged bleeding after procedures		
Blood Transfusions		
Transfusion reactions		
Exposed to toxic chemicals		
Depression		

Other: Please list other medical conditions:

_____
_____
_____
_____

RECENTLY had:	**YES**	**NO**
Fever		
Chills		
Sweating at night		
Weight loss		
Fatigue		
Trouble with your vision		
Trouble with your hearing		
Bleeding from your nose or gums		
Hoarseness / sore throat		
Chest pain		
Palpitations or rapid heart beats		
Lightheadedness / fainting		
Shortness of breath		
Cough / sputum production		
Swelling of your abdomen		
Ankle or leg swelling		
Nausea or vomiting		

	YES	**NO**
Change in your bowel habit / stool		
Passage of dark urine		
Frequent and/or nocturnal urination		
Burning on urination		
Blood or pus in urine		
Back or flank pain		
Pain in your joints		
Neuropathy / numbness		
Headaches		
Periods of confusion		

Other: Please list other medical conditions:

_____
_____
_____
_____

Office use only

INT____ Date_____

PATIENT NAME: _____ **Page 2 - Medical Information (cont.)**

3) List all operations you have had:

Date	Type of Surgery	Hospital	Surgeon

4) MENSTRUAL HISTORY (Women only)

Age of onset of periods _____

Do you take oral contraceptives / Hormone replacement _____

Number of pregnancies _____

Number of live born children _____

How old where you when you had your first live child _____

Number of miscarriages / Abortions _____

Age of menopause _____

5) LIST ALL MEDICATIONS YOU CURRENTLY TAKE OR ATTACH A MEDICATION LIST: (include all prescription drugs, supplements & over the counter medications)

Drug Name	Dosage (e.g. mg)	Frequency (e.g. 1 pill 2 times a day)	Reason Taking

***Pharmacy Name:_____ Phone No. _____

6) DO YOU:

	YES	NO
a) Smoke now?	_____	_____
b) Ever smoked?	_____	_____
c) If yes, how many packs per day?	_____	
How many years?	_____	
When did you stop?	_____	

d) How many alcoholic beverages do you drink: _____None _____Less than 5 per week _____More than 5 per week

Office use only

INT____ Date_____

PATIENT NAME: _____ **Page 3 - Medical Information (cont.)**

7) LIST DATE OF YOUR MOST RECENT: **(Women only)**

Colonoscopy _____ Mammogram _____

Digital rectal exam _____ Pap smear _____

PSA **(men only)** _____

8) HAVE ANY OF YOUR RELATIVES HAD A HISTORY OF:

Bleeding Disorder ☐ Yes ☐ No

Cancer ☐ Yes – If yes, please list ☐ No

Type	Relationship	Maternal/Paternal	Age	Pertinent details

9) LIST ALL PHYSICIANS YOU CURRENTLY SEE:

Primary Care Physician: _____ **Phone Number:** _____

	Other Physicians	Specialty	Phone Number
1			
2			
3			
4			
5			
6			
7			

10) MARITAL STATUS:

11) ETHNIC BACKGROUND:

12) OCCUPATION:

13) NUMBER OF CHILDREN:

Notice of Privacy Practices

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION: Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plant for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment services as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS: Unless otherwise required by law your health record is the physical property of the healthcare practitioner or facility that compiled it; the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect and obtain a copy of your health record. You may obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES: This organization is required to maintain the privacy of your health information, and in addition, provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate health information by alternative means or by alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided. If we maintain a Web site that provides information about our customer services or benefits we will post our new notice on the Web site. We will not use or disclose your health information without your authorization, except as described in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

- ***Treatment***
- ***Billing & Payment***
- ***Health Care Operations***
- ***Notification***
- ***Communication with family***
- ***Funeral Directors***
- ***Organ Procurement Organizations***
- ***Food and Drug Administration (FDA)***
- ***Public Health Risks***.
- ***Workers Compensation***
- ***Correctional Institution***
- ***Law Enforcement***
- ***CRISP***
- ***Other Uses and Disclosures***

For specific information, please ask the front desk for a complete copy.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU: Although your health record is the property of Associates in Oncology/Hematology, the information belongs to you. You have the following rights regarding your health information:

- ***Right to Inspect and Copy***
- ***Right to Amend***
- ***Right to an Accounting of Disclosures***
- ***Right to Request Restrictions***
- ***Right to Request Alternate Communications***
- ***Right to a Paper Copy of This Notice***
- ***Right to Breach Notification***

For specific information, please ask the front desk for a complete copy.

CHANGES TO THIS NOTICE: We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Facility and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the Privacy Officer.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with Associates in Oncology/Hematology or with the Secretary of the Department of Health and Human Services. To file a complaint, contact Associates in Oncology/Hematology, attention Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF NOTIFICATION: The "Notice of Privacy Practices" provides information about how Associates in Oncology/Hematology, P.C. may use and disclose protected health information about you and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will be notified on you next visit to our office. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or healthcare operations. We are not required to agree with your restrictions, but if we do, we are bound by our agreement to you.

CONTACT INFORMATION: For further information about matters covered by this notice, please contact the Privacy Officer at 301-424-6231.

By signing, I acknowledge that I have read and understand the Notice of Privacy Practices. _____

Patient's Signature **Date**

Effective: April 2003; Revised: August 2013, August 2015