MARYLAND ONCOLOGY HEMATOLOGY

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: _____ Mailing Address: _____
Street 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)**

White - CONFIDENTIAL - MEDICAL RECORDS Canary - CONFIDENTIAL - BUSINESS OFFICE - MEDICAL RECORDS Pink - CONFIDENTIAL - PATIENT

Rev 5/4/16

MARYLAND ONCOLOGY HEMATOLOGY

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).

MARYLAND ONCOLOGY HEMATOLOGY

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: _____

_____

_____

_____

_____

_____

MARYLAND ONCOLOGY HEMATOLOGY

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 Initital, Last Name)

Email Address of Patient / Authorized User

Date of Birth of Patient
(First Name, Middle Initital, 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)

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

Maryland Oncology Hematology

Benjamin Bridges, MD
Ravin Garg, MD
Adam Goldrich, MD
Peter Graze, MD
Stuart Selonick, MD
Jason Taksey, MD
Carol Tweed, MD
David Weng, MD
Jeanine Werner, MD

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

(Phone #: 410-897-6200 - Fax #: 832-601-8168)

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).

810 Bestgate Road
Suite 400
Annapolis, MD 21401

12200 Annapolis Road
Suite 118
Glenn Dale, 20769