



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

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 Maryland 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: \_\_\_\_\_

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Progress Note(s)                  | <input type="checkbox"/> Pathology Report(s)            | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lab Report(s)                     | <input type="checkbox"/> Consultation Report(s)         | _____                                |
| <input type="checkbox"/> Imaging/Radiology Report(s)       | <input type="checkbox"/> History & Physical Report(s)   | _____                                |
| <input type="checkbox"/> Operative Report(s)               | <input type="checkbox"/> Discharge Summary(ies)         | _____                                |
| <input type="checkbox"/> Radiation Treatment Records (EOT) | <input type="checkbox"/> 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 be 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



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                 |
| <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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

:

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:** 1 serving is a bottle of beer, 1 glass of wine, or 1.5 ounces of liquor

Non Drinker

Beer number of servings \_\_\_\_\_ per  day  week  month

Wine number of servings \_\_\_\_\_ per  day  week  month

Liquor number of servings \_\_\_\_\_ 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