MOHC
MEDICAL ONCOLOGY
HEMATOLOGY CONSULTANTS, PA

The US Oncology Network

Name : Last 4 of SS#

❒ Male ❒ Female ❒ Transgender ❒ Other:

Gender Expression (Sex) _____ DOB _____/_____/_____ Email: _____

Pharmacy Name Phone Number: _____/ ( )_____-_____

Relationship Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Long-term Commitment

Emergency Contact: _____Relationship: _____Phone#_____

Emergency Contact: _____Relationship: _____Phone#_____

Partner's Name: _____ Phone #: _____

United States Citizenship: ❒ Citizen ❒ Permanent Resident ❒ VISA ❒ Other: _____

Please list your mailing address here *if it is not the same as where you live*:

Address:

Do you have an Advance Directive (living will)? ❒ Yes ❒ No * Please provide copies if you

Do you have a Power of Attorney for medical decisions? ❒ Yes ❒ No have either of these

Primary Care Physician_____ Phone #: _____

Whom may we thank for referring you to MOHC?

1. Ethnicity Are you Hispanic, Latino/a, or Spanish origin? (One or more categories may be selected) ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Unknown ☐ Another Hispanic, Latino/a, or Spanish Origin

2. Race What is your race? (One or more categories may be selected) ☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (Please Choose from the List In Table Two) _____ ☐ White ☐ Other Race ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander (Please Choose from the List In Table Three) __

*MOHC has limited retail pharmacy services available for use with obtaining medications prescribed by MOHC providers. Our pharmacist is available for education about medications and to help determine your insurance coverage and copayment for the medication. *However, you are always able to use your pharmacy of your choice.*

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1. I understand that I am responsible for charges not covered or reimbursed by my insurance carrier. 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 MOHC. I also authorize agents of any hospital, treatment center or previous physician to furnish MOHC copies of any records of my medical history, services, or treatments. I also authorize the release of any medical information and/or report related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research, and quality assurance reviews within MOHC.

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 MOHC. This assignment covers 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 MOHC.

4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with US Oncology.

Privacy Practice

MOHC, PA. 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 regarding your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices

☐ **I confirm that I have had the opportunity to read and review, the privacy policy provided to me by MOHC. Who may we speak with or release information regarding your care?**

Primary Spokesperson	**Relationship**
Additional Spokesperson	**Relationship**

Patient or Representative Signature: _____ **Date:** _____

Medical Oncology Hematology Consultants, PA

Patient Financial Policy

We are pleased that you have chosen our practice as the place to receive your healthcare. We will always strive to give you the best of care. To maintain our service level, it is necessary for us to have the following policies:

- Payment of all copays, coinsurance, and other patient financial responsibilities is required at the time of each office service.
- If you have an insurance that requires a copay, unless we are notified otherwise by your insurance, it will apply to every visit you make to our practice, including those visits when you do not see a physician directly—such as for an injection or port flush.
- Before receiving chemotherapy in our office, you will be meeting with one of our Patient Benefits Representatives to review the approximate financial responsibility you may have. Payment must be made before treatment can be administered. If you are unable to make full payment for treatment in our office, we will review other options with you.
- If your insurance requires referrals, you are expected to be responsible for obtaining them unless we tell you otherwise. Your visit will need to be rescheduled if there is not a proper referral in place at the time of your visit.
- You must notify our office immediately of any changes in your insurance. You will be held liable for your full balance with our practice if you have not properly informed us of any changes, as we may not be able to bill your insurance because of timely filing rules.
- If you are on traditional Medicare and switch to a Medicare replacement (or switch from Medicare replacement plan to another), you must contact our billing office at 302-366-1200 to confirm that we are participating with your plan.
- If you are uninsured, we may be able to make payment arrangements for our physician visits after thoroughly reviewing your financial situation. Any treatment costs will be reviewed with you in advance.
- Our office accepts VISA, MasterCard, Discover, American Express, debit cards, cash, and personal checks.
- There is a returned check fee of $25.00.
- It is your responsibility to promptly bring in any payments your insurance company may have sent to you instead of to us, along with the Explanation of Benefits.

Insurance policies are ultimately a contract between yourself and the insurance company. It will be your responsibility to know how your plan works, what the specifics are, including, but not limited to copays, referrals, deductibles, coinsurance, limitations of service, and non –covered services.

These policies apply only to bills from our private practice, Medical Oncology Hematology Consultants. Bills for other services such as lab work and radiology are separate from our practice. Lab work done in the lab located next to our office is provided by Christiana Care.

Please indicate that you have read, understand, and have received a copy of this policy by signing below.

Name (print)_____ Date _____

Signature_____

Signature of witness _____

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MEDICAL ONCOLOGY HEMATOLOGY CONSULTANTS, PA

NEW PATIENT MEDICAL HISTORY FORM

PATIENT NAME_____ **DATE**_____

Please list any drug/medication ALLERGIES: _____

Please name any other physicians you are currently seeing (and list their specialties):

Referring Physician_____ **Primary Physician**_____

Other Physicians _____

Your physician or nurse practitioner will review this information with you. You should also be prepared for a physical exam.

MEDICAL HISTORY:

HAVE YOU EVER HAD ANY OF THE FOLLOWING *(Please check all that apply)*?

	Yes,	No		Yes	No		Yes	No
Pneumonia	☐	☐	Diabetes	☐	☐	Anemia	☐	☐
High cholesterol	☐	☐	Thyroid disease	☐	☐	Blood clots	☐	☐
Heart attack	☐	☐	Hepatitis	☐	☐	Arthritis	☐	☐
Stroke/TIA	☐	☐	Tuberculosis	☐	☐	Osteopenia/Osteoporosis	☐	☐
Heart Disease	☐	☐	kidney disease	☐	☐	Eye Problems	☐	☐
Stomach ulcers	☐	☐	High Blood Pressure	☐	☐	Seizures	☐	☐
Cancers (list below)	☐	☐	COPD	☐	☐	Depression/Anxiety	☐	☐

_____

HAVE YOU EVER HAD SURGERY FOR ANY OF THE FOLLOWING?

	Yes,	No		Yes	No
Appendix	☐	☐	Hemorrhoids	☐	☐
Tonsils	☐	☐	Hernia	☐	☐
Hysterectomy	☐	☐	Heart	☐	☐
Gallbladder	☐	☐	Teeth	☐	☐
Cataracts	☐	☐	Vascular (veins/arteries)	☐	☐

Any other surgeries (please list) _____

Any hospitalizations (other than surgery or childbirth) _____

Women: # of pregnancies _____ **# of Deliveries** _____ **Complications Y N**

First day of last menses: _____ **Heavy Menstrual Flow Y N Age at menopause**_____

Contraceptives: _____ **Hormone Replacement Therapy Y N**

FAMILY HISTORY:

Mother's age now_____ or age when passed away_____
Her medical problems_____

Father's age now_____ or age when passed away_____
His medical problems

_____

#_____brothers/ #_____sisters
any medical problems/cancers_____

Do you have relatives with any of the following (please circle)?
Heart Attack Diabetes Heart DiseaseStroke Blood Disorders High Blood Pressure Asthma Tuberculosis
Cancer (please list types) _____

PERSONAL HISTORY:

CANCER SCREENING:

Have you had a:

Mammogram	Y	N	please give approximate date_____
Gynecologic exam/Pap smear	Y	N	please give approximate date_____
Colonoscopy	Y	N	please give approximate date_____
Prostate exam/PSA	Y	N	please give approximate date_____

Do you:
Smoke Y N-if so, Packs per day_____ or quit smoking_____years ago
Consume Alcohol Y N-if so, # drinks per week_____ or were you ever a heavy drinker Y N
Quit drinking____years ago
Have any religious beliefs/restrictions that affect your medical care? Y N (please list) _____
Have you ever had:

Asbestos Exposure Y N Other Toxin Exposure Y N (please list) _____

Please List:

Present Occupation_____Previous Occupation_____

Marital Status_____With whom do you live_____

Patient Name: _____

REVIEW OF SYSTEMS:

Have you experienced any of the symptoms?

	Yes	No
Frequent headaches	☐	☐
Change in vision	☐	☐
Sinus problems	☐	☐
Weight loss (# of lbs.____)	☐	☐
Sleep problems	☐	☐
Nervousness	☐	☐
Appetite problems	☐	☐
Painful/stiff neck	☐	☐
Coughing blood	☐	☐
Acid indigestion/heartburn	☐	☐
Pain in abdomen	☐	☐
Frequent Urination	☐	☐
Slow urine stream	☐	☐
Arthritis	☐	☐
Brief weakness of hand or leg	☐	☐
Anemia	☐	☐
Easy bruising	☐	☐
Weight gain	☐	☐
Heavy night sweats	☐	☐
Fevers	☐	☐
Sore throats	☐	☐
Trouble swallowing	☐	☐
Shortness of breath	☐	☐
Cough	☐	☐
Chest pain	☐	☐
Palpitations/ Rapid heartbeat	☐	☐
Nausea/vomiting	☐	☐
Diarrhea/constipation	☐	☐
Blood in stool	☐	☐
Back pain	☐	☐
Kidney infections	☐	☐
Blood in urine	☐	☐
Waking up to urinate more than once	☐	☐
Pain/stiff joints	☐	☐
Stroke/TI's	☐	☐
Vision loss	☐	☐
Bleeding easily	☐	☐
Moles changing color/size	☐	☐
Any skin rashes	☐	☐
Irregular menstrual cycle	☐	☐

Other_____

_____

_____

Medical Oncology Hematology Consultants, PA
Patients Medication Record

Please list all medications—prescription and non-prescription--***EACH TIME*** you come to see the doctor. *If you are not taking any medications, please write "NONE".*

DO NOT include any of your cancer treatment drugs.

Name_____ Date_____

NAME OF DRUG	DOSE	TIMES YOU TAKE A DAY