MOHC MEDICAL ONCOLOGY HEMATOLOGY CONSULTANTS, PA | The US Oncology Network

DBC Delaware Breast Care

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 MD_____**Primary MD**_____ **Others** _____

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
Pneumonia	❒	❒	Diabetes	❒	❒
High cholesterol	❒	❒	Thyroid disease	❒	❒
Heart attack	❒	❒	Hepatitis	❒	❒
Stroke	❒	❒	Tuberculosis	❒	❒
Angina	❒	❒	Kidney disease	❒	❒
Stomach ulcers	❒	❒	High blood pressure	❒	❒
Other cancers	❒	❒			

HAVE YOU EVER HAD ANY OF THE FOLLOWING SURGERIES:

	Yes	No		Yes	No
Appendix	❒	❒	Hemorrhoids	❒	❒
Tonsils	❒	❒	Hernia	❒	❒
Hysterectomy	❒	❒	Heart	❒	❒
(removal of uterus)			Teeth	❒	❒
Oophorectomy	❒	❒	Vascular (veins/arteries)	❒	❒
(removal of ovaries)			Gallbladder	❒	❒
If Yes, 1 or both ovaries removed? _____			Cataracts	❒	❒
Age at removal if both removed? _____					

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_____ **Age at menopause**_____

Age of first menses_____ **Age of first childbirth**_____

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 Disease Stroke Blood Disorders High Blood Pressure Asthma Tuberculosis

Family Cancer History (please list cancer type, relation, and age of diagnosis if known):

Relative (mother, father, sister, etc)	**Type of Cancer**	**Age of Diagnosis**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL HISTORY:

CANCER SCREENING:

Have you had a:

Mammogram □ Y □ N please give approximate date_____
Gynecologic exam/Paps 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:

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

Please List:

Present Occupation_____Previous Occupation_____
Marital Status_____With whom do you live_____

REVIEW OF SYSTEMS:

ARE YOU EXPERIENCING ANY OF THE FOLLOWING:

	Yes	No		Yes	No
Frequent headaches	❒	❒	Migraines	❒	❒
Changes in vision	❒	❒	Glaucoma	❒	❒
Sinus problems	❒	❒	Ear problems	❒	❒
	Yes	**No**		**Yes**	**No**
Weight loss #_____lbs	❒	❒	Weight gain	❒	❒
Sleep problems	❒	❒	Heavy night sweats	❒	❒
Nervousness	❒	❒	Depression	❒	❒
Appetite problems	❒	❒	Fevers	❒	❒
Painful /stiff neck	❒	❒	Sore throats	❒	❒
Thyroid problems	❒	❒	Trouble swallowing	❒	❒
	Yes	**No**		**Yes**	**No**
Bronchitis/emphysema	❒	❒	Shortness of breath	❒	❒
Coughing blood	❒	❒	Chronic cough	❒	❒
Pneumonia	❒	❒	Chest pains	❒	❒
Heart murmur	❒	❒	Palpitations	❒	❒
Angina	❒	❒	Rapid heart beat	❒	❒
	Yes	**No**			
Acid indigestion/heartburn	❒	❒		**Yes**	**No**
Gallstones	❒	❒	Nausea/vomiting	❒	❒
Pains in abdomen	❒	❒	Diarrhea/constipation	❒	❒
Hemorrhoids	❒	❒	Blood in stool	❒	❒
Liver problems/jaundice	❒	❒	Back pain	❒	❒
Kidney stones	❒	❒	Kidney infections	❒	❒
Bladder infections	❒	❒	Blood in urine	❒	❒
Frequent urination	❒	❒	Prostate problems	❒	❒
Slow urine stream	❒	❒	Waking up to urinate	❒	❒
	Yes	**No**		**Yes**	**No**
Arthritis	❒	❒	Pain/stiff joints	❒	❒
Epilepsy/seizures	❒	❒	Stroke/TIA's	❒	❒
Brief weakness of hand or leg	❒	❒	Vision loss	❒	❒
Anemia	❒	❒	Bleeding easily	❒	❒
Easy bruising	❒	❒	Moles changing color/size	❒	❒
Prior blood transfusion	❒	❒	Any skin rashes□	❒	❒
Heavy menstrual flow/severe cramps	❒	❒	Irregular menstrual cycle	❒	❒

Do you have any specific questions for your provider today? _____

_____

New Patient Registration Form

General Information (Please Print)

NAME: _____ DOB: _____ SEX: ___M ___F ___ OTHER

SOCIAL SECURITY #: _____ MARITAL STATUS: ___MARRIED ___ SINGLE ___ DIVORCED __ WIDOWED

PRIMARY ADDRESS: _____

CITY: _____STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____PHONE: _____

EMAIL ADDRESS: _____

PHARMACY NAME: _____ PHONE: _____

EMPLOYMENT STATUS: ___ EMPLOYED ___ UNEMPLOYED ___ RETIRED ___STUDENT

EMPLOYER: _____ OCCUPATION: _____

ETHNICITY: ___ HISPANIC/LATINO ___ NON-HISPANIC-NON-LATINO

RACE: ___ ASIAN ___ BLACK/AFRICAN AMERICAN ___ WHITE ___ AMERICAN INDIAN/NATIVE ALASKA

___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER

Insurance Information

Primary Insurance Information:

INSURANCE NAME: _____ INSURANCE ID#: _____

INSURANCE GROUP#: _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DOB: _____ RELATIONSHIP TO SUBSCRIBER: _____

Secondary Insurance Information:

INSURANCE NAME: _____ INSURANCE ID#: _____

INSURANCE GROUP#: _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DOB: _____ RELATIONSHIP TO SUBSCRIBER: _____

Sharing of Medical Information

I GIVE THE PHYSICIAN AND OFFICE STAFF PERMISSION TO DISCUSS MY MEDICAL CONDITION WITH THE FOLLOWING INDIVIDUALS:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

Patient Phone Message Consent

We may notify you of test results ordered by this office via phone as well as confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voice mail/machine/cell YES___ NO ___ (Initial yes or no)
- Leave a detailed message with individual answering the phone YES ___ NO __ (Initial yes or no)

General Consent for Care and Treatment

To the patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedures to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified conditions.

This consent provides us with your permission too perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request the physicians and mid-level providers at Medical Oncology Hematology Consultants PA & Delaware Breast Care to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative Date

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_____

DRUG NAME	DOSE	HOW OFTEN DO YOU TAKE?

Medical Oncology Hematology Consultants, PA & Delaware Breast Care

NOTICE OF PRIVACY PRACTICES

Effective Date: **September 1, 2024**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

About Us

In this Notice, we use terms like “we,” “us,” “our” or "Practice" to refer to **Medical Oncology Hematology Consultants, PA, and Delaware Breast Care**, its physicians, employees, staff and other personnel. All of the sites and locations of **Medical Oncology Hematology Consultants, PA and Delaware Breast Care** follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information without your written authorization:

For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another healthcare provider to be sure they have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

Individuals Involved in Your Care or Payment for Your Care and Notification: If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

We may use or disclose your information to notify or assist in notifying a family member, personal representative or any other person responsible for your care regarding your physical location within the Practice, general condition or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status and location.

We are also allowed to the extent permitted by applicable law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- Activities related to the quality, safety or effectiveness of FDA-regulated products;
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement authorities to identify or apprehend an individual.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation or banking of organs, eyes, or tissues.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.

- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.

- Sale of Your Health Information: We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **In most circumstances, we are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713**. We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713.** We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713.** You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713.**
We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713.** Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713.** You may also obtain a paper copy of this Notice at our website, www.mohcde.com

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice at **the front desk in the waiting room**. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, www.mohcde.com

Complaints

If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

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.& Delaware Breast Care 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, and have read, the privacy policy provided to me by MOHC/Delaware Breast Care.**

Patient or Representative Signature: _____ Date: _____

Questions

If you have questions about this Notice, please contact **Compliance Officer 4701 Ogletown Stanton Rd Suite 3400 Newark, Delaware 19713**

PATIENT RIGHTS AND RESPONSIBILITIES

As a PATIENT, I have the RIGHT to:

1. Receive an explanation of my diagnosis, benefits of treatment, alternatives, recuperation, risks and an explanation of consequences if treatment is not pursued.
2. An explanation of all services provided by MOHC & DBC, the days and hours of service and provisions for possible emergency care, including telephone numbers.
3. Participate in development of a plan of treatment.
4. Make known Advance Directives or a Living Will, if I wish.
5. Refuse participation in any protocol or aspect of care including investigational studies, and freely withdraw my previous given consent for further treatment.
6. Disclosure of any teaching programs, research or experimental programs in which the facility is participating.
7. Full financial explanation and payment schedule prior to beginning treatment.
8. Receive professional care without discrimination, regardless of race, creed, color, religion, national origin, sexual preference, handicap, sex or age.
9. Be treated with courtesy, dignity and respect of my personal privacy by all employees of MOHC & DBC
10. Complain or file grievances with representatives of MOHC/DBC without fear of retaliation or discrimination.
11. Confidential treatment of my condition, medical record and financial information.
12. Access to my personal records and obtain copies upon written request.

As a PATIENT, I have the RESPONSIBILITY to:

1. Disclose accurate and complete information related to physical condition, hospitalizations, medications, allergies, medical history and related items.
2. Assist in maintaining a safe, peaceful and efficient ambulatory environment.
3. Provide new/changed information related to my health insurance to the business office and be prepared to meet my agreed co-pay during my office visit.
4. Contact the office when unable to keep a scheduled appointment.
5. Cooperate in the planned care and treatment developed for me.

6. Request more detailed explanations for any aspect of service I don't understand.

7. Inform my physicians and nurses of any changes in my condition or any new problems or concerns.

8. Communicate any temporary or permanent change in my address or telephone number which might hinder contact by the office staff.

Medical Oncology Hematology Consultants, PA & Delaware Breast Care

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.
- We will verify with you your insurance coverage at every visit. It is the patient's responsibility to supply all current insurance cards.
- 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 in one of our offices.
- Before receiving chemotherapy in our one of our offices, 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 you do not have insurance or cannot provide proof of insurance at the time of service, a pre-payment not to exceed the amount of a comprehensive consultation will be required.
- 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.
- The adult accompanying a minor to a visit and the legal parents/guardians are responsible for full payment. We will not be involved in negotiating between parents in custody disputes.
- Our office accepts VISA, MasterCard, Discover, American Express, debit cards, cash, and personal checks.
- There is a returned check fee of $25.00.
- If you request that we complete forms or provide medical records for your personal purposes (including forms for your employer), we reserve the right to charge a fee for completion of each form or provision.
- 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 & Delaware Breast Care. Bills for other services such as lab work and radiology are separate from our practice. Please note that lab work done in the lab located next to our Newark 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 _____