



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 #: _____



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.
- If you need to receive chemotherapy, you will meet 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.
- If you do not cancel your appointment within 24 hours of the scheduled time, you are subject to a no show fee of 25\$.

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 _____

Date: _____

**MEDICAL ONCOLOGY HEMATOLOGY CONSULTANTS, PA
 NEW PATIENT MEDICAL HISTORY FORM**

PATIENT NAME _____ **Date of Birth** _____

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 advanced practice provider 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	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia/Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Cancers (list below)	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU EVER HAD SURGERY FOR ANY OF THE FOLLOWING?

	Yes,	No		Yes	No
Appendix	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Vascular (veins/arteries)	<input type="checkbox"/>	<input type="checkbox"/>

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 Disease/Stroke 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	<input type="checkbox"/>	<input type="checkbox"/>
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss (# of lbs. _____)	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Appetite problems	<input type="checkbox"/>	<input type="checkbox"/>
Painful/stiff neck	<input type="checkbox"/>	<input type="checkbox"/>
Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>
Acid indigestion/heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Pain in abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Slow urine stream	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Brief weakness of hand or leg	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Heavy night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Sore throats	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations/ Rapid heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea/constipation	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Kidney infections	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Waking up to urinate more than once	<input type="checkbox"/>	<input type="checkbox"/>
Pain/stiff joints	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TI's	<input type="checkbox"/>	<input type="checkbox"/>
Vision loss	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding easily	<input type="checkbox"/>	<input type="checkbox"/>
Moles changing color/size	<input type="checkbox"/>	<input type="checkbox"/>
Any skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
Irregular menstrual cycle	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

