Carolina Oncology Specialists

A Partner of OneOncology

Today's Date _____/_____/_____

Patient Information Form

Name of Patient:_____Date of Birth:_____Age: _____

Home Address:_____County:_____

City, State, Zip: _____

Mailing Address (if different):_____

Home Phone: (___)_____Cell:(___)_____Work:(___)_____

Email Address: _____

Social Security Number: _____Sex: ☐Male ☐Female

Marital Status: ☐Single(Never Married) ☐Married ☐Life Partner ☐Divorced/Separated ☐Widowed

Race: ☐African American or Black ☐Asian ☐Hispanic ☐White ☐American Indian or Alaska Native ☐Native Hawaiian or other Pacific Islander ☐Other_____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Preferred Language: ☐ English ☐Spanish ☐Other _____

Employment Status: ☐Full Time ☐Part Time ☐Not Employed ☐Active Military ☐Retired Military ☐Self Employed ☐Disabled ☐Retired, date of Retirement: _____

Employer and Address:_____

Insurance Information:

Primary Insurance Co._____ ID:_____

Secondary Insurance Co:_____ ID: _____

ADDITIONAL INFORMATION NEEDED FOR PROCESSING OF INSURANCE:

Do you have employer group health coverage? Yes☐ No☐ If yes, are you still working? Yes☐ No☐

Are you covered through your spouse's insurance? Yes☐ No☐ If yes, their date of birth:____/____/_____

Does his/her employer have more than 50 employees Yes☐ No☐ Is your spouse still working? Yes☐ No☐

Are you a resident of a skilled nursing facility? Yes☐ No☐ If yes, answer the next facility questions.

Name of Facility_____ Facility Address: _____

Facility Phone Number: _____ Does insurance pay for the stay? Yes☐ No☐

Prescription Drug Coverage:

Do you have prescription drug coverage? Yes☐ No☐ If yes, please list below and provide a copy to us.

Prescription Drug Insurance Carrier_____

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Date of Birth: _____

AUTHORIZATIONS AND CONSENT

Authorization to pay benefits to the physician: I hereby authorize payment directly to Carolina Oncology Specialists, PA for any services furnished to me by this provider. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid directly to me.
Person responsible for payment if patient is unable to pay:

Name: _____ Relation: _____ Phone #_____

Consent for purposes of treatment, payment and healthcare operations: I hereby consent to treatment by Carolina Oncology Specialists, PA. I also consent to the use or disclosure of my protected health Information by COS for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of COS. I understand that diagnosis and/or treatment may be conditional upon consent.

Acknowledgment of Receipt of Notice of Privacy Practices: I have received a copy of Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

ADVANCED PRACTITIONER (NP/PA) CONSENT

Carolina Oncology Specialists, PA utilizes Physician Assistant's and Nurse Practitioner's in our office for the levels of our practice that have been approved by the North Carolina State Board of Medical Examiners.
I confirm my agreement to being treated by a Physician Assistant or Nurse Practitioner who is under the supervision of the physicians with Carolina Oncology Specialists, PA, by signing below.

Patient Signature:_____**Date:** _____

AUTHORIZATION TO PROVIDE CONTRACTED SERVICES

During your care at Carolina Oncology Specialists, PA, your physician may prescribe medications. You have the option of receiving these services from the dispensary/pharmacy of your choice.

Dispensary Services

Carolina Oncology Specialists, PA could provide you with many prescribed medications through Carolina Oncology Specialists, PA, a dispensary in which the physician owners have an investment interest. These medications may be dispensed by your physician and transferred to you if you desire. If needed, a pharmacist/physician is available to provide you with counseling concerning your medications.

In addition to Carolina Oncology Specialists, PA, there are local pharmacies in the area that may fill your prescription. A few of the providers in this area are listed below. This is not a complete list of options.

CVS: 704.542.9210

Walgreen's: 704-367-1716

Harris Teeter: 704.364.1245

I understand that I have an option of receiving my prescriptions from the provider of my choice.

Patient Signature:_____**Date:** _____

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Patient Name: _____

Date of Birth: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please release medical information to include history, physical, pathology reports and radiological reports.

Please send information from:

_____

_____

_____

_____

_____

Please send to our office by fax at the following number:

704.377.0353

- **The intent of requesting these medical records is for my treatment. I understand I may revoke authorization by written request. I also understand the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient.**

Patient Signature: _____ Date: _____

- **This authorization expires only if, and when revoked by person signing.**

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Patient Name: _____

Date of Birth: _____

Medication List

Today's Date: _____ Preferred Pharmacy: _____ Telephone Number: _____

Do you have any known **drug** allergies? _____ Yes _____ No

If yes, please list:

Name of Drug Allergy	Reaction

Do you have any other allergies? (foods, dyes, environmental, bee stings, etc.) _____ Yes _____ No

If yes, please list:

Name of Other Allergy	Reaction

Please list all medications you are currently taking (include, prescription, over-the-counter, vaccines, herbals, vitamins, minerals, and diet supplement products).

Medication	Dose	Route	Frequency	Reason for Taking	Date Started	Prescriber

**** Please inform us of any medication changes throughout your care. ****

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Patient Name: _____

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HIPAA Information

☐ I do not authorize Carolina Oncology Specialists, PA to communicate with anyone other than me, excluding all disclosures allowed by law.

OR

I have agreed to let certain individual(s) participate in discussion and decisions related to my medical care. Therefore, I hereby give permission for Carolina Oncology Specialists, PA and staff to disclose my personal information (in person, by telephone, by fax and/or by mail)` to the following individual(s):

***Primary Contact:** _____ ***Relationship:** _____

***Phone:** _____

Additional Names	Relationship	Phone

☐ Please list any conditions of disclosure:_____

I give authorization for Carolina Oncology Specialists, PA to communicate with me regarding my Private Health Information in the following manner (please check the item(s) that apply):

Leave message on my home voicemail/cell phone	Yes☐	No☐
Send Message via Text Message	Yes☐	No☐
Email (non-encrypted)	Yes☐	No☐

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature:_____ **Date:**_____

Living Will & Power of Attorney

Do you have a living will? Yes☐ No☐ **If yes, please provide a copy for our file.**

Medical Power of Attorney to make medical decisions on your behalf? Yes☐ No☐

If yes, please provide a copy for our file. Also, please provide their information below:

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Patient Name: _____

Date of Birth: _____

FINANCIAL RESPONSIBILITY FORM

Agreement

Financial Responsibility

Please read each line below and sign the page to acknowledge that you have read and understand our office policy regarding the payment of amounts that are the responsibility of the patient.

For patients with no insurance coverage, payment is due at the time of service. As a self-paying patient you will receive a discounted rate on your visits as long as payment is made in full on the date of service. If other arrangements are agreed upon, full charges are applicable. We accept cash, checks, and all other major credit cards.

As a courtesy to you, we will bill your insurance carrier for all covered services. You will be required to pay all co-payments, deductibles and coinsurances at the time of your visit

As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. As a courtesy, we will obtain pre-certification for any procedures or treatments we schedule for you. Please understand pre-certification does not guarantee payment from your insurance company.

It is the patient's responsibility to notify us of any changes in insurance, mailing address, or contact information.

Your signature below signifies that you have read each item and understand your responsibility to this office as well as our responsibility to you and your care.

Patient Signature_____**Date:** _____

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Date of Birth: _____

NEW PATIENT HISTORY

Date:_____

Primary Care Physician:

_____

Other Physicians involved in your care:

_____

_____

Previous Surgeries: List any surgery you have ever had such as: hysterectomy, prostate, hernia, gallbladder, breast biopsy, broken bones. Include date of the surgery.

_____

_____

_____

Conditions you have been diagnosed with: List all medical conditions you have now or in the past such as: diabetes, high blood pressure, heart attack, angina, heart failure, migraines, liver disease, emphysema, asthma, positive TB test, pneumonia, kidney condition.

_____

_____

_____

Family History: List medical conditions of your blood relatives. List any cancers or blood disorders and if relatives are deceased, give cause of death and age at time of death.

Father: Alive or Deceased _____

Mother: Alive or Deceased _____

Brother(s): Alive or Deceased _____

Sisters(s): Alive or Deceased _____

Child(ren): Alive or Deceased _____

Occupation: _____

Marital Status: Single Married Life Partner Divorced/Separated Widowed

Spouse's Occupation:

_____

Hobbies: _____

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NEW PATIENT HISTORY (continued)

Alcohol Use: ____Currently ____In the Past ____Rarely/Socially ____Never

How much do (or did) you use? _____

If in the past, how long ago did you quit? _____

Tobacco Use: ____Currently ____In the Past ____Rarely/Socially ____Never

What kind? ___Cigarette ___Cigar ___Chew/Snuff ___Pipe ___e-cigarette

How much do (or did) you use? _____

How long have (or did) you use?_____

If in the past, how long ago did you quit? _____

Sexual Activity:

Are you currently or have you previously been sexually active? ___ yes ___ no

Please specify current or previous sex partner(s). ___men ___women ___both

Have you currently or previously had unprotected sex? ___ yes ___ no

Have you ever been diagnosed with HIV or other STD(s)? ___ yes ___ no

Female Only:

Are you still having menstrual periods? ___ yes ___ no

Are your periods regular? ___ yes ___ no

If you are not having periods, then how old were you when they stopped? _____

Have you had vaginal bleeding after your periods stopped? ___ yes ___ no

Have you taken estrogen hormone pills? (Premarin, birth control) ___yes ___no

If so, name of drug? _____ Still taking? ___yes ___no

How many times have you been pregnant? _____

Number of births: _____ Number of miscarriages/abortions: _____