CANCER CENTER OF SOUTH FLORIDA

PATIENT REGISTRATION FORM

(Please Print)

Reason for Visit:			**Today's date:**

PATIENT INFORMATION

Patient's Last Name:	**First Name:**		**Middle Initial:**
Date of Birth:	**Sex:** ○ M ○ F	**Marital status:**	○ Single ○ Married ○ Divorced ○ Widowed
Social Security:		**Email:**	
Home Phone:	**Cell Phone:**		**Work Phone:**
Florida Address:			
Alternative Address:			
Occupation:	**Employment Status:** ◉ Employed ○ Not Employed ○ Retired ○ Self-Employed		

Race (please check box):	○ American Indian or Alaska Native	○ Asian	○ Hispanic	○ Native Hawaiian or Other Pacific Islander
◉ Black or African American	○ White	○ Other Race: _____		○ Refused to Report

Ethnicity (please check box):	○ Hispanic or Latino	○ Not Hispanic or Latino	○ Refused to Report

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:				
Name of primary insurance:				
Subscriber's name:				
Subscriber's SS#:				**Birth date:**
Patient's relationship to subscriber:	○ Self	○ Spouse	○ Child	○ Other
Name of secondary insurance (if applicable):				
Subscriber's name:				
Subscriber's SS#:				**Birth date:**
Patient's relationship to subscriber:	◉ Self	○ Spouse	○ Child	○ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to patient:**	**Home Phone:**	**Cell Phone:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Cancer Center of South Florida or insurance company to release any information required to process my claims.

Patient/Guardian signature	***Date***

4801 South Congress Avenue • Suite 201 • Lake Worth, FL 33461
11382 Prosperity Farms Road • Suite 228 • Palm Beach Gardens, FL 33410
Phone: 561-253-3980 • Fax: 561-253-3985

CANCER CENTER OF SOUTH FLORIDA

MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Patient Name: _____Date of Birth: _____

Other Doctor Information			
Referring doctor:		**Phone:**	
Primary/Family doctor:		**Phone:**	
Radiation Oncologist Name:		**Phone:**	
Surgeon Name:		**Phone:**	

Preferred Pharmacy	
Pharmacy Name:	
Phone:	
Address:	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

Advance Directives			
☐ Living Will	☐ Durable Power of Attorney	☐ Health Care Proxy	☐ DNR

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Patient Name: _____Date of Birth: _____

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus	Date:	☐ Pneumonia	Date:
	☐ Hepatitis	Date:	☐ Chickenpox	Date:
	☐ Influenza	Date:	☐ MMR *Measles, Mumps, Rubella*	Date:

Mammogram	○ Yes	○ No	Date last performed:	Where:
Pap Smear	○ Yes	○ No	Date last performed:	Where:
Colonoscopy	○ Yes	○ No	Date last performed:	Where:
Other Cancer Screening	○ Yes	○ No	Date last performed:	Where:

Have you ever had a blood transfusion?	○ Yes	○ No

Surgical History (Check all that apply)

☐ Appendectomy	Year:	☐ Gall Bladder	Year:
☐ Cardiac Angioplasty, Stent or Bypass	Year:	☐ Hernia Repair	Year:
☐ Cardiac Catheterization	Year:	☐ Hysterectomy	Year:
☐ Cesarean Section	Year:	☐ Prostate Surgery	Year:

Other Surgical History

Other hospitalizations

Year	Reason	Hospital

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MEDICAL HISTORY

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Patient Name: _____ **Date of Birth:** _____

HEALTH HABITS AND PERSONAL SAFETY						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Alcohol	Do you drink alcohol? ◯ Yes ◯ Occasional ◯ Never					
	If yes, How many drinks per week?					
Tobacco	Do you use tobacco? ◯ Current ◯ Previous ◯ Never					
	If current, ☐ Cigarettes – pks./day:	☐ Chew - #/day:	☐ Pipe - #/day:	☐ Cigars - #/day:		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				◯ Yes	◯ No
Personal Safety	Do you live alone?				◯ Yes	◯ No
	Do you have frequent falls?				◯ Yes	◯ No
	Do you have vision or hearing loss?				◯ Yes	◯ No
	Do you have an Advance Directive or Living Will?				◯ Yes	◯ No
	Would you like information on the preparation of these?				◯ Yes	◯ No

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**		
Mother					
Sibling					
			Grandmother *Maternal*		
			Grandfather *Maternal*		
			Grandmother *Paternal*		
			Grandfather *Paternal*		

CANCER CENTER OF SOUTH FLORIDA

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner: (Check all that apply)	
☐ Home Phone:	☐ Cell Phone:
☐ OK to leave message with detailed information	☐ OK to leave message with detailed information
☐ Message with call-back number only	☐ Message with call-back number only
☐ Written Communication:	☐ Work Phone:
☐ OK to mail to my home address	☐ OK to leave message with detailed information
☐ OK to fax to this number:	☐ Message with call-back number only

I hereby give authorization to speak to the following people regarding my illness/condition.

Name	Relationship	Home Phone	Cell Phone
Name	Relationship	Home Phone	Cell Phone
Name	Relationship	Home Phone	Cell Phone
Name	Relationship	Home Phone	Cell Phone
Name	Relationship	Home Phone	Cell Phone

Patient's Signature

Date

Printed Name

Witness to Patient's Signature

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CANCER CENTER OF SOUTH FLORIDA

PRIVACY POLICY

Patient Name: _____Date of Birth: _____

Effective July 1, 2008

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of the protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for the purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will -

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorization, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, without authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will –
  - ◊ Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - ◊ Not disclose PHI data unless the patient (or his/her authorized representative) has properly authorized the release or the release is otherwise authorized by law.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes information is inaccurate or incomplete. Our practice and its physicians and staff will -
  - ◊ Permit patient's access to their medical records when their written requests are approved by our practice. If we deny the request, then we must inform the patient that he/she may request a review of the denial.
  - ◊ Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as the request is in writing.
- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of the policy is grounds for disciplinary sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon release of a revised privacy policy and will be made available to patients upon request.

CANCER CENTER OF SOUTH FLORIDA

PATIENT CONSENT OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____Date of Birth: _____

I hereby give authorization to Cancer Center of South Florida to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Cancer Center of South Florida's notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Cancer Center of South Florida reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice Privacy Practices may be obtained by forwarding a written request to Cancer Center of South Florida at 4801 South Congress Ave, Ste 201, Lake Worth, FL 33461.

With this consent, Cancer Center of South Florida, may call my home or other alternative location and leave a message on voicemail, with my spouse or myself in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Cancer Center of South Florida may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. The practice is required to agree to my requested restrictions, if in writing.

By signing the form, I am consenting to Cancer Center of South Florida's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cancer Center of South Florida may decline to provide treatment to me.

_____ _____

Patient's Name Date

_____

Date of Birth

_____ _____

Signature of Patient or Legal Guardian Printed Name of Signer

CANCER CENTER OF SOUTH FLORIDA

RESPONSIBILITY AND CONSENT STATEMENT

Patient Name: _____Date of Birth: _____

Commercial Insurance – CCSF will bill insurance provided that your carrier will make payment directly to our office. CCSF will attempt to bill your insurance company in an effort to collect payment. In the event your insurance company does not pay for billed services, the balance will be your responsibility. We will verify the insurance coverage and inform you if any percentage you will be responsible to pay. Payment is due on the date of service.

Medicare – CCSF will accept assignment from Medicare. You are responsible for the 20% co-payment on the date of service. If you have a Medicare supplement, we will file a claim with them provided they will make payment to our office.

Referrals – Certain insurances require that you have a referral from your primary care physician. Please make sure that your PCP has been notified of this appointment and has provided us and you with a copy of that referral prior to your appointment.

Insurance Release – I authorize CCSF to release to my insurance company and to communicate with hospitals and other medical providers any required information regarding services provided including; medical, psychiatry, laboratory studies, HIV testing, and other medical data related to my care. I authorize any insurer or payor to make payment directly to CCSSF. A photocopy of this authorization shall be considered as effective and valid for the duration of the claim.

Financial Agreement – I understand that my insurance contract is between me and my insurance company. I also agree that I am responsible for any charges that my insurance company will not cover. I understand that failure to pay my account or make suitable financial arrangements may result in my account being turned over to an outside collection agency. If this becomes necessary, I agree to pay all collection fees which include but are not limited to court fees, attorney fees, and any other fees for the collection of my account balance. Further, I consent CCSF inquiries into my credit history in conformity with legitimate business needs and applicable laws, rules, and regulations.

Claim Submission:
In the event the patient has insurance coverage but cannot provide documentation, charges will be entered as self-pay. Upon submittal of insurance card, we will submit a health insurance claim form. Secondary insurance is filed upon patient's submission of proof of secondary insurance.

CANCER CENTER OF SOUTH FLORIDA

RESPONSIBILITY AND CONSENT STATEMENT

Patient Name: _____Date of Birth: _____

Forms and Release of Records:
The completion of Administrative forms about your care and duplication of medical records is not a part of your routine medical services from us. We are happy to assist you in any way we can, but we reserve the right to charge appropriately for these extra services, based upon time and effort involved. If you require us to copy your medical records, in accordance with the State Law, we may charge a fee for the costs of retrieving, copying, mailing and other supplies associated with your request. Any slides that need to be sent over night to be re-read at any Hospital will incur a $125.00 service charge to cover shipping fees. Any disks to be sent over night to be re-read at any Hospital will incur a $50.00 service charge to cover shipping fees.

Minors/Dependents:
Children under the age of 18 will require the signature of a responsible adult party on the registration form. We cannot treat an unaccompanied minor for any office appointments.

Account Consultation/Financial Assistance:
OUR PHYSICIANS DO NOT DISCUSS FINANCIAL ISSUES. OUR BILLING STAFF IS TRAINED TO DISCUSS YOUR ACCOUNT AND CAN MAKE PA YMENT ARRANGEMENTS IF NECESSARY.

_____ _____
Patient's Signature Date

_____
Printed Name

_____
Date of Birth

CANCER CENTER OF SOUTH FLORIDA

Patient Authorization to Use or Disclose Protected Health Information

I_____, understand that any entity receiving this
Printed Name

document is authorized to release my protected health information to the Cancer Center of South Florida. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of the entity in receipt of this document or any other individual listed below to disclose my protected health information as described on this form to the Cancer Center of South Florida. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that this authorization remains in force unless revoked in writing according to the steps set forth below.

I authorize the recipient of this document to furnish the Cancer Center of South Florida all of my medical records.

Description of the information to be used or disclosed:

The patient's entire medical record, including demographics or specific information as indicated below:

_____

_____

Purpose(s) of the information: Continuity of care

My protected health information may ONLY go to this fax number: 561-253-3985

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, the Cancer Center of South Florida must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

I understand and accept the terms of this authorization and understand that this authorization is in effect until written revocation.

_____	_____	_____
Patient's Signature	Patient Date of Birth	Date

Witness to Patient's Signature: _____