Progressive Oncology and Hematology Center
2405 Whittier Dr. Suite 100 Frederick, MD 21702
Phone: 301-682-2988 Fax: 301-682-2989

Name: ____ Date of Birth: ___________ Age: _____
Last First MI

Address____ Home Phone____________________

City __________________________ State ______ ZIP _________ Cell Phone ____________________

Male [ ] Female [ ] Social Security # ____________________ Marital Status _________________

In Case of Emergency Contact _______________________________ Relationship ___________________

Home Phone _________________ Cell Phone __________________ Work Phone ___________________

Email Address (for Patient Portal) _____________________ Reason for Referral____________________

How did you hear about us _______________________ Mothers Maiden Name ______________________

Primary Care Physician __________________________________ Phone ________________________

Other Medical Provider __________________________________ Phone ________________________

Other Medical Provider __________________________________ Phone ________________________

Do you have an Advanced Directive [ ] YES [ ] NO Do you have a Living Will[ ] YES [ ] NO

Please provide all your insurance card(s) to the secretary for copying

REMINDER: PLEASE CONTACT YOUR INSURANCE TO VERIFY OUR OFFICE IS IN NETWORK AND IF REFERRALS ARE REQUIRED

I, ____________________________hereby certify that the above information is accurate. I agree to notify the office of any changes in insurance, address or phone number.

Signature____ Date ________________________

CLEAN CLAIM GUIDELINES

I understand that by providing Progressive Oncology & Hematology Center complete and accurate information as requested, I am complying with the "Clean Claim Guidelines". Clean Claim Guidelines state that I must provide my name, date of birth, social security number and complete address to the provider of service, in order for the provider to bill my insurance company. If any information is refused or omitted by me, I understand that I am liable for payment for the services provided.

____

Printed Name of Patient, Guardian, or Guarantor

____

Signature of Patient, Guardian, or Guarantor

____

Date

Progressive Oncology & Hematology Center

PATIENT RECORDS OF DISCLOSURE

In general, the HIPPA privacy rule gives the individual 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 communication or that a communication of PHI is 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 Telephone
[ ] OK to leave message with detailed information
[ ] Leave message with call back number only

[ ] Work Telephone
[ ] OK to leave message with detailed information
[ ] Leave message with call back number only

[ ] Other
____

[ ] Cell Phone
[ ] OK to leave message with detailed information
[ ] Leave message with call back number only

[ ] Written Communication
[ ] OK to mail to my home address
[ ] OK to mail to my work/office

[ ] OK to fax to this number
____

____
Patient Signature

____
Date

____
Print name

____
Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute and adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Date	To whom we can release information	Relationship	Phone Number

Progressive Oncology and Hematology Center
Mouhamad Bazzi, MD
2405 Whittier Dr. Suite 100 Frederick, MD 21702
Phone: 301-682-2988 Fax: 301-682-2989

MEDICAL RECORD RELEASE

Date: ____________________________

Patient Name: _____________________________________ Date of Birth: _________________________

To: ____
____
____
____

I hereby authorize you to release all my records, specimens and lab results to:

Progressive Oncology and Hematology Center
2405 Whittier Dr. Suite 100 Frederick, MD 21702

PLEASE FAX ALL MEDICAL INFORMATION CHECKED BELOW TO:

Fax: 301-682-2989

( ) RECENT History & Physical or Physicians notes

( ) ALL Operative/Procedure notes & Discharge summary

( ) RECENT Progress notes

( ) ALL CT scan, MRI, Mammogram, Ultrasound and X-Ray reports

( ) ALL Pathology reports

( ) ALL lab work to include CBC, Tumor Markers, etc.

( ) ALL chemotherapy/Radiation records

( ) Other: ____

This authorization is valid from date: ___________________________ to ____________________________.

Patient Signature: ____ Date: ________________________

Progressive Oncology and Hematology Center
Dr. Mouhamad Bazzi, MD
2405 Whittier Dr. Suite 100 Frederick, MD 21702
Phone: 301-682-2988 Fax: 301-682-2989

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the notice of Privacy practices and I have been provided an opportunity to review it.

Name____ Date of Birth_________________

Signature ____ Date_________________

Patient Name____ Date of Birth_________________________

Allergies____

Ask about using Progressive Oncology’s in-house pharmacy

Pharmacies

Preferred Local Pharmacy ___________________

Phone _______________________________________

City, State _____________________________________

Preferred Mail Order Pharmacy ___________________

Phone _______________________________________

City, State _____________________________________

MEDICATION LOG (for STAFF USE ONLY)

Medication	Dose	Frequency				

PROGRESSIVE ONCOLOGY & HEMATOLOGY CENTER

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

REFERRALS: Some managed care plans require written authorization forms from your primary care physician for each visit to Progressive Oncology & Hematology Center. It is the PATIENTS responsibility to make sure that a valid authorization form is obtained BEFORE each visit. THESE FORMS CAN NOT BE ISSUED RETROACTIVIELY.

1. Insurance is a contract between you and your insurance company. For the most part, we are not a party to this contract. We will inform you if we are a party to the contract and will handle your claims according tour agreement with the insurance company. We file insurance claims as courtesy to our patients. We will not become involved in a dispute between you and your insurance company regarding deductible, copayments, covered charges, secondary insurance, “usual & customary charges,” etc. other than the to supply the information as necessary. You are responsible at the timely payment of your account.

2. COPAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED. If it becomes necessary to send you a bill for a copayment, there will be a $15.00 processing fee. If you have any questions regarding your office visit copayment, please contact your insurance company.

3. RETURNED CHECKS will be charged *a $25.00* processing fee.

4. CANCELLATION/NO SHOW POLICY: If a NEW PATIENT CONSULT appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will NOT be covered by your insurance company

5. *If you do not have insurance, an initial payment of $75.00 is due at time of service unless prior arrangements have been made.*

WE ACCEPT CASH, CHECKS, CREDIT CARDS AND MONEY ORDERS

(Visa, MasterCard, Discover and American Express)

We would like to thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I authorize the release of any medial information necessary to process my insurance, or to another physician or medical facility if appropriate to expedite my medical care. I allow fax transmittal of my medical records, if necessary. I request payment of authorized Medicare/Insurance benefits be made to Progressive Oncology & Hematology Center on my behalf, for any services furnished to me by them. I authorize any holder of medial information about me to release to the Health Care Financing Administration and its agents, or other insurance agencies, any information needed to determine benefits payable for related services.

I understand that I am financially responsible for all charges whether or NOT paid by insurance. If full payment is not made with regard to bills for services rendered, I agree to pay all necessary and reasonable costs of collections beginning at 27% of account balance. Including, but not limited to Attorney’s or collection agency for collection, and/or court costs. I agree to this provision.

I agree to accept all Financial Responsibility for services rendered.

Signature____ Date______________________________________

Patient/Guardian

Relationship to Patient____

PROGRESSIVE ONCOLOGY & HEMATOLOGY CENTER

Consent for email and text message reminders

Patient Name (First, Last):	DOB: _____/______/_______
Person signing (if not the patient):	

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

__________ (Patient initials) I consent to receive text/voice messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all occasions, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

Text messages are generated using a secure facility. I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information that would enable an individual patient to be identified.

I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number: _____________________________
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/ information in the Patient Portal to the following Email Address:
____

Please choose method of communication for appointments reminder:

- ○ SMS Text Only
- ○ Email message
- ○ Voice message

____
Signature

______/_______/_______
Date signed (MM/DD/YYYY)

Patient name: **Today's Date:**

Social History

Smoker- Former/Never, How long, how much a day

Alcohol

Drug

Chemical Dependencies

Exercise: regularly occasionally never

____ days per week

Married Divorced Single Widow

Children:

Employment History:

Nutritional History

Diet: Well Balanced

Fat intake light moderate heavy

Caffeine coffee tea cola _____ cups per day

Family Health History

Age, any health issues, cause of death

Mother:

Father:

Maternal Grandfather:

Maternal Grandmother:

Paternal Grandfather:

Paternal Grandmother:

Sister:

Brother:

Daughter:

Son:

Past Medical History

Ongoing Medical Problems

Such as: DM/ HTN/ Heart Problems/ Breathing Problems/ Mental Illness/ Depression/ Anxiety/ ation/Thyroid or Adrenal Issues/ Gastrointestinal Issues/ Urinary Problems/ Vision or Hearing Problems/ Musculoskeletal Issues/ Neurological Problems/ Skin

Problems/ Ear Nose or Throat Issues/ Blood Issues.

Surgical History

Surgical procedure/ date/ location/ MD

Preventative Healthcare

Vaccines

COVID date/ manufacturer/ prior infection with mo and yr/ severity/ full recovery vs post COVID syndrome/ if no vaccine why?

FLU

PNA

Hep B

Tetanus

Shingles

Males:

Colonoscopy: year/ location or MD/ results/ when is next follow up

EGD: year/ location or MD/ results/ when is next follow up

Prostate Screening: year/ location or MD/ results/ when is next follow up

Females:

Colonoscopy: year/ location or MD/ results/ when is next follow up

EGD: year/ location or MD/ results/ when is next follow up

Mammogram: year/ location or MD/ results/ when is next follow up

PAP Smear: year/ location or MD/ results/ when is next follow up

Self Breast Exams: yes no

Menstrual History

Age at Onset

Cycle regularity duration heavy/ medium/ light/ pain/cramps

First Day of Last Cycle:

Long-term estrogen use: when started/ still using

Pregnancies: how many/ live births/ miscarriages/ complications

Age at first term pregnancy:

Advanced Directives

Record:

Patient does not wish to provide advance directive

Patient verbalizes wishes to have all life saving measures provided