**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 [ ] Cell Phone

[ ] OK to leave message with detailed information [ ] OK to leave message with detailed information

[ ] Leave message with call back number only [ ] Leave message with call back number only

[ ] Work Telephone [ ] Written Communication

[ ] OK to leave message with detailed information [ ] OK to mail to my home address

[ ] Leave message with call back number only [ ] OK to mail to my work/office

 [ ] Other [ ] 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.*

He

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| --- | --- | --- | --- |
| Date | To whom we can release information  | Relationship | Phone Number |
|  |  |  |  |
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**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

DO YOU HAVE ANY SIGNIFICANT? (CHECK ONE OR DESCRIBE)

GENERAL: [ ] Weight loss/gain [ ] Fever [ ] Night Sweats

 [ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EYES: [ ] Change in Vision

 [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EARS: [ ] Decrease hearing [ ] Ear Pain

 [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOSE: [ ] Sinus Problems [ ] Allergies

 [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THROAT: [ ] Frequent Sore Throats [ ] Persistent Hoarseness

 [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NECK: [ ] Frequent Neck Pain [ ] Arm Numbness, Tingling [ ] Thyroid Problems

 [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BACK: [ ] Frequent Back Pain [ ] Leg Pain, Numbness

 [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESPIRATORY: [ ] Chronic Cough [ ] Shortness of Breath [ ] Wheezing

 [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CARDIOVASCULAR: [ ] Exertional Chest Pain [ ] Palpitations [ ] Swelling of Legs

 [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GASTROENTEROLOGIC: [ ] Nausea/Vomiting [ ] Diarrhea [ ] Constipation [ ] Heartburn

 [ ] Blood or Pain w/BM [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENITOURINARY: [ ] Urinary Problems [ ] Menstrual Problems [ ] Sexual Problems

 [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NEUROLOGIC: [ ] Severe Headaches [ ] Dizzy Spells [ ] Seizures

 [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MUSCULOSKELETAL: [ ] Unusual Joint pains [ ] Unusual Muscle Pains

 [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DERMATOLOGIC: [ ] Skin Lesions [ ] Rashes

 [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEMATOLOGIC: [ ] History of Anemia [ ] Clotting Disorder [ ] Sickle Cell

 [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ENDOCRINOLOGIC: [ ] Unusual Thirst [ ] Cold or Heat Intolerance [ ] Discharge from Breast

 [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PYCHOLOGIC: [ ] Depression [ [ Anxiety [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

 **Living Deceased Age Illnesses**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Maternal Grandmother** |  |  |  |  |
| **Maternal Grandfather** |  |  |  |  |
| **Paternal Grandmother** |  |  |  |  |
| **Paternal Grandfather** |  |  |  |  |
| **Mother** |  |  |  |  |
| **Father** |  |  |  |  |
| **Siblings** |  |  |  |  |
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| **Children** |  |  |  |  |
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**Personal History**

**Childhood Illnesses** **Allergies** [ ] YES [ ] NO

**Measles** [ ] YES [ ] NO **Medications** [ ] YES [ ] NO

**Mumps** [ ] YES [ ] NO **If so, specify drugs**:

**Chicken Pox** [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other** [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Explain**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Food Allergies** [ ] YES [ ] NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Explain**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Animal Allergies** [ ] YES [ ] NO

**Adult Illnesses** **Injuries** [ ] YES [ ] NO

**Diabetes** [ ] YES [ ] NO **Have you had any broken bones or**

**High Blood Pressure** [ ] YES [ ] NO **significant accidents**: [ ] YES [ ] NO

**Heart Problems** [ ] YES [ ] NO **Please Explain**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory Problems** [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Illness** [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Depression** [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other** [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Explain**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgery** **Weight**

**Tonsillectomy** [ ] YES [ ] NO Now \_\_\_\_\_\_\_\_\_ One year ago \_\_\_\_\_\_\_\_\_

**Appendectomy** [ ] YES [ ] NO Maximum \_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_

**Hysterectomy** [ ] YES [ ] NO

**Including Ovaries**  [ ] YES [ ] NO Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hernia Surgery** [ ] YES [ ] NO

**Gall Bladder Surgery** [ ] YES [ ] NO

**Other**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST YEAR YOU LAST HAD**  **Medications**

\_\_\_\_\_\_\_ Pneumonia Shot **Please bring a list all prescription, over the**

\_\_\_\_\_\_\_ Flu Shot **counter meds, herbs, vitamins, teas. You**

\_\_\_\_\_\_\_ Tetanus Shot **may bring your medication bottles if this**

\_\_\_\_\_\_\_ Hepatitis Shot **also if this is easier.**

\_\_\_\_\_\_\_ TB Test (PPD)

\_\_\_\_\_\_\_ Eye Exam

\_\_\_\_\_\_\_ Dental Exam

\_\_\_\_\_\_\_ Cholesterol Test

\_\_\_\_\_\_\_ Stool Blood Test

\_\_\_\_\_\_\_ Rectal Exam

\_\_\_\_\_\_\_ Colonoscopy

\_\_\_\_\_\_\_ Sigmoid Exam

**Have you ever been tested for**:

**Tuberculosis** [ ] YES [ ] NO

**If so, when**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Results**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Habits** **FOR WOMEN ONLY**

 **Menstrual History**

**Do you exercise regularly** [ ] YES [ ] NO

**How often** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age at onset** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke** [ ] YES [ ] NO R**egular** [ ] YES [ ] NO

**How much**\_\_\_\_\_\_\_\_\_\_\_\_\_ How many years \_\_\_\_\_\_\_\_\_ Cycle: Every \_\_\_\_\_\_\_days

 **Usual Duration** \_\_\_\_\_\_\_\_\_\_\_\_\_days

**Did you ever smoke, chew tobacco, snuff** [ ] YES [ ] NO

**Please circle** Heavy Medium Light  **Pain or Cramps** [ ] YES [ ] NO

**How many years** \_\_\_\_\_\_\_\_\_\_

F**irst Day of Last Cycle­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you use street/illegal drugs** [ ] YES [ ] NO **How often** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Last Pap Smear** \_\_\_\_\_\_\_\_\_\_\_\_

**Do you drink Alcohol** [ ] YES [ ] NO **Ever take Estrogen** [ ] YES [ ] NO

**Please Circle**: Regular Moderate Daily Never

**How many drinks in a week** \_\_\_\_\_\_\_\_\_\_ **Regular Self Breast Exams** [ ] YES [ ] NO

**Have you ever been treated for Mammograms** [ ] YES [ ] NO

**Chemical Dependency** [ ] YES [ ] NO **Date of last Mammogram** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Result** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your diet well balanced** [ ] YES [ ] NO

**Fat Intake**: Light Moderate Heavy **Pregnancies**

 **How many** \_\_\_\_\_\_\_

**Caffeine Intake** Light Moderate Heavy  **How many live births** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How much coffee/tea in a day** \_\_\_\_\_\_\_\_\_\_\_\_\_\_  **How many miscarriages** \_\_\_\_\_\_\_\_\_\_\_\_

**How much cola in a day** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Complications** [ ] YES [ ] NO **What type** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **Age at first term pregnancy** \_\_\_\_\_\_\_\_\_\_

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacies

Preferred Local Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Mail Order Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION LOG (for STAFF USE ONLY)**

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| **Medication** | **Dose** |  **Frequency** |   |  |  |  |
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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) |