Pratibha Desai, MD
Syed Abid, MD
Sudhir Hansalia, MD
Ahmad Shaker, MD
Faseeh Khaja, MD
George Dermarkar, MD

Pinellas Hematology and Oncology

COMPASSIONATE CANCER CARE

PATIENT CONFIDENTIAL INFORMATION

Patient Name _____ **Date**_____

Date of Birth _____ **Social Security #**_____ **Female** _____ **Male**_____

Email Address _____

Street Address _____ **City** _____ **ZIP** _____

Mailing Address _____**City** _____ **ZIP** _____

Home Phone Number _____ **Other Phone Number** _____

Name of Employer _____ **Occupation** _____

Employer's Address _____ **Phone Number** _____

Name of Spouse _____**Phone umber**_____

Spouse's Employer _____**Phone Number** _____

Nearest Friend or Relative _____**Relationship** _____

Address _____**Phone Number** _____

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN** _____

INSURANCE ____YES _____NO

Medicare # _____ **Medicaid #** _____

Other Insurance Name _____

Group # _____ **Policy #** _____

Name of Insured _____ **Relationship** _____

Preferred Pharmacy _____ **Pharmacy Location** _____

Preferred Hospital _____**Hospital Location** _____

ETHNICITY _____Hispanic or Latino _____Not Hispanic or Latino PREFERRED LANGUAGE English / Spanish (Circle One)

RACE:
___White ___African American ___Asian ___American Indian or Alaska Native ___Native Hawaiian ___Other

RELEASE OF INFORMATION AND PAYMENT TO PHYSICIAN

In order to submit a claim for payment for covered services, we must have authorization to release medical information to your insurance carrier.

MEDICARE AND MEDICAID

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

ALL OTHER INSURANCE

I hereby authorize Pinellas Hematology and Oncology, P.A. to submit a claim to my insurance carrier or its intermediaries, for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering the covered services.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

I authorize Pinellas Hematology and Oncology, P.A. Pratibha Desai, MD; Syed Abid, MD; Sudhir Hansalia, MD; Ahmad Shaker, MD; Faseeh Khaja, MD; George Dermarkar, MD to use to use, disclose and furnish my personal health information, including but not limited to, information about the services rendered to me, as may be requested by my insurance carrier or its intermediaries, and to those providers of its treatment, payment, and health care operations and as described more fully in the Pinellas Hematology and Oncology, P.A. written Notice of Privacy Practices which I have been provided a copy of. I further agree that I am responsible for paying any balances which remain after insurance payments have been made.

Patient Signature_____ **Date** _____

Spouse Signature_____ **Date** _____

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REVIEW OF SYSTEMS

Todays Date_____ Name _____ Date of Birth _____ Age_____

Allergies_____ No Allergies ☐

Occupation_____ Retired ☐ Daily Exercise: YES ☐ NO ☐

Married ☐ Single ☐ Widowed Divorced Number of Children _____ Number of Pregnancies_____

Smoking: YES ☐ NO ☐ _____ Packs Per Day for Geo_____ Years Quit Smoking _____ Years / Months Ago

Alcohol: YES ☐ NO ☐ _____ Drinks Per Day. Drug Use: YES ☐ NO ☐ If Yes_____

Date of Last Mammogram _____Date of Last Colonoscopy _____

Please List All **Surgeries** With Dates (year)	Please List All **Illnesses**/Serious **Injuries** With Dates (year)

Family History (check only those boxes that apply): ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure
☐ Stroke ☐ TB ☐ Cancer ☐ Kidney Disease ☐ Anemia ☐ Arthritis ☐ Mental Illness

Mother: ☐ Living ☐ Deceased Age Deceased _____ Cause of Death_____

Father: ☐ Living ☐ Deceased Age Deceased _____ Cause of Death _____

Do you have a Living Will? ☐ Yes ☐ No

How is your present appetite? ☐ GOOD ☐ FAIR ☐ POOR

Have you experienced any recent weight loss? ☐ YES ☐ NO If yes, how much weight loss? _____

Do you live alone? ☐ YES ☐ NO If yes, is there someone who helps you prepare the meals? ☐ YES ☐ NO

Do you have any oral or dental problems that might interfere with chewing, eating or swallowing? ☐ YES ☐ NO

If yes, please explain: _____

_____

When did you first notice symptoms related to your present illness_____

_____

What were the symptoms_____

_____

When did you first see a doctor for your present illness _____ Have you been hospitalized for this illness? ☐ YES ☐ NO Name of hospital: _____ Date: _____

Was a biopsy performed? ☐ YES ☐ NO Did you have surgery? ☐ YES ☐ NO

Have you received chemotherapy? ☐ YES ☐ NO If yes, where? _____

Have you had any previous radiation therapy? ☐ YES ☐ NO

If yes, where? _____ When?_____

Have you had recent X-rays, CT scans, PET scans or MRI's ? ☐ YES ☐ NO

If yes, where? _____ When?_____

NAME: _____ _____Today's Date

Date of Birth _____

Please Complete By Checking Yes or No to All That Apply

CONSTITUTIONAL	Y	N	**RESPIRATORY**	Y	N	**HEMATOLOGIC/LYMPH**	Y	N
Weight Loss			Cough			Easy Bruising		
Fatigue			Coughing Up Blood			Gums Bleed Easily		
Fever			Shortness of Breath			Enlarged Glands		
Sweats			Wheezing			Prolonged Bleeding		
EYES	Y	N	**GASTROINTESTINAL**	Y	N	**MUSCULOSKELETAL**	Y	N
Glasses / Contacts			Heartburn			Joint Pain/Swelling		
Eye Pain			Nausea / Vomiting			Stiffness		
Double Vision			Constipation			Muscle Pain		
Glaucoma			Change in Bowel Habits			Back Pain		
Cataracts			Diarrhea			**SKIN**	Y	N
EAR, NOSE, THROAT	Y	N	Difficulty Swallowing			Rash/Sores		
Difficulty Hearing			Jaundice			Itching/Burning		
Ringing in Ears			Abdominal Pain			**NEUROLOGICAL**	Y	N
Vertigo			Dark / Black Stool			Seizures		
Sinus Trouble			**GENITOURINARY**	Y	N	Weakness/Paralysis		
Nasal Stuffiness			Pain Urinating			Numbness		
Frequent Sore Throat			Burning			Tremors		
Hoarseness			Frequency			Memory Loss		
CARDIOVASCULAR	Y	N	Nighttime			**ENDOCRINE**	Y	N
Murmur			Blood in Urine			Loss of Hair		
Chest Pain			Difficulty Urinating			Heat/Cold Intolerance		
Palpitations			History of Kidney Stone			Change in Nails		
Dizziness or Fainting Spells			History of STD			**IMMUNOLOGICAL**	Y	N
Shortness of Breath			Abnormal Discharge			Hay Fever / Asthma		
Difficulty Lying Flat						Hives / Eczema		
Swelling Ankles / Other						**PHYCHIATRIC**	Y	N
FEMALE ONLY	Y	N	**FEMALE ONLY**	Y	N	Anxiety / Depression		
Are you pregnant			Date of last period:			Mood Disorder		
Number of pregnancies:			Number of live births:			**FEMALE ONLY**	Y	N
Menstrual Periods Regular			Recent Vaginal Bleeding			Do you take hormones		
Take birth control pills			Recent Vaginal Discharge			Menopause		

Revised: 12/21/17

Pinellas Hematology and Oncology
COMPASSIONATE CANCER CARE

PATIENT NAME:
_____

Date of Birth _____

Please list additional health information you feel may be important to your physician:

_____
_____
_____
_____
_____
_____

5000 Park Street North, Suite 1017, St Petersburg, FL 33709 (T) 727-344-6569 (F) 727-384-4388
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Revised: 12/21/17

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MEDICATION RECORD

PATIENT NAME: _____DOB: _____ DATE: _____

PRESCRIPTION NAME	DOSE	FREQUENCY	NOTES

PREFERRED PHARMACY: _____PHONE: _____

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PATIENT DISCLOSURE TO REQUEST RECORDS FROM OTHER PROVIDERS

PATIENT NAME: _____ DATE: _____
DOB:_____ SOCIAL SECURITY#_____

Purpose of Disclosure:
_____ Continuing care with another physician or hospital _____ Personal copy
_____ Other: _____

I AUTHORIZE THE FOLLOWING PHYSICIAN(S), PHARMACY(S) AND/OR HOSPITAL(S) TO RELEASE MY MEDICAL RECORDS IN THEIR ENTIRETY OR AS INSTRUCTED BELOW TO: PINELLAS HEMATOLOGY AND ONCOLOGY, P.A.

_____

_____

_____

_____

PLEASE FAX RECORDS TO 727-384-4388

I understand that:

1. This authorization will remain in effect for 365 days
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authorization and that it is strictly voluntary.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. If I do not sign this form, my health care and the payment for my health care will not be affected.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, or if I ask for it.
7. I will receive a copy of this form after I sign it.

Patient Signature:_____ Date: _____

RepresentativeSignature:_____ Date:_____

Relationship to Patient: _____

Witness Signature: _____ Date: _____

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PATIENT DISCLOSURE TO RELEASE OUR RECORDS

PATIENT NAME: _____ DATE: _____

DOB: _____ SOCIAL SECURITY #_____—_____—_____

DO YOU LIVE IN AN ASSISTED LIVING FACILITY OR A NURSING HOME ____ YES ____NO

I AUTHORIZE PINELLAS HEMATOLOGY AND ONCOLOGY, P.A. TO RELEASE MY RECORDS IN THEIR ENTIRETY TO:

_____

_____

PLEASE FAX RECORDS TO _____

Purpose of Disclosure:

___Continuing care with another physician or hospital ___Personal copy _____Other:_____

I understand that:

1. This authorization will remain in effect for 365 days
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
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Relationship to Patient: _____

Witness Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO SHARE MEDICAL INFORMATION

Date _____ Patient Name _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative **Print Name of Patient or Personal Representative**

_____

Description of Personal Representative's Authority

Contact Information for Personal Representative:
Address:

_____

Phone Number:
_____ **Daytime** _____ **Evening**

I authorize Pinellas Hematology and Oncology, P.A. to share my medical information with the following:

_____	_____	_____
Name	**Relationship**	**Phone Number**
_____	_____	_____
Name	**Relationship**	**Phone Number**
_____	_____	_____
Name	**Relationship**	**Phone Number**
_____	_____	_____
Name	**Relationship**	**Phone Number**

This authorization will remain in effect from the date it is signed until I cancel it in writing. By signing below, I acknowledge I have reviewed and understand this authorization form.

Patient Signature_____ Date _____

Spouse Signature_____ Date _____

Pinellas Hematology and Oncology
COMPASSIONATE CANCER CARE

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed, and how you can access this information.

At Pinellas Hematology and Oncology, P.A. we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we do not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter the earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you. You have a right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Harish Gowda, (386)774-1223, for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Patient Signature_____ **Date** _____

Spouse Signature_____ **Date** _____

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COMMERCIAL INSURANCE ADVANCE BENEFICIARY NOTICE

PATIENT'S NAME_____

INSURANCE COMPANY_____(Plan)

We expect that the above named insurance plan will not pay for the products/ supplies that are described below. The plan does not pay for all of your health care cost. The plan only pays for covered items and services when the plan's rules are met. The fact that the plan may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor has recommended it.
Items/supplies to be received:

Your insurance may or may not cover these items indicated below for the following reasons:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these supplies, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.
Ask us to explain if you don't understand why the plan probably won't pay. Your cost for these items or supplies will be: $_____in case you have to pay for them yourself or through other insurance plans.

Please circle yes or no below to signify your choice

Please sign and date this form below to attest your choice

- YES I want to receive these tests/supplies

I understand that my plan will not decide whether to pay unless I receive these tests/supplies. Please submit my claim to my plan. I understand that you may bill me for tests/supplies and that I may have to pay the bill while my plan is making its decision. If my plan denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal my plans decision.

- NO I have decided not to receive these tests/supplies

I will not receive these items/supplies. I understand that you will not be able to submit a claim to my plan and that I will not be able to appeal your opinion that my plan won't pay. I will notify any referral doctor who ordered these tests/supplies that I did not receive them.

_____ _____

Signature patient or person acting on Patient's behalf Date

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A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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