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 [ ] *as assigned at birth Social Security # _____ Marital Status _____

Emergency Contact _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Reason for Referral_____

How did you hear about us _____

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

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

Date	To whom can we release information	Relationship	Phone Number

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

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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 Date

_____
Signature of Patient, Guardian, or Guarantor

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.
*Please see secretary at any time to review Privacy Practice Documents.

Name_____ Date of Birth_____

Signature _____ 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 (initial all that apply):

[ ] Home Telephone
[ ] OK to leave detailed messages
[ ] Leave message with call back number only

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

[ ] Text Communication
[ ] OK to write detailed messages
[ ] Send message with call back number only

[ ] Email/Postal Communication
[ ] OK to send written communication
[ ] OK to write for call back only

CONSENT FOR EMAIL AND TEXT MESSAGING REMINDERS

[ ] I authorize to receive text messages for appointments reminders at the following cell phone number _____ **OR** [ ] email messages for appointment reminders at the following email address _____. I agree to advise the practice if my mobile number/email address changes or is no longer in my possession. I understand that text messages are transmitted over a public network onto a personal telephone and as such may not be secure; and not all email networks are secure. I further understand that appointment reminders are an additional service and the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text/email feature at any time. *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 and details).

_____ _____

Patient Signature Date of Birth

_____ _____

Print name Date

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 an adequate record.

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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: _____

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Patient Name_____ Date of Birth_____

Allergies_____

Ask about using Progressive Oncology's in-house pharmacy

Pharmacies	
Preferred Local Pharmacy _____	Preferred Mail Order Pharmacy _____
Phone _____	Phone _____
City, State _____	City, State _____

MEDICATION LOG

***Please list ALL medications including over-the counter, herbal, and prescription medications.**

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 relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

1. **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.

2. 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 to our 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 deductibles, copayments, covered charges, secondary insurance, "usual & customary charges," etc. other than the to supply information as necessary. You are responsible for the timely payment of your account.

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

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

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

6. ***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)

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 medical 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 for services rendered, I agree to pay all necessary and reasonable costs of collections beginning at 27% of my 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/Responsible Party

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Name: _____ DOB: _____ Date: _____

Social History:

Smoker: Never/ Former/ Current
If former or current;
What did/do you smoke: _____
How many packs per day: _____
Date started smoking: _____
Date stopped smoking: _____

Drug or Chemical Dependencies: Never/ Former/ Current
If former or current;
What did/do you smoke: _____
How many packs per day: _____
Date started smoking: _____
Date stopped smoking: _____

Alcohol Use: Never/ Former/ Current
If former or current;
What did/do you drink: _____
How much per day/week: _____

Do you Exercise? Never/ Occasionally/ Regularly
How many days per week: _____

Are you Married/ Divorced/ Single/ Widowed

Do you have children?
How many? _____

Please describe your employment history and potential exposure risks:

Nutritional History:

Well balanced diet?
Fat intake: Light/ Moderate/ Heavy
Caffeine: Coffee/ Tea/ Cola

How many cups per day? _____

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Name: _____ DOB: _____ Date: _____

Family Health History:
Please include age, health history, cause of death

Mother:

Maternal Grandmother:

Maternal Grandfather:

Father:

Paternal Grandmother:

Paternal Grandfather:

Sisters:

Brothers:

Daughters:

Sons:

Past Medical History

Ongoing Medical Problems: (circle those that apply)

Diabetes/ High Blood Pressure/ Heart Problems/ Breathing Problems/ Mental Illness/ Depression/ Anxiety/ Thyroid or Adrenal Issues/ Gastrointestinal Issues/ Urinary Problems/ Vision or Hearing Problems/ Musculoskeletal Issues/ Neurological Issues/ Skin Problems/ Ear Nose or Throat Issues/ Blood Problems.

Past Surgeries (please list below)

1.
2.
3.
4.
5.
6.

7.

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Preventative Healthcare:
Vaccines:

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

FLU:
Pneumonia:
Hepatitis 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: