CANCER CENTER OF SOUTH FLORIDA

Affiliated with Massachusetts General Hospital Cancer Center

PATIENT REGISTRATION FORM

PATIENT'S NAME: ______________________

DATE OF BIRTH: ______________________

SEX: ______________________

PHONE: ______________________

FLORIDA ADDRESS: ______________________

____

ALTERNATE ADDRESS: ______________________

____

SOCIAL SECURITY: ______________________

MARITAL STATUS: ______________________

OCCUPATION: ______________________

EMPLOYER: ______________________

EMPLOYER'S ADDRESS: ______________________

____

SPOUSE'S NAME: ______________________

DATE OF BIRTH: ______________________

SPOUSE'S SS#: ______________________

EMPLOYER ADDRESS: ______________________

____

EMPLOYER PHONE: ______________________

NEAREST RELATIVE: ______________________

RELATIONSHIP: ______________________

PHONE: ______________________

REASON FOR VISIT: ______________________

____

____

4801 South Congress Avenue • Suite 201 • Lake Worth, FL 33461-4746 • Phone: 561-253-3980 • Fax: 561-253-3985

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PATIENT REGISTRATION FORM

ALLERGIES, PLEASE LIST:

1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

LIST OF CURRENT MEDICATIONS AND DOSAGES:

1) ______________________ 6) ______________________
2) ______________________ 7) ______________________
3) ______________________ 8) ______________________
4) ______________________ 9) ______________________
5) ______________________ 10) ______________________

REFERRED BY: ____

FAMILY DOCTOR: ______________________
DOCTOR PHONE: ______________________
DOCTOR ADDRESS: ______________________

PREFERRED PHARMACY: ______________________
PHARMACY PHONE: ______________________
PHARMACY ADDRESS: ______________________

RADIATION ONCOLOGIST NAME: ______________________
RADIATION ONCOLOGIST PHONE: ______________________
RADIATION ONCOLOGIST ADDRESS: ______________________

SURGEON NAME: ______________________
SURGEON PHONE: ______________________
SURGEON ADDRESS: ______________________

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Health History Questionnaire

Family History

Relationship	Age	State of Health	Age of Death	Cause of Death
Father	____	____________	__________	________________
Mother	____	____________	__________	________________
Brother	____	____________	__________	________________
	____	____________	__________	________________
	____	____________	__________	________________
Sister	____	____________	__________	________________
	____	____________	__________	________________
	____	____________	__________	________________
Son	____	____________	__________	________________
	____	____________	__________	________________
Daughter	____	____________	__________	________________
	____	____________	__________	________________

Please check if your blood relatives had any of the following:

Disease	Relationship
Arthritis, Gout	________________
Asthma, Hay Fever	________________
Cancer	________________
Chemical Dependency	________________
Diabetes	________________
Heart Disease, Stroke	________________
High Blood Pressure	________________
Kidney Disease	________________
Tuberculosis	________________
Other: please specify	________________
	________________

Hospitalizations/Past Surgeries

Year	Hospital	Reason for Hospitalization and outcomes
____	___________	________________________
____	___________	________________________
____	___________	________________________
____	___________	________________________
____	___________	________________________

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Health History Questionnaire

Serious Illness/Injuries

Description	Date	Outcome
______________________________	________	______________________________
______________________________	________	______________________________
______________________________	________	______________________________
______________________________	________	______________________________
______________________________	________	______________________________
______________________________	________	______________________________
______________________________	________	______________________________
______________________________	________	______________________________

Have your ever had a blood transfusion? ______Yes ______No
Date(s): __________________________________

Pregnancy History

Year of birth	Sex	Complications if any
_____________	_________	____
_____________	_________	____
_____________	_________	____
_____________	_________	____
_____________	_________	____

Health Habits

Check which substances you use and describe how much you use.

Caffeine	Yes___	No___	___________________________
Tobacco	Yes___	No___	___________________________
Drugs	Yes___	No___	___________________________
Other	Yes___	No___	___________________________

Occupational Concerns

Check if your work exposes you to the following:

Stress	Yes___	No___	___________________________
Hazardous Substances	Yes___	No___	___________________________
Heavy Lifting	Yes___	No___	___________________________
Other (specify)	Yes___	No___	___________________________

Your occupation: ____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: ___________________________

I herby authorize you to release all medical records to:
Cancer Center of South Florida
Dr. Abraham Schwarzberg
Dr. Talya Schwarzberg
4801 South Congress Avenue Suite 201
Lake Worth, FL 33461
Phone: 561-253-3980
Fax: 561-253-3985

Patient Name: ____

Date of Birth: ____

Signature: ____

Relationship to patient (if not signed by patient): ________________________

CANCER CENTER OF SOUTH FLORIDA

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PRIVACY POLICY

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

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PATIENT CONSENT OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 anytime. 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
____________________________	____________________________
Signature or Patient or Legal Guardian	Printed Name of Signor

CANCER CENTER OF SOUTH FLORIDA

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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.

Forms – 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 the extra services based upon time and effort involved.

Signature: ______________________________ Date: ______________

Spouse/Guarantor: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________

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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.

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.

FORMS AND RELEASE OF RECORDS:
The completion of Administrative forms about your care and duplication of medical records is 110t 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, base upon time and effort involved. If you require us to copy your medical records, in accordance with the State Law, our policy is to charge $0.50 per page ISO, $0.25 per page for pages I J and higher plus postage. Additional charges may apply for records that are STAT and that need to be certified. You may pick-Up the records for our office to save the postage fee. Any slides that need to be sent over night to be re-read at Massachusetts General Hospital will incur a $20.00 service charge to cover shipping fees.

- Requests must be made in writing by filling out our records release form.
- There is no cost to provide records to facilities or physicians that we refer you to see.
- Please allow up to 10 Business days for records to be available for pick up or delivery.

Minors/Dependents:
Children under the age of J 8 will require the signature of a responsible adult party on the registration form. We cannot treat an unaccompanied minor 011 their initial visit for in-office procedures.

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 Signature

_______________ Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ___________________________________, have received a copy of Cancer Center of South Florida's Notice of Privacy Practices.

_________________________________ Signature of Patient

_____________________ Date

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CANCER CENTER OF SOUTH FLORIDA

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Date: ____________________

Patient Name: __________________________________

Date of birth: ___________________________________

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

Name	Relationship	Phone number
______________________________	_____________________________	____________________
______________________________	_____________________________	____________________
______________________________	_____________________________	____________________
______________________________	_____________________________	____________________
______________________________	_____________________________	____________________

This authorization will expire in 1 year unless otherwise specified.

____
Patient's Signature

____
Witness

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CANCER CENTER
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CANCER CENTER OF SOUTH FLORIDA
CONSENT TO USE OF PHOTOGRAPH

The undersigned patient or responsible person hereby consents to the taking, use and copying of a photograph of my/the patient's face by Cancer Center of South Florida (the "Cancer Center") for use in identification in the course of treatment at the Cancer Center. I understand that this consent is separate from and in addition to my consent to photographs and image guided technologies used in the course of treatment, to which I have separately consented as part of the consent to treatment.

I understand that no photographic image of my/the patient's face will be disseminated outside or the Cancer Center, or used for any commercial purpose, or other purpose other than identification of me, without my further consent. I also understand that this consent and the use of this photographic image will be subject to and in accordance with the Cancer Center's Notice of Privacy Practices, which I acknowledge I have separately received.

I THE UNDERSIGNED PATIENT, OR RESPONSTBLE PERSON ON BEHALF OF THE PATIENT, HEREBY AUTHORIZE AND CONSENT TO THE ABOVE.

Patient Name: ________________________________

Signature of Patient or Responsible Person: ________________________________

Witness: ________________________________

Date: ________________________________

Name of Witness: ________________________________

Relationship if responsible person: ________________________________

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