

FOR SCANNING PURPOSES, USE DARK BLACK INK ONLY

Referred By: _____ Diagnosis _____ Today's Date: _____

SECTION A: PATIENT'S INFORMATION:

Patient's Legal Name: First _____ M.I. _____ Last _____
Address _____ City _____ State _____ Zip _____ Birthdate _____
Telephone _____ Work Phone _____ Race _____ Nickname _____
Gender (circle) M F Marital Status _____ Social Security Number _____
Emergency Contact: In case of emergency, please contact _____
Relationship to Patient _____ Phone Number for Emergency Contact _____

SECTION B: GUARANTOR INFORMATION (Responsible Party):

If any information is same as above, please indicate by writing "same" in each appropriate section.

Guarantor First Name _____ M.I. _____ Last _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Emergency Telephone _____ Work Phone _____
Driver's License No. _____ Relationship to patient _____
Employer Information: Employer's name _____ Telephone _____
Address _____ City _____ State _____ Zip _____

SECTION C: INSURANCE INFORMATION:

Please verify we have a copy of your insurance card.

Primary Coverage _____ Effective Date _____ Co-pay _____
Address _____ City _____ State _____ Zip _____
Group Number _____ Policy Number _____ ID Number _____
Subscriber/Insured Name _____ Birthdate _____
SSN _____ Relationship to patient _____
Employer _____ Phone _____ Contact/Office person _____
Address of Employer _____ City _____ State _____ Zip _____
Second/Supplement _____ Effective Date _____ Co-pay _____
Address _____ City _____ State _____ Zip _____
Group Number _____ Policy Number _____ ID Number _____
Subscriber/Insured's Name _____ Birthdate _____
SSN _____ Relationship to patient _____
Employer _____ Phone _____ Contact/Office Person _____
Address of Employer _____ City _____ State _____ Zip _____

ACKNOWLEDGEMENT OF RESPONSIBLE PARTY AND PATIENT

Please carefully read the following and sign.

I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT. I CERTIFY THAT THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of responsible party Date Signature of patient (If different from responsible party) Date

INSURANCE AUTHORIZATION AND ASSIGNMENT

Please carefully read the following and sign.

I hereby authorize Southwest Hematology/Oncology Associates, P.A. to furnish information to insurance carriers and/or third party payers concerning my illness and treatments. I hereby assign Southwest Hematology/Oncology Associates, P.A. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance, and agree to pay any such amount in a timely manner.

Signature of responsible party Date

The pharmacy is now able to fill prescriptions for patients and their family members.

Ask for details.

If you are on HOSPICE or reside in a Skilled Nursing Facility (SNF) please notify the receptionist.

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VERY IMPORTANT REQUIRED INFORMATION, PLEASE COMPLETE VERY THOROUGHLY

PATIENT QUESTIONNAIRE

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Age _____ Date of Birth ____/____/____ Referring Doctor _____

REFERRAL SOURCE: (self-referral, doctor referral, other) _____

DESCRIBE YOUR PRESENT ILLNESS: (dates symptoms began, describe symptoms, list treatments given for illness, such as radiation therapy, chemotherapy, surgeries)

CONFIDENTIAL RECORD: This information is confidential. It will not be released to others unless you authorize us to release it.

ALLERGIES: (medications, others) _____

****CURRENT MEDICATIONS:** (list all prescribed, herbal, and over-the-counter)** _____

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SOCIAL HISTORY

With whom do you live? _____

How would you rate your household tension? (please circle)

HIGH LOW NOT PRESENT UNSURE

Is there one dominant decision-maker in the family? (please circle)

YES NO WHO? _____

DEVELOPMENTAL INFLUENCES: (family disruptions or problems, employment difficulties)

SCHOOL HISTORY: (highest grade level achieved and where, performance, involvement in special programs, academic strengths and weaknesses)

WORK HISTORY: (current and past jobs, training or vocational education, attitudes regarding work, plans for the future)

MARITAL HISTORY: (number of years married/divorced/widowed, special problems or concerns)

DRUGS (LEGAL OR ILLEGAL) USED PRESENTLY AND IN PAST: _____

ALCOHOL USED PRESENTLY AND IN PAST: _____

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FAMILY HISTORY

PLEASE BE AS THOROUGH AS POSSIBLE, HISTORY IS VERY IMPORTANT

	IF LIVING		IF DECEASED	
Name	Age	Health	Age	Health previously
Father _____				
Mother _____				

Brothers/Sisters (circle gender)				
----------------------------------	--	--	--	--

_____	M F			
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_____	M F			
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_____	M F			
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_____	M F			
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_____	M F			
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_____	M F			
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_____	M F			
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Spouse _____				
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Sons/Daughters (circle gender)				
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_____	M F			
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_____	M F			
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_____	M F			
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_____	M F			
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_____	M F			
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_____	M F			
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Do you know of any blood relative who has or has had any of the following problems?
 (circle and give relationship)

- Nervous breakdown
- Insanity
- Alcoholism
- Suicide
- Epilepsy
- Migraines
- Stroke
- Heart disease
- High blood pressure
- Bleeding tendencies
- Leukemia

- Diabetes
- Thyroid disease
- Kidney disease
- Arthritis
- Lung disease
- Emphysema
- Tuberculosis
- Stomach ulcers
- Colitis
- Hepatitis
- Cancer

Other illnesses or diseases not listed above: _____

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MEDICAL HISTORY

Do you have or have you had any of the illnesses listed on the previous page?

YES NO

If yes, please list below and give dates:

SURGICAL HISTORY

Have you had any of the surgeries noted below? YES NO If yes, check and note the year:

<input type="checkbox"/> Tonsils removed	<u>YEAR</u>	_____	<input type="checkbox"/> Appendix removed	<u>YEAR</u>	_____
<input type="checkbox"/> Esophagus or hiatal hernia		_____	<input type="checkbox"/> Small intestine		_____
<input type="checkbox"/> Stomach surgery		_____	<input type="checkbox"/> Colon		_____
<input type="checkbox"/> Gallbladder removed		_____	<input type="checkbox"/> Rectum, hemorrhoids		_____
<input type="checkbox"/> Pancreas		_____	<input type="checkbox"/> Uterus, hysterectomy		_____
<input type="checkbox"/> Other: _____		_____	<input type="checkbox"/> Other: _____		_____
<input type="checkbox"/> Other: _____		_____	<input type="checkbox"/> Other: _____		_____
Date of last flu shot		_____	Date of pneumonia shot		_____

MEDICAL HISTORY (women)

How many times have you been pregnant? _____

How many babies have you had? _____

How many miscarriages or terminations have you had? _____

Was any pregnancy complicated? If yes, describe: _____

Are you still menstruating? _____ How often? _____

Do you remember your age when you had your first menstrual period? _____

Do you remember your age with your first pregnancy? _____

Do you remember your age when you stopped menstruating? _____

When was your last mammogram? _____

Thank you for your time and help.

Rodolfo E. Martinez, M.D.

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CONSENT TO TREATMENT & AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name (Please Print): _____

DOB: _____ Acct. # _____

I, _____, hereby voluntarily consent to such diagnostic procedures and care, to such medical, surgical, chemotherapy treatment, or antimicrobial therapy treatment as is necessary in the judgment of Rodolfo E. Martinez, M.D., at the Southwest Hematology/Oncology Associates, Lubbock, Texas.

PROHIBITION ON REDISCLOSURE

This information has been disclosed to you with the written permission of the patient/parent/legal guardian from medical records whose confidentiality is protected by the Southwest Hematology/Oncology Associates. You may not make any further disclosures of this confidential information without the specific written consent of the patient/parent/legal guardian.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO TREATMENT, THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN, AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.

Patient is is not a minor (Check one)

Patient Name (Please Print) _____

Patient Signature _____

Date _____ Witness _____

If patient unable to sign, state reason: _____

Authorized Patient Representative (Print Name) _____

Relationship (Family Member) _____

Representative Signature _____

Date _____ Witness _____

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CMS MEDICARE DMEPOS SUPPLIER STANDARDS

1. We are in compliance with all applicable Federal and State licensure and regulatory requirements.
2. We have provided complete and accurate information on the DMEPOS supplier application. Any changes to this information will be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) has signed the application for billing privileges.
4. We will fill orders from our own inventory, or contract with another company for the purchase of items necessary to fill the order. We will not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement of non-procurement programs.
5. You may rent our infusion pumps with an option to purchase at the end of the capped rental period
6. We will notify you of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. We will maintain a physical facility on an appropriate site.
8. We will permit CMS (formerly HCFA), or its agents to conduct on-site inspections to ascertain our compliance with these standards. Our location is accessible to you during reasonable business hours, and we will maintain a visible sign and posted hours of operation.
9. We will maintain a primary business telephone listed under the name of the business in a local directory or toll free number available through directory assistance. The exclusive use of a beeper, answering machine or cell phone is prohibited.
10. We comprehensive liability insurance in the amount of at least \$300,000 that covers both our place of business and our customers and employees.
11. We agree not to initiate telephone contact with you, with a few exceptions allowed. This standard prohibits us from calling you in order to solicit new business.
12. We are responsible for delivery and will instruct you on use of Medicare covered items, and maintain proof of delivery.
13. We will answer questions and respond to complaints made by you, and maintain documentation of such contacts.
14. We will maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items we have rented to you.
15. We will accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for you at the time it was rented) from you.
16. We disclose these standards to each beneficiary to whom we supply a Medicare-covered item.
17. We will disclose to the government any person having ownership, financial, or control interest in us.
18. We will not convey or reassign our supplier number, i.e., we will not sell or allow another entity to use our Medicare billing number.
19. We have a complaint resolution protocol established to address your complaints that relate to these standards. A record of these complaints will be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. We agree to furnish CMS (formerly HCFA) any information required by the Medicare statute and implementing regulations.

I have read and understand the 21 Standards listed above are a responsibility of Southwest Hematology/Oncology Associates, P.A.

Signature

Date

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PRIVACY PRACTICES ACKNOWLEDGEMENTS

1) Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by Southwest Hematology/Oncology Associates, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Southwest Hematology/Oncology Associates, P.A..

I understand that diagnosis or treatment of me by Southwest Hematology/Oncology Associates, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Southwest Hematology/Oncology Associates, P.A. is not required to agree to the restrictions that I may request, and does not accept restrictions on protected health information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Southwest Hematology/Oncology Associates, P.A. or Southwest Hematology/Oncology Associates, P.A. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse.

This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Southwest Hematology/Oncology Associates, P.A.'s Notice of Privacy Practices prior to signing this document. The Southwest Hematology/Oncology Associates, P.A.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Southwest Hematology/Oncology Associates, P.A..

The Notice of Privacy Practices for Southwest Hematology/Oncology Associates, P.A. is also provided at 4002 - 21st Street, Lubbock, Texas, and on the Southwest Hematology/Oncology Associates, P.A. web site at lubbockcancercenter.com.

This Notice of Privacy Practices also describes my rights and the duties of Southwest Hematology/Oncology Associates, P.A. with respect to my protected health information.

Southwest Hematology/Oncology Associates, P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Southwest Hematology/Oncology Associates, P.A.'s web site, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

2) Consent for Special Disclosure of Protected Health Information

Please check Yes or No for the following:

I consent to Southwest Hematology/Oncology Associates, P.A. employees identifying themselves and leaving messages on my answering machine (if I have one) for the purposes of appointment related information, medical follow-up or information regarding my account. I consent to Southwest Hematology/Oncology Associates, P.A. employees identifying themselves and leaving a message with those who answer my home phone for the purposes of appointment related information, medical follow-up or information regarding my account. I consent to Southwest Hematology/Oncology Associates, P.A. employees contacting me at work if applicable for the purposes of appointment related information, medical follow-up or information regarding my account.

Yes _____ No _____

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3) Notice of Privacy Practices

I acknowledge that I have received a copy of Privacy Practices for The Health Trust under the Health Insurance Portability and Accountability Act (HIPAA).

Patient Name (Please Print) _____

Patient Signature _____

Date _____ Witness _____

If patient unable to sign, state reason: _____

Authorized Patient Representative (Print Name) _____

Relationship (Family Member) _____

Representative Signature _____

Date _____ Witness _____

QUALITY OF LIFE ASSESSMENT

Date: _____

Patient: _____

Date of Birth: _____

ATTENTION !! Please let the receptionist know if you are enrolled in HOSPICE or reside in a Skilled Nursing Facility (SNF).

To help assess your current condition, please complete the following chart. Rate yourself in each category, using a scale of 0 to 10. Place an X in the box by the number which most accurately describes how you believe you are doing.

SHORTNESS OF BREATH

SEVERE 10	
8	
6	
4	
2	
NONE 0	

TIREDDNESS

SEVERE 10	
8	
6	
4	
2	
NONE 0	

ANXIETY

SEVERE 10	
8	
6	
4	
2	
NONE 0	

DEPRESSION

SEVERE 10	
8	
6	
4	
2	
NONE 0	

PAIN LEVEL

SEVERE 10	
8	
6	
4	
2	
NONE 0	

NAUSEA/VOMITING

SEVERE 10	
8	
6	
4	
2	
NONE 0	

CONSTIPATION

SEVERE 10	
8	
6	
4	
2	
NONE 0	

DIARRHEA

SEVERE 10	
8	
6	
4	
2	
NONE 0	

APPETITE

GOOD 10	
8	
6	
4	
2	
POOR 0	

PHYSICAL FUNCTION

GOOD 10	
8	
6	
4	
2	
POOR 0	

SOCIAL ACTIVITY

GOOD 10	
8	
6	
4	
2	
POOR 0	

OVERALL QUALITY OF LIFE

GOOD 10	
8	
6	
4	
2	
POOR 0	

Do you smoke? _____ Yes _____ No

Form completed by _____

Patient

Other

Relationship to Patient _____

**** THIS SECTION FOR MEDICAL STAFF USE ONLY**

INITIAL REVIEW:

Carmie Leake, R N, OCN _____

Shauna Sandell, RN, OCN _____

Jeneé Gibson, R N, OCN _____

Cindy Furlow, CNA _____

SMOKING COUNSELING? _____ Yes _____ No

Performed by: _____

FINAL REVIEW:

Rodolfo E. Martinez, M.D. _____