

Place Label Here

**GENERAL CONSENT FOR CARE AND TREATMENT**

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**TO THE PATIENT:** You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Witness

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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### PATIENT DEMOGRAPHIC FORM

Please return completed packet with signature pages to the front desk.

Age: \_\_\_\_\_  Male  Female SS#: \_\_\_\_\_

Primary Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone:  Preferred (\_\_\_\_\_) \_\_\_\_\_

Cell Phone:  Preferred (\_\_\_\_\_) \_\_\_\_\_

May we leave a message on your answering machine/voicemail?  Yes  No

Email Address: \_\_\_\_\_ May we email you?  Yes  No

Preferred Language: \_\_\_\_\_ Do you require an interpreter?  Yes  No

Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino

Race:  Native American or Alaska Native  Asian  Black or African American

Native Hawaiian or Other Pacific Islander  White  Other

Emergency Contact Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

#### Advanced Directives:

Living Will  Yes  No  Unknown

Durable Power of Attorney  Yes  No  Unknown

DNR  Yes  No  Unknown

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

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### INSURANCE INFORMATION

**Primary Insurance Carrier:** \_\_\_\_\_

Name of primary policy holder: \_\_\_\_\_

Policy#/Group ID: \_\_\_\_\_

Policy holder's date of birth: \_\_\_\_\_ Policy holder's SS#: \_\_\_\_\_

Policy holder's employer (Name, City, State, Phone Number):  
\_\_\_\_\_  
\_\_\_\_\_

Does plan have prescription coverage?  Yes  No

**Secondary Insurance Carrier:** \_\_\_\_\_

Name of secondary policy holder: \_\_\_\_\_

Policy#/Group ID: \_\_\_\_\_

Policy holder's date of birth: \_\_\_\_\_ Policy holder's SS#: \_\_\_\_\_

Policy holder's employer (Name, City, State, Phone Number):  
\_\_\_\_\_  
\_\_\_\_\_

Does plan have prescription coverage?  Yes  No

**Pharmacy Insurance Carrier:** \_\_\_\_\_

Name of pharmacy policy holder: \_\_\_\_\_ Policy#/Bin# \_\_\_\_\_

I certify that the information provided is accurate. I will notify Low Country Cancer Care (LCCC), a division of American Oncology Partners, P.A. (AOP), of any changes as soon as they become available. I understand that it is my responsibility to update LCCC/AOP of any changes to my insurance plan or I may be held liable for the full balance of my treatment.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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## OFFICE AND FINANCIAL POLICIES

Thank you for choosing Low Country Cancer Care (LCCC), a division of American Oncology Partners, P.A. (AOP). We are so pleased that you have selected our practice to receive care and treatment from us. We believe that our patient's time is valuable, and our goal is to provide medical care in a timely manner. In order to achieve our goal, we have implemented these Office and Financial Policies to better utilize appointments for patients in need of care. Please feel free to contact our office if you have any questions regarding the policies.

### \_\_\_\_\_ **Appointments**

(Initial)

If you are unable to keep your appointment, please notify our office as soon as possible. This courtesy allows us to give appointments to another patient in need. If you are more than 30 minutes late to your appointment, please be aware that your appointment may need to be rescheduled. Please be advised that if you have 3 or more 'No Shows' within a 12-month period, you may be discharged from the practice. While we strive to schedule appointments appropriately, emergencies can and do occur in our facilities. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary during the time of your appointment.

### \_\_\_\_\_ **Financial Policy**

(Initial)

- During the check-in process of your appointment, we will ask for your insurance card(s) and a photo ID to ensure that we have the most recent information.
- Co-payments must be paid prior to being seen by one of the providers, on the date that service(s) are rendered. Self-pay or uninsured patients will be required to pay a deposit prior to being seen. Patients are responsible for their deductibles or charges not covered by insurance. As a courtesy to you, we file your insurance claims, therefore it is your responsibility to provide our office with up-to-date billing information.
- Please understand that your insurance is a contract between you and your insurance company, and you are ultimately responsible for the bill. If you have not received an explanation of benefits within 30 days of seeing your health care provider, you are expected to contact your insurance company for an explanation as to why payment has been delayed.
- Self-pay patients are required to pay for services prior to being seen for their visit and the remaining balance from the total visit cost will be billed to the patient. Our office offers a discount if payment can be made in full. If payment cannot be made in full for services rendered, our office is unable to offer a discount.
- It is understood that returned checks made payable to this office for insufficient funds, stop payments, or other reason for non-payment will be assessed a \$30.00 NSF fee for which the patient will be held responsible.
- Patients with no financial ability to pay will be assessed by our Financial Counselors to see if they qualify for any type of financial assistance. Please notify the front desk if you would like more information from a Financial Counselor.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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## OFFICE AND FINANCIAL POLICIES CONTINUED

\_\_\_\_\_ **Patient Portal**

(Initial)

The patient portal (CareSpace) allows patients to manage their personal health information at their own convenience. You will be able to securely send non-emergent messages to our practice, send refill requests, request and keep track of appointments, and view your medical history/summaries from your office visits.

\_\_\_\_\_ **Prescription Refills**

(Initial)

In order to assist all patients in a timely manner, please contact your pharmacy directly and they will work on refills in partnership with your providers. Please allow up to 72 hours to process your refill request(s). Please note that prescriptions will not be refilled after hours, on weekends or holidays. Some prescriptions cannot be filled if you have not seen your provider within the last 3-6 months. If you have a mail service for prescriptions, please allow 7-10 business days for the necessary forms to be completed. It is very important you plan accordingly with mail service prescriptions to allow adequate time for paperwork to be processed.

\_\_\_\_\_ **Referrals and Prior Authorizations**

(Initial)

Most insurance plans require a patient to be seen by their primary care provider prior to seeing a specialist. If your insurance plan requires a prior authorization, you must verify your insurance has approved the visit before seeing the specialist. Otherwise, you will be responsible for any incurred charges.

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

(Initial)

**Patient is responsible for the protection and safety of patient's property. Low Country Cancer Care (LCCC), a division of American Oncology Partners, P.A. (AOP), shall not be responsible or liable to patient for any damage or loss of property in the Building of Premises at any time. LCCC/AOP is not responsible should the patient leave premises against the advice of a medical personnel. The use of any video recording devices around patient care is strictly prohibited on LCCC/AOP property.**

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Patient Signature/ Patient Guardian Signature

\_\_\_\_\_  
Date

## ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICIES AGREEMENT

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Low Country Cancer Care (LCCC), a division of American Oncology Partners, P.A. (AOP), Financial Policies Agreement.

This notice is available in hard copy by verbally requesting a copy at the front desk of any LCCC/AOP facility or by submitting a request in writing to the corporate office at Low Country Cancer Care, a division of American Oncology Partners, P.A., 14543 Global Parkway, Suite 110, Fort Myers, FL 33913.

You may also view and/or print a copy of the Financial Policies Agreement by visiting [AONcology.com/policies/LCCC\\_FPA.pdf](http://AONcology.com/policies/LCCC_FPA.pdf)

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Patient Name (Print)

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Patient or Guarantor (Signature)

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Date

## AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED FOR ELECTRONIC MEDICAL RECORDS

I authorize Low Country Cancer Care (LCCC), a division of American Oncology Partners, P.A. (AOP), to take my photograph (digital camera/video may be used). These photos may then be placed in my LCCC/AOP electronic medical record for identification purposes and/or medical documentation. By signing this, I verify that I have received a copy of this authorization form for my records.

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Patient or Guarantor (Signature)

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Date

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Low Country Cancer Care (LCCC), a division of American Oncology Partners, P.A. (AOP), Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any LCCC/AOP facility or by submitting a request in writing to the corporate office at Low Country Cancer Care, a division of American Oncology Partners, P.A., 14543 Global Parkway, Suite 110, Fort Myers, FL 33913.

You may also view and/or print a copy of the Notice of Privacy Practices by visiting [AONcology.com/policies/LCCC\\_NPP.pdf](http://AONcology.com/policies/LCCC_NPP.pdf)

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Patient or Guarantor (Signature)

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Date

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

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**CONSENT TO DISCLOSE MEDICAL INFORMATION**

Please check one of the following:

\_\_\_\_\_ I give permission to the employees of Low Country Cancer Care (LCCC), a division of American Oncology Partners, P.A., (AOP) to disclose my Protected Health Information to me and the following individual(s):

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ I request that all my Protected Health Information be disclosed ONLY to me and no other individual(s).

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

\_\_\_\_\_  
Patient Signature/ Patient Guardian Signature

\_\_\_\_\_  
Date

## COMMUNICATION PREFERENCES

By signing below, I authorize Low Country Cancer Care (LCCC), a division of American Oncology Partners, P.A. (AOP), its affiliate and subsidiary entities, and AON Pharmacy, LLC (and any authorized LCCC/AOP texting/email service vendor) to contact me by SMS text message or email for health-related notifications, including appointment reminders, billing communications, and to provide feedback to serve me better.

I understand that I may be receiving communications related to my information (name and email address) for marketing purposes, including from third parties and/or an online resource for patients to provide feedback regarding my care.

I understand that message/data rates may apply to messages sent by LCCC/AOP under my cell phone plan. I know that I am under no obligation to authorize LCCC/AOP to send me text messages and/or email. I may optout of receiving these communications at any time by responding with "STOP" or by unsubscribing.

I understand that text messages and/or email are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile and/or email accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services and email notifications.

PLEASE MARK THE FOLLOWING:

I consent to receiving information via text and/or email. I understand I can withdraw my consent at any time.

Text Cell # \_\_\_\_\_ Email \_\_\_\_\_

I do not consent to receiving any information via text and/or email. I understand that I can change my mind and provide consent later.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Patient Signature/ Patient Guardian Signature

\_\_\_\_\_  
Date

## REQUEST FOR RELEASE OF MEDICAL RECORDS

I, \_\_\_\_\_, request a copy of my complete medical record from the office of:  
(Print Name and Date of Birth)

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Name and contact information of Provider

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Address of Provider: City, State, Zip

Please indicate below which practice you need your medical records sent to:

**For Savannah, Hinesville, Pooler, Okatie, Statesboro patients**

- Low Country Cancer Care  
ACI Building 2nd Floor, Suite 201  
Savannah, GA 31404  
PH: (912) 691-2000 • FAX: (912) 691-2100

**For Vidalia patients**

- Low Country Cancer Care  
1 Meadows Parkway, Suite B  
Vidalia, GA 30474  
PH: (912) 454-7012 • FAX: (912) 788-3003

**For Waycross Patients**

- Low Country Cancer Care  
1206 Alice St.  
Waycross, GA 31501  
PH: (912) 285-1140 • FAX: (912) 285-1125

By signing this form, I give permission to release my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Low Country Cancer Care (LCCC), a division of American Oncology Partners, P.A. (AOP), to receive copies of any medical, psychiatric, AIDS, AIDS-related syndromes, HIV testing, alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent is valid indefinitely until there is written communication received to revoke.

**DISCLAIMER:** Not signing does not prevent me from receiving care.

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Patient Signature/ Patient Guardian Signature

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Date

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**MEDICAL HISTORY FORM**

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician (if different): \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any additional Physicians you see: (Include Phone #):

\_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone # and Cross Streets: \_\_\_\_\_

**Medical History**

Have you EVER had any of the following:

- Asthma
- Psychiatric Disorder/Illness
- Cancer
- Seizures or Epilepsy
- Diabetes
- Urinary/Kidney Disorder
- Neurological Disorder/Chronic Headaches
- Blood Pressure Disorder/Hypertension
- Stroke
- COPD
- Thyroid Disorder
- Heart Attack/Heart Disease/Atrial Fib
- Arthritis
- Pulmonary Embolism/DVT/Blood Clots
- Cholesterol Disorder/Hyperlipidemia
- Sleep Apnea
- Eye Disorder (i.e. Glaucoma)
- Other

Please list any other medical illnesses or problems and provide details for any of the above conditions:

\_\_\_\_\_  
\_\_\_\_\_

**Surgery History**

Please list ANY surgeries you have had and the approximate date.

Procedure	Date	Complications

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**MEDICAL HISTORY CONTINUED**

**Prior Cancer Treatment** Do you currently have cancer?  Yes  No

Type of Cancer	Year Diagnosed	Treatment	Hospital/Doctor's Office Where You Received Treatment
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:

**Allergies**

Are you allergic to any medications or other substances?  Yes  No  Unknown

Please list allergies and reactions:

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**Medication List**

(If your list exceeds the allotted spaces below, please bring your list with you or add to the back of this page.)

Medication Name	Dose	Frequency

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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### Health Maintenance

Date of last bone density: \_\_\_\_\_ Location of scan: \_\_\_\_\_

Date of last PAP smear: \_\_\_\_\_ Have you ever had an abnormal PAP smear?  Yes  No

Date of last mammogram: \_\_\_\_\_ Were the results normal?  Yes  No

Date of last colonoscopy: \_\_\_\_\_ Were the results normal?  Yes  No

### Obstetrics History

Are you currently pregnant?  Yes  No If yes, anticipated due date: \_\_\_\_\_

Attempting to conceive?  Yes  No # of Pregnancies: \_\_\_\_\_ # of Births: \_\_\_\_\_ # of Miscarriages: \_\_\_\_\_

### Family Medical History

Please indicate any major conditions, including cancers, that your immediate family members have had.

Relative	Condition and Description	Living?	If deceased, at what age?
Mother		Y N	
Father		Y N	
Sibling		Y N	
Sibling		Y N	
Grandparent		Y N	
Grandparent		Y N	
Other		Y N	

### Social History

Do you currently smoke?  Yes  No If no, previously?  Yes  No

Years smoked: \_\_\_\_\_ Packs per day: \_\_\_\_\_ Do you use other tobacco products?  Yes  No

Consume Alcohol?  Yes  No If yes, drinks per week: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Do you suffer from domestic violence?  Yes  No Do you feel safe at home?  Yes  No

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Review of Systems** Please indicate ALL that you have experienced within the last 6-12 months.

**General**

- |                                 |  |   |                                      |
|---------------------------------|--|---|--------------------------------------|
| <input type="checkbox"/> None   | <input type="checkbox"/> Feeling Tired | <input type="checkbox"/> Fever          | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Weight Loss   | <input type="checkbox"/> Feeling Poorly |                                      |

**Eyes**

- |   |  |                                   |                                     |
|---|--|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> None           | <input type="checkbox"/> Dry Eyes          | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Itchy Eyes |
| <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Eyesight Problems |                                   |                                     |

**Ear/Nose/Throat**

- |   |                                      |  |                                      |
|---|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> None           | <input type="checkbox"/> Earache     | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Hoarseness      |                                      |

**Heart**

- |                                       |  |   |  |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> None         | <input type="checkbox"/> Chest Pain      | <input type="checkbox"/> Palpitations                                   | <input type="checkbox"/> Slow Heart Rate |
| <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Fast Heart Rate | <input type="checkbox"/> Leg pain, discomfort or fatigue during walking |  |

**Lungs/Breathing**

- |  |                                |  |  |
|--|--------------------------------|--|--|
| <input type="checkbox"/> None                            | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing                          | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Trouble breathing with exertion |                                | <input type="checkbox"/> Trouble breathing when lying flat |  |

**Gastrointestinal**

- |                                    |   |                                       |   |
|------------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> None      | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea       |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nausea         | <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Blood in Stool |

**Skin**

- |                                       |                                     |                                      |   |
|---------------------------------------|-------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> None         | <input type="checkbox"/> Acne       | <input type="checkbox"/> Itching     | <input type="checkbox"/> Change in Mole |
| <input type="checkbox"/> Skin Lesions | <input type="checkbox"/> Skin Wound | <input type="checkbox"/> Breast Lump |   |

**Neurological**

- |                                      |  |                                    |   |
|--------------------------------------|--|------------------------------------|---|
| <input type="checkbox"/> None        | <input type="checkbox"/> Limb Weakness | <input type="checkbox"/> Confused  | <input type="checkbox"/> Loss of Memory     |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty Walking |

**Psychiatric**

- |                                     |   |  |  |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> None       | <input type="checkbox"/> Suicidal           | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Disturbed Sleep |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Change in Personality |  |

**Endocrine**

- |                                       |  |                                       |                                      |
|---------------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> None         | <input type="checkbox"/> Hair Loss       | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Feeling Weak | <input type="checkbox"/> Deepening Voice |                                       |                                      |

**Hem/Lymph**

- |                               |  |  |   |
|-------------------------------|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Swollen Glands |
|-------------------------------|--|--|---|