

Place Label Here

GENERAL CONSENT FOR CARE AND TREATMENT

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: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Released – Covering the Periods of Health Care

From (date): _____ To (date): _____

From (date): _____ To (date): _____

Please Check Type of Information to be Released

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Complete Health Record | <input type="checkbox"/> Medication List | <input type="checkbox"/> Radiology Results | <input type="checkbox"/> Complete Billing Record |
| <input type="checkbox"/> New Patient Evaluation | <input type="checkbox"/> Chemo Flow Sheets | <input type="checkbox"/> Radiology CD/Films | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Pathology Slides | _____ |
| <input type="checkbox"/> Hospital Records | <input type="checkbox"/> Pathology Results | <input type="checkbox"/> Itemized Bill | _____ |

Purpose of Request

- Treatment or Consultation At Request of the Patient Billing or Claims Payment
 Other (specify) _____

I, the undersigned, authorize and request OHA to Release Information to Obtain Information from

Name: _____

Address: _____ Phone: _____

_____ Fax: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or sensitive information, I agree to its release. I understand that if I authorize the release of Drug & Alcohol Abuse treatment records that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 3860 Colonial Blvd., Suite 100, Fort Myers, FL 33966. Unless revoked, this authorization will expire on the following date or event _____, or one year from date of signature, unless otherwise specified.

Re-disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under *Purpose of Request*. I can inspect or copy the protected health information to be used or disclosed. **I authorize OHA/AOP to use and disclose the protected health information specified above.**

Signature: _____ Date: _____

Authority to Sign if not patient: _____ Date: _____

Patient Name: _____ DOB: _____

PATIENT MEDICAL HISTORY FORM

Dear Patient,

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

Patient Name: _____

DOB: ___/___/___ Age: _____ Male Female SS#: _____

Primary Address: _____

City: _____ State: _____ Zip: _____

Home Phone: Preferred (_____) _____

Cell Phone: Preferred (_____) _____

Secondary Address: _____

City: _____ State: _____ Zip: _____

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

Email Address: _____ May we email you? Yes No

Preferred Language: _____

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

Pharmacy Name: _____

Pharmacy Phone # and Cross Streets: _____

(Internal Use Only)

MRN#: _____

Patient Name: _____ **DOB:** _____

Primary Care Physician: _____ Phone: _____

Referring Physician (if different): _____ Phone: _____

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

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

Emergency Contact Name:

Relationship: _____ Phone: (_____) _____

Employment Status:

Employed/Self Employed Unemployed Retired Disabled

Occupation (or Former Occupation): _____

Name of Employer: _____ Work Phone: (_____) _____

Advanced Directives:

Living Will Yes No Unknown **Durable Power of Attorney** Yes No Unknown

DNR Yes No Unknown

Health Maintenance

Date of last bone density: _____

Date of last pap smear: _____ Have you ever had an abnormal PAP smear? Yes No

Date of last mammogram: _____ Was that mammogram normal? Yes No

Date of last colonoscopy: _____ Was that colonoscopy normal? Yes No

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: _____

Do you do any drugs (including marijuana)? Yes No If yes, what drug and for how long? _____

Marital Status: Single Married Partnered Separated Divorced Widowed

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

Patient Name: _____ **DOB:** _____

Medical History Have you EVER had any of the following:

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

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:

Patient Name: _____ DOB: _____

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	
Sibling		Y N	
Grandparent		Y N	
Grandparent		Y N	
Other		Y N	

Medication List

Medication Name	Dose	Frequency

Do you have additional medications not listed above? Yes No If yes, please use the back of this page to list all others.

Allergies

Are you allergic to any medications or other substances? Yes No Please list allergies and reactions:

Drug Name	Reaction

Vaccines (immunizations)

Vaccine Name	Date(s)	N/A
COVID-19		
Pneumonia		
Flu		
Shingles		

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 |
|-------------------------------|--|--|---|

Patient Name: _____ DOB: _____

CONSENT TO DISCLOSE MEDICAL INFORMATION

Please check one of the following:

_____ I give permission to the employees of Oncology Hematology Associates (OHA/AOP), a division of American Oncology Partners, P.A. to disclose my Protected Health Information to me and the following individual(s):

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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 Name (Print)

Date

Patient or Guarantor (Signature)