



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: _____

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

If yes, please bring a copy with you.

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:

Allergies

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

Patient Name: _____ DOB: _____

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.

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

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

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

I authorize The Center for Cancer and Blood Disorders (CCBD), a division of American Oncology Partners of Maryland, P.A. (AOPM), to take my photograph (digital camera/video may be used). These photos may then be placed in my CCBD/AOPM 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.

Patient Name (Print)

Patient or Guarantor (Signature)

Date

REQUEST FOR RELEASE OF RECORDS

I, _____, request a copy of my complete medical record from the office of:

Name and address of practitioner

To be sent to The Center for Cancer and Blood Disorders: (Internal use)

Address, City, State, Zip Code

Fax/Telephone Number

_____ 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 The Center for Cancer and Blood Disorders (CCBD), a division of American Oncology Partners of Maryland, P.A. (AOPM), 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.

Patient Name (Print)

Date

Patient Date of Birth

Patient or Guarantor (Signature)

Date

Patient Name: _____ DOB: _____

CONSENT TO DISCLOSE MEDICAL INFORMATION

Please check one of the following:

I give permission to the employees of The Center for Cancer and Blood Disorders (CCBD), a division of American Oncology Partners of Maryland, P.A. (AOPM), 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)

Patient Name: _____ **DOB:** _____

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: _____

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: _____

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 The Center for Cancer and Blood Disorders (CCBD), a division of American Oncology Partners of Maryland, P.A. (AOPM), of any changes as soon as they become available. I understand that it is my responsibility to update us 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)

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 The Center for Cancer and Blood Disorders (CCBD), a division of American Oncology Partners of Maryland, P.A. (AOPM), Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any CCBD/AOPM facility or by submitting a request in writing to the corporate office at The Center for Cancer and Blood Disorders, a division of American Oncology Partners of Maryland, 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/CCBD_NPP.pdf

Date: _____

Patient Name (Print)

DOB

Patient (Signature)

Date

Patient or Guarantor (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 The Center for Cancer and Blood Disorders (CCBD), a division of American Oncology Partners of Maryland, P.A. (AOPM), Financial Policies Agreement.

This notice is available in hard copy by verbally requesting a copy at the front desk of any CCBD/AOPM facility or by submitting a request in writing to the corporate office at The Center for Cancer and Blood Disorders, a division of American Oncology Partners of Maryland, 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/CCBD_FPA.pdf

Date: _____

Patient Name (Print)

DOB

Patient (Signature)

Date

Patient or Guarantor (Signature)

Date

By signing below, I authorize The Center for Cancer and Blood Disorders (CCBD), a division of American Oncology Partners of Maryland, P.A. (AOPM), its affiliate and subsidiary entities, and AON Pharmacy, LLC (and any authorized CCBD/AOPM 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 CCBD/AOPM under my cell phone plan.

I know that I am under no obligation to authorize CCBD/AOPM to send me text messages and/or email. I may opt-out 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)

Date

Patient (Signature)