LOW COUNTRY CANCER CARE
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.
Hematology • Oncology

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 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 (check all that apply): ❑ 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 **Durable Power of Attorney** ❑ Yes ❑ No **DNR** ❑ Yes ❑ No
If yes, please bring a copy with you.

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 (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 (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:**_____

OFFICE AND FINANCIAL POLICIES

Thank you for choosing Low Country Cancer Care (LCCC), a division of American Oncology Partners (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:**_____

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 (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 (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, 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**

_____

Patient Name (Print)

_____ _____

Patient or Guarantor (Signature) Date

AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED FOR ELECTRONIC MEDICAL RECORDS

I authorize Low Country Cancer Care (LCCC), a division of American Oncology Partners (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.

_____ _____

Patient or Guarantor (Signature) 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 (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, 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**

_____ _____

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 Low Country Cancer Care (LCCC), a division of American Oncology Partners, (AOP) 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 Signature/ Patient Guardian Signature Date

COMMUNICATION PREFERENCES

By signing below, I authorize Low Country Cancer Care (LCCC), a division of American Oncology Partners (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)

_____

Name and contact information of Provider

_____

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 (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.

_____ _____

Patient Signature/ Patient Guardian Signature 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
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:

Allergies

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

Please list allergies and reactions:

_____

_____

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:** _____

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

❑ None ❑ Feeling Tired ❑ Fever ❑ Weight Gain
❑ Chills ❑ Weight Loss ❑ Feeling Poorly

Eyes

❑ None ❑ Dry Eyes ❑ Eye Pain ❑ Itchy Eyes
❑ Vision Changes ❑ Eyesight Problems

Ear/Nose/Throat

❑ None ❑ Earache ❑ Loss of Hearing ❑ Nose Bleeds
❑ Sinus Problems ❑ Sore Throat ❑ Hoarseness

Heart

❑ None ❑ Chest Pain ❑ Palpitations ❑ Slow Heart Rate
❑ Leg Swelling ❑ Fast Heart Rate ❑ Leg pain, discomfort or fatigue during walking

Lungs/Breathing

❑ None ❑ Cough ❑ Wheezing ❑ Shortness of Breath
❑ Trouble breathing with exertion ❑ Trouble breathing when lying flat

Gastrointestinal

❑ None ❑ Abdominal Pain ❑ Constipation ❑ Diarrhea
❑ Heartburn ❑ Nausea ❑ Vomiting ❑ Blood in Stool

Skin

❑ None ❑ Acne ❑ Itching ❑ Change in Mole
❑ Skin Lesions ❑ Skin Wound ❑ Breast Lump

Neurological

❑ None ❑ Limb Weakness ❑ Confused ❑ Loss of Memory
❑ Convulsions ❑ Headaches ❑ Dizziness ❑ Difficulty Walking

Psychiatric

❑ None ❑ Suicidal ❑ Anxiety ❑ Disturbed Sleep
❑ Depression ❑ Emotional Problems ❑ Change in Personality

Endocrine

❑ None ❑ Hair Loss ❑ Weak Muscles ❑ Hot Flashes
❑ Feeling Weak ❑ Deepening Voice

Hem/Lymph

❑ None ❑ Easy Bleeding ❑ Easy Bruising ❑ Swollen Glands