SUMMIT
CANCER CENTERS
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

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

Patient Name: _____ **DOB:** _____ **Date:** _____

HEALTH HISTORY

ANY previous surgical procedures or operations: ❑ **YES** ❑ **NO**

Date	Type	Facility

IMPLANTED DEVICES: Do you have any implanted or metal devices? ❑ **YES** ❑ **NO**

❑ Venous Access Device/Type _____ ❑ Pacemaker ❑ Aneurysm Clip ❑ Stent

❑ Screws, pins, plates (Where? _____) ❑ Other _____

Claustrophobia: ❑ **YES** ❑ **NO**

PREFERRED PHARMACY: _____

ALLERGIES: ❑ **YES** ❑ **NO**

If yes, please list **ALL ALLERGIES** and **TYPE OF REACTION**: _____

_____

_____

CURRENT MEDICATIONS: (Please list all medication that you are currently taking (including non-prescription medications and/or herbal, vitamin and nutritional supplements).

Medication	Strength	Frequency	Prescriber	Purpose of Medication

Patient Name: _____ **DOB:** _____

MEDICAL HISTORY: Do you have any other previous or ongoing medical conditions? If yes, briefly describe conditions and treatments below.

High blood pressure: ❑ YES ❑ NO _____

Heart disease: ❑ YES ❑ NO _____

Diabetes: ❑ YES ❑ NO Requires Insulin? ❑ YES ❑ NO

Thyroid dysfunction: ❑ YES ❑ NO ___ Overactive? ___ Underactive?

Hernias: ❑ YES ❑ NO _____

Auto-immune Disease: ❑ YES ❑ NO _____

Any cancer history: ❑ YES ❑ NO _____

Other chronic illness: ❑ YES ❑ NO _____

Any previous radiation: ❑ YES ❑ NO If yes, where were you treated? _____

MEN ONLY:

Do you have regular PSA tests? ❑ YES ❑ NO Date of last exam: _____

WOMEN ONLY:

Obstetrics /Gynecology History

Are you pregnant? ❑ YES ❑ NO Is there a chance you could be pregnant? ❑ YES ❑ NO

Age at 1st Menstrual Period: _____ Date of last menstrual period: _____

Age at menopause (if applicable): _____

Hysterectomy: ❑ YES ❑ NO Were the ovaries removed: ❑ YES ❑ NO

Type of birth control currently used: _____

Do/did you use oral contraceptives? ❑ YES ❑ NO If yes, for how long? _____

Do/did you use hormone replacement? ❑ YES ❑ NO If yes, for how long? _____

Number of pregnancies: _____ Number of live births: _____ Age at first full term pregnancy: _____

Date of last mammogram: _____ Date of last PAP/Pelvic Exam: _____

SOCIAL HISTORY:

Married? ❑ YES ❑ NO Your Occupation: _____

Do you live: ❑ Alone ❑ With spouse/significant other ❑ With family ❑ Other _____

Do you have children? ❑ YES ❑ NO If so, how many? _____

Do you have a religious and/or cultural belief we should be aware of during your treatment? ❑ YES ❑ NO

If yes, please describe: _____

Patient Name: _____ **DOB:** _____

HEALTH MAINTENANCE:

Do you have any dental problems? ❑ YES ❑ NO Dentures: ❑ YES ❑ NO

Have you had a colonoscopy/sigmoidoscopy? ❑ YES ❑ NO If so, date of last one: _____

Have you had flu vaccination? ❑ YES ❑ NO If so, date of last vaccination: _____

Have you had pneumonia vaccination? ❑ YES ❑ NO If so, date of last vaccination: _____

Consent to give immunization history to Public Health? ❑ YES ❑ NO

Please indicate if you use any of the following in your regular routine:

❑ Crutches ❑ Wheelchair ❑ Walker ❑ Cane ❑ Other: _____

FAMILY HISTORY:

Father: ❑ Alive (age) ____ ❑ Deceased (at what age) _____ Cause of death: _____

Mother: ❑ Alive (age) ____ ❑ Deceased (at what age) _____ Cause of death: _____

Total Number of Sisters:_____ Number of Deceased Sisters: _____ Cause of death: _____

Total Number of Brothers: _____ Number of Deceased Brothers: _____ Cause of death: _____

Do/did any family members suffer from any form of cancer or blood disease?

Family Member	Type of cancer/ blood disease	Age at time of diagnosis	Alive/Deceased (circle one)	If deceased, cause of death and age
			A D	
			A D	
			A D	

SUBSTANCE HISTORY:

Have you ever smoked? ❑ YES ❑ NO *(If yes, please answer the following questions.)*

Do you currently smoke? ❑ YES ❑ NO Do you currently use chewing tobacco? ❑ YES ❑ NO

How many packs per day? _____ How many years? ____ If you no longer smoke, date you quit: _____

Do you use recreational drugs? ❑ YES ❑ NO If yes, which drugs? _____

Have you ever consumed alcohol? ❑ YES ❑ NO *(If yes, please answer the following questions.)*

Do you currently consume alcohol? ❑ YES ❑ NO If yes, number of drinks per week: _____

Please circle all that apply: Beer Wine Spirits

If you previously drank alcohol, when did you stop?_____

Patient Name: _____ **DOB:** _____

REVIEW OF SYSTEMS: *(Check all that apply.)*

❑ Recent weight change	❑ Chest pain	❑ Rectal bleeding	❑ Headaches
❑ Loss of appetite	❑ Heart palpitations	❑ Bowel incontinence	❑ Seizures
❑ Fever	❑ Light headedness	❑ Burning on urination	❑ Dizziness
❑ Shaking/Chills	❑ Swelling in legs	❑ Pain with urination	❑ Loss of balance
❑ Night sweats	❑ Passing out	❑ Blood in urine	❑ Weakness of limbs
❑ Fatigue	❑ Cough	❑ Frequent urination	❑ Loss of sensation
❑ Blurred vision	❑ Sputum production	❑ Urinary incontinence	❑ Numbness
❑ Double vision	❑ Blood in sputum	❑ Muscle pain	❑ Tingling sensation
❑ Hearing loss	❑ Shortness of breath	❑ Stiffness	❑ Memory loss
❑ Ringing in ears	❑ Nausea	❑ Joint pain/Arthritis	❑ Difficulty thinking
❑ Sinus trouble	❑ Heartburn	❑ Back pain	❑ Lumps in arm pits
❑ Trouble swallowing	❑ Vomiting	❑ Skin rash	❑ Lumps in neck
❑ Sore throat	❑ Constipation	❑ Skin problems	❑ Breast lumps
❑ Nose bleeds	❑ Diarrhea	❑ Nervousness	❑ Testicular pain/Swelling
❑ Hoarseness	❑ Abdominal pain	❑ Depression	❑ Vaginal bleeding

Advanced Directives:

Living Will ❑ Yes ❑ No ❑ Unknown

Durable Power of Attorney ❑ Yes ❑ No ❑ Unknown

DNR ❑ Yes ❑ No ❑ Unknown

Primary Care Physician: _____ Phone: _____

Referring Physician (if different): _____ Phone: _____

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

Patient Signature: _____ Date: _____

Patient Name (Please Print) _____

Reviewed by RN: _____ Date: _____

Patient Name: _____ **DOB:** _____

CANCER FAMILY HISTORY QUESTIONNAIRE:

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based on your personal and family history of cancer. Leave blank what you do not know.

The following relatives should be considered: Parents, sisters, brothers, half-sisters, half-brothers, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on **BOTH** sides of the family.

Do you have a family history of:

Breast cancer at 49 or younger ❑ YES ❑ NO

Two **breast cancers** in the same relative with at least one cancer in each breast ❑ YES ❑ NO

Three relatives with **breast cancers** in the same side of the family ❑ YES ❑ NO

Ovarian cancer ❑ YES ❑ NO

Pancreatic cancer (1st degree relative) ❑ YES ❑ NO

Male breast cancer ❑ YES ❑ NO

Metastatic prostate cancer ❑ YES ❑ NO

Colon cancer at 49 or younger ❑ YES ❑ NO

Uterine cancer at 49 or younger ❑ YES ❑ NO

Jewish by ancestry and have a Jewish family member with **breast cancer** ❑ YES ❑ NO

Have you or anyone in your family had genetic testing for hereditary cancer? ❑ YES ❑ NO

Do you have a family history of other cancers? List them here: _____

_____

_____

_____

Have you ever been diagnosed with:

Breast, ovarian, prostate or pancreatic cancer ❑ YES ❑ NO

Colon cancer ❑ YES ❑ NO

Uterine cancer at 64 or younger ❑ YES ❑ NO

Have you had other cancers? List them here: _____

_____

_____

_____

AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED FOR ELECTRONIC MEDICAL RECORDS

I authorize Summit Cancer Centers (SCC/AOP), a division of American Oncology Partners, P.A. (SCC/AOP), to take my photograph (digital camera/video may be used). These photos may then be placed in my SCC/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 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 Summit Cancer Centers: *(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 Summit Cancer Centers (SCC/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 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 Summit Cancer Centers (SCC/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)

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 Summit Cancer Centers (SCC/AOP), a division of American Oncology Partners, P.A. 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 Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP) Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP) facility or by submitting a request in writing to the corporate office at Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP), 3860 Colonial Blvd., Suite 100, Fort Myers, FL 33966.

You may also view and/or print a copy of the Notice of Privacy Practices by visiting **AONcology.com/policies/SCC_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 Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP) Financial Policies Agreement.

This notice is available in hard copy by verbally requesting a copy at the front desk of any Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP) facility or by submitting a request in writing to the corporate office at Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP), 3860 Colonial Blvd., Suite 100, Fort Myers, FL 33966.

You may also view and/or print a copy of the Financial Policies Agreement by visiting **AONcology.com/policies/SCC_FPA.pdf**

Date:_____

_____	_____
Patient Name (Print)	DOB
_____	_____
Patient (Signature)	Date
_____	_____
Patient or Guarantor (Signature)	Date

By signing below, I authorize Summit Cancer Centers, a division of American Oncology Partners, P.A., (SCC/AOP) its affiliate and subsidiary entities, and AON Pharmacy, LLC (and any authorized SCC/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 SCC/AOP under my cell phone plan.

I know that I am under no obligation to authorize SCC/AOP 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)