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), 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 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), 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.

____ ____________________

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), 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:____________

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), 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 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 (SCC), 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 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., 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/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 (SCC), 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 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., 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/SCC_FPA.pdf**

Date:________________

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

By signing below, I authorize Summit Cancer Centers (SCC), a division of American Oncology Partners, P.A. (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)