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
c consequat

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 #):

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

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:

[ ] Asthma [ ] Neurological Disorder/Chronic Headaches [ ] Arthritis
[ ] Psychiatric Disorder/Illness [ ] Blood Pressure Disorder/Hypertension [ ] Pulmonary Embolism/DVT/Blood Clots
[ ] Cancer [ ] Stroke [ ] Cholesterol Disorder/Hyperlipidemia
[ ] Seizures or Epilepsy [ ] COPD [ ] Sleep Apnea
[ ] Diabetes [ ] Thyroid Disorder [ ] Eye Disorder (i.e. Glaucoma)
[ ] Urinary/Kidney Disorder [ ] Heart Attack/Heart Disease/Atrial Fib [ ] 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.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Prior Cancer Treatment Do you currently have cancer? [ ] Yes [ ] No

<table>
<thead>
<tr>
<th>Type of Cancer</th>
<th>Year Diagnosed</th>
<th>Treatment</th>
<th>Hospital/Doctor's Office Where You Received Treatment</th>
</tr>
</thead>
<tbody>
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<td>Name:</td>
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<td></td>
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<td>Phone:</td>
</tr>
</tbody>
</table>

Allergies
Are you allergic to any medications or other substances? [ ] Yes [ ] No Please list allergies and reactions:
___________________________________________________________________________________________
___________________________________________________________________________________________
Patient Name: ___________________________________________________________ DOB: ______________

Medication List

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Relative</th>
<th>Condition and Description</th>
<th>Living?</th>
<th>If deceased, at what age?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Grandparent</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Grandparent</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

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
- [ ] Weight Loss
- [ ] Feeling Poorly

### Eyes
- [ ] None
- [ ] Vision Changes
- [ ] Dry Eyes
- [ ] Eyesight Problems
- [ ] Eye Pain
- [ ] Itchy Eyes

### Ear/Nose/Throat
- [ ] None
- [ ] Sinus Problems
- [ ] Earache
- [ ] Sore Throat
- [ ] Loss of Hearing
- [ ] Hoarseness
- [ ] Nose Bleeds

### Heart
- [ ] None
- [ ] Leg Swelling
- [ ] Chest Pain
- [ ] Fast heart rate
- [ ] Palpitations
- [ ] Slow Heart Rate
- [ ] Leg pain, discomfort or fatigue during walking

### Lungs/Breathing
- [ ] None
- [ ] Trouble breathing with exertion
- [ ] Cough
- [ ] Wheezing
- [ ] Shortness of Breath
- [ ] Trouble breathing when lying flat

### Gastrointestinal
- [ ] None
- [ ] Heartburn
- [ ] Abdominal Pain
- [ ] Nausea
- [ ] Constipation
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Blood in stool

### Skin
- [ ] None
- [ ] Skin Lesions
- [ ] Acne
- [ ] Skin Wound
- [ ] Itching
- [ ] Breast Lump
- [ ] Change in mole

### Neurological
- [ ] None
- [ ] Convulsions
- [ ] Limb Weakness
- [ ] Headaches
- [ ] Confused
- [ ] Dizziness
- [ ] Loss of Memory
- [ ] Difficulty Walking

### Psychiatric
- [ ] None
- [ ] Depression
- [ ] Suicidal
- [ ] Emotional Problems
- [ ] Anxiety
- [ ] Change in Personality
- [ ] Disturbed Sleep

### Endocrine
- [ ] None
- [ ] Feeling Weak
- [ ] Hair Loss
- [ ] Deepening Voice
- [ ] Weak Muscles
- [ ] Hot Flashes

### Hem/Lymph
- [ ] None
- [ ] Easy Bleeding
- [ ] Easy Bruising
- [ ] Swollen Glands
AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED
FOR ELECTRONIC MEDICAL RECORDS

I authorize Trident PET/CT of Savannah (TPCS), 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 TPCS/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 Trident PET/CT of Savannah: (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 Trident PET/CT of Savannah (TPCS), 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
CONSENT TO DISCLOSE MEDICAL INFORMATION

Please check one of the following:

☒ I give permission to the employees of Trident PET/CT of Savannah (TPCS), 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 Trident PET/CT of Savannah (TPCS), 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.

_________________________________________________________________________________________ Date

Patient Name (Print) ______________________________

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 Trident PET/CT of Savannah (TPCS), 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 TPCS/AOP facility or by submitting a request in writing to the corporate office at Trident PET/CT of Savannah, 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/TPCS_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 Trident PET/CT of Savannah (TPCS), 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 TPCS/AOP facility or by submitting a request in writing to the corporate office at Trident PET/CT of Savannah, 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/TPCS_FPA.pdf

Date:_________________

_________________________________________    _________________
Patient Name (Print)                                     DOB

_________________________________________    _________________
Patient (Signature)                                      Date

_________________________________________    _________________
Patient or Guarantor (Signature)                        Date
By signing below, I authorize Trident PET/CT of Savannah (TPCS), a division of American Oncology Partners, P.A. (AOP), its affiliate and subsidiary entities, and AON Pharmacy, LLC (and any authorized TPCS/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 TPCS/AOP under my cell phone plan.

I know that I am under no obligation to authorize TPCS/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)