Genesis Cancer Center

Patient Care • Education • Research

DATE: _____

PATIENT INFORMATION:

NAME _____ Date of Birth _____

Email Address_____ Social Security#_____ Gender: M___ F___

Marital Status: M___ S ___ D__ W___ Hispanic____ Non Hispanic_____ Race_____

Referring Physician_____ Primary Care Physician _____

PATIENT ADDRESS _____ Language Preference_____

CITY _____ STATE _____ ZIP _____

Circle contact preference HOME # _____ CELL #_____

PATIENT'S OCCUPATION/EMPLOYER: _____

EMPLOYER'S ADDRESS_____WORK#_____

SPOUSE'S name_____ date of birth _____social security # _____

Phone#_____ Employed by _____

NEAREST RELATIVE/EMERGENCY CONTACT (must be listed on HIPAA form)

Name_____ Relation _____

City _____State_____ Phone _____

INSURANCE (provide cards to receptionist to copy)

NAME (Primary) _____NAME (Secondary) _____

PRESCRIPTION COVERAGE: Ins.Name _____Pharmacy&Location_____

Authorization and Responsibility Agreement

I hereby authorize the insurance company to pay benefits directly to Genesis Cancer Center (a copy of this can be considered as an original for insurance purposes).

I authorize any holder of medical information about the patient to release to the insurance carrier and its agent any medical information needed to determine these benefits or benefits payable for related services.

I authorize the release of necessary medical information to the referring and/or the referred physician.

Do you wish your insurance filed for you?

Although I have requested Genesis Cancer Center to bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the remaining balance

Regarding referrals and procedures performed in the office

I understand that it is my responsibility to obtain referrals from my primary care physician for each office visit and any other special procedure performed in the office deemed necessary by my physician. All lab work that cannot be done at Genesis Cancer Center is routinely sent to Bio-Reference Laboratories. If my insurance requires my lab work be sent to another facility or provider it is my responsibility to inform the nurse at each visit.

Self-Pay patient (patients who do not have any insurance):

I agree to pay my account as services are rendered. If for any reason there is a balance owing on my account, I will make payment arrangements with Genesis Cancer Center and agree to pay promptly upon receipt of the monthly statement.

Electronic Prescription

By signing below, you provide your consent to electronically submit your prescriptions through the e-prescribing system and to request and use our prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Signature: _____ Date: _____

Genesis Cancer Center Patient History

Patient _____ Age _____ Date of birth ____/_____/_____ Today's date ____/_____/_____
Family Physician _____ How did you hear about our clinic?
_____
Referring physician _____ Reason for today's visit? Please explain _____
_____
Are you allergic to any medications? Y / N If yes, please list
_____
Did you bring a list of your medications? Y / N If no, please list name and dose (including prescriptions, over-the-counter meds, vitamins, etc)
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____
Do you have advanced directives? DNR? Y / N Living will? Y / N Healthcare power of attorney? Y / N _____
Social history Marital status _____ Do you have children? Y / N If yes, how many? _____
Are you a current or former smoker? Y / N If yes, how much per day/how many years? _____
If former smoker, date stopped? _____ Do you drink alcohol? Y / N If yes, _____ drinks per day
Have you ever been exposed to: HIV/AIDS? Y / N Hazardous chemicals? Y / N If yes, please explain _____
What is/was your occupation? _____ What are your hobbies? _____
Family history (Cancer, diabetes, blood disorder, heart disease, etc, and age diagnosed) Use back for more if necessary
Mother_____ Sibling _____ Other _____
Father _____ Sibling _____ Other _____

Review of Systems: Do you have now or have you recently had any problems with the following?							
Symptom	Y	N	Comments	Symptom	Y	N	Comments
Fatigue				Skin rash			
Fever/ Chills				Persistent itch			
Weight loss				Boils/ sores			
Headache				Joint pain			
Swollen glands				Varicose veins			
Night sweats				Urine retention			
Vision problems				Painful urination			
Numbness/ tingling				Frequent urination			
Tremors				Nausea/ vomiting			
Dizzy spells				Stomach pain			
Sinus problems				Indigestion			
Sore throat				Diarrhea			
Wheezing				Constipation			
Breathing trouble				Other:			
Frequent cough							

Medical History (Use back if necessary)	Circle one	Year diagnosed Please explain/ specify	Other medical conditions and surgeries	Year diagnosed Please explain/ specify
Heart disease	Y / N			
Diabetes Mellitus	Y / N			
High blood pressure	Y / N			
Blood disorder	Y / N			
Stroke/ TIA	Y / N			
Osteoporosis	Y / N			
Kidney disease	Y / N			
Cancer (and type)	Y / N			
Have you ever received radiation or chemotherapy for any illness? Y / N If yes, for what illness?				
What treatment was received?				

GENESIS CANCER CENTER
MEDICAL RECORDS RELEASE FORM

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- By signing the authorization, I authorize Genesis Cancer Center to use and/or disclose certain protected health information (PHI) about me to/or obtain information from an outside entity.
- This authorization permits Genesis Cancer Center to use and/or disclose individual identifiable health information about me.
- The information will be used or disclosed for continued patient care.

If requested by the patient, purpose may be listed as "at the request of individual."
The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire one year from the date specified herein below.

I do not have to sign this authorization in order to receive treatment from Genesis Cancer Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer: Lesia Landers
Genesis Cancer Center
133 Harmony Park Circle
Hot Springs, AR 71913
Telephone: 501-624-7700 Fax: 501-623-5788

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Print Name of Patient or Legal Guardian — Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION UPON REQUEST

For Internal Use:

From: _____ **To:** _____
_____ _____
_____ _____

PRIVACY NOTICE ACKNOWLEDGMENT

The signature below acknowledges a copy of this Notice was RECEIVED (not necessarily read).

_____ _____

Date Patient/Legal Representative Signature

For internal use only

Lack of Patient Acknowledgement:

Date Reason Staff Signature

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient's Name: _____ DOB: _____ SSN: _____

Below is a list of persons that you give permission for our clinic to discuss and use the patient's protected health information, including condition and treatment plan, test results, prescriptions, x-rays.
You do not need to list other medical providers, hospitals, or pharmacies. This release pertains to family, friends, and private caregivers.
If you have **NOT** listed a person on this form our staff **WILL NOT DISCUSS ANY INFORMATION** with that person either by phone or in person.

Name	Relationship to You	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to receive or use this patient's healthcare information.

_____ _____

Date Patient Signature/Legal Representative

If legal representative, explain the capacity: _____

Reviewed by: _____

Staff Signature