ONCOLOGY ASSOCIATES OF SAN DIEGO

A MEDICAL GROUP

Dr. Robert M. Barone, M.D., F.A.C.S. Dr. Paul M. Goldfarb, M.D., F.A.C.S.

Authorization to RELEASE Medical Records

I hereby authorize:

____

____

____

Dr. Robert Barone, M.D., F.A.C.S.   Dr. Paul Goldfarb M.D., F.A.C.S.

(circle one please)

Oncology Associates of San Diego 3075 Health Center Drive, Ste #102
San Diego, Ca. 92123
Phone (858) 637-7888 Fax (858) 637-7663 Fax: (858) 637-7842

Please fax any and all medical records and information pertaining to my medical history and/or treatment

____

____

____

Confidentiality notice: The information contained in this release is intended only for the use of the individual to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law.

______________________________ ______________________________ ____________

Patients Name Signature of Patient DOB

____ ____________

Maiden Name Today's Date

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BRIEF MEDICAL INFORMATION

PATIENT ______________________________________ DOB __________________

Primary Physician: ____

Dominant Hand: Right / Left

Do you have a pacemaker, stent, any metal or clips implanted? Yes / No

Do you take heart or blood pressure medication? Yes / No

Do you take blood thinners? Yes / No

Are you diabetic? Yes / No

If yes, please list any medication: ___________________________________

Please list any known allergies: ________________________________

____

Please list any recent surgeries, including type of surgery and approximate date:

____

____

____

Please list all medications you presently take:

____

____

____

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Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Oncology Associates of San Diego herein known as “Health Care Provider”, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of Heath Care Provider.

I understand that diagnosis or treatment of me by “Health Care Provider” may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. “Health Care Provider” is not required to agree to the restrictions that I may request. However if “Health Care Provider” agrees to a restriction that I request, the restriction is binding on “Health Care Provider” and “Health Care Provider” practice.

I have the right to revoke this consent in writing at any time, except to the extent that “Health Care Provider” has taken action in reliance on this consent.

My “protected health information” means information, including my demographic information collected from me and created or received by my physician, another health plan, my employer of a healthcare clearinghouse.

This “protected health information relates to my past present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that information my identify me.

I understand I have a right to review “Health Care Providers” Notice of Privacy Practices prior to signing this document.

The “Health Care Provider” Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices for “Health Care Provider” is also provided in the Reception Area and on the “Health Care Providers” web site at www.westcoasthipec.com.

This Notice of Privacy Practices also describes my rights and the duties of “Health Care Providers” with respect to my protected health care information.

“Health Care Providers” reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by accessing the “Health Care Providers” Web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____

Signature of Patient or Personal Representative

____

Name of Patient or Personal Representative

____

Date

____

Description of Patient or Personal Representative

ONCOLOGY ASSOCIATES OF SAN DIEGO

A MEDICAL GROUP

Dr. Robert M. Barone, M.D., F.A.C.S.   Dr. Paul M. Goldfarb, M.D., F.A.C.S.

REQUEST FOR RESTRICTION ON USE & DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION

Patients Name:______________________________________

Phone Number {Day}:___________________

Phone Number {Evening}:___________________________

Street or PO Box:____________________________________

City:____

State:____

ZIP: __________________

1) Medical Information Restricted:

2) Nature of Restriction:

3) Medical Information to be Communicated Confidentially:

4) Medical Information to be Communicated Confidentially:

TO OUR PATIENTS: You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree to your requested restrictions. If we do agree t the requested restriction, we will abide by the restrictions. If we do agree to the requested restriction, we will abide by the restriction unless a medical emergency requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you (1) specify the alternative location, address or telephone number and/or the alternative means of contact and (2) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Patient:_______________________________________

Request for Restriction Accepted:__________________

Request for Restriction Denied:__________________

Request to Communicate Confidentially Restriction Accepted:__________________

Request to Communicate Confidentially Restriction Accepted Denied:__________________

This Request for Restriction and Confidential Communication Form is to be made part of the medical record of: (Patient Name) ____

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FINANCIAL POLICY

Dear
Patient,

Our office will be happy to bill your primary and secondary insurance carrier if the proper information has been provided. We will need to copy your insurance card at the time of your visit.

If you wish to bill your own secondary insurance, please use a copy of your itemized monthly statements If you need assistance with secondary billing procedure or if you have any questions regarding your account, please contact our Business Office at (858) 637-7880.

Our Office will bill your HMO insurance for services provided. In addition, most HMO insurance companies require the patient pay a co-payment at the time of the service. Please inform our office if your insurance provider requires a ”co-pay”.

Patients are responsible for the balance due in full if your insurance company fails to pay. If you feel that your insurance company has not responded to your claim, please contact your insurance company. It is your responsibility to assist with problems that result from an unpaid claim. Also, be advised that if we are not notified of changes (I.e., Group number, insurance address, HMO changes) or new insurance coverage, you will be responsible for payment in full.

Patients are responsible for the balance due in full if your insurance company fails to pay. If you feel that your insurance company has not responded to your claim, please contact your insurance company. It is your responsibility to assist with problems that result from an unpaid claim. Also, be advised that if we are not notified of changes (I.e., Group number, insurance address, HMO changes) or new insurance coverage, you will be responsible for payment in full.

Please contact our Business Office if you have any questions regarding our financial policy.

Patient’s Signature: ____ Date: _________________

Witness: ____ Date: ________________

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Name: ______________ Date:________________

Age: ______________ Occupation:_____________________________

The information requested in this questionnaire is important to give you the best care.
Please take the time to fill out this form completely and accurately.

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES AND OPERATIONS

○ Rheumatic Fever
○ Heart Murmur
○ Bleeding Disorders
○ Tonsillectomy
○ Appendectomy
○ Obesity

Other:____

____

WOMEN: Obstetric and Menstrual History:

Number of Pregnancies:_____

Age at First Pregnancy:_____

Number of Live Births:_____

Miscarriages/Abortions:_____

Birth Control? Yes_____ No_____

Did You Breastfeed? Yes_____ No____

Age at First Period:_____

Date of Last Period:_____

Obstetric Complications:_____

Estrogens? Yes_____ No_____

Breast History:

Any history of breast or ovarian cancer in the family? Yes_____ No____

If Yes, Which Side of the Family?

Mother's Side? Yes_____ No_____

Father's Side? Yes_____ No_____

Any Nipple Discharge? Yes_____ No_____ Any Nipple Changes? Yes_____ No_____

Any Trauma to the Beast? Yes_____ No_____

PAST MEDICAL HISTORY CONTINUED

ADULT: Serious Illness and Hospitalizations:

☐ Cancer ☐ Heart Disease ☐AIDS/HIV Exposure ☐ Diabetes
☐ Hepatitis ☐ Blood Transfusion ☐Bleeding Abnormally ☐Blood Clots
☐ Colitis ☐ Kidney Disease ☐Blood Pressure ☐Phlebitis ☐Stroke

DATE ILLNESS TREATMENT

____

____

ADULT: Major Surgery and Serious Injuries:

DATE OPERATION or INJURY

____

____

____

ALLERGIES:

Allergy to Medications:___________________________________ None_______

Allergy to Substances::____

MEDICATIONS YOU TAKE: List of Medications you presently use:

Drug Dose and Frequency	Drug Dose and Frequency

HABITS:

Did You or Do You Use Tobacco? Yes_____ No____ If yes, amount?____________
Did You or Do You Use Alcohol? Yes_____ No____ If yes, amount?_____________
Have You Ever Been Treated for Drug Addiction? Yes___ No___ If yes, when?______

FAMILY HISTORY: Parents, Grand Parents, Brothers and Sisters:

MEMBER	LIVING?	DECEASED?	AT AGE	ILLNESS OR CAUSE OF DEATH

Any Family History of:

☐ Obesity ☐ Lung Disease, Asthma, Emphysema
☐ Diabetes ☐ Kidney Disease
☐ High Blood Pressure ☐Bleeding Tendency or Blood Disorder
☐ Heart Disease ☐ Breast Cancer
☐ High Blood Pressure ☐Colon Cancer
☐ Allergy to Latex

Names of Your Doctors: Please list Doctors you currently attend with:

SPECIALTY	NAME	LOCATION	PHONE
Family Doctor			
Internist			
Orthopedist			
Gynecologist			
Other			

SYSTEM REVIEW: Circle All Symptoms Which You Have or Have had. Write in Any Additional Problems

HEAD, EARS NOSE AND THROAT: Stuffy Nose, Runny Nose, Hay-Fever, Sinus Trouble, Earache, Headache, Blurry Vision, Double Vision, Haloes Around Lights, Loss of Night Vision, Buzzing in Ears, Ringing in Ears, Discharge From Ears, Loss of Hearing, Dizziness, Vertigo, Loss of Balance, Sore Throat. Lump in Throat, Trouble Swallowing, Pain with Swallowing, Hoarseness.

RESPIRATORY: Cough, Wheezing, Shortness of Breath at Night, Use Two Pillows, Blood in Sputum, Out of Breath with Exertion, Wake up a t Night Short of Breath, Wake up at Night Coughing or Choking, Asthma, Emphysema, Bronchitis.

CARDIO VASCULAR: Palpitations, Pounding of Heart, Skipping of heart beat, Pains in Chest, Pains in Neck Pains in Anus Squeezing of Chest. Heart Attack, Heart Murmur. Abnormal Electrocardiogram. Irregular Heartbeat, High Blood Pressure, Pain in Legs. Cold Feet, Blue Toes, Blue Fingers, Loss of Pulses.

GASTROINTESTINAL: Heartburn, Nausea, Vomiting, Belching Fluid in Throat, Burning in Throat Food Sticking in Chest, Pains in Stomach, Burning in Stomach, Acid Stomach, Diarrhea, Constipation, Pain with Bowel Movement Blood in Stools.. Hemorrhoids, Fissures, Cramps, Gassiness, Irritable Colon, Colitis.

GENITAL URNARY: Pain With Urination, Trouble Starting Urine, Trouble Stopping Urine Small Urine Stream. Frequent Urination Getting Up at Night to Urinate, Leakage of Urine with Cough or Sneeze.

ENDOCRINE: (GLANDULAR) : Low Thyroid, Hyper 1yroid, Goiter, Grave's Disease, Thyroid Nodules, X-Ray to Thyroid, Diabetes, Adrenal Gland Tumor, Frequent flushing, Frequent Heavy Sweating.

Men: Discharge from Penis Loss of Erection, Painful Erection.

Women: Vaginal Discharge, Vaginal Bleeding, Pain With Intercourse.

MUSCULOSKELITAL: Pain in Joints, Swelling in Joints, Redness of Skin Over Joints, Warm Joints, Fluid in Joints, Arthritis, Broken Bones, Sprains, Low back Pain, Hip Pain, Knee Pain, Ankle Pain, Foot Pain, Flat Feet, Slipped Disk. Herniated Disk, Sciatica.

NUROLOGICAL: Dizziness, Vertigo, Falling to the Side, Falling at Night, Numbness, Tingling, Pins & Needle Feelings, Weakness of any Muscles, Twitching of Muscles, Weakness of Grip, Shakiness, Tremor. Fainting, Convulsions, Fits, Loss of Consciousness.

PSYCHOLOGICAL: Nervousness, Anxiety, Depression, Thoughts of Suicide, Suicide Attempts, Hospitalizations for Emotional Problems, Psychiatric Treatment, Psychological Counseling.

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NOTICE OF PATIENT PRIVACY Effective Date_________

We are committed to preserving the privacy of your personal heals information, in fact we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

AND HOW YOU CAN ACCESS THIS INFORMATION

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for reimbursement of the care that we provide to you and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization

As our patient you have important rights relating to inspecting and copying your information that we maintain amending or correcting that information obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date if the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our office at 858-637-7888

______________________________	_____________	____________________________
Signature of Patient	Date	Signature of Representative

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DATE: ______________ EMAIL________________

PATIENT INFORMATION

PATIENT'S NAME: ____
LAST FIRST MIDDLE

ADDRESS: ____

CITY:______________STATE:____________________ZIP-CODE: __________

PHONE NUMBER-HOME: (_______)______________CELL: (_____) ______________

DATE OF BIRTH:__________SEX:____________MARITAL STATUS:____________

SOCIAL SECURITY NUMBER:________________DRIVER'S LICENSE: ___________

REFERRED BY: ____

PHARMACY:____________________PHARMACY PHONE #: (_______) ________

NEXT OF KIN: ____
(NOT LIVING WITH YOU) ADDRESS PHONE

PERSON TO CONTACT IN CASE OF EMERGENCY: ______________________________
NAME PHONE

PATIENT'S EMPLOYER:______________WORK PHONE: (______)__________EXT: ______

EMPLOYERS ADDRESS: ____

SPOUSE NAME: ____
LAST FIRST MIDDLE

EMPLOYER: ____

EMPLOYER ADDRESS:______________WORK PHONE: (______)__________EXT: ______

SOCIAL SECURITY NUMBER:______________DRIVER'S LICENSE: ______________
(SPOUSE) (SPOUSE)

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INSURANCE INFORMATION

PRIMARY INSURANCE: ____

I.D. NUMBER:____GROUP NUMBER: __________________________

SUBSCRIBER NUMBER:______________________________GROUP NUMBER:_______________M__F___

SECONDARY INSURANCE: ____

I.D. NUMBER:_______________________________________GROUP NUMBER: __________________________

SUBSCRIBER NUMBER:______________________________GROUP NUMBER:_______________M____F____

I herby authorize:____to furnish to my insurance company or a designated attorney all information which the insurance company or attorney may request, I herby assign to the above referenced physicians all monies to which I am entitled and/or surgical expense relative to the services rendered by either of them It is understood that any money received from the above-named insurance company over and above the indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible WEATHER MY INSURANCE COMPANY PAYS OR NOT, for all charges incurred by me. I further more agree that in the event of non-payment, I will bear the cost of collection and-or Court cost and reasonable legal fees should such court action be required. I agree that a photocopy of this authorization shall be valid as the original.

_____________________________________ Insured or Guardian Signature

__________________________ Patient's Signature

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PATIENT REGISTRATION

DATE ____________________

FIRST NAME ________________________MIDDLE _____

LAST NAME____

SEX___DATE OF BIRTH____/____/____

PRIMARY LANGUAGE _________________________________

MARITAL STATUS____MARRIED____SINGLE

___DIVORCED____WIDOWED

WORK STATUS____EMPLOYED____RETIRED

___OTHER ____

EMPLOYER ____

HOME ADDRESS ____

____

CITY _______________STATE ________ZIP ________________

EMAIL____

HOME PHONE (_____) ___________________________

CELL PHONE (_____) _____________________________

REFERRINGPHYSICIAN______________________________

HOW DID YOU HEAR OF US? _________________________

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

___COMMERCIAL____MEDICAL____MEDICARE____OTHER ____

INSURANCE COMPANY ____

INSURED / CARD HOLDER'S NAME _________________________RELATIONSHIP ______________________

POLICY # ________________GROUP# __________________________PHONE (_____) ___________________________

SECONDARY INSURANCE

___COMMERCIAL____MEDICAL____MEDICARE____OTHER____

INSURANCE COMPANY____

INSURED / CARD HOLDER'S NAME_________________________RELATIONSHIP___________________________

POLICY #________________GROUP#__________________________PHONE (_____) ___________________________

EMERGENCY CONTACT

FIRST NAME_____________________________MI________

LAST NAME____

HOME PHONE (_____) ___________________________

CELL PHONE (_____) _____________________________

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

RELATIONSHIP____________________________________

FIRST NAME _____________________MIDDLE ________LAST NAME____

ADDRESS____

CITY ______________STATE ____________ZIP _____________

SEX_______DATE OF BIRTH ____/ ____/_____

DAYTIME PHONE (_____) _______________________

EMPLOYER ADDRESS

CITY ______________STATE______________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

____

SIGNATURE DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

____

SIGNATURE DATE