

Matthews Hematology Oncology Associates

Richard S. Foulke, MD
Lance K. Lassiter, MD
Alfred J. Newman, MD

Patient Registration

Date: _____ MR #: _____

Patient Name: _____

Last

First

Middle

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____

Maiden Name: _____ Married: _____ Single: _____ Widow: _____ Divorced: _____

Referring Physician: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Primary Insurance Information

****ALL information MUST be filled out****

Name of Insurance Company: _____

Insured's Name: _____ Relationship to Insured: Self Spouse Other

Date of Birth: _____ Social Security #: _____

Insured ID #: _____ Group #: _____

Insurance Address: _____

Secondary Insurance Information

****ALL information MUST be filled out (if applicable)****

Name of Insurance Company: _____

Insured's Name: _____ Relationship to Insured: Self Spouse Other

Date of Birth: _____ Social Security #: _____

Insured ID #: _____ Group #: _____

Insurance Address: _____

I hereby authorize Matthews Hematology Oncology Associates to furnish my medical records to insurance carriers and physicians assisting in my care, concerning my illness and treatments. I hereby assign Matthews Hematology Oncology Associates all payments for medical service rendered to dependents or myself. I understand that these authorizations remain in effect as long as my dependent or I remain a patient.

Patient Signature: _____ Date: _____

Relationship, if other than patient: _____

MATTHEWS HEMATOLOGY ONCOLOGY ASSOCIATES

PATIENT NAME: _____

CHIEF COMPLAINT: Why have you been referred to our office? _____

REFERRING DOCTOR: _____

PRIMARY DOCTOR: _____

OTHER DOCTORS THAT PROVIDE CARE: _____

PREFERRED PHARMACY: _____

PHONE #: _____

ADDRESS: _____

MEDICATIONS: Please list **all** the medications you are taking, including the dosage and frequency. If necessary, please continue your list on another sheet. Always remember to bring your medications to each visit.

DRUG ALLERGIES: Please list and include reactions (rash, hives, breathing problems, etc.)

Check if you have an allergy to the contrast used in radiology procedures.

MEDICAL ILLNESSES:

Please check all that apply.

NERVOUS SYSTEM

- Stroke / TIA
- Seizures
- Severe anxiety
- Depression

SENSES

- Hearing loss / deafness
- Vision loss / blindness
- Glaucoma / cataracts

CARDIOVASCULAR

- High blood pressure
- Angina, heart attack
- Congestive heart failure
- Abnormal heart rhythm
- High cholesterol
- Peripheral vascular disease
- Cardiac stents

LUNGS

- Asthma
- Emphysema / COPD

GASTROINTESTINAL

- Ulcers, reflux, gastritis
- Colitis / diarrhea
- Liver disease

BONES / JOINTS

- Arthritis
- Fractures
- Joint replacements

ENDOCRINE

- Diabetes
- Thyroid- High Low

INFECTIONS

- HIV / AIDS
- Hepatitis

KIDNEYS

- Kidney failure
- Kidney stones

BLOOD DISORDERS

- Anemia
- Abnormal blood counts
- Clotting problems
- Bleeding problems

CANCER

Current diagnosis (what type):

 Previous diagnosis (when, what type):

OTHER ILLNESSES: _____

SURGICAL PROCEDURES:

FAMILY HISTORY: If any family member has had cancer, please note what type and their relationship to you.

SOCIAL HISTORY:

Married Yes No Divorced Yes No
Widow(er) Yes No Separated Yes No

Who lives with you? _____

Cigarettes:

Are you or have you ever been a smoker? Yes No
If "Yes", when did you start? _____
Have you stopped smoking Yes No
If "Yes", when did you stop? _____
If "No", would you like help quitting smoking? Yes No

Other Tobacco: Pipe Cigars Snuff Chewing tobacco

Alcohol Use: Yes No If yes, how many drinks per week? _____

Illegal Drugs: Yes No If yes, explain. _____

SYMPTOMS:

| | Currently | In the Past | | Currently | In the Past |
|-----------------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Cough | <input type="checkbox"/> | <input type="checkbox"/> |
| Easy bruising / bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody stool | <input type="checkbox"/> | <input type="checkbox"/> | Nausea | <input type="checkbox"/> | <input type="checkbox"/> |
| Fevers | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty emptying bladder | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness | <input type="checkbox"/> | <input type="checkbox"/> | Poor appetite | <input type="checkbox"/> | <input type="checkbox"/> |

Weight loss: How much, if any, in the last 6 months? _____

Pain: Describe location, intensity and what makes it worse or better. _____

Please describe any other important symptoms. _____

Are you having any difficulty coping with your diagnosis related depression or anxiety? Yes No

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O | A

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HIPAA Acknowledgement

Questions and Complaints

If you have any questions about this notice, please contact:

Matthews Hematology Oncology Associates
Beth Scott
Office Administrator
3036 Senna Drive
Matthew, NC 28105
Phone: 704-841-8151

If you think that we have violated your privacy rights, please contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

Signature: _____

Date: _____



Matthews Hematology Oncology Associates

FINANCIAL POLICY

Patient's Name: _____

Date of Birth: _____

BASIC POLICY: Payment for service is due in full at the time services are rendered in our office.

FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All co-payments or deductibles are due and payable at the time service is provided.

MEDICAID PATIENTS: All Medicaid patients must provide a current, valid insurance card before being seen. Co-pays are also due before services are rendered, if required.

NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are rendered or upon notice of insurance claim denial.

PERSONAL INJURY CASES: The office does not bill for auto accidents or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

WORKER'S COMPENSATION: If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.

LATE FEES: Should your insurance fail to cover your entire visit, you will be mailed a statement each month. You have 15 days to return payment or you will be charged a \$20 late fee. This fee will be charged each month and will continue to accrue until payment is made on your account.

| | |
|-----------------------------------|--|
| For Patients with Medicare | <p>FOR MEDICARE PATIENTS ONLY:</p> <p>I request payment of authorized Medicare benefits be made on my behalf to Matthews Hematology Oncology Associates for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.</p> <p>I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. The coinsurance and deductible are based upon the charge determination of the Medicare carrier.</p> <p>Patient's Name (Please Print): _____ Date: _____</p> <p>Patient's Signature: _____</p> |
|-----------------------------------|--|

| | |
|--|--|
| For Patients with Private Insurance | <p>FOR PRIVATELY INSURED PATIENTS ONLY:</p> <p>Assignment of Insurance Benefits: I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Matthews Hematology Oncology Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.</p> <p>Patient's Signature: _____ Date: _____</p> |
|--|--|

I have read, understood, and I agree to the above financial policy for payment of professional fees.

The patient is ultimately responsible for all professional fees.

Patient's Signature: _____

Date: _____

PATIENT RECORD OF DISCLOSURES

Name: _____

Medical Record #: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____

- O.K. to leave message with detailed information
- Leave message with call-back number only

Work Telephone: _____

- O.K. to leave message with detailed information
- Leave message with call-back number only

Written Communication

- O.K. to mail to my home address
- O.K. to mail to my work/office address
- O.K. to fax to this number: _____

According to the HIPAA laws, we may also release information to the people you specify. Please list the people we may release your protected health information (PHI) to and their relationship to you:

| Name | Relationship to Patient |
|-------|-------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Patient Signature

Date

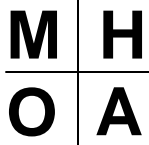
Print Name

Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.



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No Show Policy

The goal of the providers and staff of Matthews Hematology Oncology Associates is to provide you with excellent medical care and we sincerely appreciate the opportunity to participate in your care.

Should you need to cancel or reschedule your appointment for any reason, we kindly ask that you call our office at 704-841-8151 at least 24 hours before your scheduled appointment time.

If you are unable to keep your initial New Patient appointment and our office is not notified, please be aware that a \$75.00 “No Show” fee will be applied to your account. In the future, each Follow-Up appointment that you fail to present for without giving prior notice will incur a \$25.00 “No Show” fee.

Also note, these fees are not billable to your insurance company and are therefore entirely your responsibility.

I understand the above policy and agree to provide adequate notice if I am unable to keep any future appointment(s) I may make.

Print Patient's Name

Patient's Signature

Date

M | H
O | A

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Request for the Release of Medical Records

****Please print clearly!****

Date: _____

To: _____
(Previous physician/practice name)

Address: _____

City: _____ State: _____ Zip code: _____

Phone #: _____ Fax #: _____

I hereby request that my medical records be released to:

Matthews Hematology Oncology Associates

3036 Senna Drive
Matthews, NC 28105
Phone: 704-841-8151
Fax: 704-841-9228

Date of Birth: _____

Patient Name Printed: _____

Patient Signature: _____