AUGUSTA ONCOLOGY

Miriam J. Atkins, MD
David R. Squires, MD
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3696 Wheeler Road
Augusta, GA 30909
Telephone: (706) 736-1830
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820 St. Sebastian Way, 3-A
Augusta, GA 30901
Telephone: (706) 821-2944
Fax: (706) 821-2966

Please complete the enclosed forms in the New Patient Packet and return them to us when you arrive for your office visit. Please try to arrive at least 30 minutes before your scheduled appointment time.

We pride ourselves in going above and beyond the ordinary measure to ease our patient's financial burdens to the extent available to us. We have patient representatives to assist you with community resources and payment arrangements.

For patients without insurance or whose insurance does not cover all the costs, there are many sources of financial assistance that may be available. You will find that we also have resources for a number of chemotherapy medications that our doctors at Augusta Oncology prescribe.

For patients undergoing treatment, you may make an appointment with a patient representative to see if you qualify for any patient assistance. At that time you will be counseled on assistance eligibility and you will need to bring the following documents for the entire household. You cannot be screened for eligibility without these documents.

1040 page 1 & 2 of previous tax year
Social Security Statement

Financial counseling can lead to peace of mind about medical expenses, leaving you free to concentrate on recovering. We appreciate the opportunity to serve you.

Sincerely,
Augusta Oncology

New Patient Information DATE: _____

Phone numbers:

Home:_____ **Preferred Pharmacy:** _____

Mobile: _____ **Pharmacy Phone Number:** _____

Work: _____ **Preferred Hospital:** _____

Please list your Doctors: _____

_____

Please list all ALLERGIES (and reaction): _____

_____

Please list all your medications (with dose and frequency):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical History

Please list all medical problems and surgeries:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Last Colonoscopy: _____ **Last PSA or Prostate Exam:**_____

Last PAP Smear: _____ **Last Mammogram:** _____

Last Flu Shot: _____ **Last Pneumovax:** _____

Social History

Marital Status: _____ **Occupation:**_____

Tobacco Use: # of packs per day_____ # of years _____ # of years quit _____

Alcohol Use: # of drinks per day_____ # of years _____ # of years quit _____

Exposure to: Radiation_____ Asbestos _____ Benzene _____ Lead _____ Illegal Drugs _____

How old are your children?_____
Which family members or friends help you make medical decisions?

_____

Family History

Family members who had cancer:_____

_____

_____

Family members with blood problems:_____

Review of Systems

Please circle any of the symptoms below that you are feeling:

Constitutional: Fever, chills, hot flashes, drenching night sweats, fatigue, weight loss _____.
Head: Headache, dizziness, hearing loss, vision changes, mouth sores, hoarseness, runny nose, nasal/sinus congestion, sputum.
Lungs: Shortness of breath (at rest, lying down, or with exertion), cough, congestion
Heart: Chest pain or discomfort, palpitations
Abdomen/GI: Decreased appetite, nausea, vomiting, pain, heartburn (reflux), indigestion, diarrhea, constipation, change in bowel habits, blood in stool, hemorrhoids
Genitals/Urinary: Incontinence, difficulty urinating, frequent urination in day or night, pain or burning, bleeding, discharge, kidney stones
Arms, Back & Legs: Weakness, pain, swelling - if so where? _____
Neurologic: Numbness, tingling, burning, memory loss, seizures
Psychologic: Anxiety, depression, insomnia
Skin/Breasts: Rash, redness, new lumps or lesions
Blood: Bruising, bleeding, blood clots

Anything else?

_____ _____

_____ _____

_____ _____

Your Social Security # : _____ **Date of Birth:** _____

Your eMail address: _____

Home address: _____

City: _____ **State:** _____ **Zip Code:** _____

Where do you live? Home ___ Apartment ___ Assisted Living ___ Nursing Home ___ With Relative ___ Other

Sex: Male Female **Preferred Language**_____

Ethnicity:_____**Race**_____

Employer: _____ **Business Phone:** _____

Business Address: _____

Occupation: _____ **Referring Physician:** _____

Spouse's Name: _____ **Date of Birth:** _____

Spouse's Social Security #: _____

Advanced Directives

Please check all that apply:

___ Healthcare Durable Power of Attorney

___ Organ Donor

___ Autopsy Request

___ Living Will / Personal Directive

___ Do Not Hospitalize Status

___ Do Not Resuscitate Status

___ Feeding Restrictions

___ Medication Restrictions

___ Other Treatment Restrictions

___ No Advanced Directives

Financial Policy

Thank you for choosing Augusta Oncology as your healthcare provider. In order to provide our patients with the best possible service, we want to communicate to you our financial policies. A copy will be provided to you upon request.

Health Insurance Coverage: Our practice participates in most health insurance plans. As a service to you, we will submit your claims and assist you in any way we reasonably can in order to get your claims processed correctly. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Proof of Insurance: Our practice requires a copy of your driver's license and current valid health insurance card. Failure to provide correct insurance information in a timely manner may result in the balance of a claim becoming your responsibility. If your health insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. Further, all bills for patient balances are mailed to the address of record. Therefore it is imperative that you update us with any and all changes to your account whether it is a change of address, phone number, insurance coverage, etc.

Insurance Benefits: Prior to your visit, our staff will verify your health insurance benefits. However, if you have any questions concerning your benefits, please contact your insurance company for clarification.

Co-payments and deductibles: All copayments must be paid at the time of service. Payment plans are available for deductible and out of pocket costs. We accept cash, personal checks and major credit cards (Visa, Master Card, and Discover). We cannot waive any copayments, coinsurance, and/or deductibles. Please understand that payment plans will be separate from any per-visit copay required by your insurance company.

Referrals and Pre-Certification: Your insurance company may require a referral from a primary care physician (PCP) in order for you to see a specialist. Your insurance company may also require pre-certification of office or outpatients services. Pre-certification may also be required for admissions, CT scans, X-rays, and other diagnostic tests. As a courtesy, our office will make every reasonable effort to obtain these referrals and pre-certifications for you. However, it is ultimately your responsibility to ensure that all requirements are met before services are rendered. Please contact your insurance company to notify them of all services you are scheduled for.

Outside Lab Services: Our practice utilizes an outside lab company for certain tests. You are responsible for informing our staff which outside lab your insurance company covers.

I hereby authorize payment directly to **Augusta Oncology** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I verify that I have read and understand this Financial Policy.

Signature of Responsible Party: _____

Please Print Name of Responsible Party: _____

Date: _____

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RECORDS REQUEST AUTHORIZATION

Patient Name: _____

Date of Birth: _____

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM ALL TREATING INSTITUTIONS TO AUGUSTA ONCOLOGY. THIS FORM HAS NO EXPIRATION DATE UNLESS THE FOLLOWING HAS OCCURRED:
WRITTEN NOTIFICATION FROM PATIENT TO REVOKE PRIVILEGES.
AUGUSTA ONCOLOGY HAS THE RIGHT TO REVOKE THESE PRIVILEGES.

This information will include any records pertaining to physical or mental health, alcohol, drugs, tobacco, and the diagnosis or treatment of HIV (AIDS virus) infection or other sexually transmitted diseases.

I release Augusta Oncology and any member of their staff from all liability regarding the disclosure of this information.

_____ **DATE:** _____
Signature of Patient

_____ **DATE:** _____
Signature of Witness

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Notice of Privacy Practices Patient Acknowledgment

Patient Name: _____

I have received Augusta Oncology's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand Augusta Oncology reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions regarding all protected health information maintained by this practice. I understand that if a provision is made, I will receive an addendum explaining the change.
I understand that I can obtain this practice's current Notice of Privacy Practices on request.

_____ **DATE:** _____
Signature of Patient

_____
Relationship to Patient (If signed by a personal representative of patient)

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

_____ An emergency existed and a signature was not possible at the time.

_____ The individual refused to sign.

_____ A copy was mailed with a request for a signature by return mail.

Other:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Augusta Oncology is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Patient Name: _____

Person(s) who can receive information:

Name: _____ Relationship: _____
Last First

Phone Numbers: _____
(Home Phone) (Cell Phone) (Work Phone)

_____

Name: _____ Relationship: _____
Last First

Phone Numbers: _____
(Home Phone) (Cell Phone) (Work Phone)

_____

Name: _____ Relationship: _____
Last First

Phone Numbers: _____
(Home Phone) (Cell Phone) (Work Phone)

Is it okay to leave protected health information on voice mail? (circle one) YES NO

Is it okay to leave financial information on voice mail? (circle one) YES NO

Rights of the patient:
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Julie Stiefel.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal or State law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient. I understand that I have the right to have someone accompany me during my visits and that my protected health information will be disclosed.

_____ Date: _____
Signature of Patient or Personal Representative

*Attach additional forms if more contacts are needed.

*Attach necessary documentation if personal representative is needed.