



AUGUSTA ONCOLOGY

**Miriam J. Atkins, MD
David R. Squires, MD
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Esther Tan, MD
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**3696-Wheeler Road
Augusta, GA 30909
Telephone: (706) 736-1830
Fax: (706) 736-4521**

**1303 D'Antignac St. Ste 1000
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

Do Not Resuscitate Status

Organ Donor

Feeding Restrictions

Autopsy Request

Medication Restrictions

Living Will / Personal Directive

Other Treatment Restrictions

Do Not Hospitalize Status

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 outpatient 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.

Signature of Patient **DATE:** _____

Signature of Witness **DATE:** _____

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.

Signature of Patient or Personal Representative Date: _____

*Attach additional forms if more contacts are needed.

*Attach necessary documentation if personal representative is needed.



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RECORDS RELEASE AUTHORIZATION

Patient Name: _____

Date of Birth: _____

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM AUGUSTA ONCOLOGY TO

_____.

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.

Signature of Patient **DATE:** _____

Signature of Witness **DATE:** _____