Patient Name: _____ Patient D.O.B. : _____

Conditions of Service

In this document, **"Patient"** means the person receiving treatment. **"Patient Representative"** means any person acting on behalf of the Patient and signing as the Patient's representative. Use of the word "I," "you," "your" or "me" may in context include both the Patient and the Patient Representative. With respect to financial obligations "I" or "me" may also, depending on the context, mean financial guarantor "Guarantor".

"Provider" means the practice and may include healthcare professionals on the practice's staff and/or practice physicians, which may include but are not limited to: Oncologists, Radiologists, Radiation Oncologists, Physician Assistants, Nurse Practitioners, Social Workers, Behavioral Health Practitioners, as well as certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors or assignees acting on their behalf.

1. **Consent to Treatment.** I consent to the procedures that may be performed during my care, including, but not limited to, emergency treatment or services, and which may include laboratory procedures, x-ray and other imaging examinations, diagnostic procedures, or other medical, nursing or surgical treatment or procedures rendered as ordered by the Provider. I consent to allowing residents and other supervised individuals enrolled in a healthcare professional education program as part of their training in health care education to participate in and/or observe the delivery of my medical care and treatment. I further consent to the Provider conducting blood-borne infectious disease testing, including but not limited to, testing for hepatitis, Acquired Immune Deficiency Syndrome **("AIDS")**, and Human Immunodeficiency Virus **("HIV")**, if a Provider orders such tests or if ordered by protocol. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

2. **Consent to Photographs, and Video, Digital and Audio Recordings.** I acknowledge that the practice's security, quality improvement, patient care, healthcare operations and/or risk management activities may involve photographs, video, digital or audio recordings, and/or other images of me, including telephone calls, being recorded and consent to such images and recording. I understand that the practice retains the ownership rights to the images and/or recordings. Images and/or recordings in which I am identified will only be used and disclosed as permitted by law.

3. **Financial Agreement.** I understand that the practice may bill an insurance company offering coverage. Regardless, in consideration for the services rendered and except where prohibited by law, I (the Patient or Guarantor) agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions, or failure to comply with insurance plan requirements. I understand that in the event any amounts paid by me are ultimately greater than my final patient responsibility, such amounts may be applied to patient responsibility on other unresolved accounts prior to refund. An itemized billing statement is available upon request and free of charge.

   If supplies and services are provided to Patient who has coverage through a governmental program or through certain private health insurance plans, the facility may accept a discounted payment for those supplies and services. In this event any payment required from the Patient or

Conditions of Service

Guarantor will be determined by the terms of the governmental program or private health insurance plan.

4. **Professional services rendered by independent contractors and practitioners are not part of the practice bill.** I understand and acknowledge that the independent contractors and advanced practice professionals providing services to me at the practice are not agents or employees of the practice. I understand that I may not actually see or be examined by all physicians or other advanced practice professionals participating in my care; for example, I may not see the radiologists or pathologists participating in my care. I understand that, in most instances, there will be a separate charge for professional services rendered by these providers and that I will receive a bill for these professional services that is separate from the bill for practice services.

5. **Legal Relationship between Practice and Physicians and Advanced Practice Professionals.** Independent physicians and advanced practice professionals are responsible for their own actions and the practice shall not be liable for the acts or omissions of any such independent physicians and/or advance practice professionals. To the extent that any duty to perform any care, procedure, service and/or treatment is imposed upon the practice, the responsibility for the performance of such care, procedure, service and/or treatment is delegated to the applicable healthcare professionals.

6. **Assignment of Benefits.** Patient assigns all of his/her rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorizes direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient for the professional services, including emergency services, if rendered. I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by initially accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment.
   I agree to take all actions necessary to assist the Provider in collecting payment from any such Responsible Party should the Provider(s) elect to collect such payment, including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment acknowledge that it is my duty and responsibility to immediately pay any such payments to the Provider(s).

   I hereby **irrevocably appoint** the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies for any and all benefits due me for the payment of charges associated with services and treatment rendered by the Provider. These authorized actions include administrative and non-administrative appeals of any denial or underpayment of benefits or coverage, litigation, other forms of dispute resolution in any forum or for any type of relief (including monetary and equitable) available under applicable laws, including without limitation all provisions of the Employee Retirement Income Security Act of 1974, on my behalf against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party **("Responsible Party")**. I also transfer and assign to the Provider all of my rights to demand and receive the production of or access to any documents or information, including without limitation, copies of health plan

Conditions of Service

documents and materials, from any entity or person to the fullest extent of my rights to do so under my health plan and applicable laws. The foregoing rights are assigned in their entirety without limitation and without reservation of any part or aspect thereof. This assignment shall not be construed as an obligation of the Providers to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.

7. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide in applying for payment under Title XVIII **("Medicare")** or Title XIX **("Medicaid")** of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the practice or physician by the Medicare or Medicaid program.

8. **Outpatient Medicare Patients.** Medicare does not provide coverage for "self-administered drugs" or drugs that you normally take on your own, with only a few limited exceptions. If you get self-administered drugs that aren't covered by Medicare Part B, we may bill you for the drug. However, if you are enrolled in a Medicare Part D Drug Plan, these drugs may be covered in accordance with Medicare Part D Drug Plan enrollment materials. If you pay for these self-administered drugs, you can submit a claim to your Medicare Part D Drug Plan for a possible refund.

9. **Communications About My Healthcare.** I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others I designate to be responsible for my care. I will provide the names of those individuals on the HIPAA Disclosure Release Form provided to me by the Practice. I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

10. **Consent to Telephone Calls, Email or Text Message.** I authorize the use of any email address or telephone number I provide (including email addresses or telephone numbers that I provide for my family or designated representatives) (whether wireless or a landline and including email addresses and telephone numbers forwarded or transferred from provided information) for receiving information relating to my healthcare services and financial obligations, including, but not limited to: (i) healthcare-related information, including appointment reminders, discharge instructions, pre-operative or post-operative instructions, follow-up instructions, dietary information, prescription information, referrals, insurance or health plan eligibility or coverage, follow-ups related to a visit or other interaction, information about my condition(s), diagnosis, treatment plan, available treatment options and capabilities, reference materials, information about programs or services that might be of interest to me, invitations to participate in surveys, reviews or evaluations of my experience(s), instructions for how to access my information or records, or inquiries regarding my preferences; and (ii) financial communications, including without limitation, financial assistance and benefits screening, payment reminders, delinquent notifications, instructions, and links to practice Patient billing information.

    I expressly agree and consent that you or your customer service personnel and collection agents may contact me by telephone, on a recorded line and/or using automated dialing technology, at any telephone number I have provided or you or your customer service personnel and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. I represent (if I am not the patient) that

Conditions of Service

I am authorized by the patient to receive calls, text messages or email messages on their behalf and that I am involved in assisting in the patient's care and/or payment. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable. I represent that I am the account holder for any telephone number(s) that I may provide and am responsible for notifying Provider of any changes or updates to such telephone number(s).

I understand that emails and text messaging are unencrypted and that there is some risk that information included in unencrypted messages, including email and text messages, may be intercepted or received by unintended third parties and/or stored or archived by our service providers and system operators. Information included in such messages may include your name, date/time of appointments, physician/practice name, physician/practice specialty, patient account number or other information related to your financial obligation or our services. Message and data rates may apply to text messages. Additional text messaging terms may be located on the Provider's website and may be updated from time to time. To stop receiving a certain text message type (e.g., subsequent messages about my treatment plan), I understand that I can opt out of receiving additional messages of such type, by notifying The Practice in writing of my desire to opt-out of receiving such type of message, but I may continue receiving text messages of other types subject to separate opt-out notification.

11. **Use and Disclosure of Information.** I consent to Providers using and disclosing health information about me for purposes of treatment, payment, healthcare operations public health and other purposes permitted by applicable law. Information covered by this consent specifically includes, without limitation, history and physical records, emergency records, laboratory reports, pharmacy claims and prescription history, physician office notes, nurse notes, discharge summaries, genetic information, psychological information, psychiatric information, intellectual disability information, and information about substance abuse disorder and chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS. This consent applies, without limitation to uses and disclosures for coordinate care or for case management purposes; to any person or entity liable for or involved in payment on Patient's behalf including to verify coverage; and to my employer's designee when the services delivered are related to a worker's compensation claim. If I am covered by Medicare or Medicaid, I authorize the release of my healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. Provider participates, or may in the future participate, in Health Information Exchanges (HIEs) or other organizations with healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order to share health information for treatment, payment, health care operations and other purposes permitted by law. Unless I notify Provider in writing that I desire to opt-out of participation, I consent to health information about me being shared with participants in HIEs and other organizations as described above.

12. **Other Acknowledgements.**

    - **Personal Valuables.** I understand that the practice shall not be liable for the loss of or damage to any of my property (regardless of whether placed in lockers, etc.).

    - **Weapons/Explosives/Drugs.** I understand and agree that if the practice at any time

Conditions of Service

believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage on my person or with my belongings, the practice may terminate the practice/patient relationship.

13. **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the Provider may use and disclose my health information. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. I understand that I may contact the practice Privacy Officer designated on the notice if I have a question or complaint.
Acknowledge: _____ (Initial)

14. **Acknowledgement of Notice of Patient Rights and Responsibilities.** I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law. I understand that I can provide an advance directive to the Provider, and I can request information about formulating an advance directive at registration or thereafter.
Acknowledge: _____ (Initial)

15. **Acknowledgement:** I have been given the opportunity to read and ask questions about the information contained in this form, specifically including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers.
Acknowledge: _____ (Initial)

Date:	I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, hereby certify I have read, and fully and completely understand this Conditions of Physician Practice Services, and that I have signed this Conditions of Physician Practice Services knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.
Time:	

Patient Name: _____ Patient D.O.B. : _____

Conditions of Service

Patient/Patient Representative Signature:	**Witness Signature and Title:**
X_____	**X**_____
If you are not the Patient, please identify your Relationship to the Patient. ***(Mark relationship(s) from list below):*** □ Spouse □ Parent □ Legal Guardian □ Neighbor/Friend □ Sibling □ Healthcare Power of Attorney □ Guarantor □ Other (please specify):_____	Additional Witness Signature and Title: (required for Patients unable to sign without a representative or Patients who refuse to sign) **X**_____ *Standard OP 10/7/24*

MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

PATIENT CONFIDENTIAL INFORMATION

Patient Name_____DOB_____Date

Social Security #_____ Female ___Male ____

Email Address _____

Street Address_____City _____ZIP_____

Skilled Nursing/Rehab Address _____ City_____ ZIP _____

Home Phone Number_____ Mobile Phone _____ Other Phone _____

Name of Employer_____ Occupation_____

Employer's Address_____ Phone Number_____

Name of Spouse _____ Phone Number_____

Spouse's Employer_____ Phone Number_____

Nearest Friend or Relative _____Relationship_____

Address_____Phone Number_____

Insurance: YES___NO___ Medicare #_____Medicaid # _____

Primary Insurance: _____ Group # _____ Policy #_____

Secondary Insurance:_____ Group # _____ Policy #_____

Name of Insured_____ Relationship_____

Preferred Hospital _____ Hospital Location_____

RELEASE OF INFORMATION AND PAYMENT TO PHYSICIAN

In order to submit a claim for payment for covered services, we must have authorization to release medical information to your insuranc carrier.

MEDICARE AND MEDICAID

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize an holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign th benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organizatio to submit a claim to Medicare for payment to me.

ALL OTHER INSURANCE

I hereby authorize Mid Florida Hematology & Oncology Centers, P.A. to submit a claim to my insurance carrier or its intermediaries, for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering the covered services.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

I authorize Mid Florida Hematology & Oncology Centers, P.A., Gregory L. Ortega, MD, Neeraj Sharma, MD, Rene Cabeza, MD, Atif Khan, MD, Beatrice Alvarado-Roberts MD, Santosh Nair, MD, Daniel Castro, MD, Bushra Ajaz, MD, Wandaly Pardo, MD, Gary Graham, MD, Alan Forbes, MD to use, disclose and furnish my personal health information, including but not limited to, information about the services rendered to me, as may be requested by my insurance carrier or its intermediaries, and to those providers of its treatment, payment, and health care operations and as described more fully in the Mid Florida Hematology & Oncology Centers, P.A. written Notice of Privacy Practices which I have been provided a copy of.

I further agree that I am responsible for paying any balances which remain after insurance payments have been made.

Patient Signature_____ **Date**_____

Spouse Signature_____ **Date**_____

MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

Patient Rights & Responsibilities

PATIENT RIGHTS

At ***Mid Florida Hematology & Oncology Centers*** we believe that the protection and support of the basic human rights of freedom of expression, decision and action are important to the healing and well-being of our patients. Therefore, we strive to treat patients with respect and with full recognition of human dignity. Decisions regarding healthcare treatment will not be based on race, creed, sex, national origin, age, disability or sources of payment. As a patient of Mid Florida Cancer Centers, you have the right to:

1. Be fully informed in advance about care/services to be provided to you, including the scope of planned care/services and any specific limitations, the expected frequency of visits.
2. Be informed of your financial responsibility for any care/services.
3. Participate in the development and periodic revision or modification of your plan of care.
4. Refuse care, services or treatment after being fully presented the consequences of refusing care, services or treatment.
5. Receive information about the creation of Advanced Directives upon request.
6. Be treated with respect, consideration, and recognition of your dignity and individuality.
7. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse.
8. Voice grievances/complaints regarding treatment or care or lack of respect to your property, recommend changes in policy, personnel, or care/service without discrimination, or reprisal.
9. Have your records and communications treated as confidential. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.
10. Receive appropriate care without discrimination in accordance with your providers' orders.
11. To have your family take part in your care decisions with your express permission.
12. To request and/or be provided with language assistance i.e., interpreter services, if you have a language barrier or hearing impairment. This will be provided at no cost to you to help you actively participate in your care.
13. Be fully informed of your responsibilities.

PATIENT RESPONSIBILITIES

Your contribution to your health care is vital, and you can be involved in the health care process by fulfilling certain responsibilities. As a patient, you, or your designated representative (if you have one) have a responsibility to:

1. Submit forms, insurance cards or other documents that are necessary to receive services or care from Practice.
2. Keep appointments scheduled with your healthcare provider. If you need to cancel an appointment, you should do so promptly with at least 24 hours before your appointment time when possible.
3. Provide accurate medical, pharmacy and contact information and any changes to such information:
    - Provide, to the best of your ability, accurate and complete information about your present condition, past illnesses, hospitalizations, medications, and other matters related to your health, including information about home and work that may impact your ability to follow the proposed treatment.
    - Tell your care team if you have an Advanced Directive and the intent it contains.
    - Notify your care team of any potential side effects and/or complications that you experience.
    - Tell your caregivers about any changes in your health.
4. Maintain any equipment provided to you by ***Mid Florida Hematology & Oncology Centers,*** if applicable.
5. Notify ***Mid Florida Hematology & Oncology Centers*** staff of any concerns about the care or services provided.
    - Ask questions so that you may understand your health problems and what to reasonably expect during your treatment.
    - Ask questions if you do not understand or need more information.
6. Make Informed Decisions
    - If you are unable to make decisions about your care, your legally appointed decision-maker has a responsibility to make healthcare decisions that are consistent with your values and life goals.
7. Participate in your care and follow the instructions for taking medication as directed.
8. Follow the mutually agreed to treatment plan developed with your provider.
    - Express any concerns about your ability to understand or comply with a proposed course of treatment.
    - You are responsible for the outcomes if you refuse treatment or do not follow your care provider's instructions.
    - Remain adherent to your treatment plan, and work with your ***Mid Florida Hematology & Oncology Centers*** care team to address any obstacles that may prevent you from following your care plan.

9. Accept Financial Responsibilities

    - Provide information necessary for claims processing and maintain personal and financial integrity with respect to healthcare services provided on your behalf.

    - You are responsible for meeting your financial responsibility for any amounts required by your insurance carrier or any care or services not covered by your insurance.

10. Support ***Mid Florida Hematology & Oncology Centers*** policies that apply to patient care and conduct:

    - Treat all ***Mid Florida Hematology & Oncology Centers*** staff, other patients, and visitors with courtesy and respect. Follow all ***Mid Florida Hematology & Oncology Centers*** rules and safety regulations, and be mindful of noise levels, privacy, and the number of visitors.

    - Respect the privacy and confidentiality of other patients.

    - Refrain from using a smart device to record your experience in audio, video, or photography format in the practice without the consent of everyone involved including ***Mid Florida Hematology & Oncology Centers*** physicians, nurses, and other staff.

    - Express any needs you may have, so we can provide reasonable accommodation.

    - Inform the healthcare team when you have issues or concerns related to your safety.

11. Patient Conduct

    - Patient is responsible for their behavior and is subject to be discharged from the practice for any aggressive, belligerent, or demeaning behavior towards staff.

Patient Signature: _____ Date _____

MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO SHARE MEDICAL INFORMATION

Date _____ **Patient Name** _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative **Print Name of Patient or Personal Representative**

_____
Description of Personal Representative's Authority

Contact Information for Personal Representative:

Address:

_____

_____

Phone Number:

_____ _____
Daytime **Evening**

I authorize Mid Florida Hematology and Oncology Centers, P.A. to share my medical information with the following:

_____	_____	_____
Name	**Relationship**	**Phone Number**
_____	_____	_____
Name	**Relationship**	**Phone Number**
_____	_____	_____
Name	**Relationship**	**Phone Number**
_____	_____	_____
Name	**Relationship**	**Phone Number**

This authorization will remain in effect from the date it is signed until I cancel it in writing.

By signing below, I acknowledge I have reviewed and understand this authorization form.

_____ _____
Patient Name **Date**

MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

PATIENT DISCLOSURE TO RELEASE OUR RECORDS

PATIENT NAME: _____ **DATE:** _____

DOB: _____ **SOCIAL SECURITY #**_____

DO YOU LIVE IN AN ASSISTED LIVING FACILITY OR A NURSING HOME _____ **YES** _____ **NO**

I AUTHORIZE MID FLORIDA HEMATOLOGY AND ONCOLOGY CENTERS, PA TO RELEASE MY RECORDS IN THEIR ENTIRETY TO:

_____

_____

_____

PLEASE FAX RECORDS TO _____

Purpose of Disclosure:

☐ **Continuing care with another physician or hospital** ☐ **Personal copy** ☐ **Other:**_____

I understand that:

1. This authorization will remain in effect for 365 days
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authorization and that it is strictly voluntary.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. If I do not sign this form, my health care and the payment for my health care will not be affected.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, or if I ask for it
7. Copy fees for records are 0.25c per page up to 100 pages. Records over 100 pages will be placed on a disc. Discs incur a charge of $25.00. Payment is due upon pickup of the records.
8. I will receive a copy of this form after I sign it.

Patient Signature:_____ **Date:** _____

Representative Signature: _____ **Date:** _____

Relationship to Patient: _____

Witness Signature: _____ **Date:** _____

MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

PATIENT DISCLOSURE TO REQUEST RECORDS

PATIENT NAME: _____ DATE: _____

DOB: _____ SOCIAL SECURITY #_____

I AUTHORIZE THE FOLLOWING PHYSICIAN(S), PHARMACY(S) AND/OR HOSPITALS TO RELEASE MY MEDICAL RECORDS IN THEIR ENTIRETY OR AS INSTRUCTED BELOW TO:
MID FLORIDA HEMATOLOGY AND ONCOLOGY CENTERS, PA

_____

_____

_____

I understand that:

1. **This authorization will remain in effect for 365 days**
2. **I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.**
3. **I may refuse to sign this authorization and that it is strictly voluntary.**
4. **If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.**
5. **If I do not sign this form, my health care and the payment for my health care will not be affected.**
6. **I understand that I may see and obtain a copy of the information described on this form for a reasonable copy fee.**
7. **I will receive a copy of this form after I sign it.**

Patient Signature:_____ Date: _____

Representative Signature: _____ Date:_____

Relationship to Patient: _____

Witness Signature: _____ Date: _____

MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

PATIENT HISTORY FORM

CONTACT INFORMATION

Legal First Name _____ Last Name _____

Preferred Name _____ D.O.B _____

Home Address _____
Street City State Zip

Phone Numbers (H) _____ (C)_____ (W)_____

Email Address _____

Sex Assigned at Birth ☐ Male ☐ Female Intersex ☐ Other please specify:_____ ☐ Choose not to disclose

Gender Identity ☐ Male ☐ Female ☐ Non-binary ☐ Trans-Male ☐ Trans-Female ☐ Other

Preferred pronouns ☐ He/Him ☐ She/Her ☐ They/Them Other_____

Sexual Orientation ☐ Bi Sexual ☐ Gay or Lesbian ☐ Straight Other _____ ☐ Choose not to disclose

Race (Select all that apply) ☐ Asian ☐ Black or African American ☐ Latino/ Latina/Latinx ☐ Native American or First American

☐ Native Hawaiian and Pacific Islander ☐ Middle Eastern ☐ North African ☐ White Other_____ ☐ I wish not to disclose

Ethnicity _____ Preferred Language _____

Please list your preferred pharmacy below

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____ ☐ *Please check if mail-order pharmacy.*

PERSONAL MEDICAL HISTORY

Are you currently on Oxygen (O_2) ? ☐ Yes ☐ No

Please list all current prescriptions and over-the-counter medications. Include herbals, supplements, and vitamins below:

Medication	Dosage (ex. mg. ml.)	How often?	When prescribed?

Legal Name _____ D.O.B. ____/____/_____

Allergies

Latex Allergy ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list the medication *(include dyes or contrasts)* and type of reaction:

1. _____ 2. _____

3. _____ 4. _____

Hospitalizations

Please list all hospitalizations **within the past 2 years**

Date	Reason for Hospitalizations	Where	Doctor

Surgeries/Procedures

Please list all surgeries and procedure details and year occurred (e.g. pacemaker, dental extractions)

Date	Type of Surgery or Procedure	Where	Doctor

Previous Treatment for Cancer (if applicable)

Radiation Therapy _____

Chemotherapy/Immunotherapy/Targeted Therapy _____

Hormone Therapy _____

Blood Transfusions

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, did you have a reaction? ☐ Yes ☐ No

Date of last transfusion : _____

Please check if you had or currently have any of the following.

☐ Anemia		☐ High Cholesterol	
☐ Anxiety		☐ Jaundice/Hepatitis Type:	
☐ Arthritis		☐ Kidney Disease	
☐ Asthma		☐ Liver/Gallbladder Disease	
☐ Blood Disorder/Blood Clots		☐ Measles/Mumps/Rubella/Chicken Pox	
☐ Bladder Problems		☐ Mental Illness	
☐ Cancer type:		☐ Migraine or Frequent Headaches	
☐ Chronic Pain		☐ Sexually Transmitted Infections (Herpes, HIV)	
☐ Colitis/Crohn's Disease		☐ Seizure Disorder	
☐ Autoimmune Disorder (*ex. Lupus*)		☐ Skin Disease (eczema, psoriasis, hives)	
☐ COPD/Emphysema		☐ Stroke	
☐ Congestive Heart Failure		☐ Thyroid Problem	
☐ Depression		☐ Other medical problems not listed. List below.	
☐ Diabetes			
☐ Heart Condition (Afib, Heart Attack)			
☐ High Blood Pressure			

Exam/Vaccine History

Please list the **month or year** you last had:

Flu Shot: _____ Pneumonia Vaccine: _____ Hepatitis Vaccine _____ TB Test _____ Tetanus Shot _____

Shingles Shot _____ Rectal Exam _____ Colonoscopy/Sigmoid Exam _____ or Stool Blood Test _____

Covid-19 Vaccine (Last Dose) _____
Name of Brand: _____

List **month/year** you last had:

Last PSA screening _____ Last prostate exam: _____

Age at first menstrual period _____ If still menstruating, date of last period _____

Age at menopause _____ Have you ever taken birth control pills? ☐ Yes ☐ No If yes, how long? _____ Yrs

Do you currently use birth control? ☐ Yes ☐ No If yes, what type? _____

Have you ever taken fertility drug treatments? ☐ Yes ☐ No

Have you ever taken hormone replacements? ☐ Yes ☐ No If yes, how long? _____ Yrs

Are you currently taking hormone replacements? ☐ Yes ☐ No If yes, what type? _____

Number of pregnancies _____ Number of live births _____ Age at first childbirth _____

Did you breastfeed? ☐ Yes ☐ No If yes, how long? _____

Have you had a hysterectomy? ☐ Yes ☐ No If yes, when? _____
Are your ovaries intact? ☐ Yes ☐ No If no, when were they removed?

List **month/year** you last had:

Pap Test _____ ☐ Normal ☐ Abnormal Breast Exam _____ ☐ Normal ☐ Abnormal

Mammogram _____ ☐ Normal ☐ Abnormal

Do you perform monthly self-breast exam? ☐ Yes ☐ No

Legal Name _____ D.O.B. ____/____/_____

SOCIAL HISTORY

Relationship Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic

Partner Living Arrangement ☐ Alone ☐ With spouse ☐ With significant other or roommate

☐ Supervised Living Other _____

Do you have any of the following?

☐ Organ Donor Card ☐ Health Care Proxy ☐ Power of Attorney ☐ Living Will

If you have signed any of these legal documents, please bring copies to your next appointment. Would you like more information on any of these? ☐ Yes ☐ No

Do you have Medical Power of Attorney, Living Will, or Out-of-Hospital Do Not Resuscitate Forms? ☐ Yes ☐ No

Advance Care Planning (ACP) is an ongoing process of learning about the choices we each have for our future medical care.
Would you like more information about Advance Care Planning? ☐ Yes ☐ No

Is there someone who you would like to list as your primary contact regarding your healthcare? ☐ Yes ☐ No

Name _____ Relationship _____ Phone _____

Are your currently employed? ☐ Yes ☐ No ☐ Retired

Occupation (previous if retired) _____ Employer_____

Are you a Veteran? ☐ Yes ☐ No

Do you now or did you ever:

Smoke cigarettes/cigars/pipes/vaping/chewing tobacco? ☐ Yes ☐ No

If yes, # of pack(s)/day _____ # of yrs _____ When did you quit? _____

Consume alcohol? ☐ Yes ☐ No

If yes, # of drinks/day _____ Drinks/week _____ When did you quit? _____

Consume cannabis? ☐ Yes ☐ No

If yes, # times/day _____ # times/week _____ When did you quit? _____

Use illegal drugs? ☐ Yes ☐ No

If yes, which ones? _____ When did you quit? _____

MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

REVIEW OF SYMPTOMS

Please Complete by Checking **Yes or No** to All That Apply

CONSTITUTIONAL	**Y**	**N**	***RESPIRATORY***	**Y**	**N**	***PSYCHIATRIC***	**Y**	**N**
Weight Loss			Cough			Anxiety / Depression		
Fatigue			Coughing Up Blood			***ENDOCRINE***	**Y**	**N**
Fever			Shortness of Breath w/ exertion at rest			Hyperthyroidism		
Chills			Wheezing			Hypothyroidism		
Sweats			***GASTROINTESTINAL***	**Y**	**N**	Loss of Hair		
Appetite			Heartburn			Heat/Cold Intolerance		
HEMATOLOGIC/LYMPH	**Y**	**N**	Nausea / Vomiting			Change in Nails		
Easy Bruising/Bleeding			Constipation			***IMMUNOLOGICAL***	**Y**	**N**
Enlarged Glands			Change in Bowel Habits			Hay Fever / Asthma		
EYES	**Y**	**N**	Diarrhea			Hives / Eczema		
Glasses / Contacts			Difficulty Swallowing			***FEMALE ONLY***	**Y**	**N**
Eye Pain			Abdominal Pain			Date of last period:		
Blurred Vision			Dark / Black Stool			Menopause		
Glaucoma			***GENITOURINARY***	**Y**	**N**	Recent Vaginal Discharge		
Cataracts			Pain Urinating			Do you take hormones?		
EAR, NOSE, THROAT	**Y**	**N**	Burning			Are you pregnant?		
Difficulty Hearing			Blood in Urine			Number of pregnancies:		
Ringing in Ears/Tinnitus			Difficulty Urinating			Menstrual Periods Regular?		
Vertigo / Dizziness			History of Kidney Stone			Abnormal Vaginal Bleeding		
Sinus Trouble			History of STD			Do you take birth control pills?		
Nasal Stuffiness			Abnormal Discharge			Pelvic Pain		
Frequent Sore Throat			***MUSCULOSKELETAL***	**Y**	**N**	Breast Mass		
Hoarseness			Joint Pain/Swelling			Tenderness		
Mouth Sores			Stiffness			Nipple Discharge		
CARDIOVASCULAR	**Y**	**N**	Muscle Pain					
Murmur			Back Pain					
Chest Pain			***SKIN***	**Y**	**N**			
Palpitations			Rash/Sores					
Dizziness or Fainting Spells			Itching/Burning					
Shortness of Breath			***NEUROLOGICAL***	**Y**	**N**			
Difficulty Lying Flat			Seizures					
Swelling Ankles / Other			Weakness/Paralysis					
Hypertension (High BP)			Numbness					
Hypotension (Low BP)			Tremors					
			Memory Loss					

MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

All Treating Physicians

Please list any physicians that are involved with your care:

Referring Physician: _____

Primary Care: _____

Pain Management: _____

Cardiology: _____

Pulmonologist: _____

Nephrologist: _____

Urologist: _____

Gastroenterologist: _____

Neurology: _____

Surgeon: _____

Rheumatology: _____

Other: _____

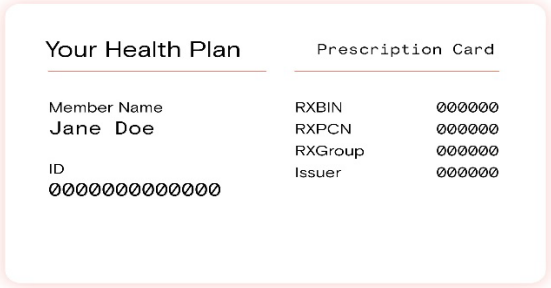
_____

MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

Pharmacy Benefits Information

Please help us in expediting your pharmacy benefits by providing your pharmacy card to the front desk staff to save in your chart. You would show this card when picking up prescriptions at your preferred pharmacy.

SAMPLE :



Please provide the following information:

Member Name_____

RXBIN # _____

RXPCN #_____

RXGroup #_____

ID#_____

In the event financial assistance is needed for your prescriptions please complete the following sections

Social Security #_____

Household Size_____

Household Income _____

805 N. Spring Garden Ave. Deland, FL 32720 (T) 386-734-1013 (F) 386-734-1028
2776 Enterprise Road, Suite 100, Orange City, FL 32763 (T) 386-774-1223 (F) 386-774-4658
2100 W. First Street, Sanford, FL 32771 (T) 407-323-2250 (F) 407-321-5550
658 Oviedo Medical Dr. Oviedo FL 32765 (T) 407-901-9076 (F) 407-901-9075

MID FLORIDA
Hematology & Oncology Centers, P.A.
Caring for Your Life

Patient Change of Information

Patient Name: _____

Patient DOB: _____

☐ No Changes Needed-Please sign below

Please check all that apply:

☐ Name Change

☐ Address Change

☐ Phone Number Change

☐ Emergency Contact Change

☐ New/Updated Email Address

☐ Any updates to your medical information?

(i.e) new medications, diagnosis, treatments, (etc)

_____

_____

Please completed all below fields with updated information :

Patient Name: _____

Mailing Address: _____

_____

Contact Information:

Home_____ Cell_____ Work_____

Email Address:

_____

Emergency Contact Information:

Name_____ Relationship to Patient_____

Phone_____

Patient Signature _____ Date _____