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

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed, and how you can access this information.

At Mid Florida Hematology Oncology, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we do not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method; number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter the earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you. You have a right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint. Please contact our Privacy Officer, Harish Gowda, (386)774-1223, for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Patient Signature: _____ Date: _____

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

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PATIENT CONFIDENTIAL INFORMATION

Patient Name_____DOB_____Date_____

Social Security #_____ Female _____ Male _____

Email Address _____

Street Address_____City _____ZIP_____

Mailing 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_____

Ethniciy: Hispanic or Latino____Not Hispanic or Latino. **Prefered Language**: English___ Spanish___
Race: Caucasian___ African American___Asian___American Indian or Alaska Native___Native Hawaiian___Other___

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**_____

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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**

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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. **I will receive a copy of this form after I sign it.**

Patient Signature:_____ Date: _____

Representative Signature: _____ Date:_____

Relationship to Patient: _____

Witness Signature: _____ Date: _____

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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

PLEASE FAX RECORDS TO 386-774-4658

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.**
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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. **I will receive a copy of this form after I sign it.**

Patient Signature:_____ Date: _____

Representative Signature: _____ Date:_____

Relationship to Patient: _____

Witness Signature: _____ Date: _____

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MEDICATION RECORD

Patient Name _____DOB_____Date _____

Allergies: (please list all allergies, reactions and the severity) _____

_____

_____

_____

PRESCRIPTION NAME	DOSE	FREQUENCY	NOTES

Preferred Pharmacy:_____Address:_____

Phone #_____

Secondary:_____ Address:_____

Phone#_____

Specialty: _____ Address: _____

Phone #_____

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Review of Symptoms

Today's Date_____ **Name** _____ **Date of Birth** _____**AGE** _____

Occupation_____**Retired** _____ **Daily Exercise: YES** _____ **NO** _____

Married _____ **Single** ____ **Widowed** ____ **Divorced** ____ **Number of Children** _____ **Number of Pregnancies**_____

Smoking: YES_____**NO**___ _____ **Packs Per Day for** _____ **Years** **Quit Smoking** _____ **Years / Months Ago**

Alcohol: YES____ **NO**___ _____ **Drinks Per Day. If yes, (list all here)**_____

Drug Use: YES__ **NO**_____ **I f yes (list all here):** _____

Date of Last Mammogram: _____ Date of Last Colonoscopy: _____
Date of last Prostate screening: _____ Date of last Pap Smear: _____
Date of Last Flu Shot: _____ Date of Last Pneumonia Vaccine: _____
Covid-19 Vaccinated? Yes___ No___
Shot 1 Date: _____ Brand: _____
Shot 2 Date: _____ Brand: _____
Booster Date: _____ Brand: _____

Do you have any oral or dental problems that might interfere with chewing, eating or swallowing? YES___ NO___
If yes, please explain:
_____

When did you first notice symptoms related to your present illness? _____

What were the symptoms
_____

When did you first see a doctor for your present illness?
_____

Have you been hospitalized for this illness? YES___ NO___

Name of hospital: _____ Date: _____

Was a biopsy performed? YES____ NO___ Did you have surgery? YES___ NO____

Have you received chemotherapy? YES___ NO____

If yes, where? _____

Have you had any previous radiation therapy? YES____ NO____

If yes, Where? _____ When? _____

Have you had recent X-rays, CT scans, PET scans or MRI's? YES____ NO____

If yes, Where? _____When? _____

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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			Are 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					

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Additional Health Information

PATIENT NAME: _____ DATE OF BIRTH: _____

Family History: (check only those that apply)

Diabetes ____ heart disease ____ High Blood Pressure____

Stroke ____ TB____ Cancer ____ kidney disease ____ Anemia ____ Arthritis____ Mental Illness ____ Thyroid Disease____

Mother: Living ____ Deceased_____ Age Deceased _____ Cause of Death _____

Father: Living ____ Deceased_____ Age Deceased _____ Cause of Death _____

Other family history list here: _____

_____

_____

Personal History: (check only those that apply)

Diabetes____ heart disease____ High Blood Pressure____ Stroke____

TB____ Cancer _____ kidney disease_____ Anemia____ Arthritis____ Mental Illness_____ Thyroid Disease____

Do you have a Living Will? Yes____ No_____ Durable Power of Attorney? Yes_____ No____ DNR? Yes____ No____

Do you live alone? Yes _____ No____ If yes, do you require assistance with your daily activities? Yes___ No_____

Surgeries (please list any surgeries & corresponding date) _____

_____

_____

Injuries (please list any injuries & corresponding dates) _____

_____

_____

Please list any additional health information you feel may be important to your physician

_____

_____

_____

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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: _____

_____

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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 _____

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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

Please complete all pertinent sections below with new/update information

Patient Name: _____

Mailing Address: _____

_____

Contact Information:

Home_____ Cell_____ Work_____

Email Address _____

Emergency Contact Information:

Name_____ Relationship to Patient_____

Phone_____

Patient Signature _____ Date _____