Hematology Oncology Care of Northern Virginia, P.C.

Patient's Name: _____ _____ _____ **Age:** ___
First Middle Last

Social Security No: __ __ __-__ __- __ __ __ __ **Race:** _____ **Hispanic: Yes□ No□**

Sex: M□ F□ Marital Status: Married□ Single□ Widow□ Divorced□ Date of Birth: _____

Address: _____ ____

Home Phone: _____ **Work Number:** _____ **Cell Number:** _____

Email: _____ **Pharmacy Name & Location:** _____

Patient's Employer: _____
Name & Address of Company

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

Spouse's Social Security No: __ __ __-__ __- __ __ __ __ **Spouse's Phone:** _____

Spouse's Employer: _____
Name & Address of Company

Person Responsible if not patient: _____ **Relationship to Patient:** _____

Address: _____**Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Referred By: _____ **Family Physician:** _____

Primary Insurance Information: _____ _____
Policy Holder's Name Insurance Company Phone Number

_____ _____ _____
Insurance Company Name ID Number Group Number

Primary Insurance Information: _____ _____
Policy Holder's Name Insurance Company Phone Number

_____ _____ _____
Insurance Company Name ID Number Group Number

By Signing this consent, you:

- **Accept personal responsibility for all services rendered to you. In the event that your Insurance Company does not pay for the services rendered, you accept personal responsibility for the amount not covered by Insurance.**
- **Authorize payment of medical benefits to Hematology Oncology Care of Northern Virginia, PC for any medical and/or surgical services rendered to you.**
- **Authorize this office to release any information acquired in the course of my examination and treatment to your Insurance Company.**
- **Authorize your physician or designated, qualified assistants to provide you with medical treatment. You consent to all medical or diagnostic care ordered for you. This consent includes testing for infections such as Hepatitis B and HIV and providing blood and body fluids for such test in order to protect you and/or those who provide you services.**

I believe the above information is correct to the best of my knowledge:

_____ _____ _____
Patient's Signature **Responsible Party Signature** **Date**

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

NO SHOW - A **fee $50.00** will be charged for failure to come to a scheduled appointment. **Failure to cancel** the appointment at least 24 hours in advance will result in a **$50.00 fee**. This time has been reserved with the physician and prevented others from scheduling that time.

REFERRALS: Some managed care plans require written authorization forms from your primary care physician for each visit to **Hematology Oncology Care**. It is the patient's responsibility to make sure that a valid authorization form is obtained before each visit. These forms cannot be issued retroactively.

1. Insurance is a contract between **you** and your **insurance company**. For the most part, we are not a party to this contract. We will inform you if we are a party to this contract, and will handle your claims according to our agreement with the insurance company. We file insurance claims as a courtesy to our patients. We will not become involved in a dispute between you and your insurance company regarding deductible, copayments, covered charges, secondary insurance, "usual and customary charges," etc. other than to supply information as necessary. You are responsible for the timely payment of your account.

2. **Co-payments** are due at the time services are rendered. If you have any questions regarding your office visit co-payment, please contact your insurance company.

3. **Returned checks will be charged a $25.00 processing fee.**

4. **If you do not have insurance, an initial payment will be due at time of service unless prior arrangements have been made with our billing department.** For minor patients, the adult accompanying a minor (even in the case of a divorce) will be responsible for payment at the time services are rendered. We will not bill a different party.

WE ACCEPT CASH, CHECKS, CREDIT CARDS AND MONEY ORDERS
(Visa, MasterCard, Discover and American Express)

I authorize the release of any medical information necessary to process my insurance, or to another physician or medical facility if appropriate to expedite my medical care. I allow fax transmittal of my medical records, if necessary. I request payment of authorized Medicare/Insurance benefits be mad to Hematology Oncology Care of Northern Virginia on my behalf, for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or other insurance agencies, any information needed to determine benefits payable for related services.

I understand that I am financially responsible for all charges allowed by my insurance. If full payment is not made with regard to the allowed amount for services rendered, I agree to pay all necessary and reasonable cost of collection beginning at 27% of account balance. Including, but not limited to Attorney's fees on the balance outstanding at the time this matter is turned over to an attorney or collection agency for collection. I agree to this provision.

Signature: _____

Relation to Patient: _____

Date: _____

Family History

	Living	Deceased	Age	Illnesses
Mother				
Father				
Siblings				
Children				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Childhood Illnesses

Measles Yes No
Mumps Yes No
Chicken Pox Yes No
Other: _____

Injuries

Broken Bones Yes No
Accidents: _____

Adult Illnesses

Diabetes Yes No
High Blood Pressure Yes No
Heart Problems Yes No
Respiratory Problems Yes No
Mental Illness Yes No
Depression Yes No
Other: _____

Weight & Height

Current Weight: _____
Weight 1 year ago: _____
Maximum weight: _____
When: _____
Height: _____

Surgeries

Tonsillectomy Yes No
Appendectomy Yes No
Hysterectomy Yes No
Including Ovaries Yes No
Hernia Repair Yes No
Gall Bladder Yes No

Patient History

Medications: List all Medications, including vitamins and over the counter medications, you are currently taking including dosage and frequency.

Medication Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Medication Allergies:	Type of Reaction
_____	_____
_____	_____
_____	_____

Food or Animal Allergies:

_____ _____

Habits:

Do you exercise regularly : Yes No
Do you smoke: Yes No
If Yes how much: _____
How many years: _____
Did you ever smoke: _____
How many years: _____
Do you chew tobacco/snuff: Yes No
If yes how often: _____
How many years: _____
Regular self breast exam: Yes No
Do you drink alcohol: Yes No
If Yes how many drinks per week: _____
Treated for Chemical dependency: Yes No

Immunizations:

Pneumovax: Yes No When: _____
Tetanus : Yes No When: _____
Hepatitis B: Yes No When: _____
Flu Vaccine: Yes No When: _____

Have you been treated for Tuberculosis (TB):
Yes No

Women Only

Menstrual History:
Age at onset: _____
Regular: Yes No
Cycle: Every ____ days
Usual Duration: _____
Heavy Medium Light
Pain or Cramps: Yes No
First day of LMP: _____
Date of last Pap Smear: _____
Have you ever taken Estrogen: Yes No How long: _____

Pregnancies:
How many: _____
How many live births: _____
How many miscarriages: _____

Do you have regular Mammos: Yes No
Date of last Mammo: _____

Hematology Oncology Care of Northern Virginia, PC

Do you have any of the following? (Check or Describe)

GENERAL: Weight Loss/Gain Fevers Night Sweats
Other _____

EYES: Change in Vision
Other_____

EARS: Decrease in Hearing Ear Pain
Other_____

NOSE: Sinus Problems Allergies
Other_____

THROAT: Frequent Sore Throat Persistent Hoarseness
Other_____

NECK: Frequent Neck Pain Arm Numbness Tingling Thyroid Problems
Other _____

BACK: Frequent Back Pain Leg Pain Numbness
Other_____

RESPIRATORY: Chronic Cough Wheezing Shortness of Breath
Other _____

CARDIOVASCULAR: Chest Pain Palpitations Swelling of the Legs
Other_____

GASTROENTEROLOGIC: Nausea/Vomiting Diarrhea Constipation Heartburn
Other _____

GENITOURINARY: Urinary Problems Menstrual Problems Sexual Problems
Other_____

NEUROLOGIC: Severe Headaches Dizzy Spells Seizures
Other_____

MUSCULOSKELETAL: Joint Pain Muscle Pain
Other _____

DERMATOLOGIC: Skin Lesions Rashes
Other _____

HEMATOLOGIC: History of Anemia Clotting Disorders Sickle Cell
Other _____

ENDOCRINOLOGIC: Unusual Thirst Cold or Hot Intolerance Discharge from Breast
Other _____

PYCHOLOGIC: Depression Anxiety
Other _____

Patient Record of Disclosures

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 applies):

- o Call Home telephone
- o Ok to leave message with detailed information
- o Leave message with call back number only
- o Call Cell number and leave detailed message
- o Ok to call work number and leave message

Patient Signature _____ Date: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of 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.

Date	To whom can we release information to:	Relationship

Patient Signature _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

About Us:
In this Notice, we use terms like "we," "us" or "our" to refer to Hematology Oncology Care of Northern Virginia, its physicians, employees, staff and other personnel. All of the sites and locations of HOC of Northern VA follow the terms of this notice and may share health information with each other for treatment, payment or health care operations purposes as described in this notice.

Purpose of this Notice:
This notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

How We May Use or Disclose Your Health Information:
For treatment, payment, health care operations, appointment reminders and Individuals involved in your care or payment for your care.

We are also allowed by law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court order. We may also release your health information in response to a subpoena, discovery request, or other law process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes such as: cout order, warrant, subpoena summons, locate a suspect, fugitive, material witness, missing person or criminal conduct we believe in good faith to have occurred on our premises.

Public Health Activities: We may use and disclose your health information for public health activities, including the following: to prevent or control disease, injury, or disability, to report child abuse or neglect, to track FDA-regulated products, to notify people and enable product recalls and to notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition.

Workers' Compensation: We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information:
You have the following rights regarding health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. To inspect and copy your health information, you send a request in writing to our Practice Manager. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment as long as the information is kept by or for us. To request an amendment, you must submit your request in writing to our Practice Manager.

Changes to this Notice:

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the waiting room of our medical office.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES

Hematology Oncology Care of Northern Virginia is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. **Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.**

I acknowledge that I have received a copy of the Notice of Privacy Practices of **Hematology Oncology Care of Northern Virginia.**

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

Hematology Oncology Care of Northern Virginia (use only)

Date acknowledgement received: _____

OR

Reason acknowledgement was not obtained:

_____

_____

_____

_____

_____

Hematology Oncology Care of Northern Virginia
8316 Arlington Blvd Suite 605 Fairfax, Virginia
(P) 703-698-9400 (F) 703-698-9403
Naveen Doki MD

MEDICAL RECORD RELEASE

Date: _____

Patient Name: _____

Date of Birth: _____

To: _____
_____
_____

I, hereby, authorize you to release all my records, specimens and lab results to:

HEMATOLOGY ONCOLOGY CARE OF NORTHERN VIRGINIA
8316 ARLINGTON BLVD SUITE 605
FAIRFAX, VIRGINIA 22031

PLEASE FAX ALL MEDICAL INFORMATION CHECKED BELOW TO:
(703) 698-9403

- ☐ **RECENT History/Physical and Physician notes**
- ☐ **ALL Operative/Procedure notes/Discharge summary**
- ☐ **ALL X-ray, CT scans, MRI, Mammogram/Ultrasound reports**
- ☐ **ALL Pathology reports/Blocks/Slides**
- ☐ **ALL Lab results to include CBC, tumor Markers, etc.**
- ☐ **ALL Chemotherapy/Radiation records**

This authorization is valid from date: _____ to _____.

Patient Signature: _____

Date: _____