STOCKTON HEMATOLOGY ONCOLOGY
TRUTH • COMPASSION • RESPECT

Dr. Prasad Dighe
Dr. Ajithkumar Puthillath
Dr. John Kiraly
Dr. Sunny Philip
Kari Gardner, FNP-C

Dr. Aminder Mehdi
Dr. Neelesh Bangalore
Dr. Chunhui Fang
Katie Larimer-Redmond, NP-C
Kelly Shannon, NP

PATIENT REGISTRATION AND INFORMATION

Patient's Name_____
(Last Name, First Name, Middle Initial)

Address_____ **City**_____ **State**_____ **Zip**_____

Phone Number: Home_____ Mobile_____

Social Security_____/_____/_____ **Date of Birth**_____/_____/_____ **Gender:** ☐ Male ☐ Female

- **Are you:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____
- **Preferred method of contact:** ☐Home Phone ☐Mobile
- **May we leave voice mail and messages on your phone?** ☐ Yes ☐ No
- **Race:** ☐Caucasian ☐African American ☐Hispanic ☐Asian ☐Pacific Islander ☐Native American
  - ☐Other_____
- **Preferred Language:** ☐English ☐Spanish ☐Tagalog ☐Thai ☐Japanese ☐Other_____
- **Are you currently employed?** ☐Full-time ☐Part-time ☐Unemployed ☐Retired
- **Emergency Contact**_____**Phone**_____**Relationship**_____
- **Who is your primary care doctor?** _____
- **Which doctor referred you to our practice?** _____
- **Preferred Laboratory Facility:** ☐ Quest ☐ LabCorp ☐ Other: _____

To better meet our patients' needs we can now dispense many of the prescriptions as prescribed by our physician(s). We will bill your pharmacy insurance and charge the applicable co-pay. Please understand that you are not obligated to have prescriptions filled here and you have the option of receiving your medications from the pharmacy of your choice.

Medications available in the office are Oncology related drugs only- not including controlled substance drugs
Do you want us to fill medications in the office: ☐ **Yes** ☐ **No**
** **If NO: please list your preferred pharmacy and address:** _____

- **Do you have insurance?** ☐ Yes ☐ No

****IF YES, FOR FUTURE CHANGES, PLEASE CALL OUR OFFICE FOR ANY UPDATES TO PREVENT DELAY IN TREATMENT****

<PLEASE PROVIDE YOUR INSURANCE CARDS (MEDICAL AND PRESCRIPTION) AND ANY GOVERNMENT ISSUED I.D. FOR US TO COPY>

_____ _____
(Signature of Patient, Legal Guardian, Conservator, DPA or Legal Representative): Date:

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

MEDICAL HISTORY QUESTIONNAIRE

Please check if you have had any of these medical conditions or problems. This information will help us to provide you with the best possible treatment. If you answer YES to any, please describe below.

	Yes	No
Anemia	☐	☐
Abdominal Swelling/Pain	☐	☐
Arthritis (Where?)	☐	☐
Asthma/Bronchitis	☐	☐
Bladder Infection	☐	☐
Bleeding Disorder or Easily	☐	☐
Blood Clots (phlebitis)	☐	☐
Blood in Stool/Urine	☐	☐
Chest Pain	☐	☐
Chronic Cough	☐	☐
COPD	☐	☐
Constipation/Diarrhea	☐	☐
Convulsion/Seizure	☐	☐
Depression/Anxiety	☐	☐
Diabetes	☐	☐
Dizziness Fainting Spells	☐	☐
Emphysema / Pneumonia	☐	☐
History of Falling	☐	☐

	Yes	No
Frequent Headache	☐	☐
Gall Bladder Problem	☐	☐
Heart Condition (Type?)	☐	☐
Heartburn ARD	☐	☐
Hepatitis _____ (Type?)	☐	☐
High Blood Pressure	☐	☐
Hyperthyroidism	☐	☐
Hypothyroidism	☐	☐
Kidney Problems (Type?)	☐	☐
Leg Pain / Swelling	☐	☐
HIV/AIDS	☐	☐
Back Pain	☐	☐
Nausea / Vomiting	☐	☐
Osteoporosis	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Other condition or pain	☐	☐

If you answered YES to any above, please provide details. Please also list any other conditions not mentioned above:

_____

_____

Do you have any known **Allergies to Medications or Foods** ☐ Yes ☐ No

If yes, please list the medication/food:

_____

_____

List all medications that you are currently taking:

Please bring all your current medications with you on your first visit so our physicians can thoroughly assess your regimens.

_____

_____

Do you drink alcohol? (even occasionally) ☐ Yes ☐ No How often? _____Drinks per Week

Do you smoke? ☐ Yes ☐ No If yes, how often?_____ Packs per Week

Did you quit smoking? ☐ Yes ☐ No Since when?_____

How would you rate your overall health and physical condition?

☐ Excellent ☐ Above Average ☐ Average ☐ Below average ☐ Poor

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PATIENT CONFIDENTIALITY FORM

By signing this form, I hereby consent Stockton Hematology Oncology Medical Group Inc. to use and disclose my protected health information for the purpose of treatment, payment and health care operations.

I acknowledge receipt of the physicians *"Notice of Privacy Practices."* The Notice of Privacy Practice provides detailed information about how they may use and disclose my confidential information.

I understand that the physician has reserved the right to change his Privacy Practices that are described in the notice. I also understand that a copy of any revised noticed will be provided to me by calling the main office at (209) 466 - 2626. A copy of the revised notice will be mailed to me or given to me at my next appointment.

I have the right to revoke this consent in writing, except to the extent Stockton Hematolology Oncology Medical Group Inc. has already used or disclosed my protected health information in reliance on my consent.

I give authorization to discuss my treatment options and have access to my medical records to the following people:

Name: _____ Phone#:_____ Relationship: _____

Name: _____ Phone#:_____ Relationship: _____

Name: _____ Phone#:_____ Relationship: _____

Name: _____ Phone#:_____ Relationship: _____

_____ _____

Signature of Patient, Legal Guardian, Conservator, DPA or Legal Representative **Date**

_____ _____

Print Name **Relationship to patient**

OPT OUT: I hereby revoke the consent given above:

_____ _____

Signature of Patient, Legal Guardian, Conservator, DPA or Legal Representative over printed name **Date**

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DOCUMENT REQUEST FORM

- Due to the time involved in all forms, letters, or other document requests, a processing fee may be charged.
  - Medical records are charged at a rate of ***$25.00 per up to 100 pages.***
  - Other documents are charged a ***minimum processing fee*** depending on the type of document noted below:
    - Standard Format Letter **- $ 5.00**
    - Letter dictated by Physician or nurse **- $10.00**
    - Disability forms, Cancer Policies **- $15.00**
  - Letters may be charged by the time required to complete them rather than length.
- All requests will be reviewed, but some requests may be denied by the provider. There is no charge for a request which is denied.
- Each request is priced individually. Requests for modifications or repeat requests will be charged as new requests.
- Please have patience as requests may take ***up to seven (7) business days to complete***. We will notify you when your item is ready for pick-up.
- A Medical Record Release form may be required before release of some requests.

Please describe your request: _____

_____

Standard Format Letter
-Caregiver
-Disability Extensions
-DMV
-Employee
-Excuse from Jury Duty
-Immigration
-Return to work

Letter Dictated by Physician or Nurse
-FMLA Paper Work
-Insurance
-Physician certificate statement

We thank you for your cooperation and understanding. Practice of medicine is our first priority and takes precedence. By signing below, you are agreeing to these terms and conditions.

Patient's Name: _____

Patient's Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

Physician or Medical Facility to Release Information:

Name: _____ Phone: _____

Address: _____ Fax: _____

I hereby authorize the above named physician or medical facility to release my complete personal health information (medical records including diagnosis, physician notes, diagnostics, films, and other information) for purposes as needed, and as allowed by law, in the treatment and/or further diagnosis of my condition or illness.

I authorize this information to be released in its entirety to:

_____ Stockton Hematology Oncology
(Initial)

c/o Medical Records Dept.
2626 N. California St. Ste B,
Stockton CA 95204
Phone: 209-466-2626
Fax: 209-466-7153

and/or

_____ _____
(Initial) (Name and Address of Physician, Medical Facility, or Other Individual or Group)

This authorization is to remain in effect indefinitely, as allowed by law. I also realize that I may revoke and terminate this authorization, for any future release or disclosures of my personal health information at any time, by submitting written notice of revocation to the previously authorized individual or entities authorized.

_____ _____
(Signature of Patient, Legal Guardian, Conservator, DPA or Legal Representative) (Date)

_____ _____
(Printed Name) (Relationship to Patient)

User Electronic Mail Authorization Form

Patient Portal: CareSpace

My Care Plus, the Patient Portal (the "Portal") offers convenient and secured access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique like that you will use to create a password in order to access the Portal. **Please look for an email from CareSpace promptly after submitting this form.** For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contract information so that you will continue to receive updates and other pertinent information about the Portal or your records .Please choose an email address that will not be subject to access y anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

☐ **Check this box if you wish to have access to the Portal and continue with the Terms below:**

☐ **Check this box to *Decline***

TERMS

You are receiving access to the Portal; the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization form. Please write legibly.

Patient Name (First Name, Middle Initial, Last Name)

Email Address of Patient/ Authorized User

Date of Birth of Patient

Physicians Name

Authorized user is:
- ☐ Patient
- ☐ Patient's Designee

Patients Designee's Name (Printed)

Patient's Medical Record Number

Patient's Designee's Signature

Patient's Signature

Date

Signature of Practice Staff
(confirming user's identity and authority)

Date

Note to staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose. Please make a copy for the patient

PATIENT NAME: _____ MRN # _____ DATE OF BIRTH: _____

TREATMENT AND FINANCIAL RESPONSIBILITY INFORMATION

Appointments: When you arrive, please stop at our check in area, and let the office staff know you are here before being seated. In order to serve all patients promptly, please schedule all appointments in advance. This includes infusion, injection, and PET/CT scan appointments.

Treatments: If your doctor ordered a treatment on your behalf, please be advised that you will receive calls from our office to coordinate the following: *authorization of your treatment with insurance company or medical group, financial counseling for possible cost of the treatment, scheduling the appointment for treatment, courtesy call for an appointment reminder and possible instructions or preparations prior to your treatment.*

Cancellation Policy: Please understand that it is important to us to be available for all our patients and appointment times are precious. Please notify us 24-hours in advance if you need to cancel or change appointments. This allows us to accommodate patient who need to be seen urgently. We reserve the right to charge up to $25.00 appointment cancellation fee if we are not notified in advance that you cannot make your appointment.

Patient with Insurance: Although we will bill your insurance company/medical group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your insurance company/medical group, we will contact you for assistance. Should your insurance company/medical group deny coverage for any reason, you will be responsible for payment in full within thirty (30) days of your billing statement.

Dual Coverage: We abide by the California State insurance laws, which govern coordination of benefits. Therefore, you are responsible for providing us with all billing information for primary, secondary, and tertiary insurance plans.

Co-pay/Co-insurance Policy: If your insurance has a co-pay, they require that you pay the co-pay at the time of the visit. A co-pay is collected for all office visits, including visits with the doctor or other medical staff, unless we indicate otherwise. Also included are office visits when chemotherapy is scheduled (even if the treatment is held due to medical condition) and visits for injections. This is regardless of whether the patient sees the doctor or not since the doctor is involved wit medical decision-making. Co-insurance is also due at the time of service and will be communicated with you prior to the initial treatment. If you anticipate any financial difficulty with paying your co-pay and/or co-insurance, please contact our billing staff as soon as possible.

Authorization & Assignment of Benefits: Please refer to our Notice of Privacy Practices. This authorizes us to release medical information to your insurance plan/medical group that may be needed to process/pay your claims. The "assignment of benefits" request that insurance payment be made directly to us, also acknowledges that you are responsible for payment if this assignment is not honored.

Patient without insurance: Our fees cannot always be determined in advance, since they depend on the services rendered. You will be quoted a deposit amount, which must be paid at the time of service. Any change over the deposit amount will be billed to you and will be due in full within thirty (30) days from the date of your billing statement. Please make payment arrangements in advance with our billing staff for costly services.

Miscellaneous Fees: Our fee for copying medical records is $25.00 and may take up to seven (7) business days. For completion of forms, such as disability forms, family leave applications, and DMV forms, as well as excuses from work letter and other letters, there will be a nominal fee of $5.00 to $15.00 depending upon the item being completed.

Returned check: There is a $25.00 service fee for all returned checks.

I have read and understand the above policies and I agree to comply with them. I attest that all information given is true and accurate to the best of my knowledge.

_____ _____

(Signature of Patient, Legal Guardian, Conservator, DPA or Legal Representative) (Date)

_____ _____

(Printed Name) (Relationship to Patient)

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PRE-SCREENING PATIENT ASSISTANCE APPLICATION

This form is optional. Complete if you wish to pursue Patient Assistance for treatments.

Cancer treatments are expensive and, unfortunately, not all insurance companies will pay all of the associated costs. However, there are patient assistance programs available that may help offset some of the expenses you may incur. If you would like for our Financial Counselor to see if you qualify for any of these programs, please complete and provide the following information:

- Total Household income: _____
- Total number of people in the household: _____
- Social security number (If you have not provided it already) _____
- Proof of income, if approved, you may be asked to provide one of the following:
  - Copy of your most recent federal tax return, if you file taxes or tax-exempt form
  - Copies of all current income documentation (W2, SSI, bank statements, paystubs, Award letter from social security, etc.)

By signing this form:

- I hereby authorize Stockton Hematology Oncology Medical Group to use the information above to apply on my behalf and enroll for Patient Assistance Program.
- I acknowledge that the information I have provided on this form is accurate and complete to the best of my knowledge.
- Also, I understand that being enrolled under the Patient Assistance Program does not guarantee full coverage of the services that I have received or will be receiving, and it is my responsibility to pay the remaining balance thereafter.
- I acknowledge that Stockton Hematology Oncology Medical Group reserves the right at any time, and without notice, to modify this application form.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____