FORT WAYNE
MEDICAL ONCOLOGY
AND HEMATOLOGY

2514 East Dupont Road, Fort Wayne, IN 46825 (260) 484-8830
7910 West Jefferson Boulevard, Fort Wayne, IN 46804 (260) 436-0800

Welcome New Patient

Enclosed, you will find a patient history form and a statement of our financial policies. Please read and complete these forms to the best of your ability before your appointment.

We encourage you to contact your insurance company to verify your benefits. We participate with many networks, but not all. It is to your benefit to call before your appointment as some plans offer no out-of-network benefits, or benefits that are extremely reduced.

We sincerely hope that your experience with our office is as pleasant as possible. Please understand that our physicians see patients at area hospitals and work at outlying clinics, therefore they may not always be available when you need to come in. It may be necessary for you to see someone other than your primary physician in our office in order for us to provide the best possible care for you.

Your First Visit
It is normal to feel overwhelmed at first and to not know what to expect from your disease or from treatment. We will do all that we can to ease the process.

When You Arrive
All of our doctors see patients on an appointment basis. Upon arrival, check in with the receptionist who will direct you to a patient registrar; wheelchairs are available at all locations. You will need your social security number, insurance cards, driver's license, and prescription cards at registration. Bring your insurance card(s) to each visit as our receptionist will ask to see them when you check in. Please make your insurance co-payment at this time.

Patient Phone Calls
We have phone nurses on duty from 8:00am - 5:30pm Monday through Friday. Our phone nurses are very knowledgeable and are able to advise you. Our phone nurses will also inform your physician about any problems you may be having.

Diagnostic Testing
Lab visits are made only by appointment. When you have tests run such as CT scans, bone scans, MRIs, PET scans, or lab work, it usually takes several days for our office to obtain your results. Our office will schedule a return appointment for you to obtain your results. Our office policy is that phone nurses are not to give out any results over the phone.

Filling Prescriptions
Many prescriptions can be filled over the telephone. Narcotics require a special prescription and, by law, cannot be refilled over the phone. You or a family member will need to come to the office to pick up the prescription. When picking up your prescription you will be required to show identification. If your family member or a friend is picking up your prescription, he or she must have identification. Prescription refills should be requested when you have a 2-3 day supply left. Also, please check your prescriptions prior to weekends and holidays. No narcotic pain prescriptions can be made after our regular office hours or during weekends or holidays. Our office will process refills within 24 hours of receiving your request.

Return Appointments
At the end of each visit, we will schedule your return appointment before you leave our office. We have Physician Assistants and Nurse Practitioners on staff to see when your doctor is not available. Any X-Ray films or discs brought to the office should go home with you. Sometimes we need to send out medical information or pathology slides to consulting laboratories; this is done by Federal Express and you may incur these charges.

Fort Wayne Medical Oncology and Hematology, Inc.

2514 East Dupont Road, Suite 100, Fort Wayne, IN 46825 (260) 484-8830
7910 West Jefferson Boulevard, Suite 108, Fort Wayne, IN 46804 (260) 436-0800

Please bring your insurance card(s) to your appointment

Patient name: _____ Date of birth: _____ Gender: ☐ Male ☐ Female

Social Security #: _____

Race/Ethnicity: ☐ African American ☐ Asian ☐ Hispanic ☐ Native American
☐ Pacific Islander ☐ White ☐ Unknown

Preferred language: _____ Email address: _____

Street address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Living Status: ☐ Lives alone ☐ Lives with family ☐ Lives in a nursing home

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

Name of spouse (if applicable): _____ Spouse's employer: _____

Primary Insurance Information

Name of insurance co.: _____ Name of policy holder: _____

Policy holder's date of birth: _____ ID#: _____

Policy holder's Social Security number: _____

Group number: _____ Employer: _____

Secondary Insurance Information

Name of insurance co.: _____ Name of policy holder: _____

Policy holder's date of birth: _____ ID#: _____

Policy holder's Social Security number: _____

Group number: _____ Employer: _____

Emergency Contact Information

Contact name: _____ Relationship: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone number: _____

I authorize my insurance benefits to be paid directly to the above physician/corporation. I am responsible to pay non-covered services and I authorize the release of pertinent medical information to my insurance carrier(s).

Signature: _____ Date: _____

Fort Wayne, North Office
2514 East Dupont Road
Fort Wayne, IN 46825
Phone: (260) 484-8830

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Fort Wayne, South Office
7910 West Jefferson Boulevard, Suite 108
Fort Wayne, IN 46804
Phone: (260) 484-8830

Patient's name:	Sex: ☐Male ☐Female Date:
Date of birth:	Email address:
Family physician:	Family physician's phone number:
Emergency contact:	Emergency contact's phone number:
Relationship of emergency contact to the patient:	
Pharmacy name:	Pharmacy phone number:
Pharmacy address:	

Family History

	(Living) Current Age	*(Deceased)* Age at Death	Medical Problems	History of Cancer	List Types of Cancer
Paternal grandfather				☐	
Paternal grandmother				☐	
Maternal grandfather				☐	
Maternal grandmother				☐	
Father				☐	
Mother				☐	
Siblings:				☐	
1. ☐Male ☐Female				☐	
2. ☐Male ☐Female				☐	
3. ☐Male ☐Female				☐	
4. ☐Male ☐Female				☐	
Husband/Wife				☐	
Children:				☐	
1. ☐Male ☐Female				☐	
2. ☐Male ☐Female				☐	
3. ☐Male ☐Female				☐	
4. ☐Male ☐Female				☐	

Additional relevant information:

Past Medical History

	Yes	No	Date Diagnosed
Asthma			
Emphysema/COPD			
History of pneumonia			
High blood pressure (hypertension)			
High cholesterol			
Heart attack			
Cardiac arrhythmia (rhythm problem)			
Rheumatic fever			
Kidney disease			
If you answered yes to kidney disease, what stage? _____			
Kidney stones			
Hepatitis/Jaundice			
Gall stones			
Shingles			

	Yes	No	Date Diagnosed
Depression			
Thyroid disease ☐Hypo- ☐Hyper-			
Stomach/duodenal ulcers			
Colon problems/diverticulitis			
Diabetes			
Arthritis			
Osteoporosis			
Chronic back pain			
Gout			
Blood clots			
Anemia or blood disorder			
Stroke/TIA			
Seizures			

Other medical problems not listed above:

Past Surgical History

Date	Type of Surgery	Location

Prior cancer diagnosis: ☐Yes ☐No If yes, what type(s) and when?

Prior chemotherapy: ☐Yes ☐No If yes, when?

Prior radiation therapy: ☐Yes ☐No If yes, when?

Women's Health History

Date of last menstrual period:			At what age did you start menstruating?
Are you menopausal?	☐ Yes	☐ No	Age of onset of menopause:
Date of last PAP:	☐ Normal	☐ Abnormal	Location:
Date of last mammogram:	☐ Normal	☐ Abnormal	Location:
Are you using birth control?	☐ Yes	☐ No	
Do you have hot flashes?	☐ Yes	☐ No	
Do you have cramps?	☐ Yes	☐ No	
Number of pregnancies:			Number of births:
Number of abortions:			Number of miscarriages:
Age at first pregnancy:			
Do you have problems with your cycle? Is so, please explain:			

Men's Health History

Have you had a PSA test?	☐ Yes	☐ No	If so, date of last PSA:
Have you had a prostate exam?	☐ Yes	☐ No	If so, date of last prostate exam:

Social History

Marital status: ☐Single ☐Married ☐Widowed ☐Divorced

Current occupation:

Previous occupations:

Have you had a pneumonia vaccination?	☐Yes	☐No	Date:	Provider:	
Have you had a flu vaccination this season?	☐Yes	☐No	Date:	Provider:	
Have you had a bone density test?	☐Yes	☐No	Date:	Provider:	
Have you had a colonoscopy?	☐Yes	☐No	Date:	Provider:	
Have you had an upper GI?	☐Yes	☐No	Date:	Provider:	
Have you had a blood transfusion?	☐Yes	☐No	Date:	Provider:	
Do you smoke cigarettes or have you ever?	☐Yes	☐No	How much?	How long?	Quit date:
Do you use E-cigarettes or have you ever ?	☐Yes	☐No	How much?	How long?	Quit date:
Do you chew tobacco or have you ever?	☐Yes	☐No	How much?	How long?	Quit date:
Do you drink alcohol or have you ever?	☐Yes	☐No	How much?	How long?	Quit date:
Do you use illegal drugs or have you ever?	☐Yes	☐No	How much?	How long?	Quit date:

General	Yes	No	If yes, please explain
Fever			
Hot flashes			
Night sweats			
Significant fatigue			
Weakness			
Weight loss			

Skin	Yes	No	If yes, please explain
Itching			
Rash			
Lumps			
Change in mole			

Eyes	Yes	No	If yes, please explain
Recent visual changes			
Cataracts			
Glaucoma			
Double vision			
Blurry vision			

Breasts	Yes	No	If yes, please explain
Lumps			
Drainage			
Tenderness			
Skin changes			

Lungs	Yes	No	If yes, please explain
Shortness of breath			
Cough			
Coughing up blood			
Wheezing			
Difficulty lying flat			

Heart	Yes	No	If yes, please explain
Chest pain			
Palpitations			
Swelling of feet/legs			
Fainting episodes			
Heart murmur			

Additional information:

Abdomen	Yes	No	If yes, please explain
Vomiting			
Black stools			
Jaundice			
Nausea			
Blood in stool			
Abdominal pain			
Trouble swallowing			
Abdominal bloating			
Diarrhea			
Constipation			
Hemorrhoids			
Loss of appetite			

Urinary	Yes	No	If yes, please explain
Painful urination			
Incr. freq. of urination			
Difficulty initiating urine			
Blood in urine			
Incontinence			
Kidney stones			
Urinating at night			

Musculoskeletal	Yes	No	If yes, please explain
Muscle weakness			
Arthritis			
Joint stiffness			
Backache			

Neurological	Yes	No	If yes, please explain
Headaches			
Seizures			
Numbness/tingling			
Memory loss			
Tremors			
Confusion			
Dizziness			

Blood	Yes	No	If yes, please explain
Anemia			
Bleeding			
Excessive bruising			

Medication Allergies

Medication	Type of Reaction
1.	
2.	
3.	

Medication List

Name of Medication	Dose	Quantity Per Day	Reason for Taking Medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			

List All Physicians You See

Physician Name	Specialty
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

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Notice of Financial Interest in a Healthcare Entity
Fort Wayne Medical Oncology and Hematology, Inc.

In the course of your diagnosis and treatment, the physicians of Fort Wayne Medical Oncology and Hematology, Inc. may refer you to other providers and facilities for services. One or more of the physicians of Fort Wayne Medical Oncology and Hematology, Inc. is part owner of and has a financial interest in Dupont Hospital, LLC.

You are hereby notified of our financial interest in Dupont Hospital, and that we may refer you there for services from time to time. Nevertheless, the selection of a specific healthcare entity/facility rests with the patient, and you may choose at any time to be referred to an alternate entity/facility of your choice.

The undersigned hereby acknowledges and certifies that he or she has received a copy of this Notice of Financial Interest in a Healthcare Entity.

Signature of the individual: _____

Printed name of the individual: _____

Date: _____

If the individual is unable to make written acknowledgement because of age or physical condition, please complete the following:

Relationship to patient: _____

Signature of representative: _____

Printed name of representative: _____

Date: _____

FORT WAYNE
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Consent to Treat and Patient Financial Policy

Consent for Care and Treatment

I, the undersigned, hereby voluntarily consent and authorize Fort Wayne Medical Oncology and Hematology, through its physicians, to perform diagnostic procedures and/or medical treatment judged necessary or advisable by the physician(s). I acknowledge that no guarantees or representation have been made to me as to the results of this treatment. The services provided are considered medically necessary, advisable and proper in the diagnosing or treatment of his/her/my condition or presenting problems.

Financial Policy Statement

We bill your health insurance company as a courtesy to you. You are responsible for any co-pay or deductible at the time of service. We require that payment of your estimated share be made at the time of your appointment. If you are not covered by insurance, we require a $75 minimum deposit per visit, at the time of service. In the event your insurance company requests a refund of payment or denies coverage for your service, you will be responsible for all charges not paid or covered by your insurer. If your health insurance is through the health insurance exchange marketplace or COBRA, you are required to show us proof of payment of your insurance premium (such as a receipt from your insurer or a copy of your cancelled check) each 30 day period. Any unpaid balances will be your responsibility. Payment, in full, is due upon receipt of your statement. We do not write off "usual and customary" balances unless a contract with your insurer requires us to do so. If payment is made to you for services provided by Fort Wayne Medical Oncology and Hematology, you are obligated to promptly pay us for those services; if your account goes into collection status with Fort Wayne Medical Oncology and Hematology, your privileges with us will cease. We realize that temporary financial problems may arise and affect your timely payment on your account. Please call our office and make payment arrangements, if necessary. Financial assistance may be available for medically necessary services. To qualify for assistance, you must bring proof of financial need by providing the most current year tax return and two most recent pay stubs, along with any and all other documentation or information requested.

Pre-certification by your insurer is not a guarantee of payment of benefits. Any questions regarding your insurance coverage need to be directed to your insurance carrier. You will be responsible for all fees incurred for collection of monies owed including attorney fees and/or court costs.

There may be a $50 "no-show" fee for visits not cancelled with 24 hours' notice. This is not billable to your insurance company; therefore it is the patient's financial responsibility.

Please note: All lab services and bone marrow procedures done in our office are sent for analysis and interpretation to an outside pathologist. They may not be a member of your insurance network and reduced benefits may apply. All imaging services done in our office will be sent for interpretation by an outside radiologist. You will receive a separate billing for these outside services.

Benefit Assignment/Release of Information

I hereby authorize release to my insurance company of all information necessary for the payment of benefits. I hereby assign payment benefits by my insurance company, Medicare, Medicaid or any other third party payer, to Fort Wayne Medical Oncology and Hematology.

I hereby agree to the above and foregoing and financial responsibility for services provided.

Patient name, printed	Date
Signature of patient	Signature of spouse
Signature of other guardian/custodian	Type of responsibility *Power of Attorney, Guardian* *Provide a copy of your designation*

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HIPAA Privacy Receipt Acknowledgement
Fort Wayne Medical Oncology and Hematology, Inc.

The Fort Wayne Medical Oncology and Hematology (FWMOH) Notice of Privacy Practices has been offered to me. I understand I have the right to review the Notice of Privacy Practices prior to signing this document and by signing this document, acknowledge only that I have been offered the Notice of Privacy Practices or have declined the offer.

FWMOH reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent to me by mail or asking for one at the time of my next appointment.

☐ Accept notice ☐ Decline notice

_____ _____

Signature of patient *Signature of personal representative*

_____ _____

Patient's date of birth *Personal representative's authority*

_____

Date

I authorize the following person(s) minimal access (this does not include copies of medical records) to my protected Health information (PHI):

Name	Date of birth	Telephone number	Relationship

Patient's signature: _____ for authorization to release limited PHI to the above listed individuals.

☐ I further authorize FWMOH to communicate with me electronically through email at the following email address: _____. I understand that this email communication is not secured by encryption, therefore its not considered a secured or private communication. FWMOH will not be held responsible for further disclosure of my information sent via unencrypted email.

Patient's signature: _____ for authorization of email communications.

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Patient Rights and Responsibilities

Fort Wayne Medical Oncology and Hematology, Inc.

Through research and education, we provide compassionate, quality care in an atmosphere which provides support, respect, and dignity to our patients. Our team of physicians and staff is committed to providing state of the art care to patients with cancer and blood disorders.

- Be fully informed in advance about treatment to be provided, including the representatives who provide care, and the frequency of visits as well as any modifications to my individual care plan.
- Be treated, and have my property treated, with dignity, courtesy, and respect, recognizing that I am a unique individual.
- Be informed both orally and in writing, in advance, of care being provided, of the estimated charges, including expected payment for treatment services from third parties, and any charges for which I will be responsible.
- Receive information about the scope of services that the organization will provide and specific limitations on those services.
- Participate in the development and revision of my individual plan of care.
- Refuse care or treatment after the implications of refusing care or treatment are fully presented and explained.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of my property.
- Voice grievances and concerns regarding treatment services, lack of respect of property, or recommend changes in policy, personnel, or services without restraint, interference, coercion, discrimination, or reprisal. Concerns may be reported to:
  - ◊ FWMOH Patient Experience Officer, (260) 969-7853
  - ◊ Office of Indiana Attorney General, (312) 232-6201
  - ◊ United States Department of Health and Human Services, (877) 267-2323
  - ◊ Accreditation Commission of Health Care, (855) 937-2242
- Have complaints regarding treatment services or lack of respect investigated.
  - ◊ Grievances shall be investigated within 5 days of reporting to FWMOH and resolved within 14 days. If the grievance involves death or serious injury, investigation shall begin within 24 hours and be resolved within 3 days.
- Confidentiality and privacy of all information contained in my record and of protected health information.
- Be advised on the agency's policies and procedures regarding the disclosure of clinical records.
- Choose a health care provider.
- Receive appropriate care without discrimination in accordance with physician orders.
- Be informed of any financial benefits when referred to another organization.
- Be fully informed of my responsibilities.

_____ _____

Patient signature Date