AO MULTISPECIALTY CLINIC

AUGUSTA ONCOLOGY
AIKEN ONCOLOGY
pelvic health ESSENTIALS
RHEUMATOLOGY CENTRE

Welcome to AO Multispecialty Clinic. To prepare for your visit, please complete the following New Patient forms and return them to Patient Registration when you arrive for your appointment. Whether you are being seen at Augusta Oncology, Aiken Oncology, the Rheumatology Centre, or Pelvic Health Essentials at the Essentials Center, we ask that you please try to arrive at least 30 minutes before your scheduled appointment time.

Oncology Patients:

We pride ourselves in going above and beyond the ordinary measure to ease our patient's financial burdens to the extent available to us. For cancer patients without insurance or whose insurance does not cover all the costs: there are many sources of financial assistance for which you might qualify. We also have financial resources for a number of chemotherapy medications prescribed by our providers. On-site patient representatives can assist you with community resources and payment arrangements.

If you are undergoing cancer treatment, you may make an appointment with a patient representative to find out if you qualify for patient assistance. At that time, you'll be counseled on assistance eligibility. Financial counseling can lead to peace of mind about your medical expenses, leaving you free to concentrate on recovery. For that appointment, you will need to bring your federal tax return, form 1040 page 1 & 2 of previous tax year, and a Social Security statement for each adult member of your household. Please be advised that you cannot be screened for eligibility without these documents.

Pelvic Health Patients:

Please come to your pelvic health appointment with a comfortable full bladder. In order for us to understand how the bladder is functioning, you may need to be catheterized. If you are having difficulty holding your bladder on arrival, please inform the receptionist immediately.

You will have a physical and a pelvic exam during your visit. If you are menstruating at the time of the appointment, it will not hinder the exam.

New Patient Information

Patient Name: _____ Date: _____

Home phone: _____ Mobile: _____ Work: _____

Preferred pharmacy (include location): _____

Pharmacy phone number: _____ Preferred hospital: _____

Please list all of your current doctors/healthcare providers:

_____ _____

_____ _____

Please list all allergies, and any reactions, below. If none, check this box: ☐

_____

Reason for visit: _____

List **ALL** current medications - prescription & over-the-counter - include Aspirin, Motrin, Ibuprofen & vitamins:		
Drug	**Dosage**	**Frequency**

PAST MEDICAL HISTORY

# of pregnancies:		# of vaginal deliveries:		# of Cesarian sections:				
# of daughters:			# of sons:					
When was your last menstrual period?						Allergic to Latex?	YES	NO
Do you have, or have you ever had, any of the following? Please circle YES or NO								
Heart Disease	YES	NO	Diabetes	YES	NO	COPD	YES	NO
Heart Attack	YES	NO	Asthma	YES	NO	Thyroid Disease	YES	NO
High BP	YES	NO	Emphysema	YES	NO	Kidney Disease	YES	NO
Stroke or TIA	YES	NO	Liver Disease	YES	NO	IBS	YES	NO
Blood Clot/DVT	YES	NO	Kidney Stones	YES	NO	Depression	YES	NO
Cancer: YES NO If YES, what type:								
Last PSA or Prostate exam: _____ Last Colonoscopy or Sigmoidoscopy: _____								
Last PAP Smear: _____ Last Mammogram: _____								
Last Flu Shot: _____ Last Pneumovax: _____								

Date: _____

SURGICAL HISTORY

Date of Surgery	Type of Surgery

FAMILY HISTORY

			Relationship				Relationship
High BP	YES	NO		Breast Cancer	YES	NO	
Stroke or TIA	YES	NO		Ovarian Cancer	YES	NO	
Heart Disease	YES	NO		Uterine Cancer	YES	NO	
Heart Attack	YES	NO		Colorectal Cancer	YES	NO	
Blood Clots	YES	NO		Bladder Cancer	YES	NO	
Diabetes	YES	NO		Kidney Cancer	YES	NO	
Urinary Incontinence	YES	NO		Pelvic Organ Prolapse	YES	NO	

SOCIAL HISTORY

Marital Status (Circle one): SINGLE MARRIED DIVORCED WIDOWED

Smoke cigarettes?	YES	NO	If yes, how many packs a day?	# years quit:	
Drink alcohol?	YES	NO	If yes, how many drinks per week?	# years quit:	
Use recreational drugs?	YES	NO	If yes, what type and how often?		

Have you been exposed to any of the following?

_____ RADIATION _____ ASBESTOS _____ BENZENE _____ LEAD _____ ILLEGAL DRUGS

Please list the full name of family members or friends who help you make medical decisions:

_____ _____

REVIEW OF SYSTEMS

Please circle any of the symptoms below that you are feeling:

Constitutional - Fever, chills, hot flashes, drenching night sweats, fatigue, weight loss (how many lbs): ____

Head - Headache, dizziness, hearing loss, vision changes, mouth sores, hoarseness, runny nose, nasal/sinus congestion, sputum

Lungs - Shortness of breath (at rest, lying down, or with exertion), cough, congestion

Heart - Chest pain or discomfort, palpitations

Abdomen/GI - Decreased appetite, nausea, vomiting, pain, heartburn (reflux), indigestion, diarrhea, constipation, change in bowel habits, blood in stool, hemorrhoids

Genitals/Urinary - Incontinence, difficulty urinating, frequent urination in day or night, pain or burning, bleeding, discharge, kidney stones

Arms, Back & Legs - Weakness, pain, swelling - if so, where? _____

Neurologic - Numbness, tingling, burning, memory loss, seizures

Psychologic - Anxiety, depression, insomnia

Skin/Breasts - Rash, redness, new lumps or lesions

Blood - Bruising, bleeding, blood clots

Anything else? _____

Social Security #: _____ Date of Birth: _____

E-mail address: _____ Sex: MALE FEMALE

Street Address: _____

City: _____ State: _____ Zip Code: _____

Where do you live? (Check one)
House _____ Apartment _____ Assisted Living _____
Nursing Home _____ With Relative _____ Other (please describe) _____

Preferred Language: _____

Ethnicity: _____ Race: _____

Employer: _____ Employer phone number: _____

Employer Address: _____

Occupation: _____

Referring Physician: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Social Security #: _____

ADVANCED DIRECTIVES

Please inform the front desk and indicate below with a checkmark if you have any legal documentation for any of the following items:

_____ Healthcare Durable Power of Attorney

_____ Organ Donor

_____ Autopsy Request

_____ Living Will / Advance Directive

_____ Do Not Hospitalize Status

_____ Do Not Resuscitate Status

_____ Feeding Restrictions

_____ Medication Restrictions

_____ Other Treatment Restrictions

_____ No Advanced Directives

Please provide us a copy of your Advance Directive for your chart if you have one.

Do you need information on Advance Directives? _____

Financial Policy

Thank you for choosing AO Multispecialty Clinic as your healthcare provider. In order to provide our patients with the best possible service, we want to communicate to you our financial policies. A copy will be provided to you upon request.

Health Insurance Coverage: Our practice participates in most health insurance plans. As a service to you, we will submit your claims and assist you in any way we reasonably can in order to get your claims processed correctly. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Proof of Insurance: Our practice requires a copy of your driver's license or other government-issued picture identification & current valid health insurance card. Failure to provide correct insurance information in a timely manner may result in the balance of a claim becoming your responsibility. If your health insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. All bills for patient balances are mailed to the address of record. Therefore, it is imperative that you update us with any and all changes to your account whether it is a change of address, phone number, insurance coverage, etc.

Insurance Benefits: Prior to your visit, our staff will verify your health insurance benefits. However, if you have any questions concerning your benefits, please contact your insurance company for clarification.

Co-payments and Deductibles: All copayments must be paid at the time of service. Payment plans are available for deductible and out of pocket costs. We accept cash, personal checks and major credit cards (Visa, Master Card, and Discover). We cannot waive any copayments, coinsurance, and/or deductibles. Please understand that payment plans will be separate from any per-visit copay required by your insurance company.

Referrals and Pre-Certification: Your insurance company may require a referral from a primary care physician (PCP) in order for you to see a specialist. Your insurance company may also require precertification of office or outpatient services. Pre-certification may also be required for admissions, CT scans, X-rays, and other diagnostic tests. As a courtesy, our office will make every reasonable effort to obtain these referrals and pre-certifications for you. However, it is ultimately your responsibility to ensure that all requirements are met before services are rendered. Please contact your insurance company to notify them of all services you are scheduled for.

Outside Lab Services: Our practice utilizes an outside lab company for certain tests. You are responsible for informing our staff which outside lab your insurance company covers.

I hereby authorize payment directly to Augusta Oncology Associates, P.C., DBA AO Multispecialty Clinic, for all insurance benefits otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges incurred by the patient named below, whether or not paid by insurance, and for all services rendered on my behalf.*

I authorize any provider or supplier of services in this office to release any information required to secure the payment of insurance or government benefits. I authorize the use of this signature on all insurance and government benefit submissions.

I verify that I have read and understand this Financial Policy and agree to all its terms & conditions.

Signature of Responsible Party: _____

Printed Name of Responsible Party: _____

Today's Date: _____

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Records Request Authorization

Patient's Name: _____ **Date of Birth:** _____

I HEREBY AUTHORIZE THE RELEASE OF THE ABOVE PATIENT'S MEDICAL RECORDS FROM ALL TREATING INSTITUTIONS TO AO MULTISPECIALTY CLINIC.

THIS FORM HAS NO EXPIRATION DATE UNLESS THE FOLLOWING HAS OCCURRED:

WRITTEN NOTIFICATION FROM PATIENT TO REVOKE PRIVILEGES.

AO MULTISPECIALTY CLINIC HAS THE RIGHT TO REVOKE THESE PRIVILEGES.

I specifically authorize release of any records pertaining to physical or mental health, alcohol, drugs (legal and illegal), tobacco, and the diagnosis or treatment of HIV (AIDS virus) infection or other sexually transmitted diseases.

I release AO Multispecialty Clinic and any member of their staff from all liability regarding the disclosure of this information.

_____

Signature of Patient or Personal Representative *Date*

_____

Signature of Witness *Date*

WEST AUGUSTA
3696 Wheeler Rd
Augusta, GA 30909
Ph: 706-736-1830

DOWNTOWN AUG
1303 D'Antignac St
Augusta, GA 30901
Ph: 706-821-2944
Fax: 706-821-2966

AIKEN
222 University Pkwy
Aiken, SC 29803
Ph: 803-306-1438
Fax: 732-702-6069

PELVIC HEALTH
1220 George C Wilson
Augusta, GA 30909
Ph: 706-941-8206

Notice of Privacy Practices
Patient Acknowledgment and Consent

AO Multispecialty Clinic places the highest priority on a patient's right to privacy. We are committed to respecting your rights to privacy and confidentiality of your health information at all times and have detailed policies and procedures in place to safeguard these rights.

AO's Notice of Privacy Practices are written in plain language and posted in the front office of each location, on our practice's website, and on our Patient Portal. Additionally, printed copies of the Notice of Privacy Policies are available by request.

Patient Name: _____

By signing this form, I acknowledge that AO Multispecialty Clinic's Notice of Privacy Practices is available to me and can be obtained by me on request. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. *I consent to the uses and disclosures of my protected health information as outlined in the Notice.*

I understand AO Multispecialty Clinic reserves the right to change the terms of the Notice and to make new provisions regarding all protected health information maintained by this practice. I understand that if a change is made, I will receive an addendum explaining the change and will have another opportunity to consent to any new terms regarding the use and disclosure of my protected health information.

_____ _____

Signature of Patient (Or personal representative of patient) **Date**

Relationship to Patient (If signed by a personal representative of patient)

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

___ An emergency existed and a signature was not possible at the time.

___ The individual refused to sign.

___ A copy was mailed with a request for a signature by return mail.

Authorized Communication of Patient Information

AO Multispecialty Clinic is authorized to release protected health information about the patient named below to the persons named below. The purpose is to inform the patient or others in keeping with the patient's instructions. Unless a person is explicitly named on this document, AO Multispecialty Clinic personnel are unable to share any information about my care and treatment.

Patient Name: _____

Person(s) who can receive information:

Name: _____ Relationship to patient: _____

Phone Numbers: _____ _____ _____
Home *Cell phone* *Work*

Name: _____ Relationship to patient: _____

Phone Numbers: _____ _____ _____
Home *Cell phone* *Work*

Name: _____ Relationship to patient: _____

Phone Numbers: _____ _____ _____
Home *Cell phone* *Work*

Is it okay to leave protected health information on voice mail? *(circle one)* YES NO
Is it okay to leave financial information on voice mail? *(circle one)* YES NO
It is okay to text information to cell phones? *(circle one)* YES NO

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the **Practice Site Manager.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal or State law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked. I understand that I have the right to have someone accompany me during my visits and I understand that my protected health information will be disclosed to that person.

_____ _____
Signature of Patient or Personal Representative **Date**