AO MULTISPECIALTY CLINIC

WELCOME TO OUR PRACTICE!

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 patient in oncology, hematology, radiation oncology, rheumatology or urology, we ask that you please arrive at least 30 minutes before your scheduled appointment time.

At AO Multispecialty Clinic, 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 Account Representatives can assist you with community resources and payment arrangements.

For patients undergoing cancer treatment, you may make an appointment with a Patient Account Representative to see 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.***

Patient Name: _____ **DOB:** _____

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

Is it okay to leave text information on cell phone? *(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**

New Patient Information

Patient Name: _____ Date: _____

Phone: _____ Phone (Alt): _____ Email: _____

Preferred Pharmacy (Name, Location, Phone): _____

Preferred Hospital(s): _____

Current Primary Doctor & Location: _____

Doctor Specialists: _____

_____

Reason for Visit: _____

Please list allergies (and reactions) below. If none, check _____ Latex Allergy? _____

_____

Do you have an implantable device such as a Pacemaker or Port-A-Cath? _____ Yes _____ No

If yes, what is it? _____

Medications (Please list drug, dose, and frequency of all medications including prescription and over-the-counter.)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Health Maintenance & Vaccinations

Vaccination: Flu _____ Covid _____ Pneumovax _____ Shingles _____ HPV _____

Last Colonoscopy _____ **Men:** Last PSA/Prostate exam/date: _____

Women: Last Mammogram place/date: _____ Last PAP Smear: _____

# of Pregnancies _____ Vaginal _____ C-Section _____ # Daughters _____ # Sons _____

Last Menstrual Period _____ Age of Menarche (started menses) _____ Age at Menopause _____

Medical & Surgical History—include dates if possible

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Social History

Marital Status: _____ Occupation: _____

Emergency contact, relationship and phone: _____

Children (son/daughter and age): _____

Other important caregivers info, if any: _____

Tobacco Use: # of packs / day: _____ # of years: _____ When did you quit (if applicable): _____

Alcohol Use: # of drinks / day: _____ # of years: _____ When did you quit (if applicable): _____

Exposures: Radiation _____ Asbestos _____ Vaping _____ Illegal drugs _____ Other _____

Family History

Please list family members (not by name) who have had cancers or other disorders.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Review of Systems

Circle any symptoms you have had and fill in the blanks.

GENERAL: Fevers - Chills - Hot Flashes - Drenching night sweats - Fatigue - Weight loss*

* How much weight have you lost or gained in the last _____ months? _____ pounds.

HEAD: Headache - Dizziness - Vision loss or changes - Hearing loss - Mouth sores - Hoarseness

Runny nose - Nasal or sinus congestion - Sputum production - Dental problems

NECK: Pain - Lumps or nodules: *tender* or *non-tender* - Swallowing problems

HEART: Palpitations - Rapid pulse - Slow pulse - Chest pain or discomfort, where? _____

LUNGS: Cough - Congestion - Wheezing - Difficulty breathing: *at rest, lying down, exertion*

BREASTS: Rash - Redness - Lesions - Lumps - Discharge

BACK: Pain or Lumps, if so where? _____

ARMS & LEGS: Weakness, Pain or Swelling, if so where? _____

ABDOMEN/GI: Worse appetite - Heartburn - Nausea - Vomiting - Diarrhea - Constipation

Indigestion - Bloating - Change in bowl habits - Bloody stool - Hemorrhoids

GENITALS/URINARY: Incontinence - Difficulty urinating - Frequent urination in day or night - Pain

Burning - Bleeding - Discharge - Kidney stones - Lesions

SKIN: Rash - Redness - Lesions - Lumps - Bruising - Bleeding - Dry Skin - Itchy - Hair Loss

ENDOCRINE: Heat or cold intolerance - Excessive thirst

LYMPH NODES: Swelling or tenderness. If so, where? _____

NERVES: Difficulty walking - Slurred speech - Numbness, tingling or burning, where? _____

MENTAL: Depressed - Anxious - Insomnia - Trouble focusing/concentrating - Memory loss

Anything else: _____

Purpose of Visit

What do you understand about your condition and what would you like the doctor to address?

_____

_____

_____

Social Security Number: _____ Date of Birth: _____

Email Address: _____ Sex: Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Where do you live?

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 Number: _____

Advance 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 Report

_____ Living Will / Advance Directive

_____ Do Not Hospitalize Status

_____ Do Not Resuscitate Status

_____ Feeding Restrictions

_____ Medication Restrictions

_____ Other Treatment Restrictions

_____ No Advance Directive

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

Do you need information on Advance Directives? YES NO MAYBE

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, Deductibles and Out-of-Pocket Responsibilities: Copayments must be paid at the time of service. We cannot waive any copayments, coinsurance and/ or deductibles. We accept cash, check and all major credit cards. Payment on outstanding balances is due 30 days after receiving a billing statement. Payment plans are offered for deductible and out-of-pocket expenses, separate from any per-visit copays required by your insurance company. Please reach out to our office to arrange payment options.

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.

_____ _____

Responsible Party Name (Print) **Date**

_____

Responsible Party Signature

AO MULTISPECIALTY CLINIC

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**

Aiken 222 University Pkwy. Aiken, SC 29803 Ph: (803) 306-1438 Fax: (732) 702-6069	**Downtown** 1303 D'Antignac St. Augusta, GA 30901 Ph: (706) 821-2944 Fax: (706) 821-2966	**Essentials Center** 1220 George C Wilson Dr. Augusta, GA 30909 Ph: (706) 941-8206 Fax: (833) 481-3460	**North Augusta** 150 Bluff Ave. North Augusta, SC 29841 Ph: (803) 624-1313	**West Augusta** 3696 Wheeler Rd. Augusta, GA 30909 Ph: (706) 736-1830 Fax: (706) 650-7553

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 **Date**

_____

Relationship to Patient (if signed by a personal representative)

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.

Other: _____