MERCER BUCKS HEMATOLOGY/ONCOLOGY

In order to meet requirements for meaningful use, please circle :

Language : English Spanish Sign Language Other

Race : Asian Black Hispanic White

Ethnicity : Latino Non-Latino

eligion : _____ Living Will : Yes or No

mail Address : _____

'ATIENT NAME : _____ DOB : _____ AGE : _____

SOCIAL SECURITY : _____ HOME PHONE : _____

)RIVER'S LICENSE # : _____ STATE : _____

ADDRESS : _____ WORK PHONE : _____

_____ CELL PHONE : _____

EMPLOYER'S NAME/ADDRESS/PHONE # : _____

POSITION : _____ _____

SPOUSE'S NAME : _____ SPOUSE'S BIRTHDATE : _____

SPOUSE'S SOCIAL SECURITY # (For Insurance Purposes) : _____

NEAREST RELATIVE OTHER THAN SPOUSE : _____ PHONE # : _____

PRIMARY CARE PHYSICIAN'S NAME/ADDRESS/PHONE # : _____

_____

PHARMACY'S NAME AND PHONE # : _____

Do you have a prescription plan? Y or N Plan Name : _____ ID : _____

PLEASE LIST DRUG/FOOD ALLERGIES : _____

DO YOU HAVE ? (please circle) ASTHMA DIABETES HIGH BLOOD PRESSURE

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN : _____ SUBSCRIBER : _____

ID : _____ GROUP : _____ RELATIONSHIP: _____

SECONDARY INSURANCE PLAN : _____ SUBSCRIBER : _____

ID : _____ GROUP : _____ RELATIONSHIP: _____

TERTIARY INSURANCE PLAN : _____ SUBSCRIBER : _____

ID : _____ GROUP : _____ RELATIONSHIP: _____

(Please read back and sign where applicable) Date : _____

INSURANCE AUTHORIZATION AND ASSIGNMENT
MERCER BUCKS HEMATOLOGY/ONCOLOGY, PC

MEDICARE/MEDICAID

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I request that payment under the medical insurance program be made either to me or to the physicians of Mercer Bucks Hematology/Oncology, PC for services furnished to me by any of the doctors in the group.

ALL OTHER INSURANCES

I hereby authorize Mercer Bucks Hematology/Oncology, PC to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering the covered services. I authorize Mercer Bucks Hematology/Oncology, PC to furnish complete info to my insurance company/carrier or its intermediaries regarding services rendered. I authorize Mercer Bucks Hematology/Oncology, PC to furnish complete info to my referring and consulting physician(s) and my immediate family.

Date : _____ Signature : _____

I understand that due to constrictions in my coverage (depending on my insurance plan), I may be responsible for services not covered under the plan and it is my responsibility to pay these balances, as well as, any copayments as applicable.

ALSO, 24 HOUR NOTICE IS REQUIRED WHEN CANCELLING AN APPOINTMENT. I UNDERSTAND THAT A NO-SHOW CHARGE WILL BE ASSESSED IF MY APPOINTMENT IS NOT CANCELLED IN THAT TIME PERIOD. **($100.00 NEW PATIENT FEE/$50.00 FOLLOW UP FEE)**

Date : _____ Signature : _____

MEDICARE SECONDARY PAYER INFORMATION

Are you covered by a medical insurance plan where you work? (Y or N)

Are you covered by a medical insurance plan from your spouse's employer? (Y or N)

Do you have any medical insurance other than Medicare? (Y or N)

Is that Medicare supplement insurance? (Y or N)

RECORD TO RELEASE AUTHORIZATION

TO : _____

_____

_____

I hearby authorize and request you to release to :
MERCER BUCKS HEMATOLOGY/ONCOLOGY, PC
Two Capital Way
Suite 220
Hopewell, NJ 08534

Patient Name (Please print) : _____

Patient Signature : _____

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have an objection to this form, please ask to speak to our HIPAA Compliance Officer in person or by phone at 609-303-0747.
SIGNATURE BELOW IS ONLY ACKNOWLEDGEMENT THAT YOU HAVE REVIEWED AND UNDERSTAND THE NOTICE OF OUR PRIVACY PRACTICES DISPLAYED IN OUR OFFICE.

PRINT NAME : _____ SIGNATURE : _____

PROMISSORY NOTE

MERCER BUCKS HEMATOLOGY ONCOLOGY, PC

Patient Name: _____

SSN: _____

I have been notified by a member of the staff of Mercer Bucks Hematology/Oncology that my insurance plan **may not** be accepted by this office.

In the event my insurance company denies the claim or leaves a deductible or co-insurance balance, I am responsible for the charges for services which were provided.

I accept responsibility for the services provided and have scheduled an appointment with this understanding.

_____ _____

Patient Name Date

_____ _____

Mercer Bucks staff member Date

Mercer Bucks Hematology/Oncology

Patient Name:_____ SS#:_____

Dear Patient:

We have experienced a great deal of difficulty with patients changing their insurance plans and not informing our office prior to the effective date. Consequently, treatment has been administered with the assumption that our office participates with a particular plan, only to find that the insurance plan has changed and in some cases, to a plan we do not accept. We are in most cases not aware until several cycles of treatment have been received.

It is your responsibility to notify us of any changes in your insurance prior to the effective date so that we can help provide the best service to you and free you from the burden of receiving a large bill which is not covered under your insurance plan.

In addition, many patients who have multiple coverage are often times not sure which plan is primary (their Medicare plan versus their spouse's plan). If you are not completely sure which is primary, please call Medicare or your Human Resource Department for the correct order of coverage.

We encourage you to ask our staff for assistance prior to switching to another plan to see if we accept your insurance plan.

This document is to inform you that if the wrong information is supplied or your insurance information is not updated with our office and we are unable to obtain payment, you will be responsible for payment of the services provided.

I have read the above and agree to the terms.

_____

Patient Name Date

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE____/____/____ DATE OF LAST PHYSICAL EXAM____/____/____

LAST NAME_____ FIRST NAME_____ MIDDLE_____

Social Security No. _____ DATE OF BIRTH____/____/____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

_____

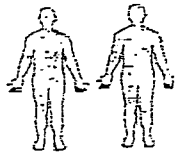
History of Present Illness

Please answer the following questions

Location of the problem

Abdomen Back Leg

Other_____



On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other_____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other_____

How long does the problem last?

30 minutes 1 hour It is always there

Other_____

Is anything else occurring at the same time?

Yes No If yes, please explain.

Nausea Rash Headaches

Other_____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other_____

Does the problem interfere with your normal functions?

Yes No If yes, please explain_____

_____

Physician use only: (Comments/Notes)

# Answers	Level of Servic
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery Date

_____

_____

_____

Do you smoke? Y N

If yes, how much? _____

Do you drink? Y N

If yes, how much? _____

Are you on any medications? Y N (If yes, list all.)

_____ _____

_____ _____

Are you on a special diet? Y N (If yes, please explain

_____

Do you have allergies? Y N (If yes, Please explain.)

_____

_____

Physician use only: (Comments/Notes)

#Answer	Level of Ser
0	1 or 2
1 - 2	3

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Headache Y N
- Other_____

Eyes
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other_____

Allergic/Immunologic
- Hay Fever Y N
- Drug allergies Y N
- Other_____

Neurological
- Tremors Y N
- Dizzy spells Y N
- Numbness/tingling Y N
- Other_____

Endocrine
- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Other_____

Gastrointestinal
- Abdominal pain Y N
- Nausea/vomiting Y N
- Indigestion/heartburn Y N
- Other_____

Cardiovascular
- Chest pain Y N
- Varicose veins Y N
- High blood pressure Y N
- Other_____

Integumentary
- Skin rash Y N
- Boils Y N
- Persistent itch Y N
- Other_____

Musculoskeletal
- Joint pain Y N
- Neck pain Y N
- Back pain Y N
- Other_____

Ear/Nose/Throat/Mouth
- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Other_____

Genitourinary
- Urine retention Y N
- Painful urination Y N
- Urinary frequency Y N
- Other_____

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other_____

Hematologic/Lymphatic
- Swollen glands Y N
- Blood clotting problem Y N
- Other_____

Psychologic
- Are you generally satisfied with your life? Y N
- Do you feel severely depressed? Y N
- Have you considered suicide? Y N
- Other_____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____ Date: ____/____/____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name:	Physician:
Date of Birth:	Date Completed:
Are you of Ashkenazi Jewish descent? YES / NO (circle one)	

Please place a check (✓) mark in the boxes below for yourself and family members who have had cancer as indicated. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

Have you or any family members ever been diagnosed with:	You			Family Members			
	No	Yes	Age of diagnosis	No	Yes**	Mother's side (✓)	Father's side (✓)
Breast cancer?							
Two or more breast cancers (bilateral or contralateral)?							
Ovarian cancer?							
Male breast cancer?							
Colon cancer?							
Two or more colon cancers in one individual?							
Uterine (endometrial) cancer?							
10 or more colon polyps found in one or more exams?							
Melanoma?							
Pancreatic cancer?							
Other cancers: stomach, kidney/urinary tract, brain, small bowel, thyroid							

List any other cancers in you or your family: _____

** List all relatives (relation, not name) diagnosed with the above cancers along with age of diagnosis: _____

If you checked yes in one or more boxes on the Family History Questionnaire ask your doctor to assess your cancer history. If your history indicates that you may have an inherited risk of cancer, there is a blood test that can help determine if you are at risk for hereditary cancer.

Please talk to your doctor about reducing your risk and possibly preventing cancer.

MERCER BUCKS HEMATOLOGY/ONCOLOGY Visit Date : _____

Patient Name : _____ Acct # : _____

Medication/Dose

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

_____

_____

_____

Smoking History (Please Circle) :

Did you ever smoke? Y or N
Smoked 100 cigarettes in lifetime? Y or N
Do you currently smoke? Y or N
If yes - - Everyday or Somedays

Circle if EVER Performed :

Mammogram Y or N
Pap Smear Y or N
Colorectal Screening Y or N
Influenza Vaccine Y or N

Preferred Language : _____
Race (circle one) : Asian Black White Hispanic
Ethnicity (circle one) : Latino Non-Latino Patient Refused

Family History : (1st degree relative) _____

_____

To be completed by staff :

Diagnosis code : _____

BP _____ Height _____ Weight _____

Education materials to patient : Y or N

Follow up plan documented (BMI) : Y or N

Visit Level : _____

M.D. Signature : _____

1111F out pt med rec

1110F in pt med rec

Mercer Bucks Hematology/Oncology

At Mercer Bucks Hematology/Oncology we understand that communication is an important part of the patient/health care provider relationship. To ensure that we get important information to our patients in a timely manner, we often leave messages on voicemail, answering machines or with family members. In some cases, we may need to leave messages on voicemail or answering machines with detailed information regarding your condition or treatment. You should be aware that other individuals who have access to your voicemail or answering machine may hear these messages. At home, this may mean that members of your family may hear these messages. At work, it may mean that your employer may hear these messages.

Please let us know on what numbers we may leave detailed or brief messages.

Home _____ ___ Detailed ___ Brief

Cell _____ ___ Detailed ___ Brief

Work _____ ___ Detailed ___ Brief

You may also designate two people with whom we may discuss your condition and treatment.

_____	_____	_____
Name	Relationship	Last 4 of SSN
_____	_____	_____
Name	Relationship	Last 4 of SSN

By signing below, I acknowledge that I have read and understand the Privacy Practices for Mercer Bucks Hematology/Oncology. I understand that Mercer Bucks Hematology/Oncology will not share my name or private information with any outside companies. I am aware that my information may be shared with my insurance company in order to have claims processed.

_____	_____
Patient Name	Date of Birth
_____	_____
Patient Signature	Today's Date