PATIENT INFORMATION

Patient's Name _____

Address _____

City, State, Zip _____

Phone Number # _____ Work Phone # _____

Cell Phone # _____ E-mail Address _____

Date of Birth _____ Social Security # _____

Patient's Employer _____ Employer Phone # _____
If retired, from where? _____

Patient's Insurance Co _____

Spouse Name _____ Spouse Date of Birth _____

Spouse Social Security # _____ Spouse Cell Phone # _____

Spouse Employer _____ Employer Phone # _____
If retired, from where? _____

Spouse Insurance Co _____

Are you covered by your spouse's insurance plan? ☐ Yes ☐ No

If yes, is it a primary or secondary insurance plan? ☐ Primary ☐ Secondary

Emergency Contact _____ Relationship _____
(Other than spouse)

Address _____ Phone Number _____
City, State, Zip _____

Referred by _____

I understand that full payment for this office visit is due today, if I do not have insurance or my insurance company does not cover this service. I understand that I will be expected to pay any co-pay, co-insurance, deductible or any "unpaid balance" due at my next scheduled appointment. I understand Oncology Associates of West KY will bill my insurance company as a courtesy to me and I may be responsible for any services not covered by my insurance. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of my medical benefits to Oncology Associates of West KY for services rendered. I also understand that I will be charged a $25.00 fee for a missed appointment or for not canceling 24 hours prior to my appointment.

In the case a claim is made or suit is filed against Oncology Associates of West KY, (to include it's physicians, it's employees, heirs or agents), the patient (to include his/her heirs, representatives and agents) undertakes and agrees to settle, adjust or defend Oncology Associates, at the sole cost to patient and, to pay any judgment rendered therein, together with all costs of court.

Signature: _____ Date: _____

PATIENT CONSENT TO USE & DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH OPERATIONS

I, _____, understand that as part of my health care, Oncology Associates of West Kentucky originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among my other health care professionals
- A source of information for submitting medical claims for payment
- A means by which a payer can verify services rendered

1. I understand and have been given a Notice of Privacy Practice that provides a more complete description of information uses and disclosures, as well as my rights regarding the use and disclosure of my health information.
2. I understand that Oncology Associates of West Kentucky is not required to agree to any restrictions requested and I may revoke this consent in writing. Such revocation will not apply to authorized uses and disclosures made prior to the revocation.
3. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.
4. I understand that Oncology Associates of West Kentucky reserves the right to change the notice and practices prior to implementation in accordance with Section 164.520 of the Code of Regulations. Should the notice be changed, the practice will send a copy of any revised notice to the mailing address I have provided.
5. I understand health information may be used or disclosed by mail, telephone, electronic means, and by fax.
6. I **AUTHORIZE** the use or disclosure of my health information for purposes of treatment, payment, or healthcare operations to other healthcare professionals involved in my care/treatment, insurance, and third-party payers, pharmacies and the following relative (s) and/or others:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

7. I wish to have the following restrictions placed on the use and disclosure of my health information:

_____

_____

_____

_____ _____

Patient/Guarantor Signature Date

PATIENT'S MEDICARE EXTENDED SIGNATURE AUTHORIZATION

_____ _____

Name of Beneficiary (Patient) Health Insurance Claim Number

"I request that payment of authorized Medicare benefits and any other insurance benefits be made on my behalf to Oncology Associates of West Kentucky. I authorized any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services."

If covered by a secondary insurance carrier that is medigap carrier or private policy, I further authorize payment from that carrier to Oncology Associates of West Kentucky for services rendered during the time period specified below.

Effective dates January 1, 2015 thru December 31, 2015.

If not covered by Medicare, but by any other commercial insurance carrier I authorize Oncology Associates of West Kentucky to submit any necessary documentation in order to process my health insurance claims for any services rendered in the facility. I further authorize my insurance company insurance company to process that claim and pay benefits directly to Oncology Associates of Western Kentucky on my behalf. I understand that I will be liable for any portion not paid by my commercial insurance carrier.

_____

Signature of Patient or Guardian

_____

Date

_____

Witness

Oncology Associates of West KY

CONSENT FOR CARE AND TREATMENT

I, the undersigned, having legal authority to do so, do hereby agree and give consent for Oncology Associates of West KY to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

HIPAA

I, the undersigned, have received a brochure that informs me of the privacy policies available to me thru the “Health Information Portability and Accountability Act”.

MISSED APPOINTMENTS

Due to the increasing number of missed appointments, we found ourselves in the unenviable position of having to manage this problem without inflaming the delicate relationship that we have with our patients. This problem not only affects the quality of care that we provide but also makes it incredibly difficult to schedule prompt and convenient appointment times for both existing and new patients. If you do not give us 24 hour advance notice that you will be unable to make an appointment you will be responsible to pay a $25.00 missed appointment fee. This fee is a non-covered item for insurance. The fee will be due at your next appointment.

Thank you in advance.

I have read and understand the statement noted above.

Patient: _____ Date _____

Please Print Your Name: _____

ONCOLOGY ASSOCIATES
OF WEST KENTUCKY
JAMES R. GOULD, M.D., F.A.C.P.
LUIS A. CONCEPCION, M.D.
WINSTON CHUA, M.D.

Phone: 270-444-3930
Fax: 270-443-5302

Cancer Risk Assessment form: Family History

Consider both your mother's and father's side of the family when answering the following questions to help in assessing your hereditary risk factors for breast and ovarian cancer. Do you have a family or personal history of any of the following (check only if your answer is Yes)*:

- ☐ You or a family member (mother's or father's side) were diagnosed with breast cancer at age 50 or younger
- ☐ You or a family member were diagnosed with ovarian cancer at any age
- ☐ You have a male family member with breast cancer at any age
- ☐ You have Ashkenazi Jewish ancestry, and a personal or family history of an hereditary (inherited) breast or ovarian cancer at any age
- ☐ There are two breast cancers in the same person or two family members with breast cancer on the same side of the family, one under age 50
- ☐ You or a family member were diagnosed with triple negative breast cancer at any age
- ☐ There is pancreatic cancer and an hereditary (inherited) cancer in the same person or on the same side of the family at any age
- ☐ There are three family members with breast cancer in the same side of the family
- ☐ You have a previously identified *BRCA1* or *BRCA2* mutation in your family

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Comments: _____

Patient Name: _____

Person Filling out form: _____

Signature of person filling out form: _____

Date: _____

ADDITIONAL NEW PATIENT HISTORY INFORMATION

- COLONOSCOPY: If yes, what year? _____
- MAMMOGRAM: If yes, what year? _____
- INFLUENZA: If yes, what year? _____
- PNEUMOVAX: If yes, what year? _____
- TETANUS: If yes, what year? _____
- Do you have a Living Will? _____

SMOKING STATUS

- 1- Current every day smoker
- 2- Current some day smoker
- 3- Former smoker
- 4- Never smoker
- 5- Smoker, current status unknown
- 6- Unknown if ever smoked
- 7- Heavy Tobacco Smoker
- 8- Light Tobacco Smoker

  -If yes, how many packs a day? _____

  -When did you start smoking? _____

  -When did you stop smoking? _____

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure 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 link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus 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 contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

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

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

_____ Physician's Name

Authorized User is:

☐ Patient
☐ Patient's Designee

_____ Patient's Designee's Name (Printed)

_____ Patient's Designee's Signature

_____ Patient's Medical Record Number

_____ 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 patient.

Staff Use Only:	MRN_____
Email in PMS or iKM_____	iKM Consent_____

Appointment and Cancellation Policy for Oncology Associates of West KY

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Schedule Appointments

To schedule an appointment please call 270-444-3930.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of our existing and new patients.

If it is necessary to cancel your scheduled appointment we require that you call by 9 a.m. one (1) working day in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments please call 270-444-3930. If you do not reach the receptionist you may leave a message with our answering service. You may not cancel via email.

Late Cancellations

Late cancellations will be considered as a “no show”.

No Show Policy

A “no show” is someone who misses an appointment without canceling it by 9 a.m. one (1) working day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients’ chart as a “no show”. An administrative fee of $25.00 will be billed to the patient’s account. The patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment by 9 a.m. one (1) working day in advance. A copy of the letter will be placed in the patient chart. This fee is non-covered by your insurance and you will bear complete financial responsibility for this fee and it is payable at your next appointment. Three “no shows” may result in the termination of services.