THE CENTERTX
THE CENTER FOR CANCER AND BLOOD DISORDERS

NEW PATIENT REGISTRATION

APPOINTMENT DATE_____ **ACCT#**_____

PATIENT INFORMATION

LAST NAME_____ **FIRST NAME**_____ **MI**_____

DOB_____/_____/_____ **SS#**_____ **EMAIL**_____

ADDRESS_____ **CITY/STATE**_____ **ZIP**_____

CELL PHONE_____ **HOME PHONE**_____

CIRCLE:
MARITAL STATUS: Single / Married / Divorced / Widowed / Partner
LANGUAGE: English / Spanish / Other_____ **GENDER:** Male / Female
ETHNICITY/ RACE: Hispanic or Latino / White or Caucasian / Black or African American / Asian / Native Hawaiian / Pacific Islander / Other:_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ **ID#**_____ **GROUP#**_____

POLICY HOLDER NAME_____ **DOB**_____ **SS#**_____

EMPLOYER_____ **REFERRAL REQUIRED** Y / N

SECONDARY INSURANCE_____ **ID#**_____ **GROUP#**_____

POLICY HOLDER NAME_____ **DOB**_____ **SS#**_____

EMPLOYER **REFERRAL REQUIRED** Y / N

PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN_____ **PHONE#**_____

REFERRING PHYSICIAN_____ **PHONE#**_____

OTHER PROVIDERS INVOLVED IN YOUR CARE:

NAME_____ **SPECIALTY**_____ **PHONE#**_____

NAME_____ **SPECIALTY**_____ **PHONE#**_____

PHARMACY INFORMATION

PHARMACY NAME_____ **PHONE#**_____

ADDRESS_____ **CITY/STATE**_____ **ZIP**_____

EMERGENCY CONTACTS

NAME_____ **PHONE #**_____ **RELATIONSHIP**_____

NAME_____ **PHONE #**_____ **RELATIONSHIP**_____

Caring for You & Your Family The Center Way

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Consent to Treat

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services at The Center for Cancer and Blood Disorders (TCCBD) provided by physicians, employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such services may include diagnostic procedures (such as lab and x-rays), examinations, and treatment that may include chemotherapy and/or radiation therapy. This consent is valid for each visit I make to TCCBD unless revoked by me in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to TCCBD's infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of TCCBD if any of these situations occur during your treatment period.

I understand that no warranty or guarantee has been made to me as to result or cure. I certify that this form has been fully explained to me, that I have read it or had it read to me*, and that I understand its contents.

RELEASE OF INFORMATION: I authorize The Center for Cancer and Blood Disorders to disclose my health information for the purpose of continued care, claims processing or other related needs. I authorize The Center to obtain health records from other providers as needed for my continued care. Any other use of this information requires written consent.

PHOTOGRAPHY: I consent to photographs or other audiovisual recordings related to my health record ____ Yes_____No

ADVANCE DIRECTIVE: I have signed an Advance Directive._____YES____NO (Patient's Initials)
If yes, is it still in effect?_____YES____NO
I have provided a signed copy to TCCBD._____YES____NO

OUT of HOSPITAL DNR: I have signed an Out of Hospital DNR.____YES____NO (Patient's Initials)
I have provided a signed copy to TCCBD._____YES____NO

NEW PATIENT BOOKLET: I have received a copy of "The Center Welcome Booklet" to review at my convenience. _____(Please Initial)

Contact and use of cell phones and email: I have provided my contact information and give permission to use any and all emails and contact phone numbers, landline and cellular, for communication regarding my treatment and/or services rendered._____Yes____NO **Email Only**___Yes___No **Cell Only**___Yes___No
Type of message allowed – **Any**_____ **Appointment Information Only** _____

_____ _____ _____
Emergency Contact Relationship Phone Number

_____/_____
DATE TIME

_____ _____
Patient Signature /Other Legally Authorized Person Witness/Translator*

_____ _____
Print Name/ Relationship to Patient Print Witness Name and Translated Language

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Financial Responsibility Agreement

ACCT #_____ **DATE** _____

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare, Medicaid, patient assistance programs, or other third-party payer benefits for medical or health care services otherwise payable to me to The Center for Cancer and Blood Disorders. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company patient assistance programs, or other third- party payer, up to the total amount of my medical and health care charges, to The Center for Cancer and Blood Disorders.

I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requested by The Center for Cancer and Blood Disorders.

Copayments are due at time of service. However, I understand I may be responsible for additional coinsurance and/or deductibles as determined by my insurance company once they have paid my claim.

I understand that if I am not able to pay my balance in full, I am responsible for contacting The Center's billing office and/or financial counselors to discuss a payment schedule. If I fail to make payments as agreed upon, my account may be referred to a professional collection agency and/or attorney. I understand I will be responsible for all costs incurred, including attorney's fees and court costs if applicable.

In the event I submit payment by check and the bank returns the check unpaid for any reason, TCCBD will add $25 to my original balance.

I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct and that it is my responsibility to notify The Center of changes to my address, telephone number, primary care physician, or insurance carrier._____(Patient's Initials)

_____/_____
DATE TIME

_____ _____
Patient/Other Legally Authorized Person Witness/Translator*

_____ _____
Print Name and Relationship to Patient Print Witness Name and Translated Language

THE CENTERTX
THE CENTER FOR CANCER AND BLOOD DISORDERS

Patient Consent to Treatment by a Nurse Practitioner or Physician Assistant

At The Center for Cancer and Blood Disorders, we are proud to bring together a team of highly qualified professionals to provide you the best possible care. Nurse Practitioners and Physician Assistants, that have a great deal of training and experience in adult medicine and oncology, are part of that team. They work very closely with the physicians and communicate your needs. They are well qualified to manage patient care in the clinic or the hospital. The NPs and PAs allow us to increase our attention to your healthcare needs.

We have the utmost confidence in our Nurse Practitioners and Physician Assistants. However, you do have a right to request to see your physician personally and we will honor your request. Always be assured we are committed to providing you excellent care with compassion and respect.

The Center for Cancer and Blood Disorders physicians,

Prasanthi Ganesa,MD
Medical Director

I consent to be treated by a NP or PA. ___Yes ___No

_____ _____
Patient signature Date

THE CENTERTX
THE CENTER FOR CANCER AND BLOOD DISORDERS

ACCT#_____ **DATE:**_____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Patient Information:
Full Name: _____
Other Name(s) Used:_____Date of Birth: _____
Address:_____City:_____State:_____Zip Code:_____
Phone: (_____)_____Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:
The Center for Cancer and Blood Disorders
800 W. Magnolia Ave. Fort Worth, TX 76104 Phone: 817-759-7000 Fax: 817-759-7007

Who do you give permission to receive this information (i.e. family members or close friends): Name:_____
_____ Address:_____City:_____State:_____Zip Code:_____
Phone: (____)_____Fax: (_____)_____

Who do you give permission to receive this information (i.e. family members or close friends): Name:_____
_____ Address:_____City:_____State:_____Zip Code:_____
Phone: (____)_____Fax: (_____)_____

Who do you give permission to receive this information (i.e. family members or close friends): Name:_____
_____ Address:_____City:_____State:_____Zip Code:_____
Phone: (____)_____Fax: (_____)_____

Specific information to be disclosed:	**Include: (*Indicate by Initialing*)**
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers. □ Other: _____	_____ Drug, Alcohol or Substance Abuse Records _____ Mental Health Records (Except Psychotherapy Notes) _____HIV/AIDS-Related Information (Including HIV/AIDS Test Results) _____Genetic Information (Including Genetic Test Results)

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The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day:_____Year:_____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:
Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional):_____ Date: _____

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Notice of Privacy Protection

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

By signing below, you acknowledge that you have received the *Notice of Patient Bill of Rights and Responsibilities* and that you understand your rights and responsibilities as a patient with this practice.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative:_____Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) :_____Date:_____

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THE CENTER FOR CANCER AND BLOOD DISORDERS

Medical Records Release

I hereby authorize the release of my records to:

The Center for Cancer and Blood Disorders
800 W. Magnolia Ave
Fort Worth, TX 76104
Telephone number: 817-759-7000 Fax No. 817-333-0162

The following information from the medical/billing record of:

Patient Name:_____

Address:_____

_____

Date of Birth:_____ SS#:_____

Purpose for the records:

☐ Patient Request ☐ Treatment/Follow-up ☐ Billing/Claims ☐ Attorney ☐ Social Security ☐ Other

Type of medical /billing record information:

_____History and Physical

_____Consultation Notes
_____Lab Reports
_____Operative Reports
_____X-ray reports and/or films when available
_____Progress Notes
_____EKG Reports

_____Pathology Reports

_____Billing Records
_____All records
_____Radiation and Dosimetry
_____Other _____

Substance Use/Abuse treatment, Psychiatric, Genetic Testing, and/or HIV/AIDS Records Release

Federal and State Law requires specific authorization from patients to release sensitive information. I understand that if my medical or billing records contains information in reference to drug tobacco and/or alcohol use/abuse, psychiatric care, genetic testing, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and/or other sensitive information, I must specifically agree to its release by checking the appropriate blank. (TX HB300)

Psychotherapy Notes_____ Yes, disclose_____Do Not
HIV/AIDS testing results_____Yes, disclose_____Do Not
Substance Use/Abuse information_____Yes, disclose_____Do Not
Genetic Testing results_____ Yes, disclose_____Do Not

I understand that this authorization will be valid for 180 days from the date signed to release any records created up to the date of signature unless revoked prior to that time or unless otherwise specified. Any records created after the date of this authorization will require a new authorization. I desire this authorization to be in effect until_____(expiration date/event). Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address. I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

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

_____
Authority to sign if not the patient (Documentation may be required)

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Print Name: **Birth Date:** **Phone:**

Hereditary Cancer Risk Assessment

Most cancer happens by chance and is not passed down generation to generation. However, in 5-10% of patients the cancer may be due to specific genetic factors. Identifying hereditary cancer can be helpful in the clinical management of your disease or to know if you are at higher cancer risk. It is also important for your family members. Learning more about your family history is the first step. Please complete the following cancer family history information.

If you have/had cancer:
Type of Cancer_____ Age at Diagnosis_____

Please tell us your family history of cancer

Is your mother living? No Yes
Did your mother have cancer? No Yes Type? _____ Age_____

Is your father living? No Yes
Did your father have cancer? No Yes Type? _____ Age____

Do you have children? No Yes If yes, # girls_____ # boys_____
Have any of your children been diagnosed with cancer?
No Yes Type? _____ Age____

Do you have sisters and brothers? No Yes If yes, # of sisters____# brothers_____
Have any of them been diagnosed with cancer?
No Yes Type? _____ Age_____
Type? _____ Age_____

Do any of your grandparents have/had cancer?
Maternal Grandmother No Yes If yes, Type_____ Age_____
Maternal Grandfather No Yes If yes, Type_____ Age_____

Paternal Grandmother No Yes If yes, Type_____ Age_____
Paternal Grandfather No Yes If yes, Type_____ Age_____

How many brother and sisters does **your father** have/had?
Brothers_____
Sisters_____
Did any of them have cancer? No Yes If yes, Type_____ Age_____

How many brothers and sisters does **your mother** have/had?
Brothers_____
Sisters_____

Did any of them have cancer? No Yes If yes, Type_____ Age_____

Any other family members with cancer_____

Are you of Jewish Ancestry? No Yes Uncertain

(Patients of Jewish Ancestry have an increased risk for hereditary breast cancer.)

Patient's Signature_____ Date_____